

Mental Wellbeing Needs Assessment for Oxfordshire



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Please note: this is a temporary document and will soon be replaced with a final version along with an interactive summary of findings

Executive Summary

Positive mental health and wellbeing are vital for building population good health. Our social circumstances, environment where we live, learn, work and play, economic factors, physical and mental health can all support good mental wellbeing. Our mental wellbeing enables us to get the most from life and feel connected to friends, family and neighbours, fulfil our potential, contribute to communities and to adopt healthy lifestyles. Conversely, poor mental health and serious mental illness can be a significant burden to individuals, families and communities, affecting the quality of lives lived and leading to preventable early deaths: people with severe mental illness are 3.7 times more likely to die early than the general population.

The COVID-19 pandemic has highlighted the importance of mental wellbeing both now and for the future. It has created many different challenges for mental wellbeing and has shone a light on health inequalities. However, in time there is hopefully the opportunity to build back fairer. In this context, improving mental wellbeing and working to reduce inequalities in this area are essential not only for mental health: they can underpin improvements across all aspects of public health, given the link to many chronic health conditions.

This report focuses on mental wellbeing – that is keeping people well and primary prevention - at the community level. It is not a needs assessment for mental health or mental illness, their associated services and care pathways. It aims to give a broad picture of mental wellbeing across Oxfordshire and the life course, and makes recommendations around steps to improve our understanding of and opportunities to improve mental wellbeing within our communities.

What is mental wellbeing like across Oxfordshire?

Oxfordshire has relatively high levels of a number of indicators for mental wellbeing – such as happiness, life fulfilment and satisfaction. As a county, however, even before the COVID-19 pandemic, around 1 in 5 Oxfordshire residents reported high anxiety scores in ONS surveys.

Similarly, data on many of the wider determinants of wellbeing (enablers to good mental wellbeing, such as physical exercise, access to green and natural spaces, financial security, connections to people and place) show Oxfordshire compares well to many other regions in the UK.

However, a county wide snapshot only tells part of the picture: across Oxfordshire and nationally the incidence of depression has been increasing year on year since 2012, highlighting the need for promotion of mental wellbeing and primary prevention. In 2019-2020, there were 73,648 patients

(aged 18 or over) with a diagnosis of depression registered by Oxfordshire's GP practices – equivalent to around 12% of registered patients.

Average levels of mental wellbeing and enablers hide inequalities across different communities and across protected characteristics, and for many potential areas of inequality, we lack data to identify local problems, monitor and track progress leading to groups with hidden mental wellbeing needs.

We know through national and local data that so far, the COVID-19 pandemic has affected mental wellbeing through a number of direct and indirect pathways and that the effects have not been felt equally through our population.

What is currently working well for mental wellbeing?

There is much across Oxfordshire which is positive, in addition to the overall relatively high levels of mental wellbeing. There is a strong history of partnership working, and links between statutory and third sectors – this is vital within such a far-reaching issue as mental health and wellbeing. For example, Oxfordshire has committed to the Prevention Concordat for Better Mental Health programme, hosted by Oxfordshire County Council's, bringing together more than 20 partner organisations committed to improving and promoting mental health and wellbeing. The Oxfordshire Mental Health Partnership brings together six local mental health organisations from the NHS and the charity sector. There are many excellent projects working with diverse communities and in different settings to improve well-being through different pathways. There has been a strong uptake of initiatives such as social prescribing, connecting people with mental wellbeing needs to different services and a number of positive (place based) initiatives to improve health with mental wellbeing as a core component.

There are local and specific initiatives which have helped understand mental wellbeing in certain groups, such as the OxWell schools survey and the Healthwatch reports for example into wellbeing in Oxford's new and emerging communities.

COVID-19 and its associated control measures have negatively impacted on the mental wellbeing and health of so many. However there have been a number of innovative projects across Oxfordshire and between multiple partners, which have sought to support mental wellbeing across a number of settings. For example, the bringing together community hubs offering holistic support to residents and the rapid transformation of many services to support people online, when face to face interactions have been limited.

Building on these aspects of systems and partnership working, alongside strong initiatives in healthy place shaping will be vital to improving mental wellbeing, especially as we cope with and recover from COVID-19.

Where are the opportunities to improve wellbeing and the gaps in knowledge?

This report has brought together a wide range of knowledge – from quantitative and qualitative existing data and reports, and views of stakeholders - to understand local needs and opportunities to improve mental wellbeing and reducing inequalities.

Understanding data around community enablers to mental wellbeing – such as access to nature and greenspace, reducing loneliness and isolation, promoting physical activity – show the need to work across these and with diverse through the life course to improve mental wellbeing locally. Through the diversity of contributors and barriers to wellbeing, it is clear that taking a systems approach to wellbeing and making it “everyone’s business” (wellbeing in all policies) is vital.

This report has highlighted the wide range of people and sources of support that residents turn to for help with mental wellbeing. This brings an opportunity to work with different partners and across settings to increase our mental wellbeing communication and provision of support, to make resources available to people before they access formal healthcare.

The need for inclusive language and reduced stigma around wellbeing and some of its enablers – such as loneliness – is clear. The report makes clear the need to re-frame important factors, such as loneliness and isolation, as issues to be addressed throughout the life course (children and young people are at high risk of loneliness) and gives recommendations to better understand these issues at a local level to inform future action.

Lastly, collating data with input from stakeholders and service providers has provided insight into communities who have less access to and access services less. Many of these communities also face a number of specific challenges around wellbeing. For example, residents from our diverse and emerging communities, people who identify as LGBTQ+, younger adults and those who have had reduced access through the pandemic (and who may be digitally excluded where services have been online).

This report highlights a number of gaps in our understanding of mental wellbeing in our communities. First, there are areas where we lack of quantitative data e.g. local level data on mental wellbeing within groups who may need more support – those living with disabilities, LGBTQ communities, data on specific enablers to wellbeing – e.g. sleep, creativity. We also lack data on mental wellbeing from a life course perspective – for example collated measures of peri-natal

wellbeing, mental wellbeing in young adults at transition points and data that would better enable support to age well. Second, whilst there have been extremely valuable reports and insights into specific communities perspectives, we lack in depth understanding on a number of issues such as lived experience of loneliness. Using novel methods and participatory approaches to better understand wellbeing and needs amongst residents is important. Third, due to the broad nature of mental wellbeing, the diversity of settings, organisations and structures through which it can be supported and rapid shifts in support in the context of COVID-19, it has not been possible to map all services – this will need to be done at the local level, to determine where specific gaps in provision are to support healthy place shaping or support for specific communities or in specific settings (e.g. in schools). Fourth, some joining up of existing data – for example on social prescribing (which is currently provided by a number of different organisations and through different settings) is important to understand some gaps in specific service provision.

Recommendations

The last section of this report makes some recommendations, based on the data collated and the gaps in understanding. Overall, the importance of being able to take a whole system and life course approach to mental wellbeing is emphasised. Recommendations are grouped under five different themes: data and monitoring; wellbeing in all policies and partnership working; inclusive services and reducing inequalities; focusing on areas with increased need; and building back from COVID-19.

Acknowledgments

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Contents

Executive Summary	1
Acknowledgments	5
1 Introduction	11
1.1 Background	11
1.2 Definitions and measuring mental wellbeing	11
1.3 Why undertake a mental wellbeing needs assessment?	13
1.4 Aims and Objectives of this Mental Wellbeing Needs Assessment	14
1.5 Structure of the Needs Assessment	16
1.6 Methods	17
1.7 Data Sources	17
1.8 Local context and links to strategic priorities	21
1.8.1 The population of Oxfordshire	21
1.8.2 Local Context of mental wellbeing	25
1.8.3 The Importance of mental wellbeing in relation to national, local strategies and priorities	27
1.9 The context of the COVID-19 pandemic	29
2 Adult mental wellbeing and mental health	31
Summary of adult mental wellbeing	31
Summary of the impact of COVID-19 on adult mental wellbeing	32
2.1 National data on mental health	33
2.2 Mental health in Oxfordshire in figures: CCG, county and district level	34
2.2.1 Oxfordshire CCG	34
2.2.2 Prescription of anti-depressants (Oxfordshire CCG)	35
2.2.3 Oxfordshire (County): Prevalence of common mental illness at county and district level	36
.....	38
2.3 Levels of Mental Wellbeing: Nationally and in Oxfordshire	38
2.3.1 National Mental Wellbeing	39
2.3.2 Oxfordshire Mental Wellbeing	39
2.3.3 ONS trends in mental wellbeing scores by district	43
2.3.4 Understanding inequalities in mental wellbeing	47
2.4 Qualitative data and mental wellbeing: felt and expressed need	50
2.5 The impacts of COVID-19 on adult mental wellbeing	51
2.5.1 Direct impact of COVID-19 and pandemic control measures on mental wellbeing	51

2.5.2	Impacts of COVID-19 across Oxfordshire	54
2.5.3	The impact of COVID-19 on local populations: input from Concordat members on felt and normative need.....	54
2.6	Partnership working for mental wellbeing	56
2.7	Making Every Contact Count (MECC).....	57
2.8	Social prescribing	57
2.8.1	Background to social prescribing	57
2.8.2	Social Prescribing in Oxfordshire	58
3	Mental Wellbeing in Children and Young People	60
	Section Summary	60
3.1	Quantitative data from national sources On Mental Health for England, South East and Oxfordshire	62
3.1.1	Mental Health Indicators	62
3.1.2	Referrals of Oxfordshire patients to Oxford Health for mental health services.....	63
3.2	Children and Young people’s Mental Wellbeing	64
3.3	The impact of COVID-19 on Children and Young people’s Mental Wellbeing.....	67
3.3.1	National data.....	67
3.3.2	Data from Oxfordshire and the South East on COVID-19 impact	68
3.3.3	OxWell Survey	68
3.3.4	Felt and normative need in 0-5s: the Healthwatch Oxfordshire Report	70
4	The wider determinants of mental wellbeing	73
5	Finances, Employment and debt	74
	Section summary	74
5.1	Background/ context – links between employment, finances and mental wellbeing	75
5.2	National level Data on finances, employment and inequalities	76
5.3	Local data	77
5.4	The impact of COVID-19.....	78
5.5	Children and Young People	80
5.6	Research with local communities	80
6	Physical Activity and mental wellbeing.....	82
	Section Summary	82
6.1	Background context: Effects of physical activity on mental wellbeing.....	83
6.1.1	Definitions of physical activity/national recommendations	84
6.2	National Strategies.....	84
6.3	Local Strategies	84
6.4	National Data	85

6.5	Local Data for Oxfordshire	86
6.5.1	Local Data from the Active Lives survey: pre-pandemic.....	86
6.5.2	Activity by mapped local geography	87
6.6	Inequalities and physical activity	88
6.7	Physical Activity in Children and Young People	90
6.8	Inequalities in physical activity in children and young people	91
6.9	The effects of COVID-19 on physical activity	91
6.9.1	Impacts of COVID-19 on physical activity in on adults	91
6.9.2	Impacts of COVID-19 on physical activity in children and young people	93
6.10	Active travel	94
7	Green Space and The Natural Environment	95
	Section Summary	95
7.1	Importance of green and natural environments for mental wellbeing.....	96
7.2	Economic benefits of green and natural environments	97
7.3	Linked Strategies and frameworks.....	97
7.4	National Level Data on green and natural spaces	98
7.5	Local Level Data on green and natural spaces	99
7.5.1	Oxfordshire Land Use Data	99
7.5.2	MENE data for Oxfordshire.....	100
7.6	Green environments and health inequities	100
7.7	Green and Natural Spaces: Children and Young People	101
7.8	Effects of COVID-19 on use of green and natural spaces	102
8	Connections to others and to place	103
	Section Summary	103
8.1	The importance of social connection to wellbeing and how we describe it	104
8.2	How is loneliness measured?.....	104
8.3	Key National and Local Strategies on loneliness and social connectivity	104
8.4	The importance of a life course approach and understanding key times of vulnerability .	105
8.5	Loneliness: Summary of national Level Data and surveys	105
8.5.1	Loneliness in the adult population.....	105
8.5.2	Oxfordshire Data: older adults.....	107
8.6	Oxfordshire Social Isolation	109
8.7	Connection to place : the Community Needs Index (Civic assets, connectedness and active and engaged community)	109
8.8	Loneliness and Social Isolation in Children and Young People	110
8.9	The impact of COVID-19 on our social connections	111

9	Recommendations	114
9.1	Taking a systems approach to mental wellbeing	114
9.2	Data: surveillance and evaluation and community insights - improving our understanding of mental wellbeing in our communities	118
9.3	Wellbeing in all policies approach and partnership working.....	120
9.4	Inclusive language, services and reducing inequalities	121
9.5	Focusing on areas of most need	123
9.6	Taking forward lessons learnt and building back fairer from COVID-19	124

1 Introduction

1.1 Background

Mental wellbeing and positive mental health are vital for building and maintaining population good health, enabling populations and individuals to fulfil their potential, contribute to their community and to adopt healthy lifestyles.

The COVID-19 pandemic has highlighted the importance on mental wellbeing both currently and going forward, with the potential for ongoing mental health impacts on our societies. It has shone a light on structural inequalities and their contribution to public health^{1 2}. In this context, improving mental wellbeing can be considered not only as a public health goal in its own right, but an essential underpinning of public health ambition given the link between mental health, many chronic health conditions and health inequalities.

1.2 Definitions and measuring mental wellbeing

Mental illness, mental health and mental wellbeing are interdependent. There is a great deal of overlap between definitions of positive mental health and mental wellbeing and some discussion as to whether they exist on a continuum. Everyone has mental health, just as all have physical health and it is generally agreed that good mental wellbeing is necessary for good mental health. Looking after mental wellbeing in a holistic manner, considering structural elements of the wider determinants of mental wellbeing, can be viewed pro-active approach to primary prevention – that is to say, it's about keeping people well.

The language we use around mental health and our perceptions of it, are also related to our cultures and individual ideas and beliefs^{3 4}. We all relate to mental wellbeing differently, for some it is about how we're coping with life; but it doesn't mean you're always happy or unaffected by your experience. It is also about how we are feeling – for example, feeling stressed or anxious, that things are worthwhile or feeling satisfied with life. Specifically, individuals can both have both a diagnosed mental illness and good mental wellbeing (figure 1 below). Mental wellbeing has been defined in the Oxfordshire Prevention Framework as “..how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole”⁵.

Box 1 summarises definitions mental health and wellbeing as used in this report.

¹ COVID-19: review of disparities in risks and outcomes - GOV.UK (www.gov.uk)

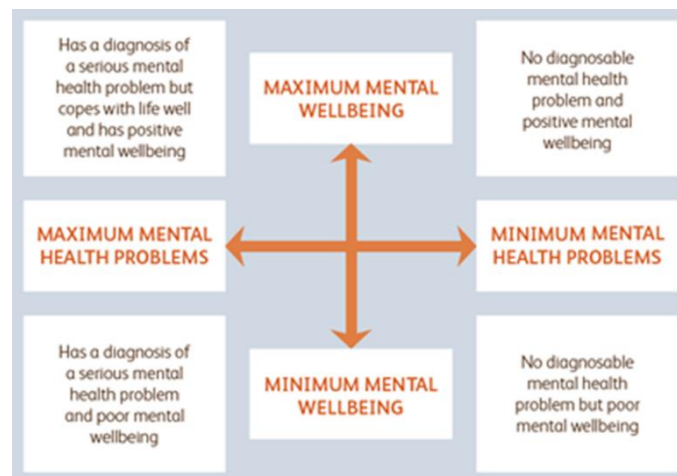
² COVID-19: understanding the impact on BAME communities - GOV.UK (www.gov.uk)

³ <https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/about-mental-health-problems/>

⁴ <https://whatworkswellbeing.org/about-wellbeing/what-is-wellbeing/>

⁵ [OxfordshirePreventionFramework](#)

Figure 1: relationship between mental health and wellbeing



Definitions of mental health and mental wellbeing

The World Health Organisation (WHO) characterise mental health disorders/problems as:

“a broad range of problems, with different symptoms. They are generally characterized, however, by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia. Many of these disorders can be successfully treated.” (The world health report 2001 - Mental Health: New Understanding, New Hope, page 10, ISBN 92 4 156201 3, WHO)

By contrast, the WHO definition of mental health is:

“a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014)

In addition to the absence of mental ill health, positive mental health encompasses the ability to learn, cope with challenges, maintain relationships and be empowered to contribute to society.

The term mental wellbeing is used frequently both in policy and in the literature and definitions have much in common with that of positive mental health. Mental wellbeing captures psychological needs and ability to experience positive emotions and also to cope with negative emotions, connectedness (to place and others or community), resilience and fulfilment. The Oxfordshire Prevention Framework defines mental wellbeing as

“..how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole”

In reality, the term mental wellbeing captures getting the most from life; feeling connected to friends, family and neighbours and leading a healthy and happy life. We all relate to mental wellbeing differently, for some it is about how we're coping with life; but it doesn't mean you're always happy or unaffected by your experience. It is also about how we are feeling – for example, feeling stressed or anxious, that things are worthwhile or feeling satisfied with life.

Box 1: definitions of mental wellbeing and mental health

1.3 Why undertake a mental wellbeing needs assessment?

Improving population mental wellbeing is a public health goal in its own right (see section 2.1 above). In addition, the overlap between the components of mental wellbeing and mental health (e.g., the psychological dimensions – anxiety, happiness) and their enablers and barriers, means that acting at primary prevention level should improve mental health and physical health more broadly.

Poor mental health can be a significant burden to individuals, families and communities, affecting the quality of lives lived and leading to preventable early deaths. Approximately 1 in 6 adults have a mental health disorder at any one time⁶ and in England severe mental illness (SMI), affects around half a million adults (based on GP register data)⁷. Those with a SMI have an increased risk of premature mortality, with those under 75 in contact with secondary mental health services having a 3.7 times higher mortality rate than the general population⁸. In England, poor mental health is estimated to cost the economy and society around £105 billion a year⁹ and mental illness along with substance and alcohol misuse accounts for 21.3% of the total burden of disease.¹⁰

There are known links between social inequalities and mental wellbeing and health, for example those in contact with secondary mental health services have employment rates which are over 67% lower than the general population¹¹ and many protective and enabling factors for mental wellbeing are less available to those already living in deprived areas. Failing to address inequalities in mental wellbeing can undermine other public health interventions to reduce inequalities in other public health and social policies.

1.4 Aims and Objectives of this Mental Wellbeing Needs Assessment

The overall aim of this mental wellbeing needs assessment is to give a broad overview of mental wellbeing needs in Oxfordshire, from early years onwards through the life course. Simply put, it aims to provide an overview of what it's like to live in Oxfordshire from a mental wellbeing perspective, to identify gaps in knowledge and to make recommendations based upon our findings.

Specifically this is not a mental health needs assessment (see the 2018 mental health needs assessment for Oxfordshire¹²). The focus is on primary prevention rather than the met and unmet needs in services for mental health and specific mental health diagnoses. Where possible, it covers the types of need identified by Bradshaw (figure 2): epidemiological, comparative needs and felt needs (through the views of communities, residents and stakeholders).

This needs assessment has been conducted during the COVID-19 pandemic, and although it is not designed to specifically assess the acute and ongoing impact of COVID-19 on mental wellbeing, where possible we include data and evidence on this.

⁶ [Wellbeing and mental health: Applying All Our Health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/wellbeing-in-mental-health-applying-all-our-health/wellbeing-in-mental-health-applying-all-our-health#fn:3)

⁷ PHE fingertips

⁸ <https://www.gov.uk/government/publications/wellbeing-in-mental-health-applying-all-our-health/wellbeing-in-mental-health-applying-all-our-health#fn:3>

⁹ [The economic and social costs of mental health problems in 2009/10](#)

¹⁰ 2018: [Health profile for England: 2018](#)

¹¹ PHE: inequalities and mental health

¹² [Mental Health JSNA February 2018 | Oxfordshire Insight](#)

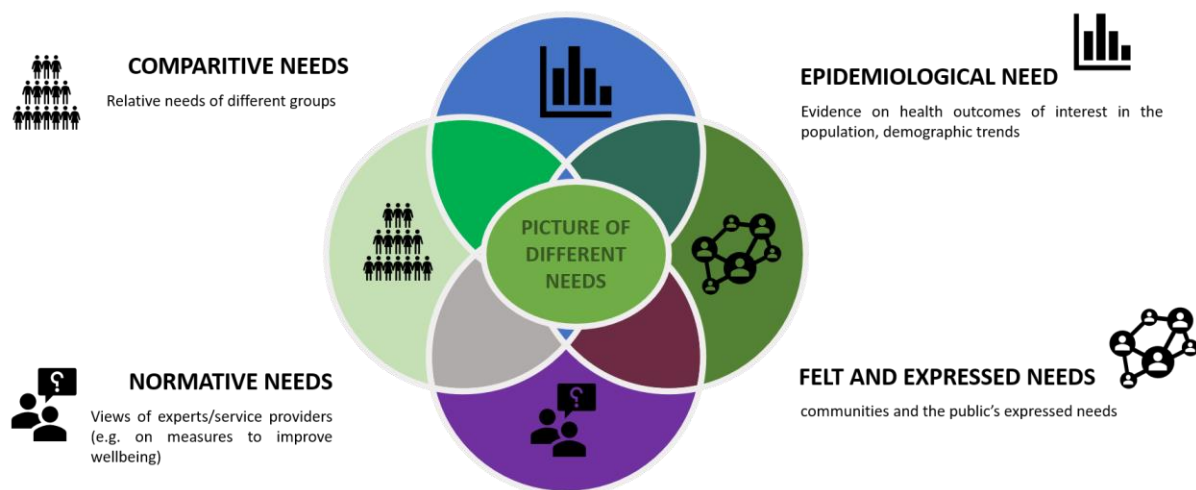


Figure 2: types of need considered

The specific objectives of this needs assessment are:

1. To understand levels of mental wellbeing across Oxfordshire and districts/ city authorities (Lower Tier Local Authorities - LTLA) and specifically answer the following questions:
 - a. How has mental health and wellbeing changed over time (epidemiological need)
 - b. How does mental wellbeing in Oxfordshire compare to nationally and the South East? (comparative need)
2. Undertake scoping of the literature to understand wider determinants of wellbeing that can be addressed through public health and systems working. Specifically, to:
 - a. Identify wider and community-based determinants (barriers to/enablers) of mental wellbeing and the evidence of how these affect mental wellbeing (epidemiological need)
3. Present data on key determinants of wellbeing identified in step 2 above, for example: economic determinants (deprivation, financial stability, employment), connection to community and others (including loneliness and isolation), physical activity, access and use of natural and greenspace (epidemiological need).
4. Collate data on the impacts of COVID-19 on mental wellbeing (epidemiological and felt need)
5. Within each of objectives 1-4, include evidence on inequalities (comparative need across different groups) where the data allows, and undertake a mapping exercise to understand how these can interact for measures of wellbeing
6. Identify areas where there are key gaps in knowledge and data around mental wellbeing and its determinants for Oxfordshire
7. Make recommendations to improve mental wellbeing and for areas of further work need to our understanding of specific needs within Oxfordshire

1.4.1 Areas this needs assessment does not cover

This needs assessment is specifically not:

1. A mental health needs assessment. This was undertaken for Oxfordshire in 2018¹³.
2. Solely a COVID-19 impact assessment. Where possible, however, potential impacts of COVID-19 are considered and the context has also influenced the data collected and available.
3. Designed to duplicate information from the JSNA: although mental wellbeing is affected by a number of diverse factors, those enabling or risk factors which have been well documented as part of the JSNA are not replicated at length
4. Designed to consider behavioural factors, such as drug and harmful alcohol use, as these have been specifically been covered elsewhere and many have their own specific needs assessment and strategies. This needs assessment takes a community and wider - determinants (socio-economic, environmental) focus. A separate needs assessment relating to domestic abuse is also currently being undertaken.
5. An assessment of community assets: the range of assets, services and third sector projects across Oxfordshire that contribute to wellbeing are extensive, in many cases hyper-local and constantly evolving - especially over the last year, meaning that undertaking this for the whole of Oxfordshire is outside the scope of this work and would soon be outdated.

1.5 Structure of the Needs Assessment

This report is divided into a number of sections. Throughout the report where possible, attention is paid to improvement of inequities and where gaps in knowledge and data exist these are highlighted for potential further work.

1. **Context and setting the scene:** This section gives a brief overview of the national and local context within which this needs assessment takes place, and how this work relates to the COVID-19 pandemic.
2. **Mental wellbeing across Oxfordshire and the impact of COVID-19:** The next section outlines the context, and gives a broad overview of the population and demographics of Oxfordshire. It then brings together data on:
 - mental wellbeing and some background data on common mental illness, to give a broad picture of mental wellbeing and the need for primary prevention across Oxfordshire. Where possible, this is undertaken for children and young people and adults - working age adults and for older people (where data allows)
 - for each of these age groups, it also highlights the main impacts known to date of COVID-19 on mental wellbeing (with the recognition that the evidence on this is constantly evolving)
3. **Wider determinants of mental wellbeing:** The third section examines levels of need across different barriers and enablers to wellbeing, predominantly based on wider and community-based determinants to mental wellbeing. It includes evidence that links each of these barriers and enablers to wellbeing and data on inequalities.
4. **Recommendations:** The last section comprises recommendations for specific areas of further work and for improvement of wellbeing, based on the previous sections.

13

<https://insight.oxfordshire.gov.uk/cms/system/files/documents/Mental%20Health%20JSNA%202018%20Feb18.pdf>

1.6 Methods

The assessment takes a lifecourse approach where possible and includes data from the whole population for both levels of mental wellbeing and on the wider determinants of mental wellbeing (enablers and barriers to mental wellbeing across the life course). Where possible, data has been collated and presented for the county, at a district level and where possible with a focus on improving inequities/on vulnerable population groups.

Many different sources of data have been used to inform this needs assessment. Importantly it has been an iterative process, with involvement from relevant stakeholders many stages.

The dynamic and subjective nature of mental wellbeing, and the fact that in many reports and studies it is defined differently, means that in reports, studies and surveys it is not measured/reported consistently. Given its broad definition, practical measurements of wellbeing can be difficult. Two are commonly referred to in this needs assessment – the Warwick-Edinburgh Mental Wellbeing Score (WEMWBS) and the “ONS4” measure of wellbeing. The Warwick-Edinburgh Mental Wellbeing Score is a well validated tool/scale for studying wellbeing¹⁴. The Office of National Statistics (ONS)¹⁵, reports four summary measures on four components of mental wellbeing - an individual's feelings of satisfaction with life, whether they feel the things they do in their life are worthwhile and their positive and negative emotions. Of note, there is some debate, around whether measures of positive mental wellbeing have been well validated in certain populations (e.g., those receiving treatment for mental illness)¹⁶.

1.7 Data Sources

1.7.1.1 Routine Data

This needs assessment has made use of a number of routine data sources, for example:

- Data from the Office of National Statistics (ONS)
- Data from PHE fingertips (collated from a variety of services)
- Oxfordshire prescribing data (NHS digital)
- Data from local insights (further details within chapters)

1.7.1.2 Survey Data

We have made use of a number of published surveys, at a national and local level, to inform specific areas of the needs assessment.

These include many sources, for example:

- Surveys and qualitative data from Healthwatch
- Surveys from active Oxfordshire and Sport UK

¹⁴ <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs>

¹⁵

<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuresofnationalwellbeingdashboard/2018-04-25>

¹⁶ https://www.cambridge.org/core/services/aop-cambridge-core/content/view/A6153999C5221E8BD1C2180D7270B6B4/S0007125000239056a.pdf/mental_wellbeing_an_important_outcome_for_mental_health_services.pdf

- The OxWell Schools Mental Wellbeing survey

For each data source, there are of course caveats and limitations. Some examples of these are outlined in the table 1 below. Specific limitations, where important to the interpretation of data are included within the text or as footnotes.

Table 1: Examples of data sources used in this needs assessment

Data Type	Examples of data source	Examples of strengths & limitations
Quantitative data on wellbeing and mental health (for background/context)	<ul style="list-style-type: none"> For adults: ONS data on wellbeing (e.g. from the APS – annual data and from monthly ONS data during the pandemic) For children and young people (CYP) – data from OxWell school survey, wellbeing measured using WEMWBS Mental health data sources: PHE fingertips (bringing together numerous sources – QOF data, NHS digital etc) and local prescribing, IAPT& service use data (e.g. some from providers) 	<ul style="list-style-type: none"> E.g. for Annual Population Survey (APS): annual data available for time trends and at LTLA . However not comparable across areas due to small numbers and those living in communal establishments (e.g. care homes)/other non-household situations are not represented OxWell school survey – tailored and bespoke survey for school pupils, high uptake. However, differences in administration and gender balance between 2019 and 2020 responses mean that further work is needed to be able to compare results between years Use of WEMWBS score in CYP (compared to the ONS4 measure in adults), means no continuous wellbeing measurement across life course available Data often not available for key life events or life stages (e.g. just by age bands, or often all “over 65” are included together)
Quantitative data on wider determinants of mental wellbeing	<ul style="list-style-type: none"> Physical activity: active lives survey (results for Oxfordshire), active travel survey Economic determinants: multiple sources (e.g. claimant data, data on deprivation indices) Social connections: ONS data (CLS), loneliness heat maps, OxWell school survey, community assets index Green and natural spaces: Natural England Survey 	<ul style="list-style-type: none"> Active lives survey - repeated, representative survey but much inequality data not available for small areas Data on inequalities across gender, ethnicity, not available at smaller scale, data on informal employment Loneliness data – only available at county level, life course aspects in adult population determined from England level data
Qualitative and community data	Healthwatch reports for Oxfordshire	Reports reflect and importantly often co-produced with community views, but only cover some aspects of wellbeing and understandably only in select communities
Concordat member and service provider input	Discussions with Concordat members, service providers	
Connections between wider determinants and mental wellbeing, and on potential community based interventions	<ul style="list-style-type: none"> Academic literature: e.g. systematic reviews, academic papers <p>Policy literature: Grey literature (government, third sector reports)</p>	<ul style="list-style-type: none"> Given emerging area of mental wellbeing, much of the literature on interventions includes low/medium quality studies <p>Given breadth of needs assessment, only broad overviews of literature possible</p>

1.8 Local context and links to strategic priorities

1.8.1 The population of Oxfordshire

Recent population estimates for Oxfordshire are available as part of the [JSNA](#)¹⁷, and use ONS mid-year population estimates. The figures here were latest available at start of June 21 and are based on ONS mid-2019 population statistics. Estimates¹⁸ are updated regularly through the [Oxfordshire insight](#) population webpages¹⁹. These sites also contain further mapping of Oxfordshire's populations by different characteristics. The 2021 Census will provide more up to date information for population estimates and by different characteristics going forward (figures not yet released).

Oxfordshire is the most rural county in the South East region. However, the majority (60%) of Oxfordshire's population are resident in Oxford City and the county's main towns.

The table below, from the JSNA gives a broad overview of key groups of Oxfordshire's population.

Population group	Count	Source	Population group	Count	Source
Total population	691,667	ONS mid-2019	Married households	128,400	ONS Census 2011
Aged 0-15	131,373	ONS mid-2019	Households in registered same-sex civil partnership	682	ONS Census 2011
Aged 16-64	432,168	ONS mid-2019	Live births	7,287	ONS 2019
Aged 65+	128,120	ONS mid-2019	Ethnic minority (non white British)	107,000	ONS Census 2011
Full time students (Oxford Uni, Oxford Brookes)	32,930	HESA 2018-19	Born outside UK	92,500	ONS Census 2011
Part time students (Oxford Uni, Oxford Brookes)	9,125	HESA 2018-19	Gypsy or Irish Traveller	623	ONS Census 2011
Estimated people with a disability	131,400	FRS 2018-19 and ONS pop	With a religion	422,576	ONS Census 2011
Claiming Personal Independent Payments	14,146	May 2020, DWP	Estimated Lesbian, Gay or Bisexual	12,887	ONS UK 2018
Claiming Attendance Allowance (over state pension age)	12,622	May 2020, DWP	Carers registered with GP practices	18,682	OCCG 30-Sept-20
Adults with Learning Difficulties supported by Adult Social Care	1,672	Oxfordshire County Council 1Apr 20	Adult carers receiving health and social care support	4,540	NHS Digital 2019-20
Pupils with Learning Difficulties in state primary, secondary and special schools	6,391	DfE January 2020	Young carers receiving support	323	Oxfordshire County Council (Dec 2020)
Pupils with Autism in state primary, secondary and special schools	1,938	DfE January 2020	Regular armed forces	9,360	MoD 1-Apr-20
			Residents in receipt of an Armed Forces pension, War pension and Armed Forces compensation scheme	6,623	MoD 31-Mar-20

Table 2: Oxfordshire's population in numbers. Source: [Oxfordshire JSNA 2021](#)

Of note, the official Oxfordshire Clinical Commissioning Group (OCCG) area is slightly smaller than the Oxfordshire county area. However, the patient count remains above the estimated population and the gap has increased. As of mid-2019, the count of OCCG registered patients was 773,400 compared with an ONS estimate of Oxfordshire's population (county) of 691,700. Within the OCCG boundary area the ONS estimate of the resident population was 13% below the number of registered patients (mid-2019). The difference is greatest in the age group 18 to 24. Maps of these areas can be found within the JSNA.

¹⁷ [Oxfordshire JSNA 2021](#)

¹⁸ [Nomis - Official Labour Market Statistics \(nomisweb.co.uk\)](#)

¹⁹ [Population | Oxfordshire Insight](#)

Oxfordshire and its Population

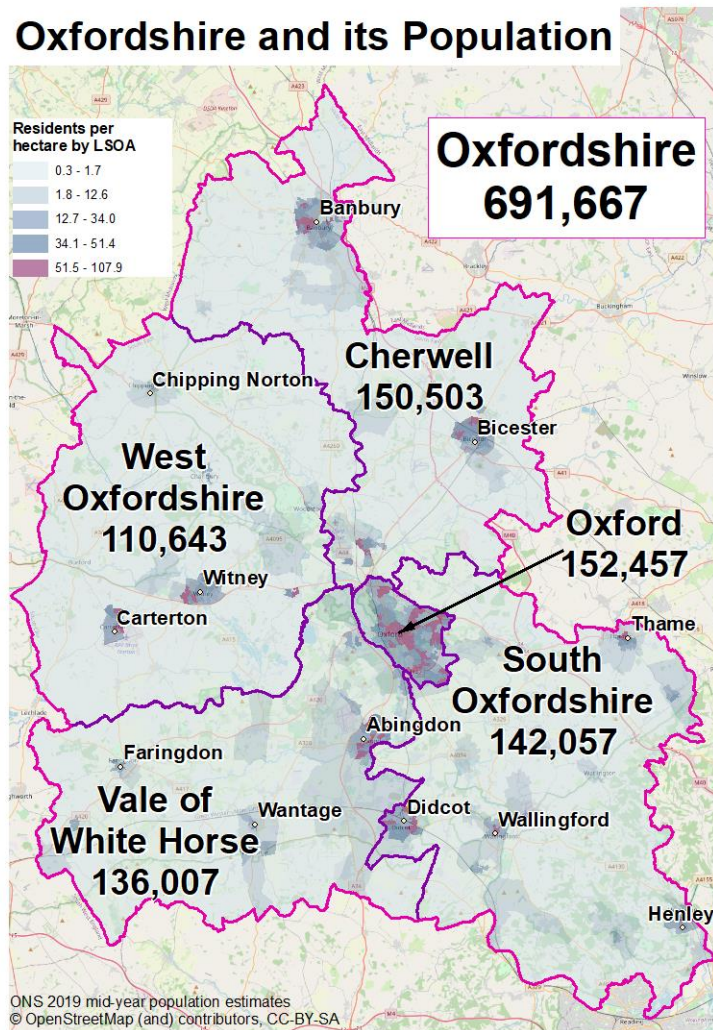


Figure 3: Office for National Statistics (ONS) mid-2019 estimate of the resident population of Oxfordshire. As illustrated in Oxfordshire's JSNA.

The median age of Oxfordshire's population has increased slightly from 39.7 years as of mid-2017 to 40.1 years at mid-2019. In mid-2019, the median age was lowest in Oxford City (28.9) and highest in West Oxfordshire (44.7). At a small area level, wide areas of rural Oxfordshire had a median age above 49 years.

Median age across Oxfordshire

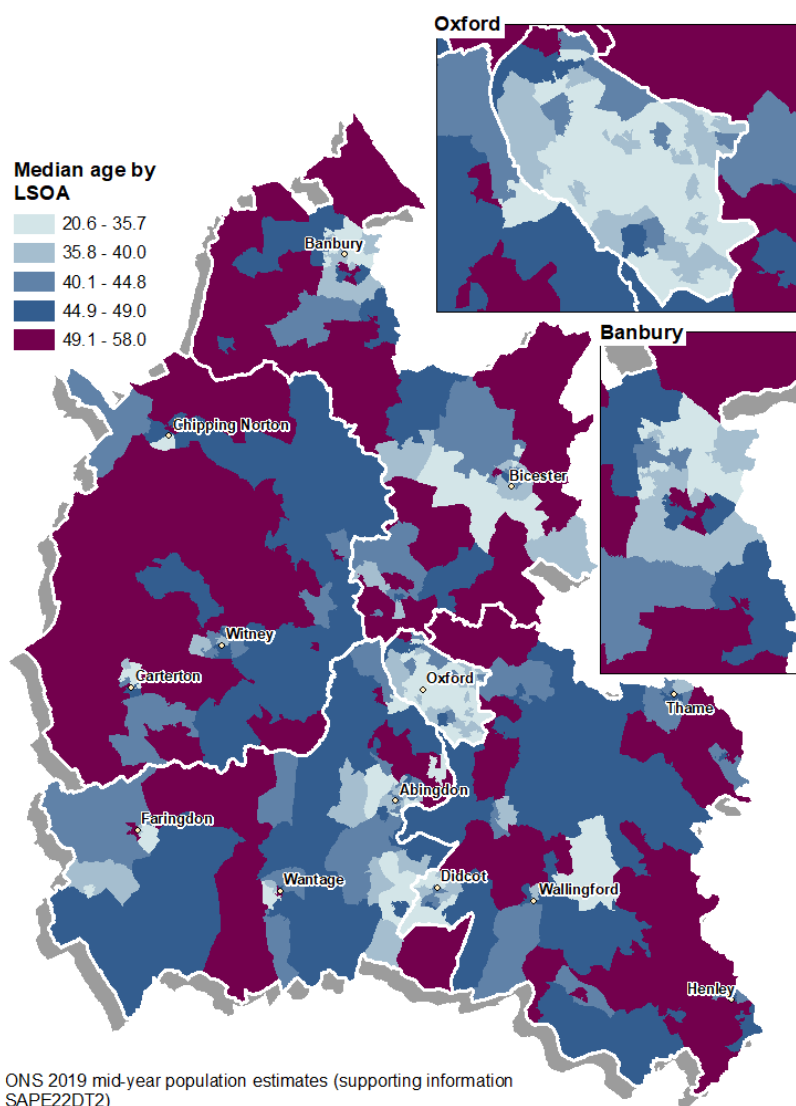


Figure 4: median age across Oxfordshire by LSOA using ONS 2019 mid-year estimates. As illustrated in Oxfordshire's JSNA

Over the past 20 years (between 1999 and 2019), there was an increase in the population of Oxfordshire from 603,800 to 691,700, a growth of 87,900 (+15%). The younger age group, aged 0-15, increased by 10%. However, the older age group, aged 65+, has increased by 49%. At district level, all districts other than Oxford City have seen a significant increase in the older population aged over 65 years and relatively little change in the number of young people aged 0-15. For South Oxfordshire, Vale of White Horse and West Oxfordshire, the number of people aged over 65 now exceeds the number of 0-15s. More details can be found, along with population forecasts on the JSNA webpages²⁰.

Of note, there are two alternative scenarios for the future change in population: Oxfordshire County Council's housing-led forecasts which incorporate district council plans for a higher rate of house

²⁰ [Oxfordshire JSNA 2021](#)

building than in the recent past and ONS projections based on past trends. The OCC housing-led forecasts (interim, Sept20) predict a total population in Oxfordshire of 801,700 by 2028, a growth of 110,400 (16%) since 2018. Over the same period the ONS projections show an increase of +5%. The largest differences in estimates are for young people and working age adults, where OCC forecasts are higher than those based on ONS data.

According to the ONS Census 2011, 16% of the total resident population of Oxfordshire was identified as being from an ethnic minority background, compared with 20% across England. The majority of those identifying as being from ethnically diverse heritage are based in urban areas of Oxford and Banbury.

Out of term time ethnic minority as a percentage of population

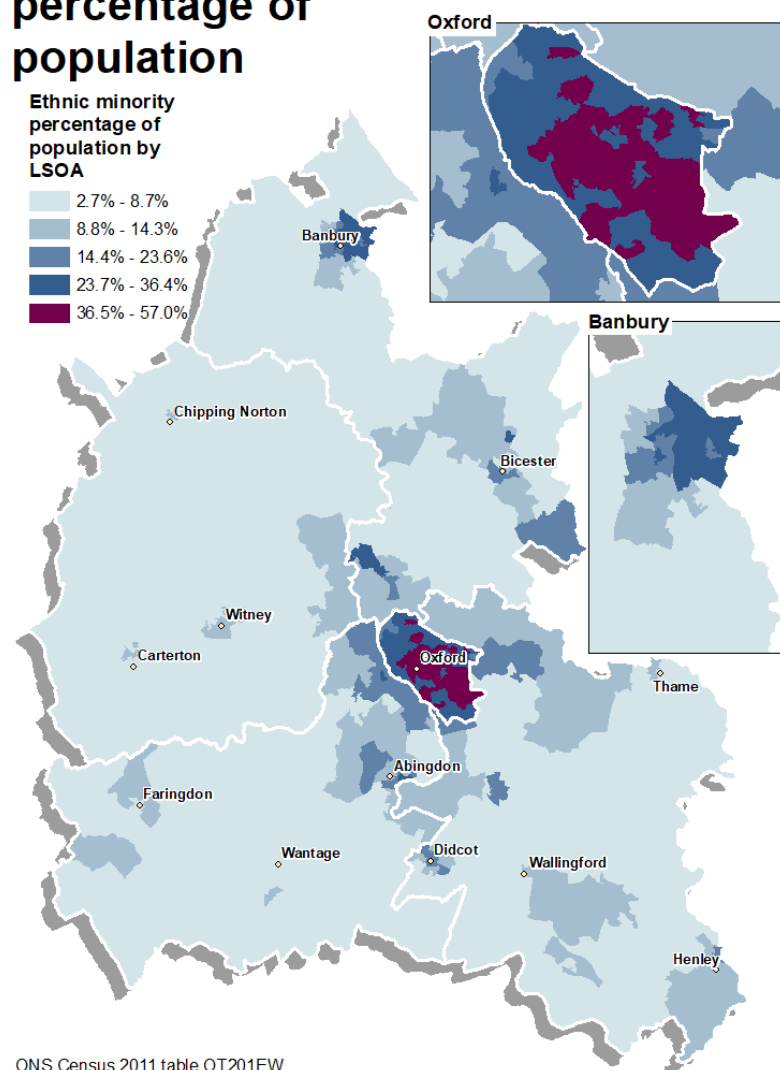


Figure 5:ONS Census 2011 table LC2101 and table OT201EW from nomis, mapped by Lower Super Output Area. Public Health England Local action on health inequalities: understanding and reducing ethnic inequalities in health

Each year, the school census collects data submitted from state-funded schools to the Department for Education. Information relevant to Oxfordshire is published on the Oxfordshire Insight pages²¹. The charts below are from these pages and summarise information on the proportion (%) of pupils for whom English is not their first language and who identified as being from an ethnic minority in this survey by district in which they live, from the January 2021 School Census.

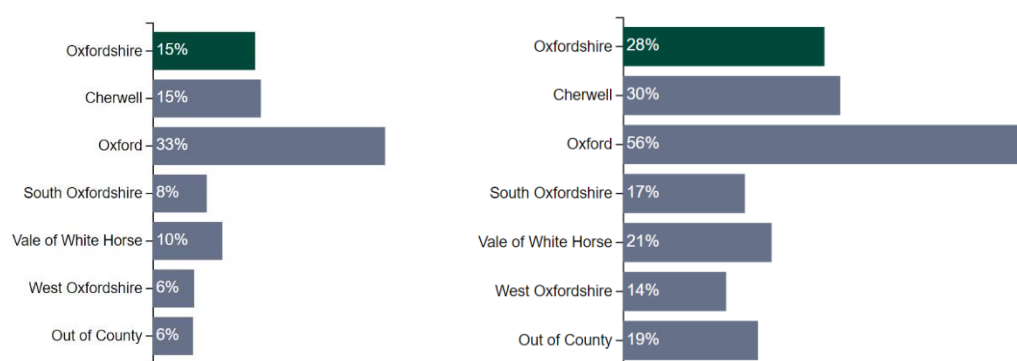


Figure 6: a) % of school pupils years 1-11 for whom English is not the first language and b) who identify as being from an ethnic minority in the School Census. From [Oxfordshire schools - pupil ethnicity and first language 2021 | Oxfordshire Insight](#)

1.8.2 Local Context of mental wellbeing

Across Oxfordshire the rate of depression diagnoses has increased year on year since 2012, in keeping with national trends. In 2019/20 there were 73,648 patients (aged 18 or over) with a diagnosis of depression registered by Oxfordshire's GP practices. In 2020, there were 59 deaths by suicide registered in Oxfordshire²².

Taking a life course approach recognises that protective and risk factors are interconnected over an individual's lifetime. (e.g., see reports by the WHO²³, Public Health England (PHE)²⁴ and the Oxfordshire County Council's (OCC) Mental Health Prevention Concordat Strategy).

There are a wide range of enablers and barriers to mental wellbeing across the life course, that act at all levels, from personal, to across communities, places and at national levels. The enablers for which needs in this report have been assessed are those promoted in the Concordat strategy and which are supported by evidence from a scoping review of the literature (figures 3&4).

²¹ [Oxfordshire schools - pupil ethnicity and first language 2021 | Oxfordshire Insight](#)

²² [Suicides in England and Wales - Office for National Statistics \(ons.gov.uk\)](#)

²³ <https://www.who.int/life-course/publications/life-course-approach-literature-review.pdf?ua=1>

²⁴ <https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach>

Factors that promote mental wellbeing ('enablers')		Factors that reduce mental wellbeing and risk factors for poor mental health	
Environment ("outdoors, active travel")	<ul style="list-style-type: none"> • Access and use of greenspace • Supports active commuting 	Environment	<ul style="list-style-type: none"> • Limited access to and use of greenspace
Social and community networks ("friends and family")	<ul style="list-style-type: none"> • Positive relationships and connectedness • Volunteering 	Social and community networks	<ul style="list-style-type: none"> • Increased screen time (<18s), cyber-bullying, lack of community and social support, loneliness
Employment ("workplaces, money")	<ul style="list-style-type: none"> • Working conditions • Job security 	Employment	<ul style="list-style-type: none"> • Insecure working conditions, lack of control, • Lack of job security
Financial security ("money")	<ul style="list-style-type: none"> • Not living in poverty 	Education	<ul style="list-style-type: none"> • Educational level
Education	<ul style="list-style-type: none"> • Educational level • Possibility of educational growth 	Financial security	<ul style="list-style-type: none"> • living in poverty, reduced income, fuel poverty
Housing	<ul style="list-style-type: none"> • Secure, warm 	Housing	<ul style="list-style-type: none"> • Insecure housing, homelessness, fuel poverty,
Family and early experiences	<ul style="list-style-type: none"> • Positive family environment 	Family and early experiences	<ul style="list-style-type: none"> • Early years negative experience, exposure to violence, factors in pregnancy and perinatal period
Lifestyle factors ("sport, sleep")	<ul style="list-style-type: none"> • Healthy lifestyle habits 	Lifestyle factors	<ul style="list-style-type: none"> • Smoking, alcohol use
Physical health and sleep	<ul style="list-style-type: none"> • Good physical health • Healthy sleep 	Physical health and sleep	<ul style="list-style-type: none"> • Living with a chronic illness, • Lack of sleep

Figure 7: Enablers and barriers to wellbeing, based on a scoping literature review

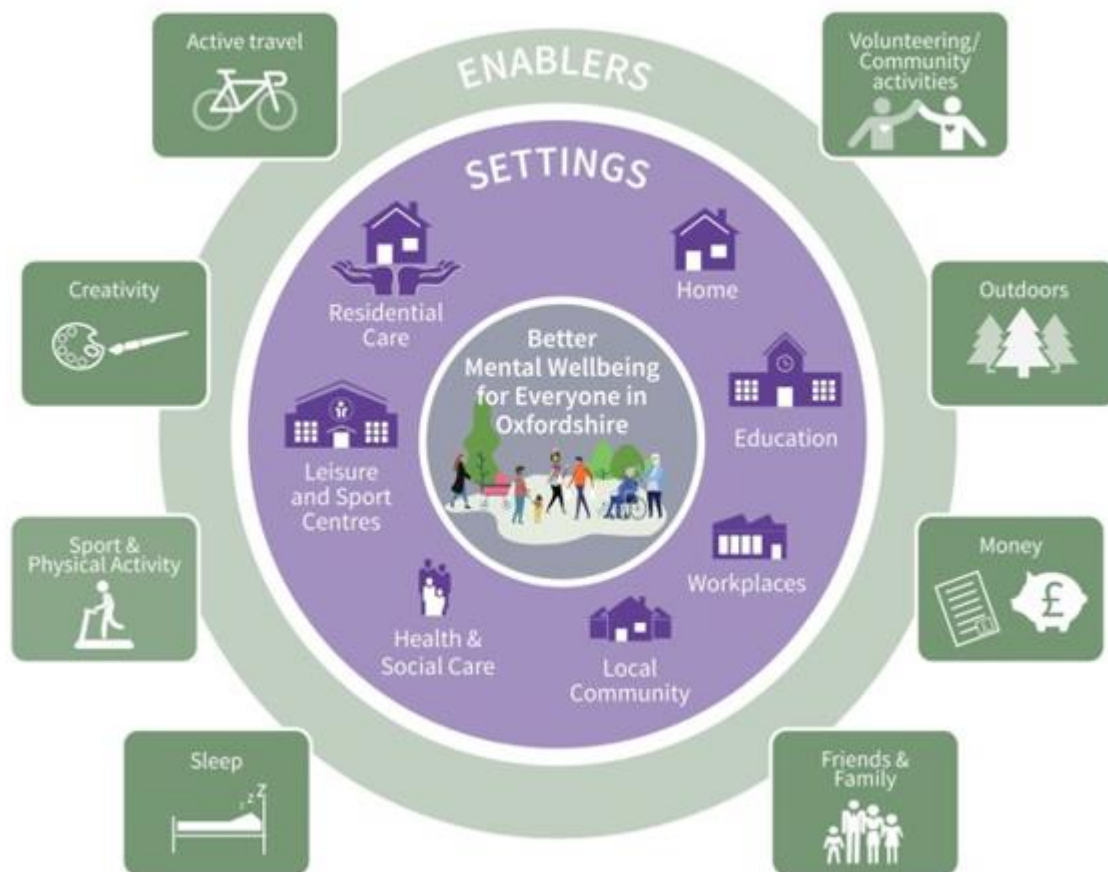


Figure 8: Enablers to mental wellbeing and settings across which they occur

1.8.3 The Importance of mental wellbeing in relation to national, local strategies and priorities

Given the diverse factors which can interact over the course of a lifetime to strengthen or reduce mental wellbeing, this report links to a number of national and local strategies. These include:

Nationally:

- In 2016 NHS launched its Five Year Forward View for Mental Health²⁵. This included 7 priority areas for action, of particular relevance to this mental wellbeing needs assessment int highlighted the need for: Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens; Creating mentally healthy communities; Prevention at key moments in life; An integrated mental and physical health approach

Locally:

- Oxfordshire’s Mental Health Prevention Framework²⁶, which has prioritised four areas for action: informed partners, insight and evaluation, confident professionals and resilient communities (figure 9, below).
- The 2018-2023 Oxfordshire Joint Health and Wellbeing strategy²⁷, which has committed to delivering across four key areas: a good start in life; living well; ageing well; and tackling health inequalities and using a “prevent, reduce and delay” approach. A wide and systems based view of the determinants of mental wellbeing links to Healthy Place Shaping²⁸, prioritised in the Health and Wellbeing Strategy.
- The Director of Public Health’s Annual Report focused on the importance of addressing health inequalities – highlighting the hidden inequalities in Oxfordshire, with 10 wards in Oxfordshire being in 20% most deprived wards in the country²⁹. It highlighted the prevention spectrum (figure 10), including the promotion of wellbeing, prevention of ill health focused on prevention, promoting healthier communities and the importance of Healthy Place Shaping.

²⁵ <https://www.england.nhs.uk/publication/the-five-year-forward-view-for-mental-health/>

²⁶ [OxfordshireMentalHealthPreventionFramework](#)

²⁷ [Oxfordshire Joint Health and Wellbeing Strategy](#)

²⁸ “Healthy Place Shaping” means ensuring the physical environment, housing and social networks can nurture and encourage health and wellbeing:

There is growing evidence that there are significant benefits for local people by taking an approach to planning housing, infrastructure, and the economy, with health and wellbeing as the centre of focus. This approach is known as “Healthy Place Shaping.” Healthy place shaping is a collaborative approach to creating sustainable communities which promote healthier behaviours through integrated and coordinated planning of the built environment, services, and community activation. Successful healthy place shaping involves: • Shaping the built environment so that homes are healthier, people can easily access green spaces, are enabled to walk, cycle, and socially interact in order to improve health and wellbeing. • Working with local people and community groups, schools, and businesses to support them in adopting healthier lifestyles. Engaging communities in planning places, facilities, and services through ‘community activation’. • Re-shaping and developing local health, wellbeing and care services, and the infrastructure which supports people to achieve health benefits which are fitting for local circumstance (models of care

²⁹ <https://www.oxfordshire.gov.uk/sites/default/files/file/public-health/PublicHealthAnnualReportMay2020.pdf>

- A number of strategies linked to specific parts of this needs assessment, for example relating specifically to children and education or access to green infrastructure. These are detailed in each specific section.



Figure 9: Priority areas within the Mental Health Prevention Concordat framework and strategy (OCC)

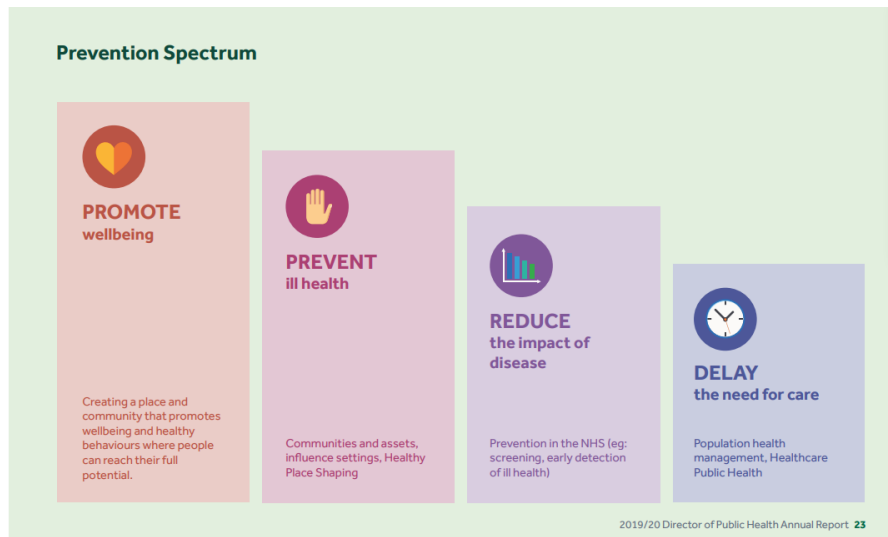


Figure 10: Promotion Spectrum, 2019/2020 Director of Public Health Annual Report

1.9 The context of the COVID-19 pandemic

This needs assessment has taken place in the context of COVID-19, and whilst not the specific focus of this report, the impacts of COVID-19 on our society and communities has been far reaching, acute, ongoing and are likely to persist for many years. The physical effects and excess mortalities have been well recorded and there is concern at all levels about its impact on mental health and wellbeing through many linked pathways (figure 11). COVID-19 has shone a light on existing health inequities, having a disproportionate impact on many of those who already had worse health outcomes before the pandemic including those in lower-paid work, from black and ethnic minority backgrounds and living in poorer areas³⁰

Evidence indicates that self-reported mental health and wellbeing have worsened in the COVID-19 pandemic: mental distress (as measured by the GHQ-12) was 8.2% higher in April 2020 than between 2017 and 2018 and in April 2020³¹ over 30% of adults reported levels of distress that were indicative that treatment could be needed (compared to around 20% in 2017-2019)³². Recent surveys^{33, 34} indicate that during the COVID-19 pandemic depression and anxiety are highest amongst young adults and women, those with a lower household income, with diagnosed mental illness and those who living alone. There is some evidence that mental wellbeing is more affected in those living in urban compared to rural areas, and mixed evidence on being a key worker and it's association with mental wellbeing.

Whilst levels of anxiety and depression fell over the summer from the higher pre-/start of lockdown levels, they remain higher than before the pandemic. Clearly there is concern going forward about the long-term effects on mental health and wellbeing.

³⁰

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

³¹ <https://www.ifs.org.uk/publications/14874>

³² [Michael Daly, Angelina Sutin and Eric Robinson. Longitudinal changes in mental health and the COVID-19 pandemic: evidence from the UK Household Longitudinal Study. 2020. Pre-release publication.](#)
[Claire L Niedzwiedz and others. Mental health and health behaviours before and during the COVID-19 lockdown: Longitudinal analyses of the UK Household Longitudinal Study. 2020. Pre-release publication.](#)
[Tarani Chandola, Meena Kumari, Cara L Booker, Michaela J Benzeval. The mental health impact of COVID-19 and pandemic related stressors among adults in the UK. 2020. Pre-release publication.](#)

³³ <https://whatworkswellbeing.org/wp-content/uploads/2020/11/Covid-Mental-health-briefing-Nov-2020.pdf>

³⁴ <https://www.covidsocialstudy.org/results>

In this needs assessment, the effects of COVID-19 on wellbeing are considered, where possible, within each section, with the recognition that our knowledge and understanding of these will change over time.

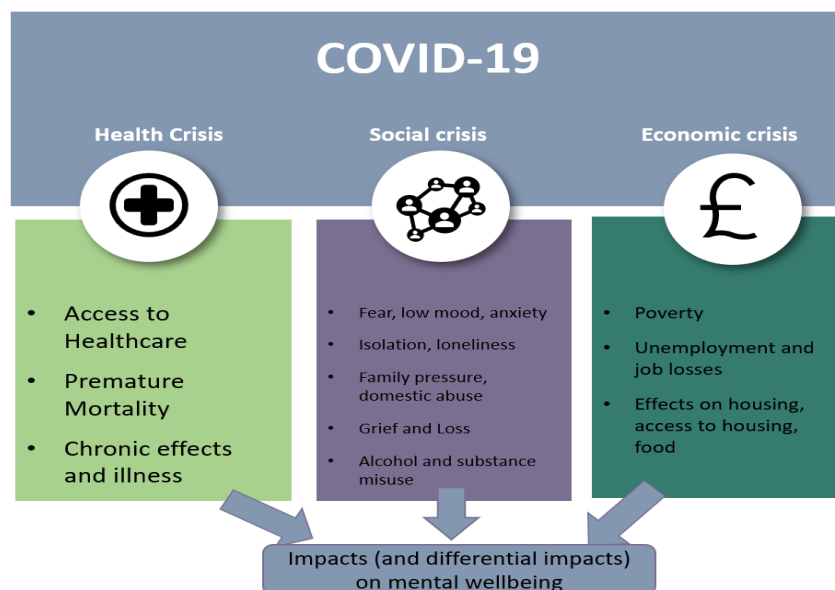


Figure 11: Wide ranging effects of COVID-19 and associated control measures on population

2 Adult mental wellbeing and mental health

Summary of adult mental wellbeing

The context and importance of promoting mental wellbeing are clear.

Nationally:

- 1 in 4 adults in England experience a diagnosable mental health problem in a given year
- young women have a higher risk of common mental disorders and the gap between mental illness in young females and males has increased
- males are at increased risk of suicide
- mental illness is more common in people living alone, in poor physical health, and not employed
- adults including adults from Black, Asian and Ethnic minority backgrounds, LGBTQ+, disabled people, and people who have had contact with the criminal justice system, among others are at increased risk of mental illness

Across Oxfordshire:

- The incidence of depression and anxiety has risen year on year since 2012, in keeping with national and regional trends
- In 2019/20 there were 73,648 patients (aged 18 or over) with a diagnosis of depression registered by Oxfordshire's GP practices.
 - This is equivalent to 11.81% of registered patients (compared to a national level of 11.56% across England) .
- Over half of social care users reported being moderately or extremely anxious or depressed
- For mental wellbeing
 - Oxfordshire residents score relatively well on measures of happiness, life satisfaction and feeling that their life is worthwhile
 - However even before the COVID-19 pandemic, 1 in 5 residents had high anxiety scores (>6/10 on the scale) based on ONS surveys of wellbeing

Within Oxfordshire there is:

- Variation across districts of the number of adults living with common mental disorders (CMD)
 - the highest prevalence of common mental disorders in residents over 16 years is in Oxford, and the lowest in West Oxfordshire
 - Variation across districts in levels and trends of time across different measures of wellbeing
- Understanding of the expressed and felt needs of specific communities. For example, research from Healthwatch Oxfordshire and Oxfordshire Community Action in their "Oxford's new and emerging communities - views on wellbeing" report, highlights factors important to communities for wellbeing and where people turn to for help and opportunities for action to improve wellbeing before residents access formal healthcare
- A strong history of partnership working and links between statutory and third sector

Summary of the impact of COVID-19 on adult mental wellbeing

Nationally, the evidence indicates that self-reported anxiety and depression both increased in the UK during the first lockdown of the COVID-19 pandemic

- When the lockdown started at the end of March 2020, 49.6% of people reported high levels of anxiety, compared with just 21% in the last quarter of 2019. By August 2020, this had fallen to 30% and appeared to stabilise to pre-pandemic levels between August and September 2020.
- Almost one in five adults (19.2%) were likely to be experiencing some form of depression during the initial phase of the Covid-19 pandemic in June 2020; this had almost doubled from around 1 in 10 (9.7%) before the pandemic (July 2019 to March 2020).
- Evidence also shows that there was a second deterioration in population mental wellbeing during October 2020 and February 2021, coinciding with national lockdown periods.
- Evidence of the impacts of COVID-19 on mental wellbeing are ongoing

Those adults at particular risk of deteriorating mental health and wellbeing during the initial stages of the pandemic were:

- Young adults (18-34 year olds) and women
- Those living alone, with a lower household/loss of income and not in employment
- People living with children and in particular lone mothers
- Those with a diagnosed mental illness and longstanding physical illness
- Those who felt lonely
- Some ethnic minority populations
- Of note, some of these groups although being more likely to experience a decline in mental wellbeing, were also more likely to have greater improvements in mental health after initial deteriorations in the first wave of the pandemic (e.g. women, people with lower education and people living with children).
- Locally, partners and service providers have been contacted during the lockdown periods for support relating to a wide range of issues, including
 - Isolation, Bereavement, Parenting, Finances, Mental health specifically

2.1 National data on mental health

Estimates suggest that 1 in 4 adults in England experience a diagnosable mental health problem in a given year³⁵.

According to the latest available Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing Survey (APMS, undertaken in 2014, published Sept 2016) in a given week, an estimated 1 in 6 adults in England have experienced a common mental disorder (CMD)³⁶(which includes forms of depression and anxiety). Of those with a recognised common mental disorder, around 39% were receiving medical treatment³⁷, which had increased from 24% in the previous survey in 2007. The most common form of treatment was pharmacological (medication). At any one time, approximately one in eight of all adults in England were receiving medical treatment for a mental illness and 3% of were receiving psychological therapy. The survey gave national level insights into groups at higher risk of mental illness. It indicated that:

- young women have a higher risk of CMD and self-harm and that the gap between young female and male mental illness has increased³⁸
- mental illness is more common in people living alone, in poor physical health, and not employed
- adults including black and ethnic minority adults, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, are at increased risk of mental illness³⁹

A survey by Mind in 2018, of around 1000 GPs in England, found that two in five consultations (40%) involve mental health⁴⁰.

In 2018/2019, there were 2, 726,721 people were in contact with secondary mental health, learning disabilities and autism services at some point during that year of which 632,261 were under 18 years of age. This equates to 4.9% of the population in England being in contact with secondary mental health services and of these, 3.8% have spent time in hospital in 2018-2019 as a result of contact with these services⁴¹. In 2019/2020, the NHS planned to spend £13 billion on mental health services

³⁵ <https://www.england.nhs.uk/mental-health/adults/>

³⁶McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). [Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014.](#)

³⁷ Some care is needed when interpreting these figures, as common mental disorders do not always necessarily need medical intervention, and the treatment figures do not capture those receiving community support for more mild symptoms. See the survey report for more details:
file:///C:/Users/dr728395/Downloads/Adult_psychiatric_study_CH3_WEB.pdf

³⁸ in 1993, 16 to 24 year old women (19.2%) were twice as likely as 16 to 24 year old men (8.4%) to have symptoms of CMD. In 2014, CMD symptoms were about three times more common in women of that age (26.0%) than men (9.1%).

³⁹ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

⁴⁰ <https://www.mind.org.uk/news-campaigns/news/40-per-cent-of-all-gp-appointments-about-mental-health/>

⁴¹ <https://files.digital.nhs.uk/98/150C99/MHB-1819-Annual%20Report.pdf>

across the board, which represents 14% of local funding⁴². The cost to the economy is estimated at £105 billion a year⁴³.

2.2 Mental health in Oxfordshire in figures: CCG, county and district level

The case for promoting mental wellbeing is clear in the context of data on common mental health illnesses presented below. Data on severe mental illness and treatment in secondary care for Oxfordshire are not summarised here and can be found in the Oxfordshire Mental Health JSNA⁴⁴.

Given the different sources of data, estimates in some common conditions vary slightly (e.g. some are modelled estimates based on prevalence of common mental disorders based on the 2014 adult psychiatric survey (APS), others are based on Quality Outcome Framework indicators, which have different potential biases).

Estimates based on GP practice data have been summarised based on the Oxfordshire CCG area, whereas estimates based on national surveys, where possible, are presented for Oxfordshire county council and district council populations. The difference between populations is described in section 1.8 and in the [JSNA](#).

2.2.1 Oxfordshire CCG

Recorded levels of depression in the population (based on QOF data) have risen in recent years (figure 12, table 2). This has been in keeping with trends at a national and regional level and has been attributed to a number of factors (from effects of the recession to and relevant for QOF data only - differences in GP coding⁴⁵). In 2019/20 there were 73,648 patients (aged 18 or over) with a diagnosis of depression registered by Oxfordshire's GP practices, equivalent to 11.81% of registered patients (compared to a national level of 11.56% across England). Levels of self-reported depression and anxiety have also risen in recent years.

⁴² <https://commonslibrary.parliament.uk/research-briefings/sn06988/>

⁴³ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

⁴⁴

<https://insight.oxfordshire.gov.uk/cms/system/files/documents/Mental%20Health%20JSNA%202018%20Feb18.pdf>

⁴⁵ Kendrick, Tony, et al. "Changes in rates of recorded depression in English primary care 2003–2013: time trend analyses of effects of the economic recession, and the GP contract quality outcomes framework (QOF)." *Journal of affective disorders* 180 (2015): 68-78.

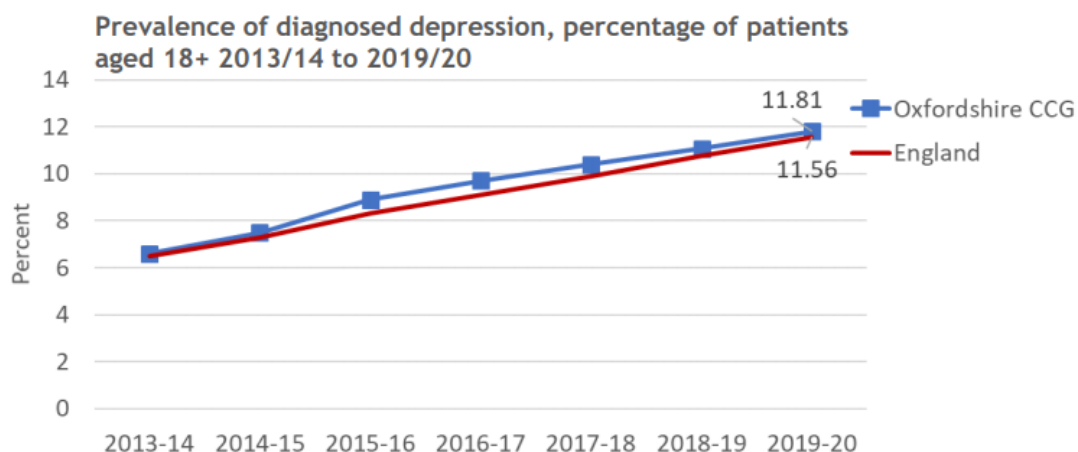


Figure 12: Percentage of patients with depression amongst GP registered adults (over 18 years), based on [NHS digital QOF](#) and [PHE fingertips indicator](#) data.

Year	Count	Oxfordshire CCG	95% LCI Oxfordshire	95% UCI Oxfordshire	South East	England
2012/13	32,634	6.00%	5.90%	6.00%	5.80%	5.80%
2013/14	37,002	6.60%	6.60%	6.70%	6.40%	6.50%
2014/15	42,594	7.50%	7.40%	7.60%	7.30%	7.30%
2015/16	50,865	8.90%	8.80%	9.00%	8.40%	8.30%
2016/17	56,795	9.70%	9.60%	9.80%	9.30%	9.10%
2017/18	61,874	10.40%	10.30%	10.40%	10.20%	9.90%
2018/19	67,557	11.10%	11.00%	11.10%	11.00%	10.70%

Table 3: Recorded depression based on QOF reporting. The recorded depression prevalence is the number of people with depression recorded on their practice register within a CCG, as a proportion of the practice list size of the CCG aged 18 years or over. Data Source: NHS digital - website, indicator available from PHE Fingertips.

2.2.2 Prescription of anti-depressants (Oxfordshire CCG)

Between August 2019 and July 2020 the spend on anti-depressants across Oxfordshire was £3,564,284 with the largest spends occurring for patients aged 50-59 years.

However, some care is needed in interpreting figure 13 below - monthly spends cannot be used to extrapolate information about or as a proxy for rates of depression: whilst spending on medications increased from March onwards this year, the number of items purchased did not increase in the same way. Over this time, there was an increase in drug cost, which may be contributing the jump in spend seen after February 2020. A similar trend was seen in Buckinghamshire (see figure 8 for comparison of trend only - actual amount expected to vary due to differences in population size and structure).

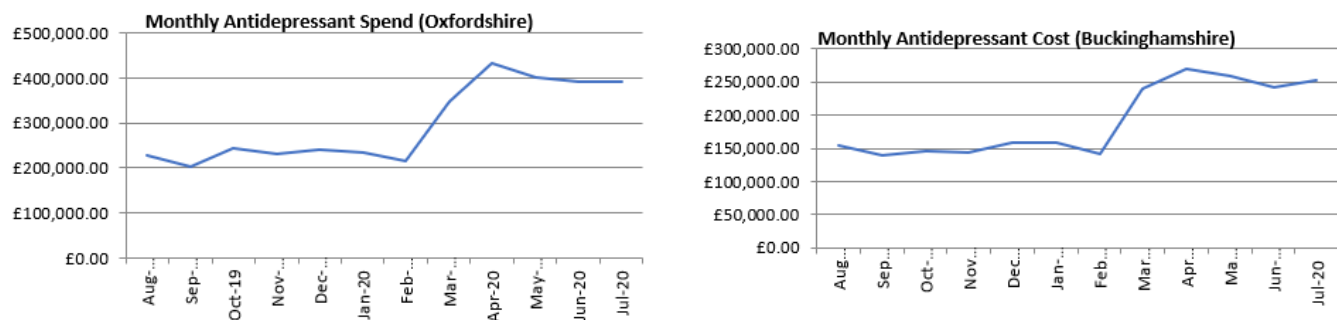


Figure 13: Monthly spend on anti-depressants Oxfordshire CCG, data from NHS digital.

2.2.3 Oxfordshire (County): Prevalence of common mental illness at county and district level

In 2017, across Oxfordshire, around 14 % (13.2%,15.2%) of the adult population (over 16 years) were estimated to have a self-reported common mental disorder based on Public Health England's calculations from the APMS⁴⁶, compared to 17% (16.2%, 18.0%) of adults across England and 14.8% (14.1%,16.0%) across the South East. For Oxfordshire, this equates to around 77,220 adults.

Key indicators for mental health across Oxfordshire county are summarised in figure 14. As expected, the prevalence of common mental illness is similar to Oxfordshire CCG (data from GP practices). Additionally, figure 14 also highlights that in Oxfordshire over half (56.8%) of social care users⁴⁷, reported being moderately or extremely anxious or depressed (compared to 50.5% at a national level).

⁴⁶ https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA/data#page/3/gid/1938132922/pat/6/par/E12000008/ati/202/are/E10000025/iid/93495/age/164/sex/4/cid/4/tbm/1/page-options/ovw-do-0_cin-ci-4_car-do-0

⁴⁷ surveyed in the Personal Social Services Adult Social Care Survey. Further information on indicator available at [Mental Health and Wellbeing JSNA - PHE](#)

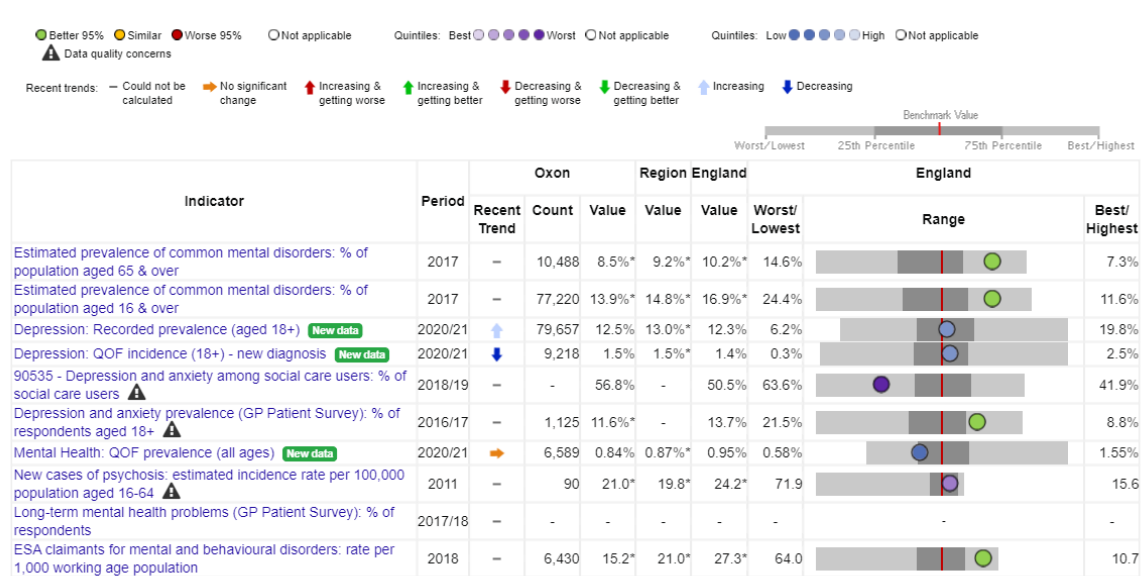


Figure 14: spine chart summarising mental health indicators for Oxfordshire county. Green circles indicate Oxfordshire compares similarly or well to England and blue circles indicate we compare less well or that incidence is increasing. Data compiled and available from PHE fingertips : [Mental Health and Wellbeing JSNA - PHE](#)

At district level in Oxfordshire, the number of adults living with a common mental disorder (CMD) according to 2017 indicators, is significantly higher in Oxford (17.7% (14.8%, 16.9%) compared to other districts (figure 15). Patterns across districts are similar for common mental illnesses in the over 65s (figure 16)

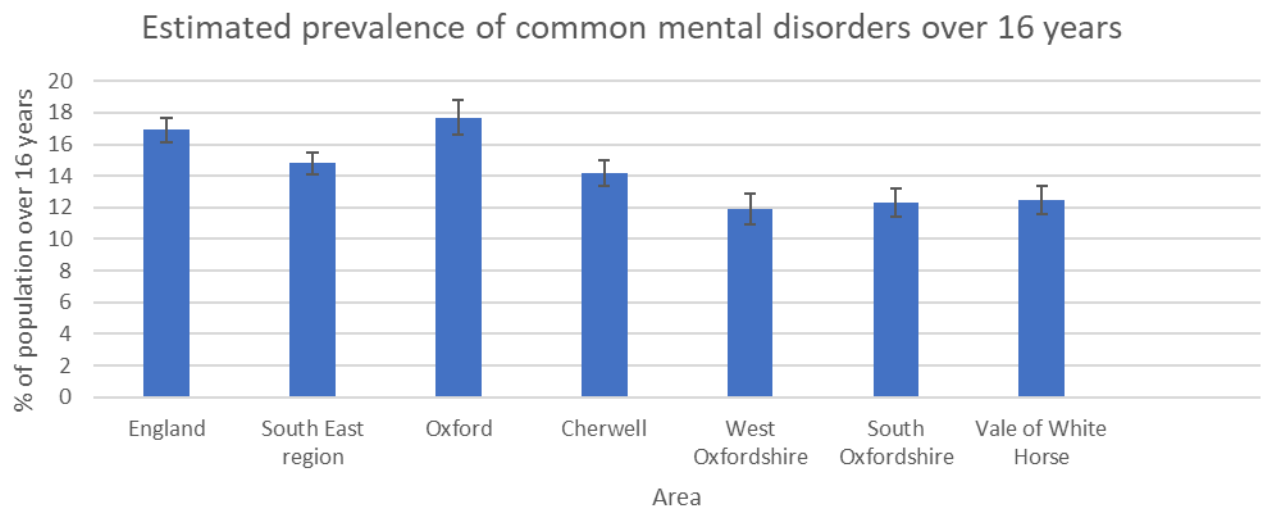


Figure 15: Estimated prevalence (self-reported) of common mental disorders (% population over 16 years). Data source: numerator based on 2014 Adult Psychiatric Morbidity Survey (APMS) owned by NatCen and NHS Digital with

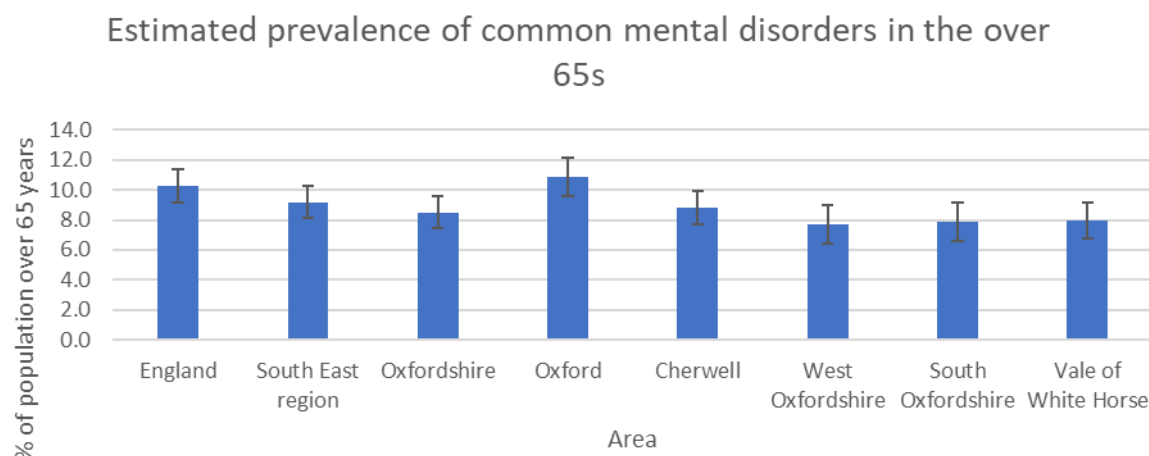


Figure 16: Estimated prevalence (self-reported) of common mental disorders (% population over 65years)

Data source: numerator based on 2014 Adult Psychiatric Morbidity Survey (APMS) owned by NatCen and NHS Digital , 2017 indicator computed by PHE. Denominator: ONS resident populations. Indicator available from PHE fingertips

2.3 Levels of Mental Wellbeing: Nationally and in Oxfordshire

The Office for National Statistics (ONS) has been collecting national data on mental wellbeing (compared to mental health) for adults (over 16 years) since 2011 as part of the Annual Population Survey (APS)⁴⁸ and Opinions and Lifestyle (OPN) survey⁴⁹, which tracks changes in personal wellbeing on a quarterly basis. It measures wellbeing across four domains, capturing some of the main of constructs of mental wellbeing divided very broadly into evaluative and affective dimensions of wellbeing. Of note, although anxiety forms one of the questions, the evaluation is much less in - depth than would be used to diagnose a clinical anxiety disorder and over a much shorter time frame (the ONS question relates to the previous day only). The four components and questions asked are:

- Life satisfaction (evaluative)
 - Overall, how satisfied are you with your life nowadays?
- Worthwhile (evaluative)
 - Overall, to what extent do you feel the things you do in your life are worthwhile?

⁴⁸ The APS is a continuous household survey covering the UK, providing estimates between censuses of important socia variables at a local area level. The data are weighted to reflect the size and composition of the general population, using the most up-to-date official population data.

⁴⁹ Since April 2018 the sample for the Opinions and Lifestyles Survey is drawn from the Annual Population Survey (APS), which consists collectively of those who successfully completed the last wave of the Labour Force Survey (LFS) or the local LFS boost. Around 38,000 households respond to the LFS each quarter and it is the largest regular household survey in the UK. The sampling frame used for the LFS is the Royal Mail's Postal Address File (PAF) of small users. The PAF is the most comprehensive address database in the UK. It is updated every three months and contains approximately 26 million addresses :

<https://www.ons.gov.uk/aboutus/whatwedo/paidservices/opinions/opinionsandlifestylesurveyemethodology>

- Happiness (affective)
 - *Overall, how happy did you feel yesterday?*
- Anxiety (affective)
 - *Overall, how anxious did you feel yesterday*

2.3.1 National Mental Wellbeing

At a national (UK) level, even before COVID-19, some indicators of mental wellbeing included in ONS surveys had shown a decrease compared to previous levels in both the third quarter of 2019⁵⁰ and the first quarter of 2020. For example, in the third quarter (July-Sept) of 2019 life satisfaction fell compared to the year below⁵¹. This was attributed to concerns about future employment. In addition, the feeling that things done were worthwhile also fell compared to 2018. For both these indicators, this was the first time since measurements started in 2011 that both measures of satisfaction had fallen. In the last quarter of 2019, around 10.6 million people in the UK reported high levels of anxiety.

In the year ending in March 2020 (including the build up to the first national UK lockdown in response to the COVID-19 pandemic, which started on 23rd March 2020) national ratings reported by the ONS of life satisfaction, happiness and anxiety all worsened significantly. The reduction in life satisfaction continued the gradual decline seen over 2019, whereas there was a sharper deterioration in self-rated anxiety and happiness: in the first quarter of 2020, compared to the same period in 2019, anxiety ratings (scores out of 10) increased by 6.3% from 2.87 to 3.05 (scale 0-10) and happiness ratings fell in England by 1.1% compared to the previous year (and by 1.7% in London, 1.6% in the South East).

In general, surveys have found some seasonal components to self – reported mental wellbeing, with reported levels of happiness and anxiety being most affected by season (see [ONS](#) report for more details⁵²)

2.3.2 Oxfordshire Mental Wellbeing

Across Oxfordshire, self-reported wellbeing across the four domains as measured by the ONS are summarised in figure 17. These estimates are best used to look at changes over time, rather than comparing different areas due to differences in sample sizes and population characteristics. As they are based on small sample sizes, they specifically shouldn't be seen as a way to rank local authorities

⁵⁰<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalandeconomicwellbeingintheuk/february2020>

⁵¹<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalandeconomicwellbeingintheuk/february2020>

⁵²

<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/personalwellbeingquarterlyestimatestechnicalreport>

within areas⁵³. In addition to this, estimates have not been standardised to account for differences in population structures – e.g. age, which may account for some of the differences and for differences comparing Oxfordshire to England and the South East. The estimates from 2019/2020 are based on data which reflect the first part of the COVID-19 pandemic and associated lockdowns.

Whilst Oxfordshire residents score relatively well for ONS wellbeing measures of happiness, life satisfaction and that things in life are worthwhile, average anxiety scores are generally higher than national and regional levels (though due to small sample sizes the differences are not statistically significant – i.e. confidence intervals for Oxfordshire estimates in general include National and South East averages within their range). The figures below represent average anxiety scores across Oxfordshire, the South East and England out of 10.

Also of importance is the proportion of residents who score poorly on anxiety (>6/10). Across Oxfordshire, this was 20.06% (95% CI 16.57%, 23.55%), which is similar to national and regional proportions, but highlights an area where further support could be offered.

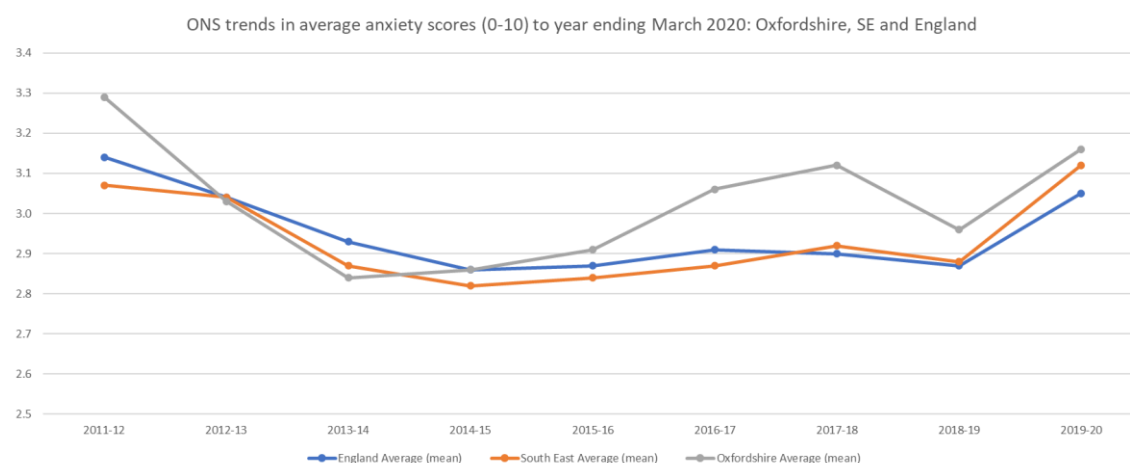


Figure 17a: ONS measures of wellbeing (mean values) for LTLA's in Oxfordshire. These illustrate trends over time only, and should not be used to compare scores between areas, due to small numbers in samples. Data source ONS: [Personal wellbeing in the UK - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2019tomarch2020)

⁵³ As per guidance from ONS in <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2019tomarch2020>

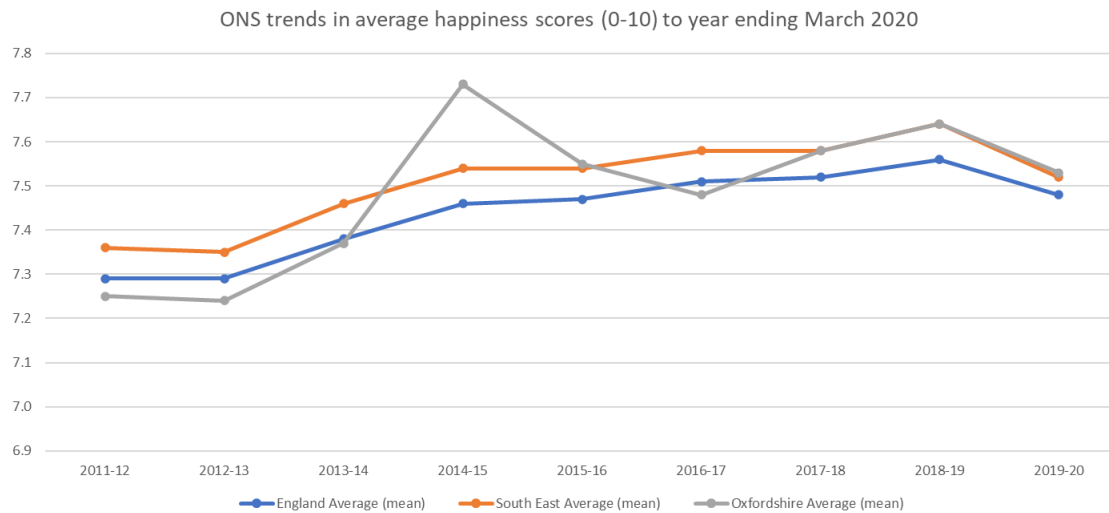


Figure 17b: ONS measures of wellbeing (mean values) for LTLA's in Oxfordshire. These illustrate trends over time only, and should not be used to compare scores between areas, due to small numbers in samples. Data source ONS: [Personal wellbeing in the UK - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/personalwellbeing)

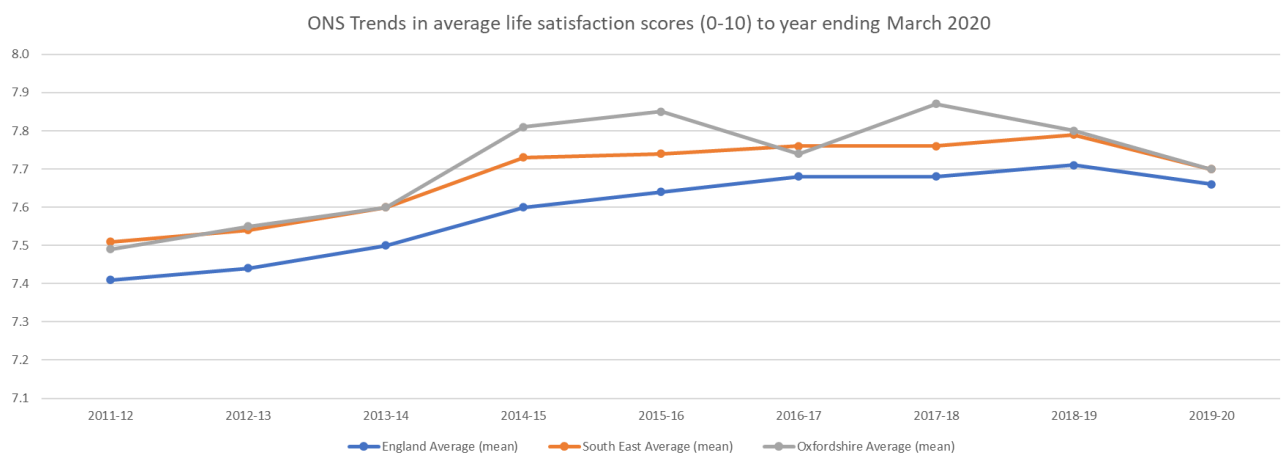


Figure 17c: ONS measures of wellbeing (mean values) for LTLA's in Oxfordshire. These illustrate trends over time only, and should not be used to compare scores between areas, due to small numbers in samples. Data source ONS: [Personal wellbeing in the UK - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/personalwellbeing)

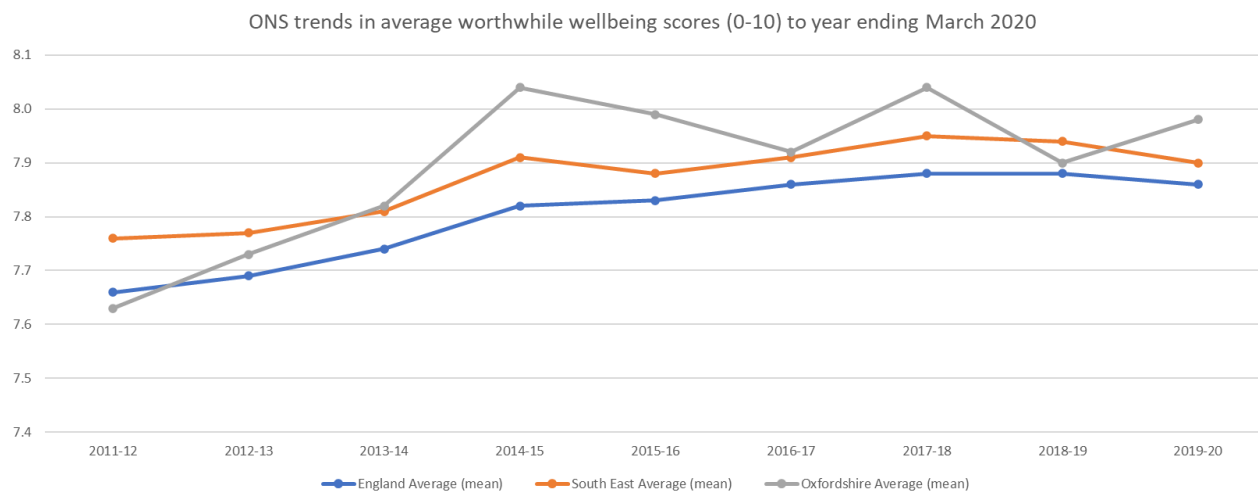


Figure 17d: ONS measures of wellbeing (mean values) for LTLA's in Oxfordshire. These illustrate trends over time only, and should not be used to compare scores between areas, due to small numbers in samples. Data source ONS: [Personal well-being in the UK - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/qualityoflife/articles/personalwellbeingintheuk/2018-19)

2.3.3 ONS trends in mental wellbeing scores by district

As for ONS scores of Oxfordshire mental wellbeing, estimates are available at district and city level (figure 18). However, as for estimates available at Oxfordshire level, these are *based on small(er) sample sizes*, and should only be used to look at trends over time rather than to compare areas. Scores across the four ONS domains of wellbeing at district and city level are illustrated below (note average anxiety scores are on a different axis).

2.3.3.1 Cherwell Mean Scores for ONS Measures of Wellbeing

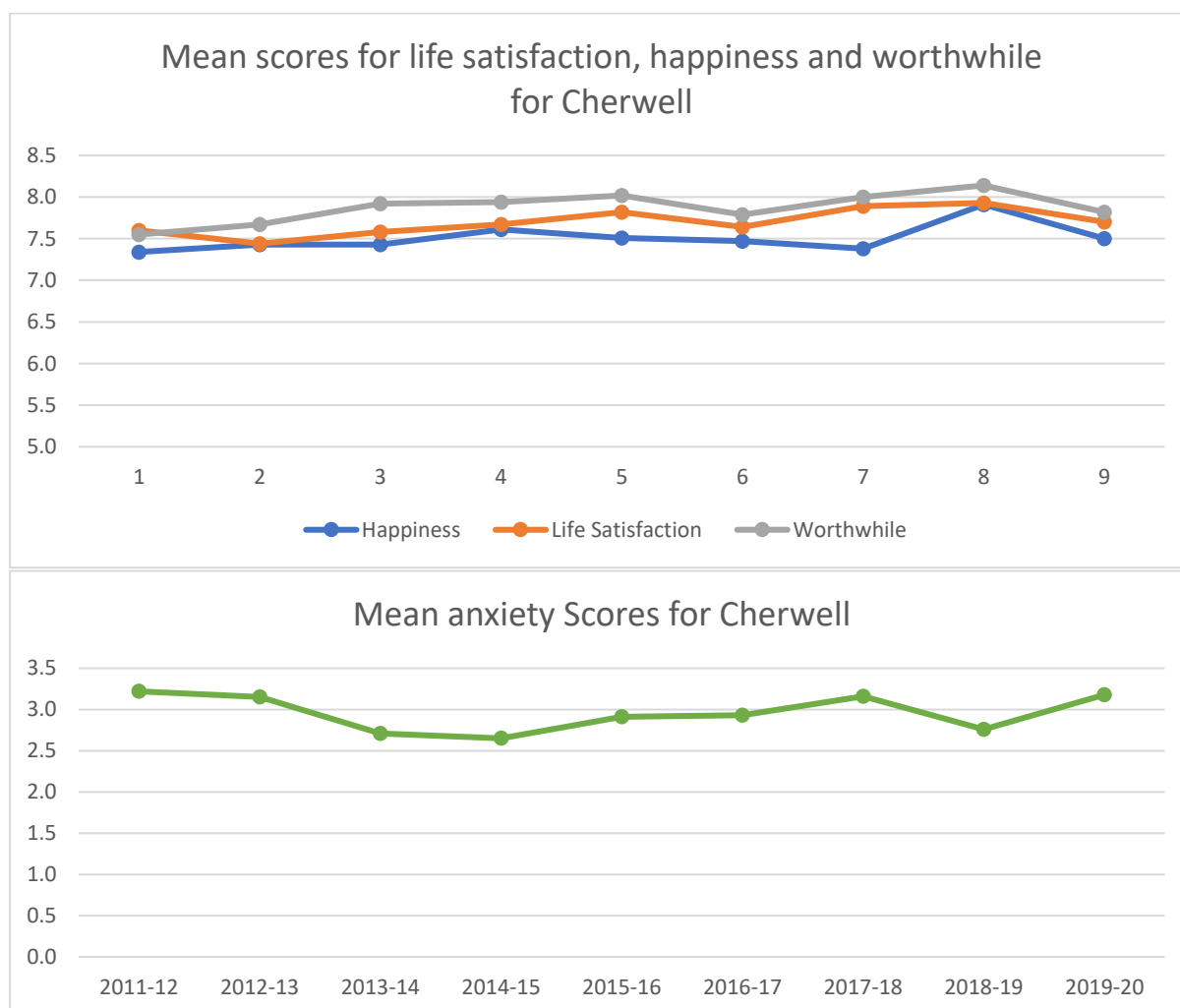


Figure 18a: Mean wellbeing scores for Cherwell from 2011/12-2019/2020 . Note, axes do not start from 0 for measures of happiness, worthwhile and life satisfaction. All scores are out of 10. Available from ONS

<https://www.ons.gov.uk/datasets/wellbeing-local-authority/editions/time-series/versions/3>

2.3.3.2 Oxford Mean Scores for ONS Measures of Wellbeing

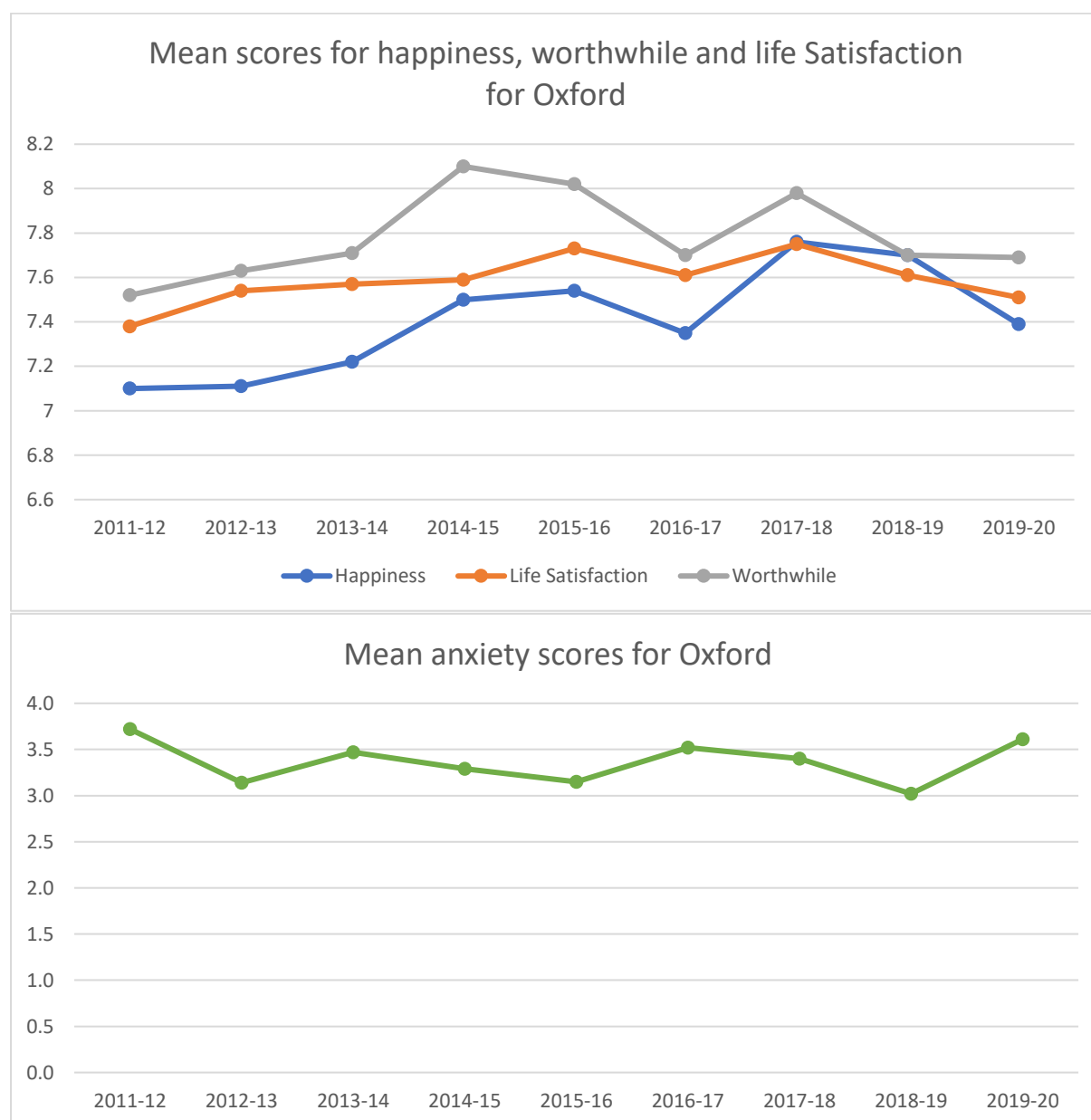


Figure 18b: Mean wellbeing scores for Oxford from 2011/12-2019/2020 . Note, axes do not start from 0 for measures of happiness, worthwhile and life satisfaction. All scores are out of 10. Available from ONS

<https://www.ons.gov.uk/datasets/wellbeing-local-authority/editions/time-series/versions/3>

2.3.3.3 South Oxfordshire Mean Scores for ONS Measures of Wellbeing

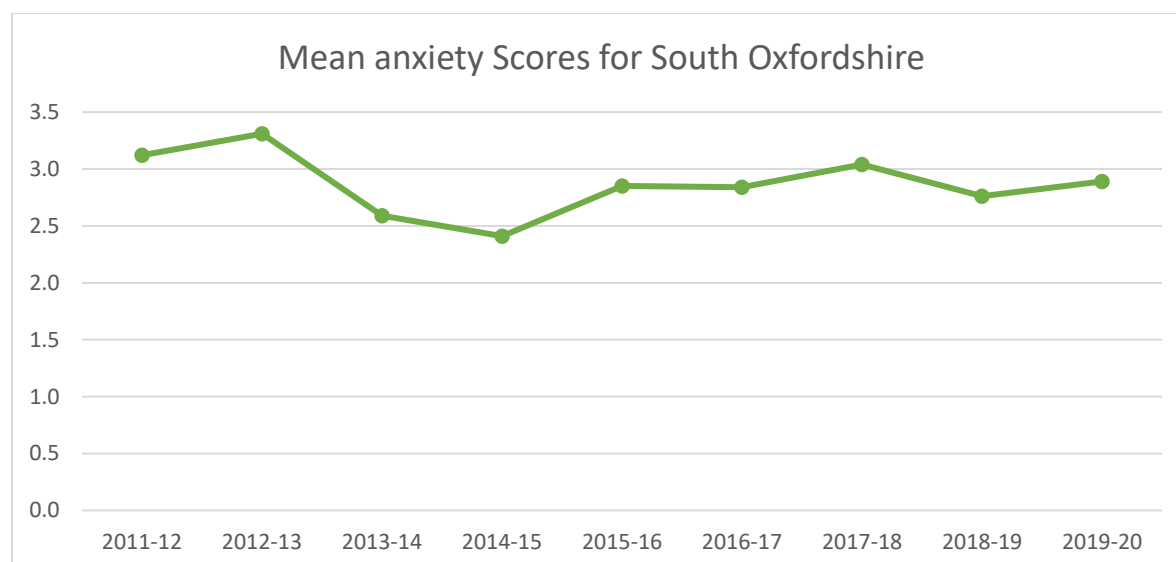
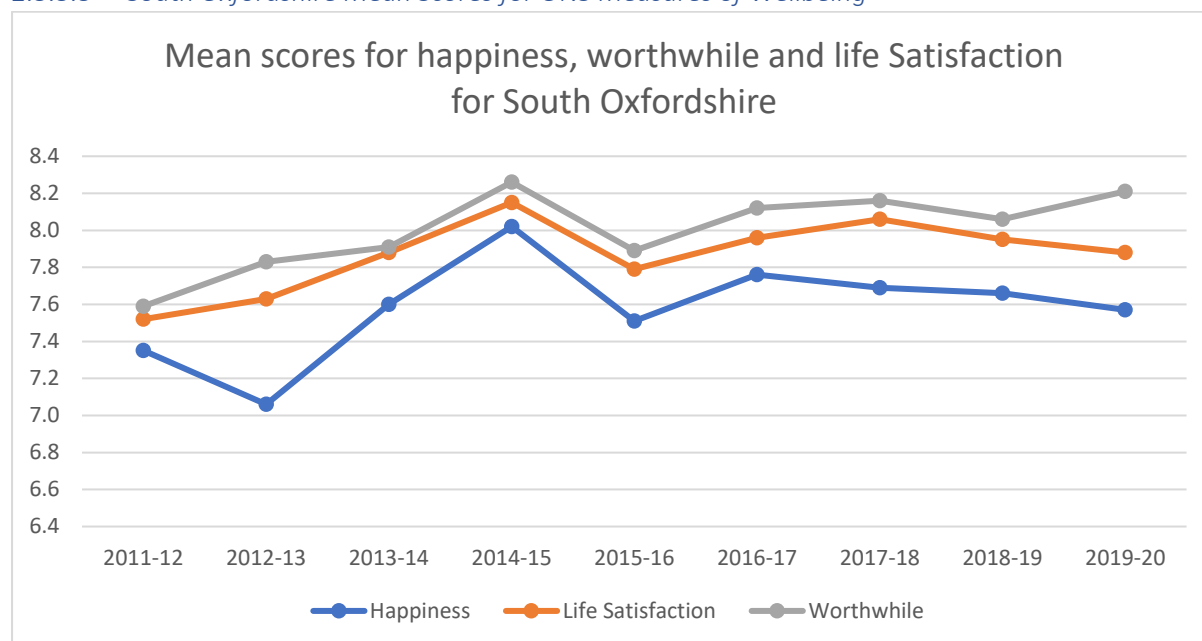


Figure 18c: Mean wellbeing scores for South Oxfordshire from 2011/12-2019/2020 . Note, axes do not start from 0 for measures of happiness, worthwhile and life satisfaction. All scores are out of 10. Available from ONS

<https://www.ons.gov.uk/datasets/wellbeing-local-authority/editions/time-series/versions/3>

2.3.3.4 Vale of White Horse Mean Scores for ONS Measures of Wellbeing

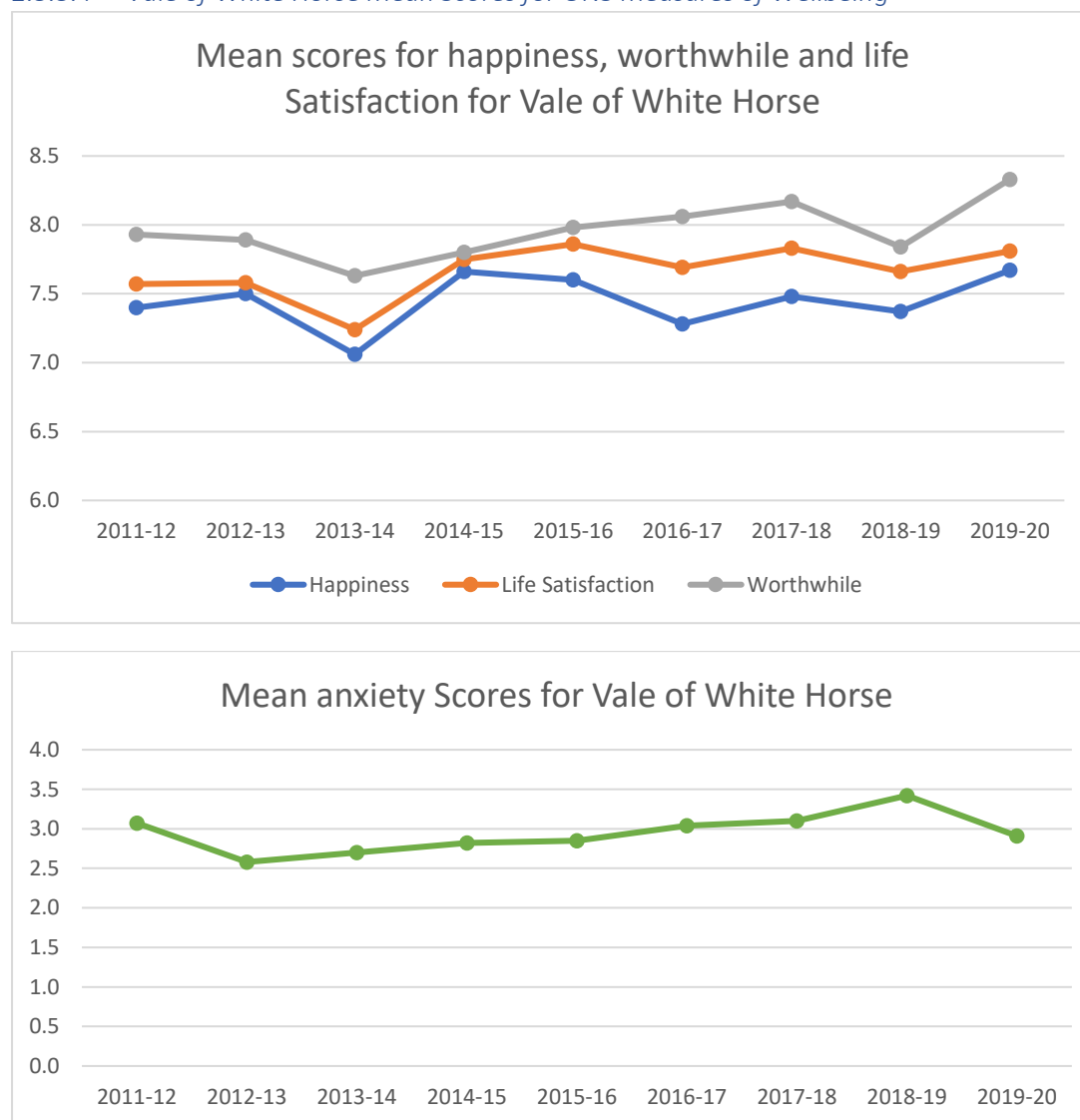


Figure 18d: Mean wellbeing scores for the Vale of White Horse from 2011/12-2019/2020 . Note, axes do not start from 0 for measures of happiness, worthwhile and life satisfaction. All scores are out of 10. Available from ONS <https://www.ons.gov.uk/datasets/wellbeing-local-authority/editions/time-series/versions/3>

2.3.3.5 West Oxfordshire Mean Scores for ONS Measures of Wellbeing

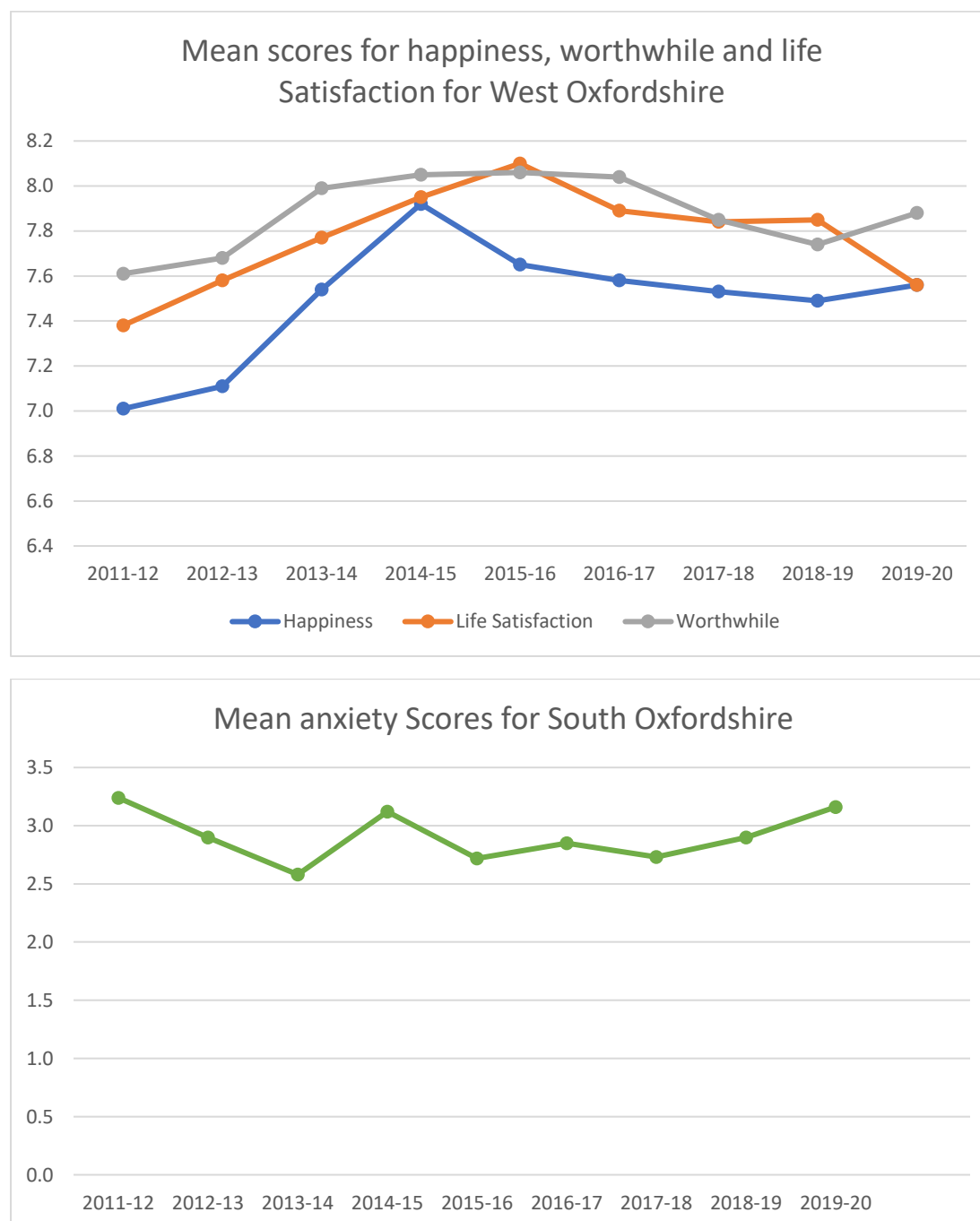


















































Figure 18e: Mean wellbeing scores for West Oxfordshire from 2011/12-2019/2020 . Note, axes do not start from 0 for measures of happiness, worthwhile and life satisfaction. All scores are out of 10. Available from ONS <https://www.ons.gov.uk/datasets/wellbeing-local-authority/editions/time-series/versions/3>




2.3.4 Understanding inequalities in mental wellbeing

Currently, there is no local data on inequalities in mental wellbeing, across all protected characteristics. This is not surprising, given the small numbers in ONS surveys of mental wellbeing at

a local level. However, national data can give some indication of groups of people more at risk of lower mental wellbeing, and is summarised in figure 19 below.

This mapping, combined with data on impacts of COVID-19, an understanding of different expressed and felt needs relating to mental wellbeing – for example, how communities understand and relate to mental wellbeing, what their barriers and enablers to wellbeing are, and who they would turn to for help – can inform areas for action and further work

Area		Inequalities/at risk groups - prevalence and impact - group with INCREASED risk stated. All data for NATIONAL level, unless indicated otherwise								
		Age	Gender	Socio-Economic	employment	Ethnicity	Rural vs urban	Sexual orientation	living alone vs not	Long term medical conditions, disability
Mental health	common mental disorders		young F> young M 	lower income 	not employed> employed 	 Identify as Black, Asian, Ethnic minorities		LGBTQ 	living alone 	Long term medical conditions, disability 
	Impact of COVID			lower income 	not employed> employed 	 not clear - recent data shows Black, Asian, Ethnic minorities higher risk, some data affected by small sample size	urban areas 			with existing mental illness
Suicide			M>F 							
Indicators of wellbeing	Life satisfaction	Bimodal distribution, life satisfaction - variable over age groups: lowest 45-59 yrs 	M<F 			Scores vary: higher than UK average (Indian), Black/ African/Caribbean significantly lower than UK average 			living alone worse life satisfaction 	long term medical conditions score less 
	Worthwhile	Bimodal distribution, worthwhile - variable over age groups: lowest 45-54 yrs, > 	M<F 			Scores vary: Bangladeshi and Black/African Caribbean significantly lower 			living alone score less on worthwhile 	long term medical conditions score less 
	Happiness	Bimodal distribution, happiness - variable over age groups: lowest 40-59 yrs, highest 60-80 yrs 	M<F 			Scores vary: Indian background - significantly higher, Black/African Caribbean significantly lower 			living alone score less on happiness 	long term medical conditions score less 
	Anxiety	Anxiety, increases across age categories until 30-34 then reduces 	F>M 	 not employed> employed	 not employed> employed	Most higher anxiety than average but not significant, "Arab" only minority with significantly increased anxiety compared to UK average 			living alone score higher on anxiety 	long term medical conditions score higher for anxiety 

KEY	
	Data available nationally but not locally
	Data available locally
	Data not available/located

2.4 Qualitative data and mental wellbeing: felt and expressed need

Understanding how individuals and communities in Oxfordshire relate to mental wellbeing and also where people turn to for help is vital, if we are to improve mental wellbeing and amongst groups who are worst affected.

Given the broad nature of this needs assessment, it was not possible to seek views with significant depth, from all communities, and deciding where to focus efforts to do this in the future is part of this work.

Healthwatch Oxfordshire, however, have undertaken a series of in-depth reports which either in their entirety or in part address mental wellbeing within specific communities – either defined by common geographical (area based reports) or common qualities (e.g. Boating communities, emerging and diverse communities).

The most recent of these, at the time of writing, is “Oxford’s new and emerging communities - views on wellbeing” report⁵⁴. For this report, Healthwatch Oxfordshire worked in partnership with Oxfordshire Community Action to understand the views of wellbeing of 152 people representing new and emerging communities’ in Oxford. The report highlights that within these communities, causes of worries and stress (as reported in the survey) were pressures of life - money, jobs and family concerns, cost of housing and food in Oxford, racism and discrimination, immigration worries and the impact of COVID. Communities reported that family, friends, faith and community, feeling safe, a secure job, being able to help others health, exercise and being able to afford healthy food were important for wellbeing.

Findings on where new and emerging communities in Oxford turn to support highlight the importance of taking a whole systems and wide approach to improve mental wellbeing literacy: for support “ 87% would turn to friends and family, 58% to a faith leader or spiritual support and 30% to their GP if worries became too much. Only 4% would seek mental health support, even though 60% would like help to manage stress, 35% would like support with mental health, and 18% would like help in managing spiritual crises”.

The report highlights the importance of inclusive language that is culturally appropriate and for diverse community services that support wellbeing. Barriers to accessing support amongst those who took part in the survey included: a lack of trust and respect, difficulty finding services that meet cultural and spiritual needs, and a lack of information in languages and formats that communities could understand. It stressed the need for healthcare providers to reach out to diverse communities to address inequalities in access and use of their services and to engage communities through workshops, community networks, faith leaders and faith settings.

⁵⁴ [Oxford's New and Emerging Communities' Views on Wellbeing - January 2021 - Healthwatch Oxfordshire](#)

2.5 The impacts of COVID-19 on adult mental wellbeing

There is no doubt that COVID-19 has had a number of direct and indirect effects on mental wellbeing nationally and locally. This section summarises the effect of COVID-19 on mental wellbeing at a national and local level as of mid 2021. However, the impacts of COVID-19 on mental wellbeing are ongoing and increasing numbers of findings will be published over coming months and years.

The wider effects of COVID acting through drivers and enablers to mental wellbeing (e.g. through effects on finances, loneliness etc.) are included later in this report in relevant chapters.

2.5.1 Direct impact of COVID-19 and pandemic control measures on mental wellbeing

Public Health England (PHE) regularly update a report on the effect of COVID-19 on mental wellbeing, based on both national surveillance data and academic research⁵⁵. This report highlights that:

- analysis of data from the UK Household Longitudinal Study (UKHLS) found a rise in proportion of adults aged 18 and over reporting a clinically significant level of psychological distress from 20.8% in 2019 to 29.5% in April 2020, falling back to 21.3% by September 2020. There was a subsequent increase to 27.1% in January 2021, followed by a further decrease to 24.5% in late March 2021⁵⁶.
- This “up and down” nature of changes coincides with periods of national lockdown and high COVID-19 cases, followed by easing of control measures. Similar patterns are seen in studies which look at anxiety^{57 58}, depressive symptoms⁵⁹, loneliness, sleep⁶⁰ and stress⁶¹
 - E.g. When the lockdown started at the end of March 2020, 49.6% of people reported high levels of anxiety, compared with just 21% in the last quarter of 2019. By August 2020, this had fallen to 30% and appeared to stabilise to pre-pandemic levels between August and September 2020
- The period of “recovery” in the UKHLS data seen in summer 2020 was not seen in all studies. In particular it was not seen in data from the Office for National Statistics (ONS) looking at depression in adults and data from the English Longitudinal Study of Aging considering mental health and wellbeing of older adults (aged over 52).

⁵⁵ PHE report can be found here: [Important findings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/important-findings-on-the-impact-of-covid-19-on-mental-wellbeing)

⁵⁶ [PsyArXiv Preprints | Psychological distress associated with the second COVID-19 wave: Prospective evidence from the UK Household Longitudinal Study](https://www.medrxiv.org/content/10.1101/2020.07.19.20157255v1)

⁵⁷ [Trajectories of anxiety and depressive symptoms during enforced isolation due to COVID-19 in England: a longitudinal observational study - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/35411111/)

⁵⁸ [Mental health during the COVID-19 pandemic in two longitudinal UK population cohorts | medRxiv](https://www.medrxiv.org/content/10.1101/2020.07.19.20157255v1)

⁵⁹ [Fancourt D, Steptoe A, Bu F. Trajectories of depression and anxiety during enforced isolation due to COVID-19: longitudinal analyses of 59,318 adults in the UK with and without diagnosed mental illness. medRxiv. 2020 Jun](https://www.medrxiv.org/content/10.1101/2020.07.19.20157255v1)

⁶⁰ <https://www.medrxiv.org/content/10.1101/2020.07.19.20157255v1>

⁶¹ PHE report can be found here: [Important findings - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/important-findings-on-the-impact-of-covid-19-on-mental-wellbeing)

- Studies⁶² also suggest that less than half of adults affected by abuse, self-harm or thoughts of self-harm accessed support in April 2020 (note there is no pre-pandemic baseline to compare this to). Another large study of adults aged 18 and over found that 26.1% of respondents reported self-harm thoughts and 7.9% self-harm behaviours at least once between March 2020 and May 2021. This study does not have a pre-pandemic comparison. Having experienced physical or psychological abuse between April and August 2021, having had COVID-19 and financial worries were also associated with increased self-harm⁶³.

Figure 20 highlights some of the more recent data from May of 2021, which shows the increase in anxiety across all ages, but especially in 16-34 year olds.

Percentage of respondents with high anxiety (score 6-10) in England, by age group – 2019 compared with most recent time period

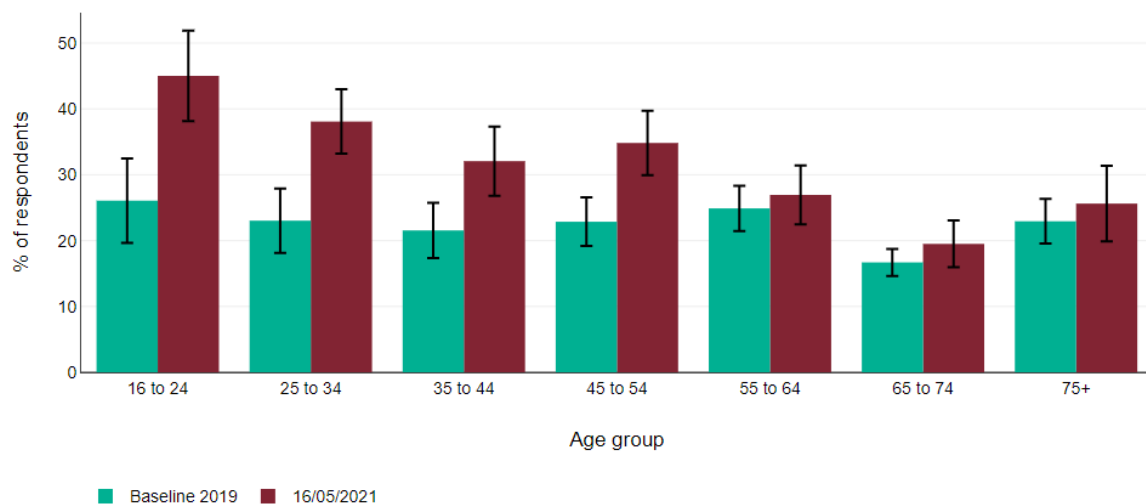


Figure 20: % of respondents with high anxiety scores in England. Data from PHE Wider impacts of COVID-19 on health monitoring tool: [Wider impacts of COVID-19 on health monitoring tool - GOV.UK \(www.gov.uk\)](https://www.gov.uk/wider-impacts-of-covid-19-on-health-monitoring-tool).

At a national level, those adults (see separate summary for children and young people (CYP)) most affected by that those most affected by anxiety and depression have been summarised in Public Health England reports⁶⁴ as:

- **Young adults (18-34) and women**, who have tended to report worse mental health and wellbeing compared to older adults and men. This is similar to patterns seen pre-pandemic, but the gap between these groups may have widened⁶⁵. The PHE report on the impacts of COVID-19⁶⁶ highlights the role of caring responsibilities in the pandemic and social factors in

⁶² [Fancourt D, Steptoe A, Bu F. Trajectories of depression and anxiety during enforced isolation due to COVID-19: longitudinal analyses of 59,318 adults in the UK with and without diagnosed mental illness. medRxiv. 2020 Jun](#)

⁶³ [Factors influencing self-harm thoughts and self-harm behaviours over the first year of the COVID-19 pandemic in the UK: a longitudinal analysis of 49,324 adults | medRxiv](#)

⁶⁴ [2. Important findings - GOV.UK \(www.gov.uk\)](#)

⁶⁵ [2. Important findings - GOV.UK \(www.gov.uk\)](#)

⁶⁶ [2. Important findings - GOV.UK \(www.gov.uk\)](#)

relating (for example women having more close friends and subsequently a larger increase in loneliness) to this.

- The impact on **Older adults** has been examined in the English Longitudinal survey⁶⁷, which includes data on adults aged over 52 years. Findings demonstrate the increase of depressive symptoms from 12.5% of the population pre-pandemic to 22.6% in July 2020 and then to 28.5% in November to December. This was alongside increased loneliness and a deterioration in quality of life. Older adults with multiple medical conditions and who had been recommended to shield were especially affected in July 2020, especially those who strictly adhered to the guidance.
- **Those living alone**
- Those living in **urban areas**
- Adults **not in employment and people with lower household income** reported more symptoms of anxiety and depression compared to those with higher household income and one study suggested that adverse experiences directly related to the pandemic (COVID-19 illness, financial difficulties, difficulties accessing food and medicine) affected people with lower incomes mental health more⁶⁸ and this group were also more likely to be lonely during lockdown⁶⁹. Those not in employment were also more likely to report increasing loneliness and anxiety if jobs had been lost early in the pandemic.
- Those with a **diagnosed mental illness** have higher levels of anxiety, depression and loneliness than those without, though this gap has not changed over the COVID-19 pandemic⁷⁰. Those with a **longstanding physical illness** were twice as likely to report symptoms of depression.
- Adults from **some ethnic minority populations** experienced a worse impact on mental wellbeing, though evidence is mixed due to low numbers in some studies and as the association between ethnicity and mental wellbeing is influenced by many other factors. A specific PHE report covers the evidence of the impact of COVID-19 by ethnicity⁷¹ and so far points towards Black, Asian and minority ethnic men (when considered together) having reported a worse decline in mental wellbeing compared to White British men, though all groups reported significant declines. Although women overall have reported larger declines in mental health and wellbeing than men, there is currently no evidence of significant differences by ethnic group. Some data shows that adults from Black, Asian and minority ethnicity backgrounds experienced increased loneliness and worry about contracting COVID-19.
- **People with children and in particular the mental wellbeing of lone mothers** may be especially affected. Working with adults with children reported a larger decrease in mental

⁶⁷ [The immediate and longer-term impact of the COVID-19 pandemic on the mental health and wellbeing of older adults in England | medRxiv](#)

⁶⁸ [Wright L, Steptoe A, Fancourt D. How are adversities during COVID-19 affecting mental health? Differential associations for worries and experiences and implications for policy. medRxiv. 2020 Jul 9;2020.05.14.20101717](#)

⁶⁹ [Wright L, Steptoe A, Fancourt D. How are adversities during COVID-19 affecting mental health? Differential associations for worries and experiences and implications for policy. medRxiv. 2020 Jul 9;2020.05.14.20101717](#)

⁷⁰ [Important findings - GOV.UK \(www.gov.uk\)](#)

⁷¹ [4. Ethnicity Spotlight - GOV.UK \(www.gov.uk\)](#)

health than other working adults in one study of the first lockdown period^{72, 73}. Qualitative research has highlighted the impact on families navigating multiple pressures and conflicting responsibilities with home, schooling, and work without usual support networks. However Adults living with children have also been less likely to report feeling lonely, or increasing loneliness over time, than adults living alone⁷⁴.

2.5.2 Impacts of COVID-19 across Oxfordshire

Most data from national level surveys on wellbeing over the COVID period to this date has not been reported at a local authority level, for comparison to national level data.

Data and local insights on the impact of COVID on mental health and wellbeing for have been gathered through input with those delivering services and members of the Concordat for better mental health.

2.5.2.1 IAPT referrals during COVID-19

In contrast to the rise in self-reported increase in anxiety and depression symptoms and reduction in wellbeing at a national level during March-April 2020, referrals to IAPT decreased initially over the initial lockdown, indicating a possible gap in needs being met (figure 21). There is concern, that increased support will be needed in order to counter-act the effects of the pandemic.

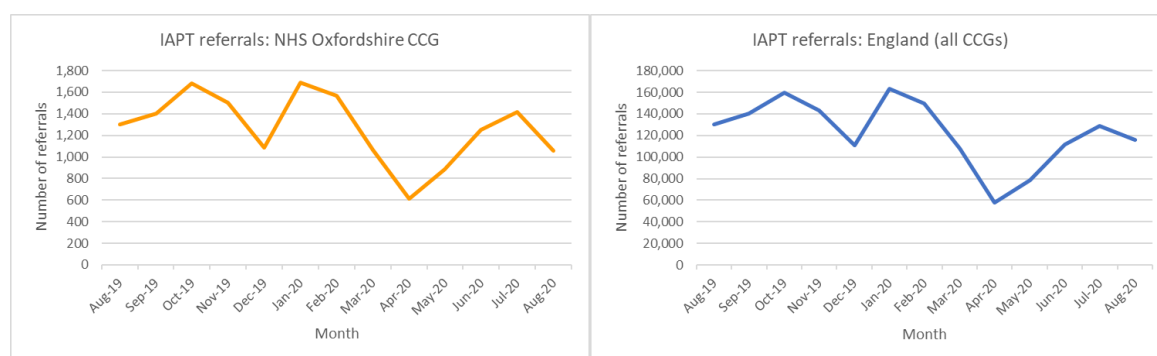


Figure 21: Local IAPT referrals: Data from NHS digital

2.5.3 The impact of COVID-19 on local populations: input from Concordat members on felt and normative need

Conversations undertaken for this needs assessment with different organisations have highlighted the difference in response to COVID-19 across populations. Some have found the pandemic an opportunity to become more digitally able but for those who are digitally excluded or have different needs then adapting can be difficult (e.g. those with loss of cognitive functioning and dementia diagnoses amongst others) are likely to find this change more challenging and therefore at increased risk of isolation. Many have faced new challenges (e.g. financial, new isolation) and for many the

⁷²Tani M, Cheng Z, Mendolia S, Paloyo AR, Savage D. Working Parents, Financial Insecurity, and Child-Care: Mental Health in the Time of COVID-19. 2020;29.

⁷³Bu F, Steptoe A, Fancourt D. Who is lonely in lockdown? Cross-cohort analyses of predictors of loneliness before and during the COVID-19 pandemic. medRxiv. 2020 Jul 16;2020.05.14.20101360

⁷⁴

pandemic and policies to mitigate spread of COVID-19 have exacerbated mental health and wellbeing issues either through affecting access to care or direct and indirect effects on mental health and wellbeing.

Feedback from those working with local populations during COVID-19 (e.g. the Oxford and West Oxford hubs – support workers and embedded mental health support teams) has highlighted a number of things:

Those who have sought help through local hubs and have seen an increased effect on mental wellbeing include:

- Those with older relatives
- Those who have had a COVID case or contact within their family
- Those who have been bereaved
- Those who have isolated for longer

People have sought support for issues relating to

- Isolation
- Bereavement
- Parenting
- Finances
- Mental health specifically

People have missed

- Seeing others – feeling isolated and lonely
- The freedom to travel and enjoy leisure activities

Mental health in clients seeking support has in general deteriorated and anxiety levels increased and many have found the change difficult (usual routine and structure disrupted). This includes

- a general loss of regular face-to face support both professional and through friends and family (though many services are now where possible operating hybrid models of face-to-face support with internet-based support)
- difficulty with lack of social inclusion, everyday activities such as shopping, collecting medication and postponement of health and hospital appointments
- those without reliable internet access have found accessing information about support and wellbeing and health support particularly difficult
- specifically some find phone or internet support challenging and are less likely to engage with this. In some instances, the use of internet and phones can exacerbate anxiety and wellbeing issues.
- Some have specific anxieties related to COVID-19 and for some, the news can exacerbate anxiety

One positive which has come out COVID-related infrastructure for support is a feeling that the hubs are a way into support for mental wellbeing concerns which otherwise would have been missed. For example, some have come with a practical concern and then talked about mental wellbeing and support. There is a feeling that mental health concerns can still be stigmatised and being able to

access support through a different and informal mechanism (e.g., not through a specific mental health/wellbeing service) has been helpful – i.e. it can act as a gateway for a conversation.

A second positive that emerged in conversations is the way in which organisations across sectors have come together to provide support where needed and working together and across systems has in general been well received. The [map](#) on Oxfordshire All in web-pages demonstrates the huge amount of COVID-19 support which has become available locally and across the county⁷⁵.

2.6 Partnership working for mental wellbeing

Input from service providers, Concordat members and the third sector, illustrate the many existing great examples of partnership working across Oxfordshire. Partnership working, and links between statutory and third sector – is vital for mental health and wellbeing.

Over 20 multi-agency partners in Oxfordshire have come together to show their commitment and make prevention a priority for mental health and wellbeing by signing up to the Prevention Concordat for Better Mental Health⁷⁶. The Oxfordshire Mental Health Partnership⁷⁷ brings together six local mental health organisations from the NHS and the charity sector. And many primary care networks benefit from social prescribers; connecting people with different services, support groups and mental wellbeing support.

In addition, there are numerous examples of partnership working to improve mental wellbeing across the county and across diverse settings. The examples which follow are not exhaustive, but rather give a flavour of the breadth of work which is currently being undertaken:

- Partnership between Public Health Oxfordshire, PHE South East and Banbury Madni Mosque for an “Every Mind Matters” [mental health campaign](#)⁷⁸
- Mental Wellbeing Grant Scheme launched in May 2021 by Oxfordshire County Council: one of the successful projects included: Ways to Wellbeing project, [Style Acre](#) to deliver a buddying programme to adults with learning disabilities. Promoting wildlife & nature activities, working with Element 6 and the Wildlife Trust & Sustainable Wantage. To be delivered in the Wallingford, Didcot and Banbury area.
- Growing Well Together project [Oxford City Farm](#) delivering farming volunteer sessions for all adults. Trained staff in mental health first aid and employed a project worker to target engagement with underrepresented ethnic minority communities Read more [here](#).
- Active Reach Residents from Blackbird Leys and Greater Leys were supported throughout COVID-19 to keep physically active. Partners include Access Sport, Age UK Oxfordshire, Aspire Oxford, KEEN, Oxford Hub, Oxfordshire Mind, OXSRAD and Oxfordshire Youth. Read more [here](#)
- Move Together: a project co-ordinated by Active Oxfordshire, in collaboration with the District Councils who are providing local place-based expertise to support

⁷⁵ [Oxfordshire All In — Covid-19 support](#)

⁷⁶ First year report of the Oxfordshire Prevention Concordat for Better Mental Health available to watch on [You Tube](#) or [Vimeo](#).

⁷⁷ [OMHP | Oxfordshire Mental Health Partnership](#)

⁷⁸ [Local mosque leaders supports ‘Every Mind Matters’ mental health campaign \(oxfordshire.gov.uk\)](#)

individuals into appropriate activity and help them move more, to improve their health. Read more [here](#).

- Partnership between Cherwell District Council, Oxfordshire Mind and Resilient Young Minds, working with Year 5 and 6 students to help them understand more about stress, anxiety and self-esteem . See [here](#).

2.7 Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing⁷⁹. It focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health and includes improving mental health and wellbeing in addition to conversations around stopping smoking, drinking alcohol only within the recommended limits, healthy eating and being physically active.

In Oxfordshire there is a MECC Systems Implementation Group (SIG) which is part of a wider MECC system in the region⁸⁰: the Oxfordshire MECC SIG reports into the BOB (Buckinghamshire, Oxfordshire, Berkshire West) MECC Oversight Group and into the South East MECC Network. A range of organisations within Oxfordshire are engaging with MECC, for example the Oxfordshire Library Service, Carers Oxfordshire, Homestart, Restore, Refugee Resource, Oxfordshire Fire and Rescue Service, District Councils and Primary Care. There has also been engagement with the Active Reach programme in Banbury. There has been work on developing MECC as an approach to support reducing health inequalities through training and engagement within the Voluntary and Community Sector and interactive training is available for working with the public (face-to-face or via phone) in Oxfordshire in a voluntary role.

2.8 Social prescribing

2.8.1 Background to social prescribing

Social prescribing allows local agencies to refer people with social, emotional or practical needs to a link worker, who in turn uses time with people to focus on 'what matters to me' and take a holistic approach to improving people's health and wellbeing. The link worker can then direct to a range of local, non-clinical services, often provided by the voluntary and community sector to support needs identified in this holistic approach. Patients can also self-refer and it is a key part of [Universal Personalised Care](#).

In the Long Term Plan, NHS England committed to building the infrastructure for social prescribing in primary care, so that across England⁸¹:

- there would be 1,000 new social prescribing link workers in place by 2020/21, with significantly more after that
- at least 900,000 people will be referred to social prescribing by 2023/24.

Social prescribing is aimed at a wide range of people, including people:

- with one or more long-term conditions

⁷⁹ [Making Every Contact Count \(MECC\)](#)

⁸⁰ [Item 11c - MECC SIG Update EON_KAv2.pdf \(oxfordshire.gov.uk\)](#)

⁸¹ [NHS England » Social prescribing](#)

- who need support with their mental health
- who are lonely or isolated
- who have complex social needs which affect their wellbeing

When social prescribing works well, people can be easily referred to link workers from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged. Nationally, social prescribing link workers are becoming an integral part of the multi-disciplinary teams in [primary care networks \(PCNs\)](#). They are part of the additional roles in the [five year framework for GP contract reform](#) and are included in the [Network Direct Enhanced Service Contract for 2020/21](#).

There is an increasing body of evidence surrounding social prescribing. A survey from 2018 by the Royal College of General Practitioners (RCGP) found that 59% of GPs thought that social prescribing could reduce their workload⁸². The NHS provides a number of case studies of social prescribing and there is emerging evidence of its positive impact. However, there is also a need for more robust evidence on its effects on outcomes^{83 84}.

2.8.2 Social Prescribing in Oxfordshire

A review of social prescribing practice across Oxfordshire is currently being undertaken by the CCG and a strategy for social prescribing is under development. Across Oxfordshire, social prescribing has been widely adopted and in the majority of Primary Care Networks (PCNs) as part of personalised care planning. Within Oxfordshire CCG, there is a social prescribing lead and facilitated groups that exist for key service providers, NHS England, members of voluntary service providers and service leads.

Across Oxfordshire, different PCNs have used a variety of options regarding link workers (social prescribers), allowing services to be adapted to local needs. For example, some have embedded link workers within GP practices employed through the practice, whereas others are commissioned through voluntary sector organisations, for example Oxfordshire Mind, Age UK Oxfordshire, Sofea. This allows for social prescribing to be tailored to population needs within a given area and link workers generally have their own directory of local community services and assets to refer to for support.

In some areas, such as Barton, social prescribing is well embedded into the GP practice system for example through the Barton health new towns project. Following welfare checks and a patient centred consultation, the social prescribing team in this area refer on to a variety of different local groups for help and support with wide ranging issues from financial problems and debt management, to early health support for children, community ladders, housing support and community centres. In this area, community development officers also meet to discuss issues such as the capacity of voluntary and support services for referrals. There is also a pro-active approach to try and reach patients who may be in need of greater support but not accessing through the usual

⁸² [RCGP calls on government to facilitate 'social prescribing' for all practices](#)

⁸³ [BMJ Open: Social Prescribing](#)

⁸⁴ [impact of social prescribing services on service users: a systematic review of the evidence | European Journal of Public Health | Oxford Academic \(oup.com\)](#)

GP route. For example, through pro-actively contacting those who haven't attended for screening or vaccinations.

Within Oxfordshire, there are partnerships also between 3 of the 4 local Citizens Advice (Oxford, North Oxfordshire and West Oxfordshire) and specific GP services, whereby through OCC Public Health grants they are able to deliver the Benefits In Practice service providing specialist benefits advice in specific GP practices in their area. This service enabled the GPs in these practices to directly refer patients to a Benefits Advisor based in their practice for a session each week⁸⁵. In addition, Citizens Advice North Oxfordshire and West Oxfordshire partnered to bid for funding from NHS England, with match funding from the district councils and OCCG to deliver a social prescribing service addressing the issues of loneliness, social isolation and inactivity. This service started in April 2018 and has funding until March 2022 delivering the Community Link Worker and Social Prescribing Champions elements of the social prescribing service provision within specific parts of Oxfordshire

The above paragraphs give only a broad overview of social prescribing in Oxfordshire. However, some challenges were also noted. For example, some observed the variety in how embedded link workers are within different areas, access to IT systems and joined up care records. As such, there is currently no overview of the numbers of patients who are seen across the county by social prescribers and how this varies according to given characteristics.

Within the social prescribing model, link workers are intended to also monitor the capacity of the voluntary sector and organisations to take their referrals. One critique of the system, however is that the NHS funding provided to date has been for the link workers, without increased financing of voluntary sector that referrals are made into. This in turn, may affect the capacity and sustainability of some local models.

⁸⁵ [Item 11a- Citizens Advice HIB Paper 14 Feb 2021.pdf \(oxfordshire.gov.uk\)](#)

3 Mental Wellbeing in Children and Young People

Section Summary

Nationally

- up to one in six (16.0%) of 5-16 year olds were identified as having a probable mental disorder, compared one in nine (10.8%) in 2017.
- children and young people who are most at risk of reduced mental health and wellbeing include looked after children, those who have witnessed domestic abuse, living in poverty and those living with a disability, LGBTQ communities and from diverse ethnic heritage.

Across Oxfordshire

- Between 2016/17 and 2019/2020, there has been a substantial increase in the number of referrals to Oxford health for children and young people
- Mental wellbeing has been assessed in primary, secondary and Further Education (FE) students as part of the OxWell Survey in 2019 and in 2020 and findings indicate:
 - Girls lower wellbeing is lower compared to boys
 - Overall mental wellbeing is worse with increasing age: in year 12, almost 1 in 5 pupils all pupils (boys and girls) who took part in the 2019 survey reported low wellbeing scores
 - Life satisfaction decreases with age, especially in girls
 - During lockdown, effects of the pandemic on loneliness, happiness and life satisfaction were worse with increasing age
 - During lockdown, 41% of those responding in 2020 often felt too worried to sleep
- Experiencing bullying is more common in younger ages : in 2019, 21% (1 in 5) of pupils in year 4 across Oxfordshire taking part in the survey reported being frequently bullied and 10% (1 in 10) sometimes bullied.
 - This had reduced to 8% and 6% respectively by year 10
- Pupils were asked in the 2020 survey where they would turn to for help for mental health. Across the South East, the most important sources of support were parents and carers, friends, someone at school, and online help (e.g. Childline, Mind)

The importance of early years and childhood experience in relation to both children and young people's wellbeing, but also mental and physical health and wellbeing through adulthood is well documented. A recent national survey, highlighted that up to one in six (16.0%) of 5-16 year olds were identified as having a probable mental disorder, compared one in nine (10.8%) in 2017⁸⁶. This increase was evident in both boys and girls.

- If these most recent national figures are applied to the Oxfordshire population⁸⁷ then this equates to 16,159 of those who are 5-16 years old across Oxfordshire with a probable mental disorder.

Between 2016/17 and 2019/2020, there has been a substantial increase in the number of referrals to Oxford Health for children and young people: the importance of primary prevention and promotion of mental wellbeing in children and young people cannot be emphasised enough.

We also know the importance of early and foundation years for children's emotional health and wellbeing, though this area is not covered in detail in this assessment. However it is well documented that disadvantage can start even before a child is born and can accumulate over time and impact on future generations. Important factors include: adverse childhood events such as being a victim of abuse; poor housing; poverty and traumatic events. Children and young people who face multiple risks have a increased risk of multiple and sustained childhood mental health difficulties⁸⁸. In addition, national data also shows us that looked after children, those who have witnessed domestic abuse, living in poverty and those living with a disability, LGBTQ communities and from diverse ethnic heritage can be at increased risk of mental health difficulties.

The government has set out its vision for a step-change in children and young people's mental health, as detailed below:

- Future in Mind (2015)⁸⁹ highlighted the need to build resilience, promote good mental health, and promote prevention, and to provide early identification and co-ordinated support.
- The Five Year Forward View for Mental Health (2016)⁹⁰ set out an ambition for transforming mental health services to achieve greater parity of esteem between mental and physical health for children, young people, adults and older people.
- In 2017 The Department for Health and Social Care (DHSC) and the Department for Education (DfE) jointly published Transforming children and young people's mental health: a green paper, setting out 3 proposals for designated mental health leads in all schools, new mental health support teams prioritised in working with children experiencing mild to

⁸⁶ [Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital](#)

⁸⁷ [Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics \(ons.gov.uk\)](#)

⁸⁸ [Health matters: reducing health inequalities in mental illness - GOV.UK \(www.gov.uk\)](#)

⁸⁹ [Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing \(publishing.service.gov.uk\)](#)

⁹⁰ [The Five Year Forward View for Mental Health \(england.nhs.uk\)](#)

moderate mental health problems and trialling reduced waiting times for specialist mental health services.

This section of the needs assessment describes national and local data on mental wellbeing in children and young people, and then goes on to describe evidence on the impact of COVID-19 and associated control measures from what we know so far.

3.1 Quantitative data from national sources On Mental Health for England, South East and Oxfordshire

3.1.1 Mental Health Indicators

Figure 22 below summarises PHE data⁹¹ for Oxfordshire on key indicators of mental health and wellbeing. It suggests that Oxfordshire has a higher number of school pupils with social, emotional and mental health needs than the English average. In 2020, across Oxfordshire there were 3.11% of school age pupils with social emotional and mental health needs compared to the England average of 2.7% (see figure 17). In 2019/20, Oxfordshire had a higher proportion of hospital admissions as a result of self-harm in 10-24 year olds (462.1 (95% CI 425.9, 526.3) per 100,000) compared to the England average (439.2 (95% CI 435.1, 443.1) per 100,000), but a lower proportion than the South East average (508.0 (95% CI 497.8, 520.2)).

Indicator	Period	Oxon		Region England				England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Estimated number of children and young people with mental disorders – aged 5 to 17	2017/18	–	–	12,632	–	–	–	–	–
Estimated prevalence of emotional disorders: % population aged 5-16	2015	–	3,018	3.2%*	3.3%*	3.6%*	2.8%		4.2%
Estimated prevalence of conduct disorders: % population aged 5-16	2015	–	4,531	4.9%*	5.0%*	5.6%*	4.0%		6.9%
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2015	–	1,207	1.3%*	1.4%*	1.5%*	1.1%		1.9%
Prevalence of potential eating disorders among young people: estimated number aged 16 - 24	2013	–	10,497	10,497*	126533*	*	–	–	–
Prevalence of ADHD among young people: estimated number aged 16 - 24	2013	–	11,265	11,265*	134099*	*	–	–	–
Percentage of looked after children whose emotional wellbeing is a cause for concern	2019/20	➔	126	37.0%	39.5%	37.4%	59.3%		17.5%
Hospital admissions as a result of self-harm (10-24 years)	2019/20	➔	600	462.1	508.9	439.2	1,105.4		126.2
Hospital admissions as a result of self-harm (10-14 yrs)	2019/20	➔	70	169.9	197.8	219.8	580.6		46.2
Hospital admissions as a result of self-harm (15-19 yrs)	2019/20	➔	290	722.5	795.2	664.7	1,640.8		151.1
Hospital admissions as a result of self-harm (20-24 yrs)	2019/20	➔	245	497.5	531.9	433.7	1,280.0		86.3
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)	2020	⬆	1,594	2.94%	2.52%	2.45%	4.05%		1.35%
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)	2020	⬆	1,249	3.09%	2.63%	2.67%	4.71%		1.28%
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)	2020	⬆	2,980	3.11%	2.73%	2.70%	4.40%		1.50%
Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS)	2019/20	–	–	17.3%	24.9%	25.8%	42.7%		11.8%

Figure 22 :Routine data available on mental wellbeing and mental health indicators at a county level, benchmarked against national data. Source – PHE fingertips. [Children and Young People's Mental Health and Wellbeing - PHE](#)

⁹¹ [Children and Young People's Mental Health and Wellbeing - PHE](#)

3.1.2 Referrals of Oxfordshire patients to Oxford Health for mental health services

Between 2016/17 and 2019/2020, there has been a substantial increase in the number of referrals to Oxford health mental health services for children and young people. This data has been highlighted in the recent Oxfordshire JSNA⁹², which reported an 83% increase in referrals for people aged 0-9 years and a 58% increase in people aged 10-19 years. Figure 23 shows referrals to Oxfordshire CCG by age over the last 4 years.

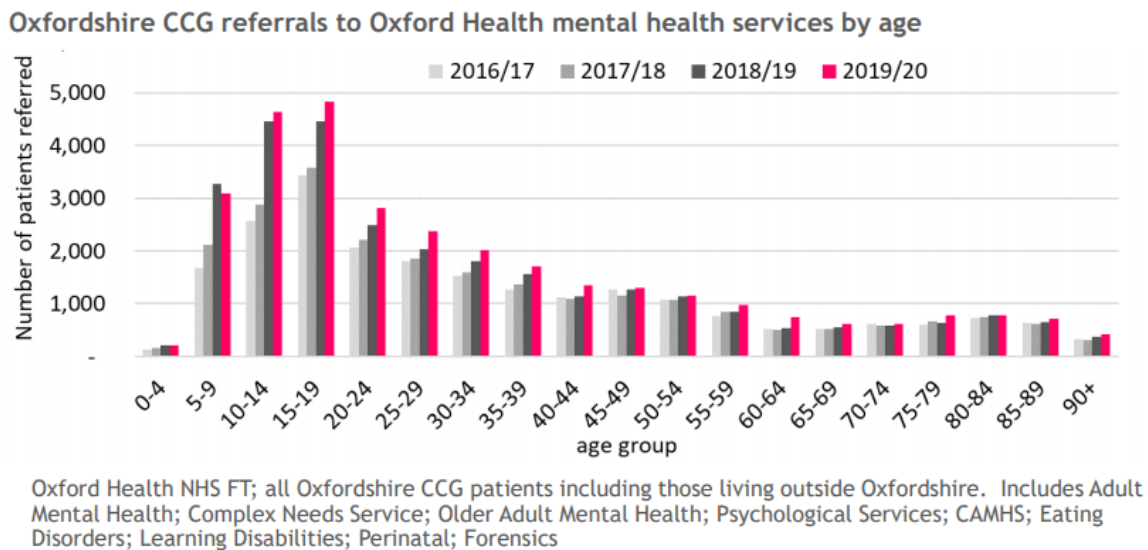


Figure 23: referrals to Oxford Health services by age. Available from the Oxfordshire JSNA.

⁹² [Oxfordshire JSNA 2021](#)

3.2 Children and Young people's Mental Wellbeing

Through the Oxwell survey^{93 94} we have a good understanding of how wellbeing varies across school pupils within Oxfordshire and factors which affect it.

The OxWell School survey is a school based survey, is an online pupil survey (OPS), which in [2019](#) ran for over 4000 pupils in Oxfordshire and in [2020](#) included 19,000 students from schools across Berkshire East, Berkshire West, Buckinghamshire, Gloucestershire, Oxfordshire, South Gloucestershire, and Wiltshire. It assesses mental wellbeing, anxiety, indicators of vulnerability and protective factors, how well children and teenagers are sleeping and access to mental wellbeing and health support. Results from the 2021 are likely to be available close to the time of publishing this report.

Mental wellbeing in this survey is measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): positively worded questions are used to calculate an overall mental wellbeing score. The categories below (high, average, below average, and low wellbeing) are based on the distribution of responses in other populations (adults and adolescents). As such, this data represents one of the most comprehensive sources of survey data available in Oxfordshire to understand wellbeing in our school age residents.

There is ongoing work to enable comparisons between 2019 and 2020 findings across Oxfordshire to be made. This requires in depth analysis, due to changes respondents and the context in which the surveys were undertaken (e.g. in 2020 more respondents identified as female, which may have skewed data towards showing lower mental wellbeing, not necessarily attributable overall to the impact of COVID 19). Of note, 2021 results will also be released shortly.

3.2.1 2019 Oxwell survey results (pre-pandemic)

3.2.1.1 *Mental wellbeing scores*

OxWell survey results from 2019⁹⁵ indicate that primary school pupils scored higher for mental wellbeing compared to secondary and Further Education (FE) college students(see figure 24 below). In addition, levels of happiness decreased with age, especially after year 6. The overall pattern is

⁹³ [Microsoft Word - OPS2019_ReportDec2nd2020.docx \(oxfordshire.gov.uk\)](#)

⁹⁴ [Preliminary Summary Report from the OxWell School Survey 2020 — Department of Psychiatry](#)

⁹⁵ [Microsoft Word - OPS2019_ReportDec2nd2020.docx \(oxfordshire.gov.uk\)](#)

consistent with knowledge that adolescence is a critical age for onset of mental health problems.

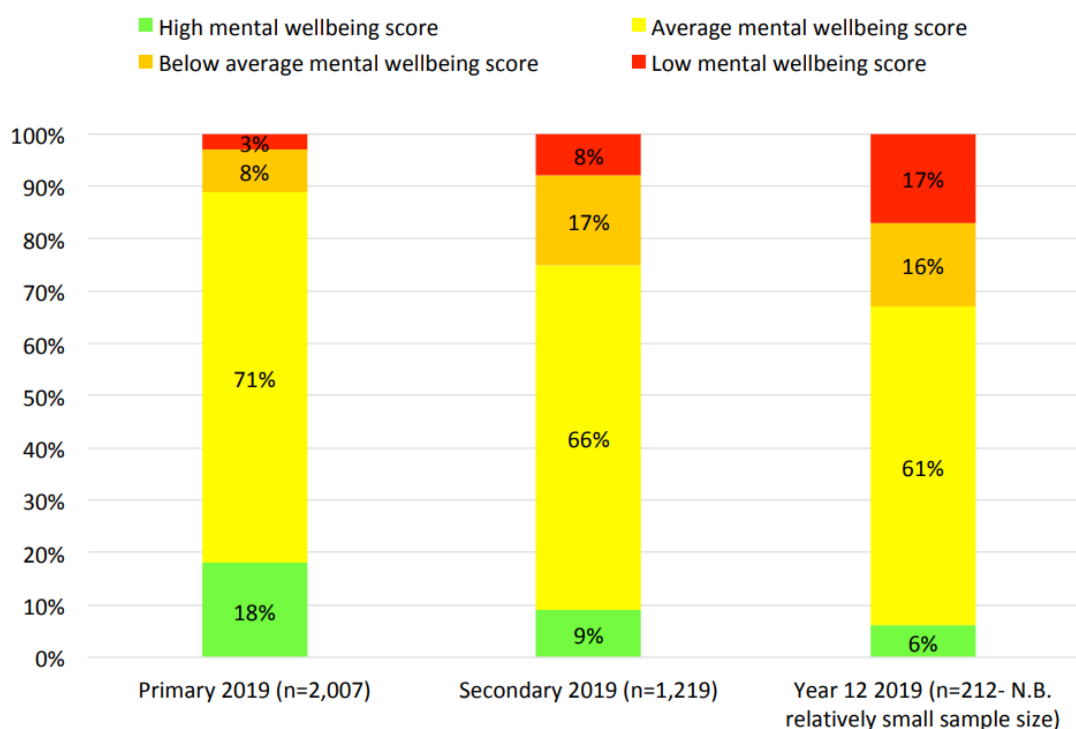


Figure 24: Mental wellbeing scores in primary, secondary and year 12 pupils in Oxfordshire from the 2019 OxWell survey

3.2.1.2 Sleep

In 2019, 31% of girls and 19% of boys in year 12 reported being too worried to sleep at least once a week. Sleep behaviour was also examined as part of the survey. In year 12, 25% of pupils were watching TV and 51% were using the internet before they went to sleep.

3.2.1.3 Friendships and bullying

When asked, 64% of pupils responding to the 2019 survey said they found it easy to make and keep friends. Whilst the majority (64% pupils) reported not being bullied in the last year, over 200 children and young people reported being bullied most days. This was worse in years 4-6 in particular (figure 25).

The most common form of bullying was verbal, followed by feeling isolated or excluded. In secondary school 23% of reported bullying was cyber bullying, compared to 10% in primary school.

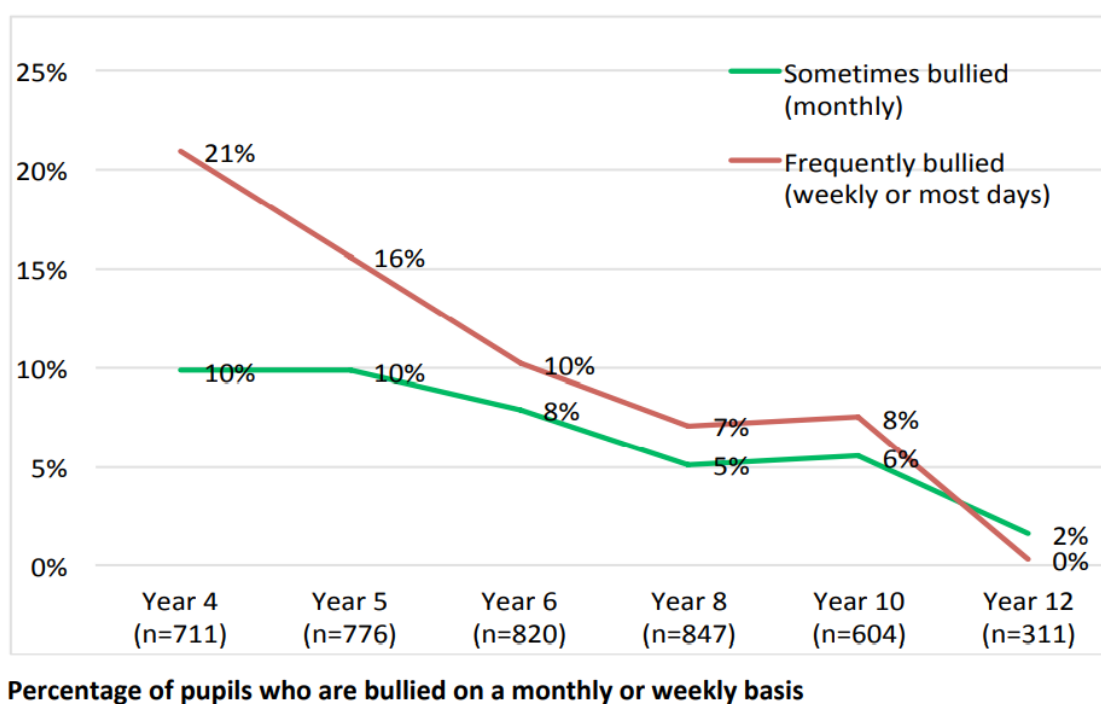


Figure 25: % of pupils in 2019 OxWell survey reporting being bullied, by age

3.2.1.4 Self-harm

Questions about self-harm were asked of those in year 12 and in secondary school. For those answering yes to “have you ever self-harmed”, further questions were asked.

When asked about support they received for self-harm, 52% said they had told someone about it – 41% had told parents/carers, 79% friends and 48% no-one. Of the young people who did not receive help for their self-harm, half did not want to burden anyone else or did not want help, 48% said they did not trust anyone, 41% were worried about what people would say, and 33% were worried about it being kept confidential. Further details can be found in the OxWell report.

3.2.1.5 Access to support

Pupils were asked where they would most likely go for help if they were “unhappy about a personal issue”.

The main sources of support (figure 26) were:

- Family (79% in primary school phase)
- Friends – increasingly with increasing age: 74% of year 12s would turn to friends (compared to 47% of primary school respondents) for help although family remained key still for this age group
- Members of school – e.g., teachers (42% of primary school respondents, 18% of year 8 respondents and 11% of year 11 and 12 respondents) and councillors or school nurses
- Websites/forums – by year 12, 16% of respondents listed this as a source of support
- Sadly 18% of year 12 and 11% of primary school pupils reported they had no-one to go to for advice.

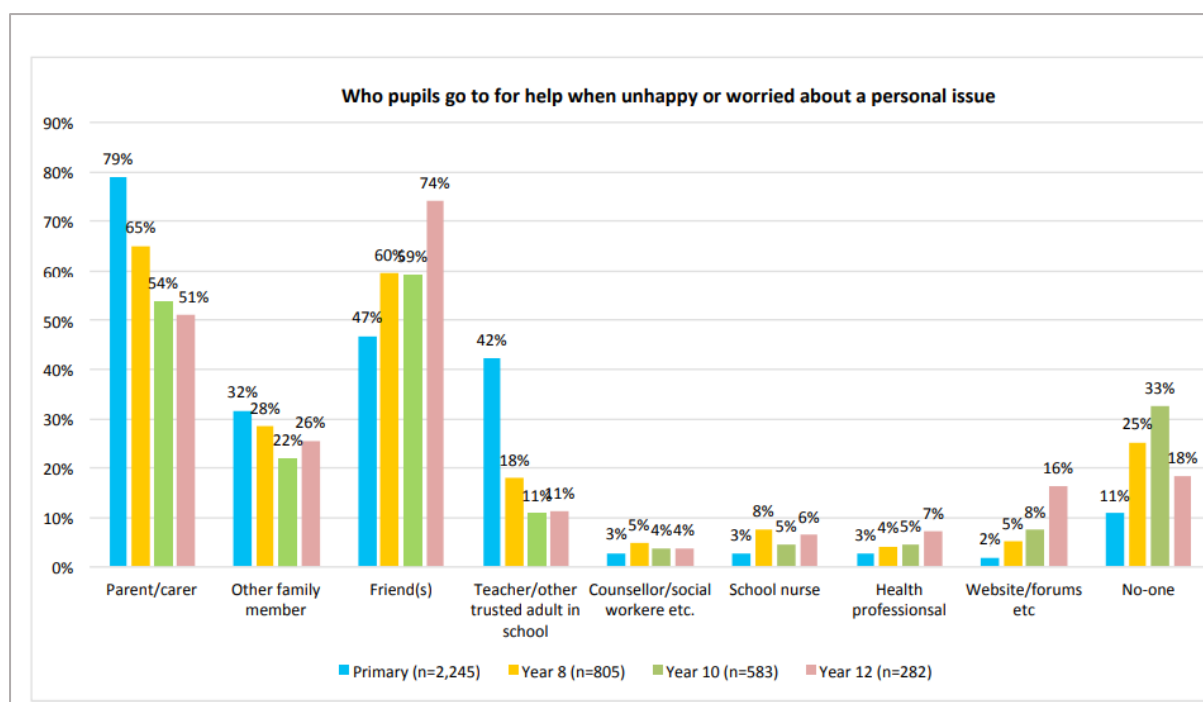


Figure 26: Where pupils turn to for help. Data from 2019 OxWell survey

3.3 The impact of COVID-19 on Children and Young people's Mental Wellbeing

3.3.1 National data

There have been a number of national level reports, which highlighted the effects of the COVID-19 pandemic and associated control measures in children and young people.

The Public Health England surveillance report ⁹⁶ highlighted a number of important gaps in knowledge around: measures of mental health in younger children, particularly primary school age; representative evidence on the experiences and mental health of children and young people from particular sub-groups, such as those living in areas of deprivation or with protected equalities characteristics (such as young people identifying as LGBTQ+); experiences of important pandemic related risk such as the experience of illness, bereavement or multiple parental stresses.

The report also highlighted that for ages 13-24 and from April 2020, 64% of young people had high scores of anxiety and 34% had high scores for depressive symptoms and that where there has been disruption to support in families with existing mental health needs, this is associated with worse mental health.

Loneliness tended to increase with age within children and young people and was associated with feeling anxious and lower life satisfaction. Many were able to maintain some contact with friends using technology, though this has led to a digital divide

Experiences have varied by CYP characteristics: evidence is mixed on whether mental health and wellbeing during COVID-19 has varied by ethnicity; the pandemic appears to have negatively affected mental health and wellbeing of young people with existing mental health conditions; in low

⁹⁶ [7. Children and young people - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/7-children-and-young-people)

income families and areas, CYP may have had less access to technology (less ability to communicate with friends) and more likely to have lost their routine including sleep.

3.3.1.1 National Findings: Mental Health of Children and Young People in England 2020: Wave 1 follow up to 2017 survey

This follow up of a previous survey undertaken in 2017, across children and young people in England, found that the rate of probable mental disorders have increased since 2017, with one in six (16.0%) of 5-16 year olds were identified as having a probable mental disorder, compared one in nine (10.8%) in 2017. The probability of mental disorders increased with age and with a significant difference in gender (females more at risk than males).

Over half (58.9%) of 5-22 year olds with a probable mental disorder reported sleep problems and this was more likely in 17-22 year olds compared to younger age groups.

Of those 11-16 year old girls with a probable mental disorder, around 64% had heard an argument amongst adults in the household compared to around 47% with no identifiable mental disorder and children between 5-16 years with a probable mental disorder were two times more likely compared to those without to live in a household fallen behind with payments (16.3% compared to 6.4%). These figures illustrate the importance of taking a holistic approach to wellbeing, considering a wide range of contributing factors.

3.3.2 Data from Oxfordshire and the South East on COVID-19 impact

The [OxWell school survey](#) and Healthwatch reports summarise local data on the effects of COVID-19 and its control measures on mental health and wellbeing for CYP across Oxfordshire.

3.3.3 OxWell Survey

The 2020 OxWell provisional survey report, which included data on the effects of the pandemic from participating schools across Berkshire East, Berkshire West, Buckinghamshire, Gloucestershire, Oxfordshire, South Gloucestershire, and Wiltshire has summarised data on a number of key factors related to wellbeing.

As for previous years, it has indicated that wellbeing was worse in older age groups. However, due to demographic differences of those taking part in the survey (2020 had higher number of girls compared to boys), these overall results cannot be directly compared.

With increasing age, life satisfaction decreased – from year 10 and above over 32% of pupils responding had low scores for life satisfaction. Lockdown had more negative impacts on happiness and loneliness for older age groups

- Generally younger pupils, primary and below Year 9 reported being the same or happier during lockdown.
- However, 70% Year 10's and of the sixth form reported being the same or more unhappy : i.e. older students were more likely to perceive their mental wellbeing to be lower during lockdown compared to before lockdown. Outcomes were worst in years 10, 12 and 13.

Sleep was also more negatively affected in older age groups – 40% of year group 13 reported often being too worried to sleep. Exercise was more negatively affected with increasing age.

Lastly, the survey also asked about where people would turn to for help during the lockdown . When asked “if you felt you needed to speak to someone to get mental health support during lockdown, what would you do? Tick all that apply”, responses were:

- 72% would turn to a parent/carer
- 57% would contact a friend
- 21% would contact someone who works at school/college
- 15% contact another adult I trust
- 17% would look for help online (e.g. childline, Mind)

The protective and risk factors for wellbeing from this survey are currently being analysed in more detail by researchers at Oxford University.

The data for Oxfordshire schools in 2020, shows similar patterns to those in the South East were found, with wellbeing generally decreasing with age and life satisfaction decreased with age, especially in girls (figure 27).

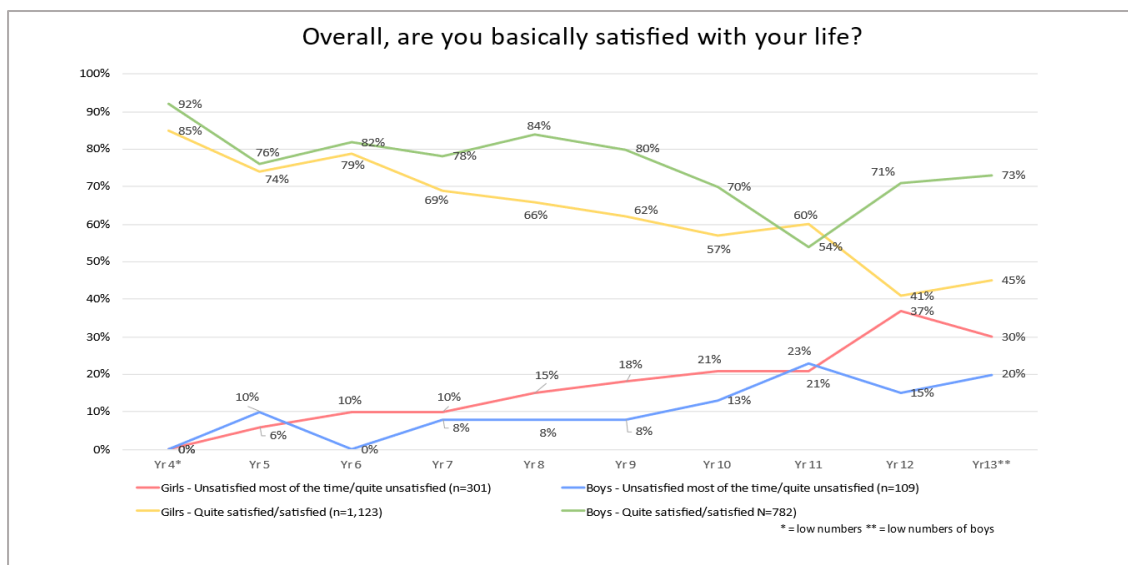


Figure 27: self-reported life satisfaction: for Oxfordshire school pupils taking part in the OxWell 2020 survey

Disrupted sleep is a key indicator of anxiety and is associated with reduced mental wellbeing. As with the happiness ratings, older pupils seem to be sleeping badly and in Oxfordshire (figure 24), this was worse in girls compared to boys.

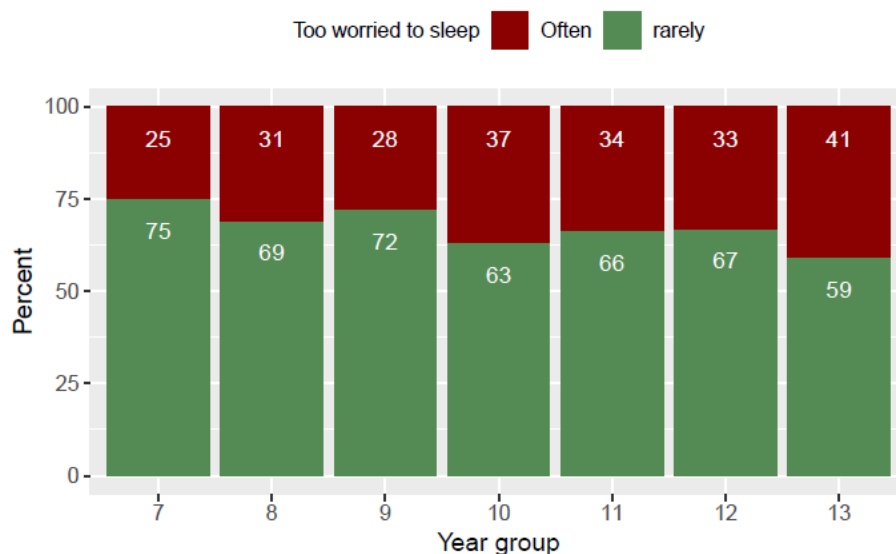


Figure 24: self-reported impact of worry on sleep, Oxfordshire pupils taking part in the Oxwell 2020 survey

The OxWell 2021 report will give further insights into ongoing effects of the pandemic on mental wellbeing for children and young people.

3.3.4 Felt and normative need in 0-5s: the Healthwatch Oxfordshire Report

The [Healthwatch report](#)⁹⁷ on mental wellbeing in 0-5s summarises evidence from an online survey that ran from March to July 2020 (coinciding with the first COVID-19 lockdown). From this survey, the report includes findings from 63 responses from parents and carers across Oxfordshire and 16 responses to supplementary questions from childcare professionals working with 0-5s. Due to the timing of the survey, it acknowledges that seldom heard communities may have been hard to reach as all childcare settings were closed.

The report found that mental health/wellbeing of 0-5s is integral to wellbeing of the family as a whole. In terms of the services offered across Oxfordshire, it illustrated that⁹⁸:

- *“There is a need for clear signposting, central information and advice but families also valued face to face support from professionals, peers and childcare settings. These are a trusted source of advice & help “*
- *“Stigma, fear of being judged or not being taken seriously could act as barriers to seeking help”*
- *“There is room for more support, training and awareness for childcare workers, health professionals and parents on understanding and supporting mental health and wellbeing in 0-5s”*
- *“Covid-19 has had an impact on mental health and wellbeing of both parents and young children in multiple ways- which may continue to become clear over time”*

Questions were asked on where parents go for help and advice. The most common response was friends and family (49/62 responses) followed by a GP (43/62 responses) and Health visitors (38 /62

⁹⁷ [Childrens-Emotional-Wellbeing-September-2020.pdf \(pressidium.com\)](#)

⁹⁸ Quotes are taken directly from the report

responses) and the internet (40/62 responses). Pre-school, nurseries or childminders, other parents and carers and community settings were also mentioned.

Parents were asked what sources of support they had heard of and most common, were health visitors, GPs, Child and Adolescent Mental Health Service (CAMHS)⁹⁹ and early years SEN. Less commonly known were the Infant-Parent Perinatal Service (IPPS)¹⁰⁰ and the Oxford Parent-Infant Project (OXPIP)¹⁰¹.

The report also elicited the views of 16 childcare professionals in gaps in support for 0-5s. Findings included¹⁰²:

- *“Black and ethnic minority families are much less likely to be referred for help with family stress/ parental mental health difficulties”.*
- *“The needs of black and ethnic minority families need specific care and attention because of the need for sensitivity to culture and religion”*
- It stressed the importance of recognising the mental health needs of fathers, and involving fathers in interventions
- There are gaps in support: support before things escalate is key
- There is a need for training about understanding mental health and wellbeing in 0-5s for those working with this age group and parents

In addition the report mentions further work planned with families in Banbury which would further add to understanding of needs in this area.

⁹⁹ [Oxfordshire | Oxford Health CAMHS](#)[Oxford Health CAMHS](#)

¹⁰⁰ [Infant-Parent Perinatal Service \(IPPS\) – Oxfordshire - Oxford Health NHS Foundation Trust](#)

¹⁰¹ [OXPIP](#)

¹⁰² Quotes are taken directly from the report

4 The wider determinants of mental wellbeing

The next sections pull together the data and evidence of need across the wider determinants of mental wellbeing, for Oxfordshire and at a district level where possible and compared to National and regional data.

The wider determinants examined as part of this needs assessment, map broadly to the enablers outlined in the Oxfordshire Mental Health Prevention Framework ¹⁰³(figure 25) and supported by evidence from the literature. Of note, for some enablers – creativity, sleep and volunteering - local level data on prevalence and inequalities could not be located (with the exception of sleep needs in children and young people, which forms part of the OxWell survey data) and these represent gaps in our understanding.

Four Key areas are examined:

- Financial drivers and enablers
- Physical Activity
- Access to and use of green and natural spaces
- Connections to others

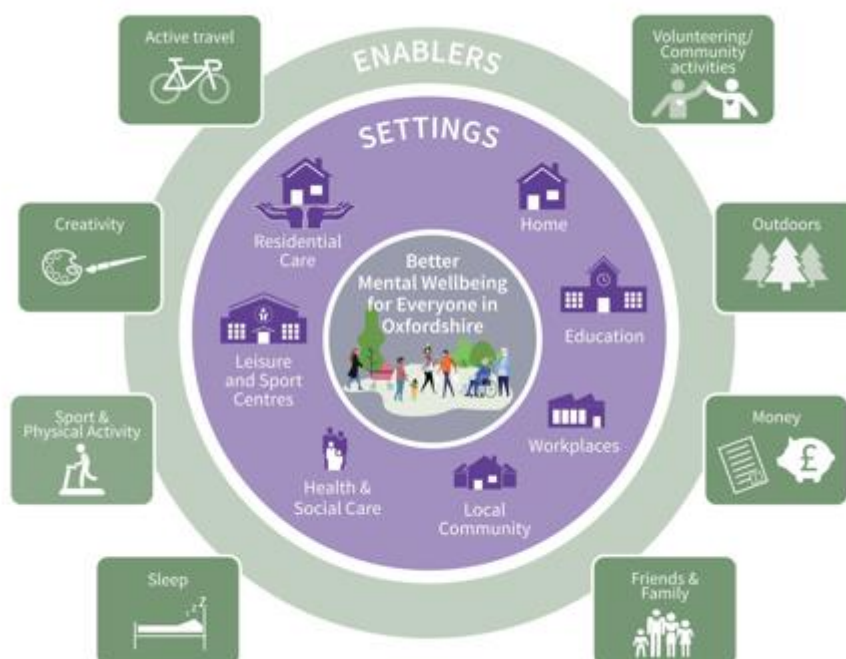


Figure 25: Community enablers for Wellbeing

¹⁰³ [OxfordshireMentalHealthPreventionFramework](#)

5 Finances, Employment and debt

Section summary:

Adults

Nationally

- There is a well established association between mental health and wellbeing, employment and financial stability
- Even before the COVID-19 pandemic, at a national level
 - weekly earnings had not recovered to the levels of 2010
 - there had been an increase in “zero hours contracts” and
 - the risk of being unemployed and long-term unemployed is higher in different population groups

Oxfordshire

- Although Oxfordshire is ranked as one of the 10th least deprived of 151 upper-tier local authorities in England, 16 Lower Super Output Areas (LSOAs) were ranked in the 20% most deprived areas nationally:
 - 9 in Oxford City, 6 in Banbury and 1 in Abingdon and one – part of Northfield Brook in South East Oxford was within the 10% of most deprived areas nationally.
- Across Oxfordshire before the COVID-19 pandemic
 - median earnings increased from £33,000 in 2017 to £34,400 in 2018 – a larger proportional rise than for the South East or England
 - gender gap, however widened to £6,642 (median male earnings £36,713 and female £30,071)
 - However these averages hide many inequalities between geographies, communities and lived experiences of work and financial security
- From March 2020
 - Unemployment claims have risen sharply compared to the same month of the previous year
 - There were 16,540 unemployment claimants in November 2020 compared to 6,110 in November 2019
 - 16-24 year olds were disproportionately affected
 - Employment rates have begun to recover after the ending of lockdowns but have not yet recovered to pre-pandemic levels

Children and young people

- After removing housing costs, 1 in 5 children in Oxfordshire are estimated to be living in poverty – within Oxford City this figure rises to a quarter of children
- Between December 2019 and December 2020: the number of 16-24 year olds claiming unemployment benefits in Oxfordshire tripled – an increase of increase of 2,105.
- In December 2020 - total of 334 (2.6%) young people in Oxfordshire aged 16 to 18yrs (school year 12-13) classified as Not in Education, Employment or Training (NEET),

5.1 Background/ context – links between employment, finances and mental wellbeing

There is a known association between mental health and wellbeing, employment and financial stability. For example, unemployment is harmful to health even after other factors have been accounted for¹⁰⁴. This can be through many mechanisms – by exacerbating poverty and also causing stress by disrupting important social factors and elements essential to mental wellbeing such as self-esteem and personal identity¹⁰⁵. A poor-quality job, however, can also be detrimental to health.

On average people with experience of common mental disorders or illnesses earn around £8,400 less per year than those without CMD¹⁰⁶. People with mental health problems are less likely to be in employment and in 2018/2019 just under half working age adults with mental health problems were in employment compared to 4 in 5 adults without. Recent research carried out by the Money and Mental Health Policy Institute¹⁰⁷ found of those who have experienced mental health problems 29% said can only make ends meet for less than a 1 month, compared to 14% without. Around 37% with mental health disorders need to borrow money/use credit to pay for everyday outgoings, which can be a source of ongoing anxiety.

The relationship between finances and mental health and wellbeing goes in both directions (poor finances can worsen mental wellbeing and equally poor mental health and wellbeing impacts upon finances through a variety of mechanisms). This can result in a cycle of self-reinforcing negative impacts (figure 26 below).

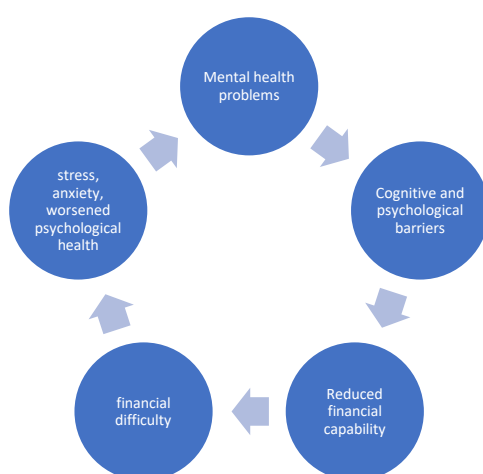


Figure 26: Self-reinforcing mechanisms and relationships between mental health and wellbeing and financial difficulty

Given that employment and finances are a component of the Oxfordshire JSNA (see [here](#)¹⁰⁸) and regular updates are provided on employment across the county [here](#), this section of the needs assessment is kept shorter than others and focuses on the most recent data at national and local

¹⁰⁴ Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Fair Society, Healthy Lives: The Marmot Review. London; 2010.

¹⁰⁵ [build-back-fairer-the-covid-19-marmot-review-full-report.pdf \(instituteofhealthequity.org\)](#)

¹⁰⁶ [Mind the mental health income gap - Money and Mental Health](#)

¹⁰⁷ [Report: Income in Crisis - Money & Mental Health Policy Institute \(moneyandmentalhealth.org\)](#)

¹⁰⁸ [Oxfordshire Health and Wellbeing](#)

level, which reflects the impact of the COVID-19 pandemic and efforts to control this on employment and finances.

Figure 27 below maps Oxfordshire by Index of Multiple Deprivation. Of note, although Oxfordshire is ranked as one of the 10th least deprived of 151 upper-tier local authorities in England, 16 Lower Super Output Areas (LSOAs) were ranked in the 20% most deprived areas nationally:

- 9 in Oxford City, 6 in Banbury and 1 in Abingdon and one – part of Northfield Brook in South East Oxford was within the 10% of most deprived areas nationally.

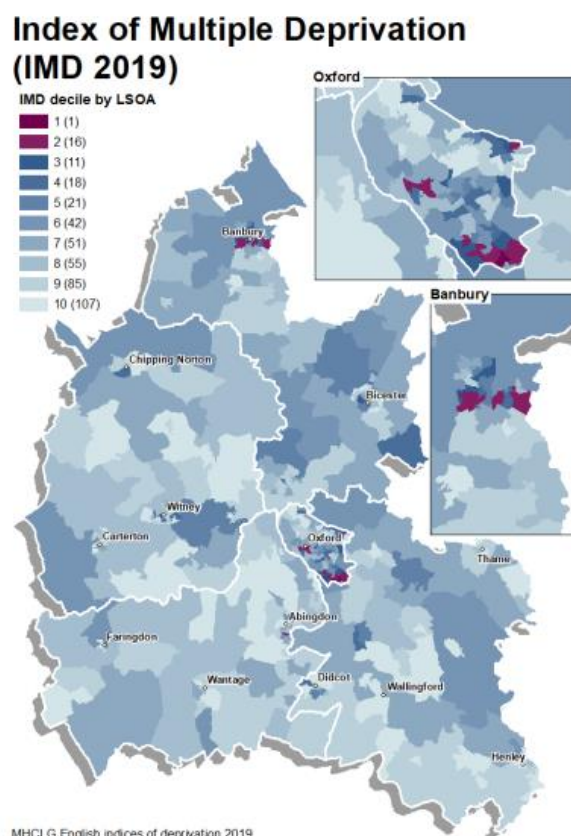


Figure 27: Map of Index Of Multiple Deprivation from Oxfordshire from the [JSNA](#)

5.2 National level Data on finances, employment and inequalities

The February 2020 “Health Equity in England: the Marmot review 10 years” [report](#)¹⁰⁹ has analysed the data on employment at a national level prior to the COVID-19 pandemic. Within this, analysis of the ONS/Nomis data indicated that employment levels had risen between 2009 and 2019 in both men and women. However, the report notes that while there are more people in work, weekly earnings have not recovered to the levels of 2010 and across the UK, the number of people in work and living in poverty was 3.7 million in 2015/2016.

The number of people in employment on zero hours contracts has risen substantially since 2011-2012 (figure 27)¹¹⁰

¹⁰⁹ [Health Equity in England: The Marmot Review 10 Years On | The Health Foundation](#)

¹¹⁰ [Contracts that do not guarantee a minimum number of hours - Office for National Statistics \(ons.gov.uk\)](#)



Figure 27: Number employed on zero hours contracts

The risk of being unemployed and long term-unemployed is still highly unequal between different population groups (e.g. gender, ethnicity) as are hourly earnings and gender pay gaps¹¹¹ (see figure 28)

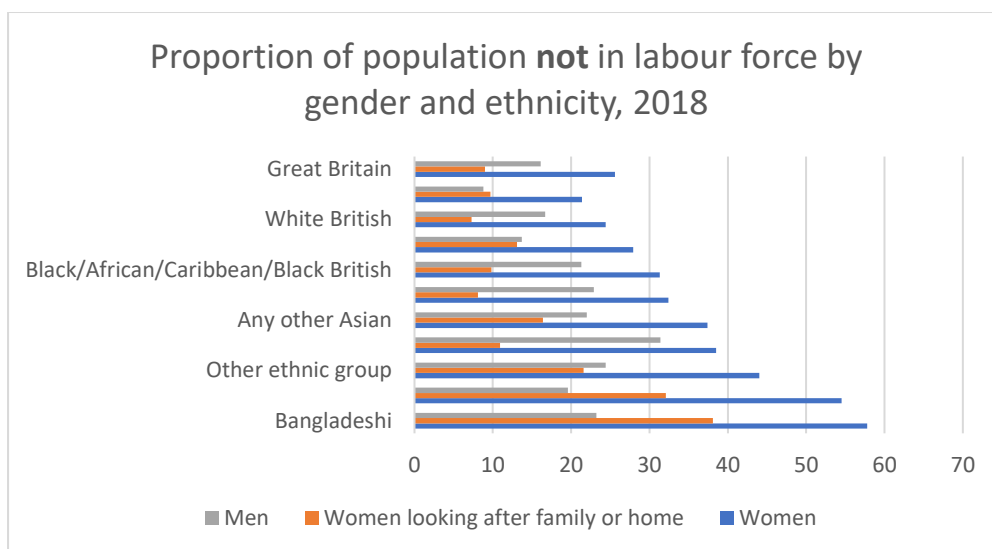


Figure 28: proportion of population not in labour force. Data source : ONS

5.3 Local data

Local level data on employment can be found in the Oxfordshire JSNA (see [here](#)¹¹²) and regular updates are provided on employment across the county [here](#). An in depth analysis of employment

¹¹¹ [Ethnicity pay gaps in Great Britain - Office for National Statistics \(ons.gov.uk\)](#)

¹¹² [Oxfordshire Health and Wellbeing](#)

and the labour force across the county was undertaken by Oxfordshire Impact and can be found [here](#)¹¹³.

In 2019, before the COVID-19 pandemic:

- Residents of Oxfordshire's median earnings increased from £33,000 in 2017 to £34,400 in 2018.
- Across the South East, earnings grew for £31,700 to £32,200
- The gender gap, however widened to £6,642 (median male earnings £36,713 and female £30,071) and was the biggest gender pay gap in Oxfordshire since 2008 though a smaller gap than at regional and national levels

There had been an increase in employment rate. In Oxfordshire in the period until June 2019. Over the year July 2018-2019, 82.5% of adults aged 16-44 across Oxfordshire were employed (compared to 75.8% across England). However, as always these values hide inequalities and actual financial need, for example differences in earnings in part time staff, single parents and carers.

5.4 The impact of COVID-19

The effects of COVID-19 on the economy and jobs are well known. According to research by the money and mental health policy institute, 2 in 5 surveyed who have been affected by mental health problems have experienced a drop in income due to the pandemic, and 1 in 3 of those have had to cut back on essentials such as food and heating as a result of this¹¹⁴. Whilst the governments furloughs scheme was welcomed, adjusting to a 20% drop in income for those affected was still challenging. As one participant in the money and mental health report is quoted as saying "20% may not seem a lot to some, but when you're living on the edge all the time it just constantly plays with your mindset."

In September 2020, there were 24,100 furloughed employments in Oxfordshire. This represented a 7% uptake of the scheme, compared with an 8% uptake across England¹¹⁵.

Across Oxfordshire, the number of unemployment claimants has rose sharply in March of 2020. In November, it stood at 16,540 but has been decreasing over the months since March 2021¹¹⁶ (figure 29 and updated monthly on the [Oxfordshire insights](#) pages). The variation by district is shown in table 3. Oxfordshire insights also makes unemployment data available by small area¹¹⁷.

¹¹³ [OxLEPLMIReportAugust2020.pdf \(oxfordshirelep.com\)](#)

¹¹⁴ [Income in Crisis.pdf \(moneyandmentalhealth.org\)](#)

¹¹⁵ [Coronavirus Job Retention Scheme statistics: November 2020 - GOV.UK \(www.gov.uk\)](#)

¹¹⁶ [Unemployment claimants to November 2020 | Oxfordshire Insight](#)

¹¹⁷ [Workbook: Oxfordshire Unemployment Dashboard \(tableau.com\)](#)

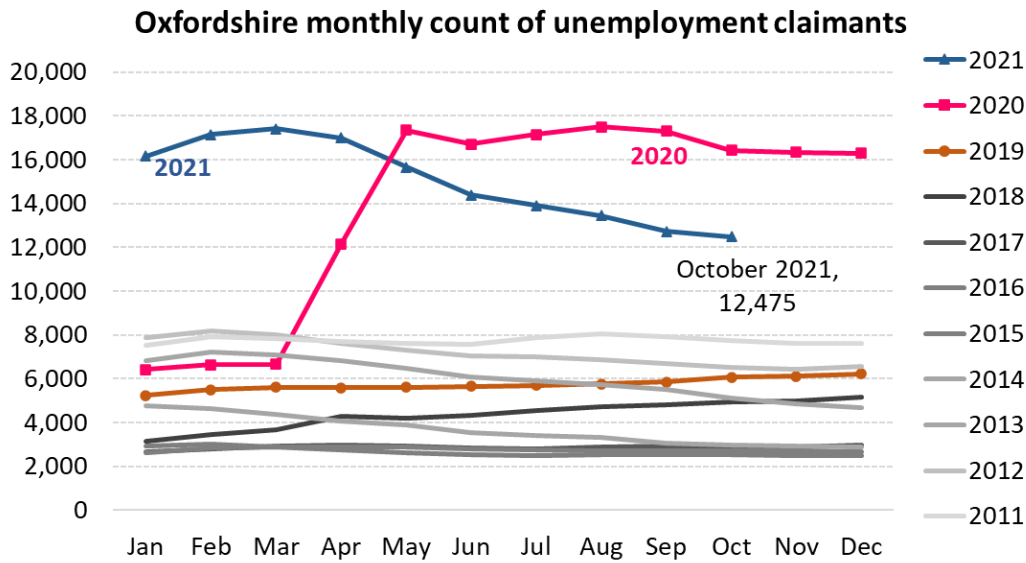


Figure 29: Oxfordshire claimant count data from the Department of Work and Pensions (DWP) and collated on [Oxfordshire Insight](#)

Unemployment claimants by age group August-21

	16-24		25-49		50+	
	count	rate*	count	rate*	count	rate*
Cherwell	545	5.9%	1,930	4.4%	720	3.1%
Oxford	630	4.8%	2,485	6.4%	1,005	6.2%
South Oxfordshire	360	4.2%	1,290	3.3%	650	2.8%
Vale of White Horse	350	4.1%	1,265	3.2%	535	2.5%
West Oxfordshire	325	4.7%	1,100	4.9%	450	2.5%
Oxfordshire	2,210	4.7%	8,075	4.2%	3,365	3.3%
England	328,635	8.8%	1,093,015	6.9%	452,855	6.0%

Table 4: unemployment claimants by County, district and city and by age. Data from the Oxfordshire JSNA webpages and originally from Nomis: [Nomis - Official Labour Market Statistics \(nomisweb.co.uk\)](#)

5.5 Children and Young People

5.5.1 Child Poverty

The JSNA provides an overview of statistics on child poverty in local authority areas along with an explanation of how estimates are derived¹¹⁸.

According to End Child Poverty estimates (2018-19)¹¹⁹, Oxford City was ranked 27th highest (higher rate of child poverty) out of 64 Local Authorities in the South East on child poverty after housing costs, above other districts in Oxfordshire. After removing housing costs, 1 in 5 children in Oxfordshire are estimated to be living in poverty – within Oxford City this figure rises to a quarter of children.

According to the 2019 Income Deprivation Affecting Children Index (IDACI)¹²⁰ there was a total of 11,990 children in poverty in Oxfordshire. Four areas of Oxfordshire were in the most deprived 10% nationally. The most deprived areas on the IDACI 2019, were in parts of Banbury Ruscote, Blackbird Leys, Littlemore and Rose Hill & Iffley wards.

5.5.2 Jobs and Employment for young people and adults

Between December 2019 and December 2020, the number of 16-24 year olds claiming unemployment benefits in Oxfordshire tripled from 950 to more than 3000. More recent data indicates that this number has now fallen (see table 4 above), but that when figures across the whole county are considered, the highest rate of unemployment is still seen in 16-24 year olds.

In December 2020 a total of 334 (2.6%) young people in Oxfordshire aged 16 to 18yrs (school year 12-13) classified as Not in Education, Employment or Training (NEET), compared to 1.6% in December 2019.

The district with the highest rate of young people classified as NEET was Oxford City (3.7%).

Some service providers feel there is a gap in provision in mental wellbeing resources and community help available for 16-24 year olds.

5.6 Research with local communities

The report on Oxford's new and emerging communities views on wellbeing undertaken by Healthwatch with Oxford Community Action and community volunteers¹²¹ explored community views on wellbeing, with people representing Oxford's diverse and multi-ethnic communities (see section 2.4 for more details). It demonstrated that financial concerns are important to local residents in relation to wellbeing. The report highlighted that within these communities, the causes of worries and stress, as reported by the survey respondents, were pressures of life - money, jobs and family

¹¹⁸ [Oxfordshire JSNA 2021](#)

¹¹⁹ End Child Poverty estimates (produced by Loughborough University) are based on the probability of children living in households with income less than 60% of the median (mid-point). Both the ECP and DWP & HMRC estimates are only for children under the age of 16.

¹²⁰ The Income Deprivation Affecting Children Index (IDACI) is the proportion of all children aged 0 to 15 living in income deprived families, that either receive Income Support or income-based benefits or families in receipt of Working Tax Credit or Child Tax Credit with an equivalised income (excluding housing benefit) below 60 per cent of the national median before housing costs. Child asylum seekers are not included in the IDACI. Data is as of 2015/16.

¹²¹ [Oxford's New and Emerging Communities' Views on Wellbeing - January 2021 - Healthwatch Oxfordshire](#)

concerns, cost of housing and food in Oxford, racism and discrimination, immigration worries and the impact of COVID.

6 Physical Activity and mental wellbeing

Section Summary

Adults

Across England, activity levels were increasing from November 2015 until Nov 2019

- Inequalities exist at a national level in physical activity levels across
 - Gender
 - Ethnicity
 - By disability and long term medical conditions
 - By socio-economic group

Across Oxfordshire,

- Sport England Active Lives Survey data suggests that:
 - Oxfordshire is more active (69.9% (95% CI: 67.8%, 72.0%) of people classified as active) than the population across England (62.8%).
 - Activity levels have increased over recent years before the pandemic
- A greater proportion of adults in Oxfordshire (35.6%) walk three days a week for travel compared to the South East and England
- A greater proportion of adults who cycle at least 3 days a week compared to England and the South East

Within Oxfordshire there is variation between districts

- Oxford having the highest level of activity and Cherwell the lowest
- Oxford has the highest proportion of adults who commute actively and Cherwell and West Oxfordshire the smallest

Children and young people

- Activity levels for children and young people are higher than the national average. However, 4 in 10 children do not meet the chief medical officer guidelines of 60 minutes physical activity per day and 1 in 5 are doing less than 30 minutes a day across the week
- Girls, children from less affluent families and from black and mixed ethnicity backgrounds are least active. Children identifying as black, have seen the largest drop in physical activity levels over the year 2019/2020 (COVID-19 pandemic)

6.1 Background context: Effects of physical activity on mental wellbeing

The Government's prevention [green paper](#)¹²² highlights the importance of becoming more active for our mental and physical health and being active an important component of the [5 ways to mental wellbeing](#)¹²³ put forward by the NHS and Mind. It is estimated that physical inactivity contributes to one in six deaths in the UK¹²⁴.

Being physically active can promote mental wellbeing through a number of pathways and across the life course^{125 126 127}. The organisation Mind and the government report on physical activity, supported by many evidence reviews¹²⁸ point to potential benefits to wellbeing through:

- Better sleep in adults¹²⁹
- Improved mood
- Managing stress and anxiety^{130 131}
- Improved self-esteem¹³²
- Reduced risk of depression^{133 134}. People who are inactive have three times the rate of moderate to severe depression of active people.
- Improved connections with others¹³⁵

The setting in which physical activity is undertaken may also be important, though it is not possible to explore this fully here^{136 137}.

¹²² [Advancing our health: prevention in the 2020s – consultation document - GOV.UK \(www.gov.uk\)](#)

¹²³ [5 steps to mental wellbeing - NHS \(www.nhs.uk\)](#)

¹²⁴ [PHE : Framework 13.pdf \(publishing.service.gov.uk\)](#)

¹²⁵ [Full article: Is exercise effective in promoting mental well-being in older age? A systematic review \(tandfonline.com\)](#)

¹²⁶ Biddle SJ, Asare M. Physical activity and mental health in children and adolescents: a review of reviews. *Br J Sports Med*. 2011;45(11):886-95.

¹²⁷ [Role of Physical Activity and Sedentary Behavior in the Mental Health of Preschoolers, Children and Adolescents: A Systematic Review and Meta-Analysis | SpringerLink –](#)

¹²⁸ Note – studies of physical activity and mental wellbeing vary greatly by design and quality, and methodological issues of physical activity measurement are discussed at length elsewhere

¹²⁹ [Effects of physical activity programs on sleep outcomes in older adults: a systematic review - PubMed \(nih.gov\)](#)

¹³⁰ [Exercise as Treatment for Anxiety: Systematic Review and Analysis | Annals of Behavioral Medicine | Oxford Academic \(oup.com\)](#)

¹³¹ [Physical Activity and Anxiety: A Systematic Review and Meta-analysis of Prospective Cohort Studies - ScienceDirect](#)

¹³² [Physical activity and depression, anxiety, and self-esteem in children and youth: An umbrella systematic review - ScienceDirect](#)

¹³³ Rimer J, Dwan K, Lawlor DA, Greig CA, McMurdo M, Morley W, et al. Exercise for depression. *Cochrane Database Syst Rev*. 2012(7):CD004366.

¹³⁴ Rosenbaum S, Tiedemann A, Sherrington C, Curtis J, Ward PB. Physical activity interventions for people with mental illness: a systematic review and meta-analysis. *J Clin Psychiatry*. 2014;75(9):964-74

¹³⁵ [The association between social support and physical activity in older adults: a systematic review \(biomedcentral.com\)](#)

¹³⁶ [Does Participating in Physical Activity in Outdoor Natural Environments Have a Greater Effect on Physical and Mental Wellbeing than Physical Activity Indoors? A Systematic Review | Environmental Science & Technology \(acs.org\)](#)

¹³⁷ [Domain-Specific Physical Activity and Mental Health: A Meta-analysis - PubMed \(nih.gov\)](#)

6.1.1 Definitions of physical activity/national recommendations

There are a wide range of physical activities and measurements of activity levels also vary widely (not discussed further here). PHE's categorisation of physical activity is highlighted in figure 31 below.

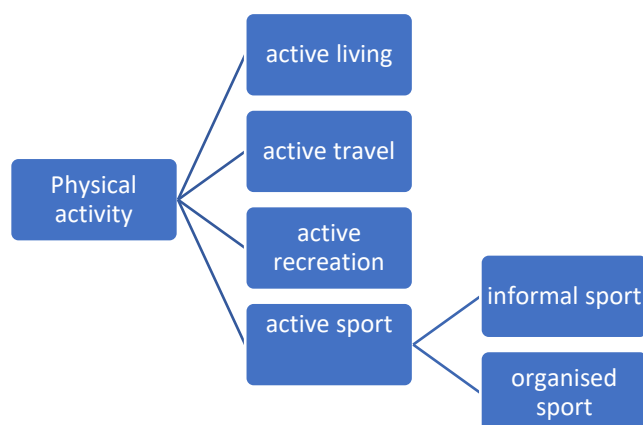


Figure 30: PHE's classification of physical activity . Source:<https://www.gov.uk/government/publications/health-matters-physical-activity/health-matters-physical-activity-prevention-and-management-of-long-term-conditions>

Public Health England physical activity indicators are based on chief medical officer (CMO) recommendations¹³⁸ and in the population over 19 years (compared to over 16 years in the active lives survey). CMO guidelines are for adults to achieve:

- At least 150 minutes of moderate intensity activity per week
- Guidelines can also be met by doing 75 minutes of vigorous activity per week, or a combination of moderate and vigorous activities
- There are also specific guidelines for disabled adults, pregnant women, and women after childbirth – though these all aim for 150 minutes moderate intensity activity every week

6.2 National Strategies

The principle national strategies that physical health links to are PHE's physical activity – prevention and management of long term conditions [guidelines](#).

However, with cross cutting areas such as active travel and activity which takes place in the natural environment, there are links to climate mitigation and adaptation strategies (see chapter on green environments for further details) and strategies on active travel such as the 2017 [Cycling and Walking](#) Investment Strategy from the Department for Transport.

As with all areas of this needs assessment, improving equity in access and taking part in physical activity will support national and local commitments to reducing health inequities.

6.3 Local Strategies

In addition to obviously supporting the health and wellbeing strategy, there are strong links between local strategies for the environment and physical activity – for example through healthy place

¹³⁸ [Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report)

shaping and creating the right spaces for active environments – and local climate change strategies (see chapter on green environments for more details).

Oxfordshire also has an active and healthy travel strategy (see here for the [plan](#)).

6.4 National Data

There are a number of different data sources available at national (and local level) based on surveys which quantify activity levels and can inform opportunities for improvement and addressing inequalities.

The Active Lives survey provides data based on a weighted sample of adults¹³⁹ across England, using an online and paper questionnaire¹⁴⁰. It uses composite activity groupings and classifies activity levels into:

- Active: > 150 minutes of activity a week
- Moderately active: 30-149 minutes activity a week
- Inactive: < 30 minutes a week

Public Health England physical activity indicators are based on chief medical officer (CMO) recommendations¹⁴¹ and in the population over 19 years (compared to over 16 years in the active lives survey) and hence results using these indicators, will differ to those reported in the Active Lives Survey. CMO guidelines are covered in section 7.1 above.

¹³⁹ Technical information on the survey can be found here: [Normal dot \(Rev02 January 2009\) \(sportengland-production-files.s3.eu-west-2.amazonaws.com\)](#)

¹⁴⁰ Note: the Active Lives Adult Survey a self-report survey and therefore potentially subjective/ influenced respondent's ability to recall and assess physical activity levels. Self-reported data may also be affected by respondent desire to confirm to expectations and social norms (e.g. physical activity over-estimated). However, although this might affect the absolute values, this should not affect comparisons if the bias is consistent across populations.

¹⁴¹ [Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK \(www.gov.uk\)](#)

Across England, activity levels as reported in the active lives survey increased from November 2015 until Nov 2019 (i.e. before the COVID-19 pandemic – see figure 31).

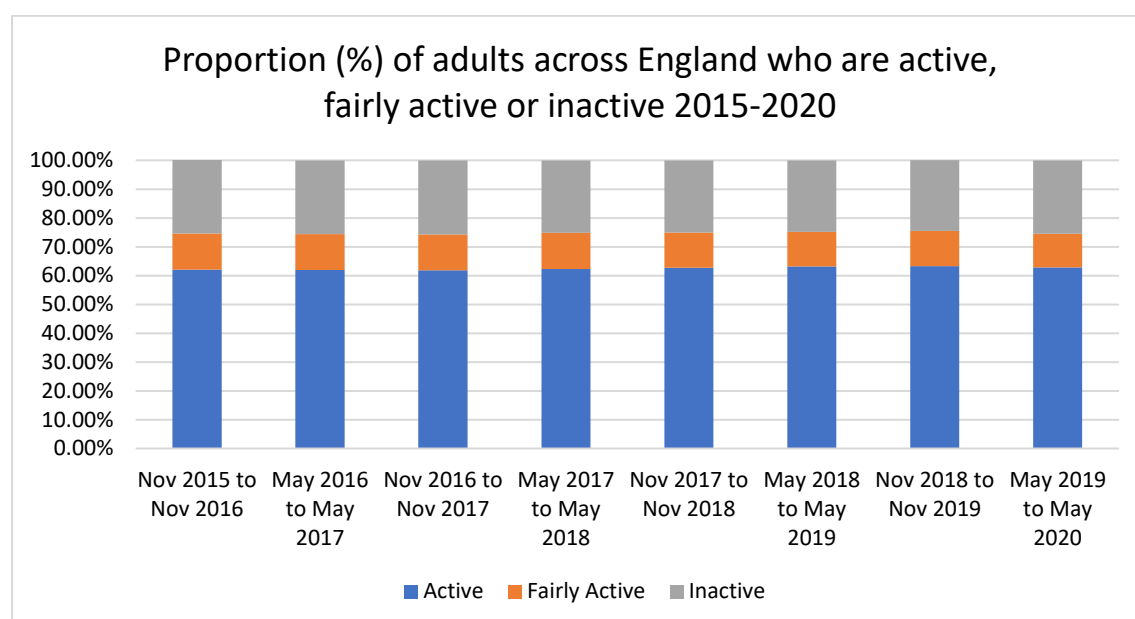


Figure 31: Proportion of adults (16 plus) who are active, fairly active or inactive between 2015 and 2020. Sport England Active Lives Adult survey. Note the 2019/2020 survey had fewer respondents than previous years.

6.5 Local Data for Oxfordshire

There are different sources of data that provide an overview of physical activity in adults across Oxfordshire and at LTLA level. These are:

- The Sport England Active Lives Survey
- PHE fingertips – which include indicators of physical activity based in the Active Lives Survey but based on chief medical officer recommendations¹⁴²
- PHE fingertips data from the department of transport on active travel
- The Oxfordshire cycle survey¹⁴³

6.5.1 Local Data from the Active Lives survey: pre-pandemic

In depth analysis of the Sport England survey has been undertaken by Active Oxfordshire in their 2019 Oxfordshire Physical activity behavior insight pack, available [here](#)¹⁴⁴. The data here is taken for pre-pandemic years and effects of the pandemic reported in the next section. In 2017/2018, this

¹⁴² The PHE aggregated data has two key differences compared to the data from the Active Lives Survey (magnitude of estimates of activity varies between these and the Sports England data): the indicators are based on the chief Medical Officers guidelines and as such are in the population of over 19s (rather than over 16s) and include additional types of activity (e.g gardening) which are excluded from the Active Lives Sport England overall estimates.

¹⁴³ [Microsoft Word - CYCLE SURVEY SUMMARY REPORT \(oxfordshire.gov.uk\)](#)

¹⁴⁴ [PowerPoint Presentation \(oxfordshire.gov.uk\)](#)

data indicated that Oxfordshire as a whole is more active when compared to national levels across England. There were differences in activity levels between districts and the city (figure 32).

Proportion of population across England, Oxfordshire and by district with different activity levels in 2017/2018

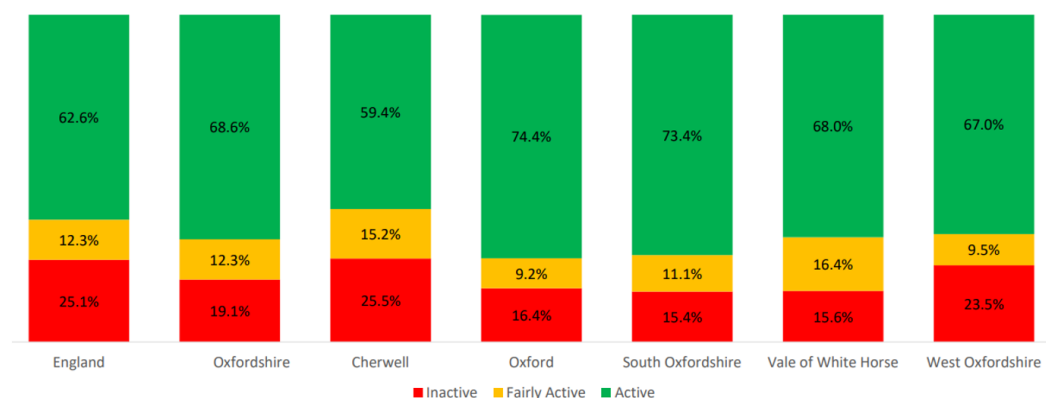


Figure 32: Proportion of active, inactive and moderately active adults across Oxfordshire. Source - Active Oxfordshire analysis of Active lives survey. Available at <https://www.activeoxfordshire.org/uploads/active-oxfordshire-physical-activity-and-sport-insight-p>

Locally, this meant that in the years before COVID-19 across Oxfordshire there were around

- 26,169 inactive adults in Cherwell
- 21,830 inactive adults in Oxford
- 20,327 inactive adults in South Oxfordshire
- 19,752 inactive adults in West Oxfordshire
- 18,136 inactive adults in the Vale of White Horse

6.5.2 Activity by mapped local geography

Active Oxfordshire has mapped inactive adults across Oxfordshire at MSOA level for November 2015 and November 2016, using the small area estimations available from Sport England¹⁴⁵. The small area level estimates highlight small pockets of inactivity across Oxfordshire, but no specific clusters of inactive adults across areas.

This years Oxfordshire JSNA, mapped physical activity in the over 16s, using the proportion of people meeting CMO physical activity guidelines for adults (150 minutes per week and for 16-18 year olds at least 60 minutes and up to several hours of physical activity per day). The maps indicate that the proportion of people aged 16+ meeting adult physical activity guidelines tends to be higher in more

¹⁴⁵ Technical report on small area estimations can be found here: [Normal dot \(Rev02 January 2009\) \(sportengland-production-files.s3.eu-west-2.amazonaws.com\)](https://www.sportengland-production-files.s3.eu-west-2.amazonaws.com/Normal%20dot%20(R%20Rev02%20January%202009).pdf): Small area estimation (SAE) is a technique used to generate estimates in small geographical areas that would otherwise have too few respondents from the survey to derive precise direct estimates.

affluent areas of the county. Percentages were lowest in the south of Oxford (Blackbird Leys, Northfield Brook, Littlemore), Banbury (Ruscote and Neithrop), Bicester and Kidlington (figure 33).

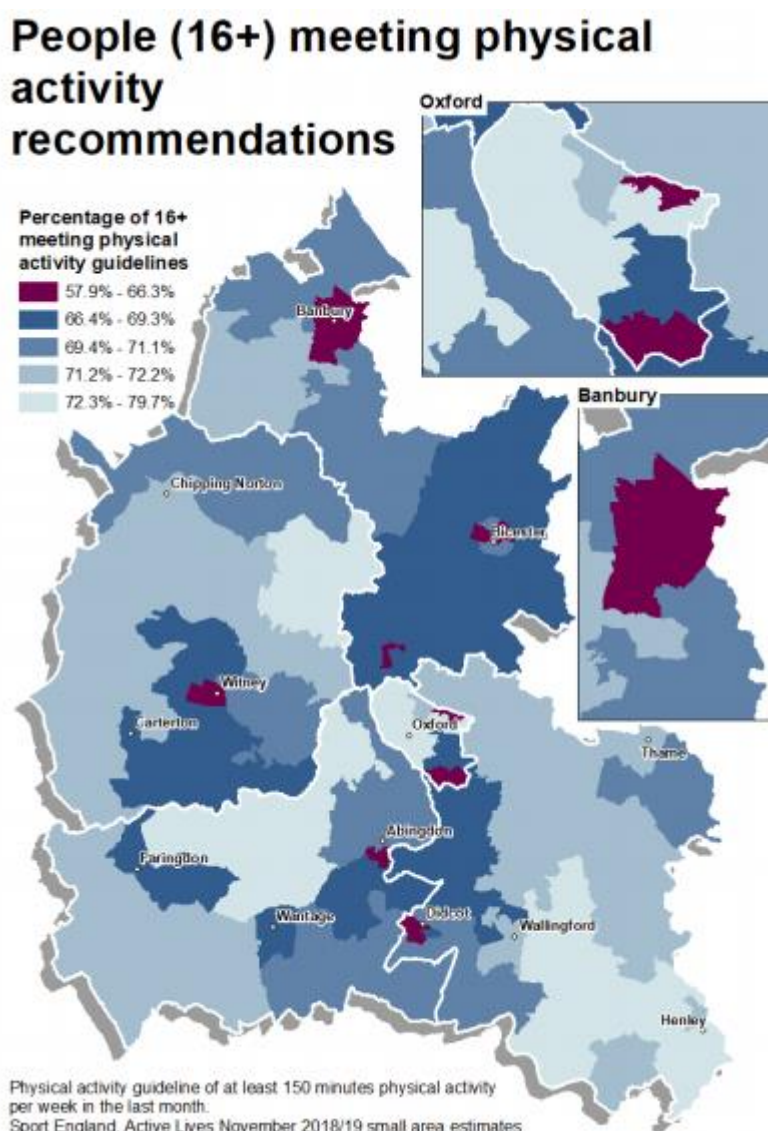


Figure 33: People aged over 16 meeting physical activity recommendations, based on data from the active lives survey Nov 2018/2019. Analysed in this years [JSNA](https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA_Final_20210331.pdf)
https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA_Final_20210331.pdf

6.6 Inequalities and physical activity

At a national level, there are inequalities in physical activity levels across many groups of the population¹⁴⁶. For example:

- People who live in the least prosperous areas are twice as likely to be physically inactive as those living in least deprived areas
- Those with long term conditions are twice as likely to be amongst the least physically active

¹⁴⁶ [PHE: Framework 13.pdf \(publishing.service.gov.uk\)](#)

- Physical activity is lower in older adults
- People with disabilities are half as likely to be active compared to those without
- There are differences in activity levels by ethnic background
- Men are more active than women

Locally, data for Oxfordshire from the Active Lives Survey¹⁴⁷ gives a picture of inequalities across Oxfordshire.

By gender

- As for national data, in Oxfordshire males are more active than females.
 - The gap is widest between inactive males and females (across Oxfordshire, absolute difference of 1.10% between inactive females and males). This is narrowing compared to previous years but is wider than gender inactivity gap for England as a whole (1%)
 - For inactivity levels, the Vale of White Horse and West Oxfordshire have the largest gender inequality gap.
 - For active adults, the gap between active males and female has narrowed across Oxfordshire (current difference of 0.82%) over recent years and is less than the 3% inequality gap across England
 - For active adults, the gender gap is widest in Oxford (over 10%)

By long standing illness or disability

As for England, those without disability are more likely to be active and less likely to be inactive.

- Across Oxfordshire activity in adults with a disability are 57% compared to 73% in those without – a difference of 16%. This gap is smaller than for England (where of those with a disability 47% are active and 68% of those without – a gap of 21%)
 - The gap is widest in Cherwell and smallest in Oxford
- Across Oxfordshire, inactivity in those without a disability is 15.3% and with a disability is 30.8% - an absolute difference of 15.5%. These inactivity levels and gap are lower than for England (40.4% of population with disability are inactive compared to 21.4% without) and narrower than for previous years.

By affluence

As for England, activity level across Oxfordshire falls moving across from the wealthier to less wealthy (from national classifications NS-SEC 1-2 to NS-SEC-6-8)

¹⁴⁷ [Active Lives | Sport England](#)

- For NS-SEC-1-2 (most affluent) and NS-SEC 3-5, activity levels are higher in Oxfordshire compared to England as a whole.
 - Across Oxfordshire there is an absolute difference of 20% between the proportion of active adults in NSSEC 1-2 (most affluent) and NSSEC 6-8 (least affluent). This is compared to a difference of 19% across England.
 - This gap is widening compared to previous years (though may be disproportionately impacted by the pandemic).

Data on inequalities by ethnicity is not available at a local level.

By age

Consistent with national trends in activity levels by age, there is a large decrease in physical activity levels over the age of 75 years amongst Oxfordshire residents (figure 34).

Physical activity levels by age across Oxfordshire 2018/2019

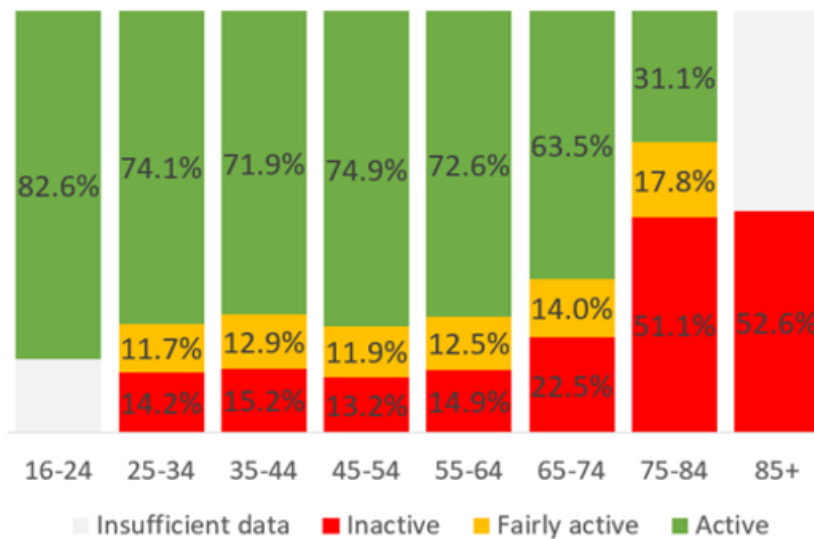


Figure 34: Physical activity levels by age for Oxfordshire, based on Active Lives Survey data for 2018/19

6.7 Physical Activity in Children and Young People

In the Oxwell survey, exercise and activity in CYP across Oxfordshire are positively associated with increased wellbeing. In the active lives survey (Active Oxfordshire analysis) physical activity is associated with :

- Positive levels of mental wellbeing (happiness)
- Positive levels of individual development (if I find something difficult, I keep trying until I can do it)
- Community development (trust of people of a similar age)
- Not feeling lonely

Physical activity levels for Oxfordshire in children and young people have increased in recent years and are higher than the national average: in the academic year 2019/20, 58.4% of children and young people in Oxfordshire were achieving an average of 60 minutes of physical activity per day,

compared to 44.9% nationally. However, this also means that across Oxfordshire, around 4 in 10 children and young people (equivalent to around 37,600 children in Oxfordshire schools) were not achieving 60 minutes of physical activity per day.

6.8 Inequalities in physical activity in children and young people

National data¹⁴⁸ indicate that more boys are active than girls (47.1% compared to 42.7%) and that physical activity is highest in those identifying as white.

Those from more affluent families are more likely to be physically active than those from less affluent families and physical activity also varies with age.

6.9 The effects of COVID-19 on physical activity

6.9.1 Impacts of COVID-19 on physical activity in on adults

At a national level, data from the Active Lives Survey¹⁴⁹ allows for comparison of activity levels during the early period of COVID-19 pandemic with previous years. The period of the May 2019/2020 survey covered included the seven-weeks from the 23 March to mid-May when England was in full lockdown in response to the coronavirus (Covid-19) pandemic. Therefore, whilst not a complete picture of the COVID-19 pandemic on physical activity it does give some indication of how this was affected during the earlier part of the pandemic. Future reports will enable us to better understand the effects of the pandemic over time.

Nationally, activity levels had been increasing up until the pandemic. Between mid-March and mid-May, compared to the same two-month period 12 months earlier, there were 3 million (-7.1%) fewer active adults and 3.4million (+7.4%) more inactive adults¹⁵⁰. If results for the whole year of 2019/2020 are compared to 2018/2019, however, the proportion of adults who were active in England was unchanged compared to last year over the full 12 months (due to the trend of increasing activity levels until the pandemic) but there was a small increase in the proportion who were inactive.

¹⁴⁸ Sport England, Active Lives Children and Young people Survey 2019/20

¹⁴⁹ [Active Lives | Sport England](#)

¹⁵⁰ [PowerPoint Presentation \(sportengland-production-files.s3.eu-west-2.amazonaws.com\)](#)

Regarding local level data from the Active Lives Survey, some care needs to be taken, due to the smaller number of respondents in 2019/2020 compared to previous years¹⁵¹. However, physical activity levels during the pandemic on average did not worsen (see figure 35, comparing activity levels in adults over the last 4 years below) and in contrast to patterns seen across England, the proportion of inactive adults in 2019/2020 has decreased compared to the previous benchmark (significant at the 5% level) and the proportion of active adults has increased (significant at the 5% level).

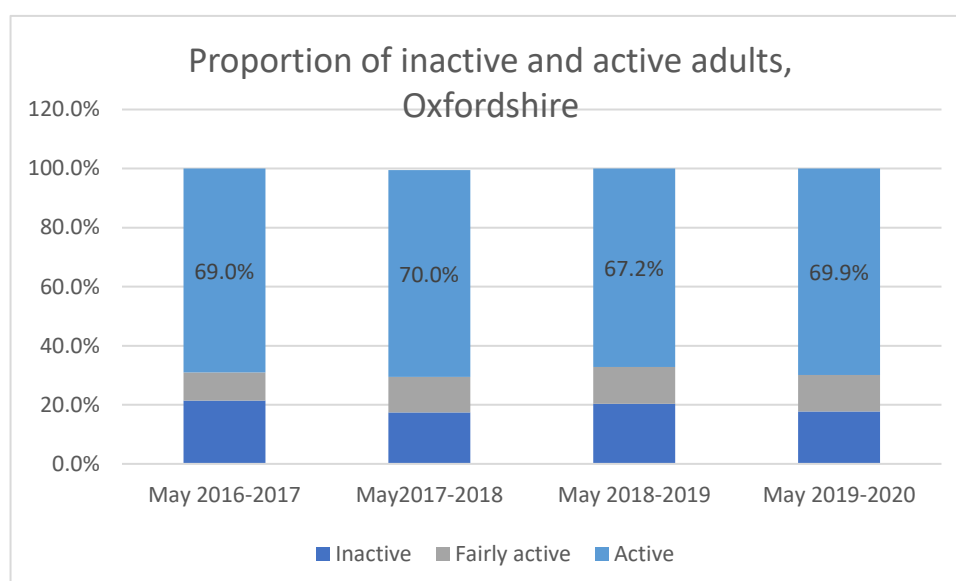


Figure 35: Activity levels across Oxfordshire over last 4 years. Data from the Active Lives Survey, Sport England

However, as we know from all other areas, the COVID-19 pandemic has not affected groups equally. For adults, the Active Lives May 2020 report highlights the way in which COVID-19 regulations have impacted different population groups¹⁵². For example:

- Male activity has fallen more (-0.9%) compared to previous estimates.
- The least affluent have been worst affected - in socio-economic groups NS-SEC-6-8¹⁵³ there has been an increase in inactive adults of 1.6%
- The pandemic has reduced activity levels across all living with disabilities and long-term health conditions
- The pandemic has had a disproportionately negative impact on physical activity in people from Asian (excluding Chinese) and Black backgrounds

¹⁵¹ E.g. number of respondents to Active Lives Survey for children and young people from Oxfordshire: 2017/2018 = 1,408, 2018/2019 = 1,630, 2019/2020 = 666

¹⁵² [PowerPoint Presentation \(sportengland-production-files.s3.eu-west-2.amazonaws.com\)](https://www.sportengland-production-files.s3.eu-west-2.amazonaws.com)

¹⁵³ NS-SEC is the National Statistics Socio-economic Classification. It is derived by combining information on occupation and employment status

6.9.2 Impacts of COVID-19 on physical activity in children and young people

Analysis by Sport England in the Active Lives Children and Young People Survey Coronavirus (Covid-19) Report¹⁵⁴ compared activity in the summer term (mid-May to late-July) 2020 to the summer term in 2019. The proportion of children and young people reporting they were active during mid-May to late-July (the summer term) fell by 2.3 % compared to the same period 12 months earlier. The data also suggest that there has been a decrease in physical literacy and confidence amongst school aged children.

However, for children and young people, data from active lives survey suggests that overall in under 16's in **Oxfordshire** there has been:

- A slight decrease (improvement) of 2.4% in those who are less active:
 - compared to last year
 - compared to a statistically significant increase (worsening) nationally of just over 2%
- An increase (improvement) in activity levels
 - compared to last year
 - compared to a statistically significant decrease (worsening) of 1.9% nationally

Again, not all groups or activities have been affected equally, and data from both the 2019/2020 Active Lives survey and Active Lives Children and Young People Survey Coronavirus (Covid-19) Report highlight these inequalities.

During the last year children and young people (CYP) from Black backgrounds have seen the largest drop in activity levels of all ethnic groups 8.6% across the year. This is likely to have been driven by the summer term (Active lives children and young people [coronavirus report](#)) when activity levels for this group saw a 17% drop. This drop was evident in both girls and boys. The drop was accompanied by a drop in those strongly agreeing with positive attitudes for physical literacy. Children and young people from mixed ethnic backgrounds also experienced a drop in physical activity levels.

A large gap remains between activity levels of poorer children compared to wealthier children. If the Active Lives Survey data from whole year from 2019/2020 is taken into account (which includes the initial part of the COVID-19 pandemic), then CYP from low affluence families saw the biggest drop in activity levels and the inequality gap has widened from 12% to 15%. However, if only data from the Active Lives Children and Young People Survey Coronavirus (Covid-19) Report (covering the summer term only) is considered then during this time activity levels did not change amongst those from the least affluent families. All in all, activity levels in less affluent families remain lower than for those from the most affluent families. In addition, those from the least affluent families saw drops in the

¹⁵⁴ [PowerPoint Presentation \(sportengland-production-files.s3.eu-west-2.amazonaws.com\)](#)

proportion enjoying taking part, feeling confident when taking part and finding it easy (competence). This reduced positivity about taking part is a cause for concern.

Regarding physical activity type: walking, cycling and fitness saw increases compared to the same period 12 months earlier. More children and young people reported going for a walk, doing fitness activities and cycling for fun or fitness.

6.10 Active travel

Last updated in 2017/2018, PHE active travel data shows that Oxfordshire has a greater proportion of people walking three days a week for travel compared to England and the South East. Active walking commuting is highest in Oxford (35.6%) compared to other areas (figure 36).

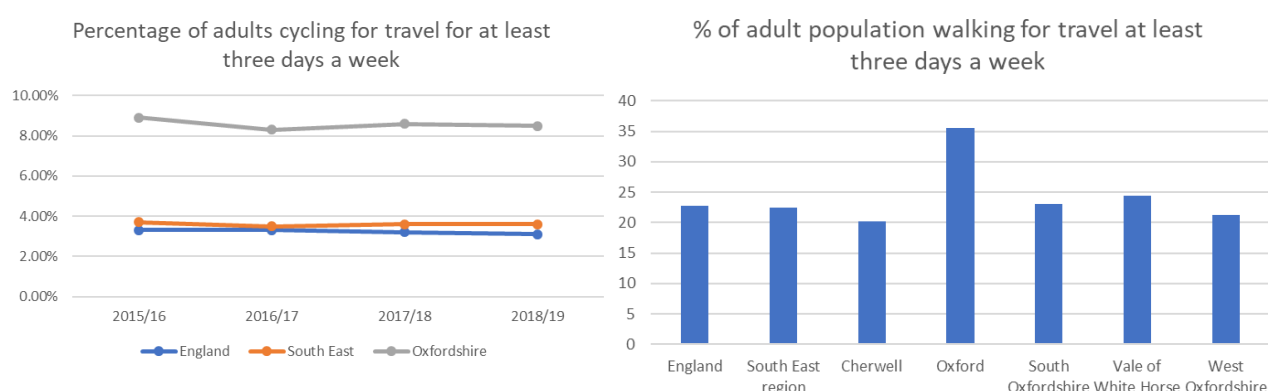


Figure 36: Data from department for Transport (based on the Active Lives Adult Survey, Sport England), available through PHE fingertips

Data on active travel by cycling also shows that Oxfordshire has a higher proportion of adults who cycle to travel compared to England and the South East. However, levels have decreased over the time period reported. The rates of cycling are substantially higher in Oxford compared to all other districts in Oxfordshire.

In 2019, Oxfordshire Council carried out the [Oxfordshire Cycle Survey](#)¹⁵⁵, to understand cyclists choices. Answered by 3,700 people it indicated that people in Oxford tend to cycle as a mode of travel and recreation, whereas those outside Oxford use the cycle predominantly for recreation. Differences were particularly clear for high frequency journeys, such as travelling to work 84% (Oxford cyclists) vs 56% (non-Oxford cyclists), shopping 65% (Oxford cyclists) vs 35% (non-Oxford cyclists) and going into the town centre 78% (Oxford cyclists) vs 41% (non-Oxford cyclists).

¹⁵⁵ [Microsoft Word - CYCLE SURVEY SUMMARY REPORT \(oxfordshire.gov.uk\)](#)

7 Green Space and The Natural Environment

Section Summary

We are increasingly understanding the importance of the natural environment, green and blue space and infrastructure for both physical and positive mental health. This has been further highlighted during the COVID-19 pandemic.

Studies show benefits of greenspace greater for socio-economically disadvantaged groups and the gap in mental wellbeing is narrower when those who are more socio-economically deprived areas have improved access to greenspace. However, there are inequalities in access to and use of green and natural spaces.

Adults

Nationally

- In 2018/2019, 94% of the population agreed having open green space close to home was important¹ and the number of visits taken for health and exercise over the last 10 years has increased from 35% in 2009/2020 to 56% on 2018/2019
- There are known inequalities at national level in access and use of green and natural environments: least affluent and older people access green and natural spaces less, compared to younger adults, the more wealthy and those that identify as being white.

Across Oxfordshire

- Data from the national People and Nature Survey (previously the Monitor of Engagement with the Natural Environment (MENE) survey) analysed for Oxfordshire shows that over the last 10 years, most visits to natural environments are made by wealthier families and those that identify as White.
- Barriers to visiting natural and green spaces included older age, long term health conditions and disability and being too busy at work or home

Children and Young People

Nationally

- during 2018/19 around two-thirds of children (67%), spent leisure time outdoors at least once a week.
- proportions visiting were highest when children were aged between 6 and 12.
- Frequency of visit taking declined into teenage years while a larger proportion of those aged 16 to 24 spent time outdoors once or twice a month (29%)
- Most children (69%) had visited urban greenspaces in the last month while around a third had visited the countryside (35%) and 16% visited the coast

7.1 Importance of green and natural environments for mental wellbeing

We are increasingly understanding the importance of the natural environment, green and blue space and infrastructure for both physical and positive mental health: the role of green spaces in promoting psychological well-being is important when thinking about optimising positive mental health outcomes in the community¹⁵⁶. Access to greenspace can promote healthy behaviours (physical activity, recreation), social contact and connectivity, foster a sense of belonging and encouraging restorative connections to nature. For young people, spending time in greenspace can promote physical development and improve academic performance and concentration.

In 2020, PHE produced a national report “Improving access to greenspace: [A new review for 2020](#)”¹⁵⁷, which summarised much of the evidence on the effects of green space and infrastructure for health. This highlighted greater exposure to greenspace is associated with increased quality of life across the ages through multiple social, economic, and environmental pathways^{158 159 160}

In children and young people (CYP)^{161 162 163} there are associations between increased exposure to greenspace and increased:

- emotional wellbeing, reduced stress and improved resilience, health-related quality of life
- these effects vary by developmental stage, the type and accessibility of greenspace

In adults, there is an association between greener living environments and positive emotions^{164 165 166}, including:

- higher life satisfaction, reduced mental distress

¹⁵⁶ World Health Organization, 2016 report

¹⁵⁷ [Improving access to greenspace: 2020 review \(publishing.service.gov.uk\)](#)

¹⁵⁸ Tillmann S, Tobin D, Avison W, Gilliland J. Mental health benefits of interactions with nature in children and teenagers: a systematic review. *Journal of epidemiology and community health*. 2018;72(10):958-66.

Wang D, MacMillan T. The Benefits of Gardening for Older Adults: A Systematic Review of the Literature. *Activities, Adaptation & Aging*. 2013;37(2):153-81.

¹⁵⁹ Wang D, MacMillan T. The Benefits of Gardening for Older Adults: A Systematic Review of the Literature. *Activities, Adaptation & Aging*. 2013;37(2):153-81.

¹⁶⁰ Mensah CA, Andres L, Perera U, Roji A. Enhancing quality of life through the lens of green spaces: A systematic review approach. *International Journal of Wellbeing*. 2016;6(1)

¹⁶¹ Vanaken GJ, Danckaerts M. Impact of Green Space Exposure on Children's and Adolescents' Mental Health: A Systematic Review. *Int J Environ Res Public Health*. 2018;15(

¹⁶² McCormick R. Does Access to Green Space Impact the Mental Well-being of Children: A Systematic Review. *Journal of pediatric nursing*. 2017;37:3-7.

¹⁶³ Tillmann S, Tobin D, Avison W, Gilliland J. Mental health benefits of interactions with nature in children and teenagers: a systematic review. *Journal of epidemiology and community health*. 2018;72(10):958-66.

¹⁶⁴ an den Berg M, Wendel-Vos W, van Poppel M, Kemper H, van Mechelen W, Maas J. Health Benefits of Green Spaces in the Living Environment: A Systematic Review of Epidemiological Studies. *Urban Forestry & Urban Greening*. 2015;14(4):806-16.

¹⁶⁵ van den Bosch M, Ode Sang Å. Urban natural environments as nature-based solutions for improved public health – A systematic review of reviews. *Environmental Research*. 2017;158:373-84

¹⁶⁶ Kondo M, Fluehr J, McKeon T, Branas C. Urban Green Space and Its Impact on Human Health. *International Journal of Environmental Research and Public Health*. 2018;15(3):445

- In adults, the relationship between greenspace exposure and mental health outcomes is moderated by age, gender and physical activity

7.2 Economic benefits of green and natural environments

There is evidence that through pathways to improve physical and mental health, access to greenspace provides large economic benefits. For example:

In London, a case study¹⁶⁷ found that each year access to greenspace saves £580 million through improved physical health, and £370 million by contributing to better mental health. The Cost Ratio Benefit (BCR) for investment in London's public parks was found to be around 27:1., with 19% of the asset value due to economic benefits for mental and physical health.

For urban greenspace settings in England, a welfare gain (QALY) of £1.2 billion was found for those undertaking one or more 'active' visits (30 minutes, moderate intensity activity daily)

7.3 Linked Strategies and frameworks

National Level

Planning for greenspace and infrastructure and their use, links to a wide range of national policies and frameworks including:

- *A Green Future: Our 25 Year Plan to Improve the Environment* (25YP; HM Government, Jan 2018). This national level strategy directly links to mental wellbeing through the goal of "Connecting people with the environment to improve health and wellbeing". It commits to "Supporting Local Authorities to assess green infrastructure provision against[...] new standards" (including an updated ANGSt standard by 2019).
- The United Kingdom Air Quality Strategy
- The 2008 UK Climate Change Act and mitigation measures
- The National Planning Policy Framework (NPPF, Feb 2019) which sets out a framework for planning policies and decisions to achieve healthy, inclusive and safe places. Including supporting healthy lifestyles, especially where this would address identified local health and well-being needs (e.g. through accessible green infrastructure)

Local Level

Locally, in addition to supporting mental wellbeing, the provision of additional greenspace and infrastructure would support:

- Oxfordshire's joint Health and Wellbeing Strategy 2018-2023 and specifically for greenspace strategic objectives for Healthy Place Making and ensuring physical environment
- OCC's Climate Action Framework¹⁶⁸
- The Oxfordshire Local Transport Plan (LTP, 2016 update), including protecting and enhancing Oxfordshire's environment and improving quality of life (including public health and wellbeing)
- The Oxfordshire Infrastructure strategy¹⁶⁹ including making better informed choices about the location of future growth

¹⁶⁷ Vivid Economics. [11015viv natural capital account for london v7 full vis.pdf](#).

¹⁶⁸ [2020 Climate Action Framework \(oxfordshire.gov.uk\)](#)

¹⁶⁹ [oxis_stage2.pdf \(oxfordshire.gov.uk\)](#)

- Partnering for Prosperity – a new deal for the CB-MK-Oxford Arc (National Infrastructure Commission , 2017) . Specifically links to objectives around linking homes and jobs (connecting the places where people live and work) and creating inclusive liveable places.

7.4 National Level Data on green and natural spaces

National and upper tier local authority data on the natural environment and how we engage with it, are available from the People and Nature Survey (previously the Monitor of Engagement with the Natural Environment (MENE) survey)– conducted by the ONS and Natural England - which has reported data for 10 years and a full report of this can be found [here](#) .

At a national level, in 2018/2019, 94% of the population agreed having open green space close to home was important¹⁷⁰ and the number of visits taken for health and exercise over the last 10 years has increased from 35% in 2009/2010 to 56% on 2018/2019 (figure 37).

The largest number of visits occur in towns and cities (36% of all visits – equivalent to 1.6 billion visits). This has increased from 24% of visits when the survey started in 2009-2010. Over time, visits closest to home have increased the most – in 2018/2019 44% of visits to the natural environment were taken on foot.

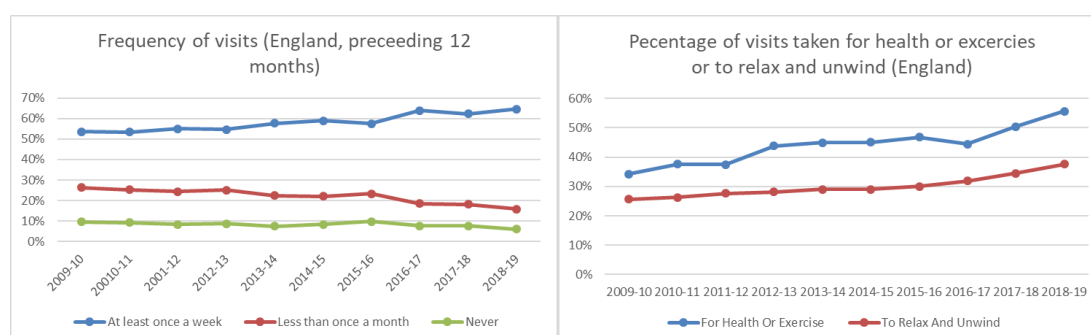


Figure 37: frequency of visits to the natural environment over the last year. Data from MENE survey - ONS and Natural England

Table 5: Motivation for visits to the natural environment, by environment type: Data from MENE survey - ONS and Natural England 2018/2019.

	Park in town or city	Playing field or recreation area	Woodland or forest	Country Park	River, lake or canal	Beach
Health/exercise	57%	79%	70%	57%	68%	61%
Relax & unwind	42%	49%	40%	40%	46%	47%
To exercise a dog	35%	50%	53%	39%	42%	32%
Enjoy scenery	25%	43%	34%	39%	46%	49%
Time with family	22%	30%	28%	27%	27%	36%

¹⁷⁰ [Monitor Engagement Natural Environment 2018 2019 v2.pdf \(publishing.service.gov.uk\)](#)

7.5 Local Level Data on green and natural spaces

A variety of data give a picture of potential need relating to green environments across Oxfordshire. These include:

- An understanding of the land-use and distribution of green environments across Oxfordshire:
 - Land use data
 - Local insight data on active and passive greenspace
- An understanding of how communities engage with the natural environment that is relevant to mental wellbeing:
 - MENE survey data of how residents engage with the natural environment. For Oxfordshire, appropriately weighted data are available from the MENE survey¹⁷¹, though not for all indicators available at national level. PHE has produced some PHOF indicators using this data, available through fingertips¹⁷².

7.5.1 Oxfordshire Land Use Data

Oxfordshire makes up around 1% of the UK land area (260,492 ha) and land cover statistics for the UTLA and LTLA's are summarised in table 6.

	Built on	Green Urban	Farmland	Natural
Local Authority				
Oxford	53%	14%	31%	1%
Cherwell	8%	3%	88%	1%
South Oxfordshire	6%	4%	81%	9%
West Oxfordshire	5%	3%	87%	4%
Vale of White Horse	7%	3%	86%	4%
Oxfordshire	7%	3%	84%	5%

Table 6: Land Cover for Oxfordshire. Data from "making the case for investment in Green Infrastructure in Oxfordshire" June 2020. Original data source: A Land Cover Atlas of the United Kingdom, the University of Sheffield, 2017, Maps produced

¹⁷¹ [Monitoring Engagement in the Natural Environment Survey \(2009 - 2019\) \(arccis.com\)](#)

¹⁷² PHE weighting of MENE data available here: [Physical Activity - PHE](#)

NB: Normally MENE data is weighted using a standard set of demographic weights which include age, sex, socio-economic status and the regional distribution of the English adult population. While this weighting approach allows for the production of robust, representative data at the national and regional level, it is not designed to allow for the production of data at a lower geographic level. As such, for the purposes of the PHOF indicator, a new series of weights were produced for every Upper Tier Local Authority in England using the following local level data:

- Age x Gender: Mid 2010 Population Estimates
- Social Grade: LA specific Social Grade from Census 2001 rebalanced using current England Social Grade: BARB 2011 and England Census 2001 Social Grade.
- Working Status: LA specific Working Status from Census 2001 rebalanced using current England Working Status from BARB 2011 and England Census 2001 Working Status.
- Presence of Children: BARB 2008
- Presence of Dog: World Panel

using data from Corine and Ordnance Survey., e.g. South Oxfordshire map here
https://figshare.com/articles/A_Land_Cover_Atlas_of_the_United_Kingdom_Maps_/5219956

The Active and Passive Green indexes for each of the LTLA's are shown at MSOA level in and are available through the local insight tool¹⁷³.

7.5.2 MENE data for Oxfordshire

At a national level, in 2018/2019, 94% of the population agreed having open green space close to home was important and the number of visits taken for health and exercise over the last 10 years has increased from 35% in 2009/2020 to 56% on 2018/2019.

The same survey combines results over the last 10 years to give a picture of the barriers to use of the natural environment by residents of Oxfordshire. These are shown in figure 38 below and highlight the importance of age, poor health and living with a disability and being able to find the time to visit.

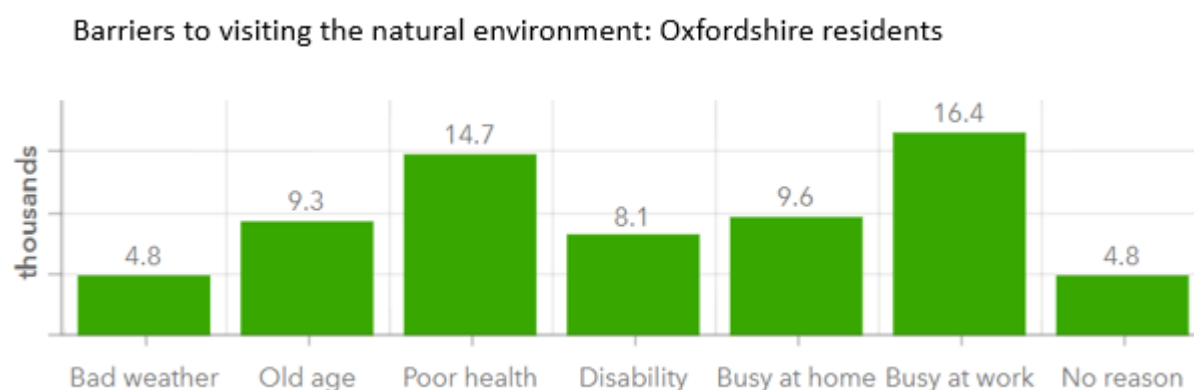


Figure 38: Barriers to visiting the natural environment: Oxfordshire residents. Data from 2010-2019 MENE survey combined

7.6 Green environments and health inequities

Evidence highlights the importance of greener environments in reducing health inequalities – beneficial effects in studies are greater for socio-economically disadvantaged groups. The gap in mental wellbeing is narrower when those who are more socio-economically deprived have improved access to greenspace^{174 175}. However, we also know that in general, there are inequities in access to quality and quantity of greenspace: most economically deprived areas have less good quality public greenspace (see below) and therefore the unequal distribution of greenspace means that those who could benefit most are unable to.

¹⁷³ https://local.communityinsight.org/map/?indicator=ahah_green_space_20170101#

¹⁷⁴ Gascon M, Triguero-Mas M, Martínez D, Dadvand P, Fornes J, Plasència A, et al. Mental Health Benefits of Long-Term Exposure to Residential Green and Blue Spaces: A Systematic Review. *International Journal of Environmental Research and Public Health*. 2015;12(4):4354- 79.

¹⁷⁵ Natural England. Natural England Access to Evidence Information Note EIN018: Links between natural environments and mental health: evidence briefing. 2016

MENE survey data¹⁷⁶ examines whether green spaces are within easy walking distance varies by population group. Those who strongly agreed that greenspace is within easy walking distance are more likely to be from the least deprived areas (IMD), from white backgrounds and be aged between 34-64, highlighting known issues around inequity (figure 39).

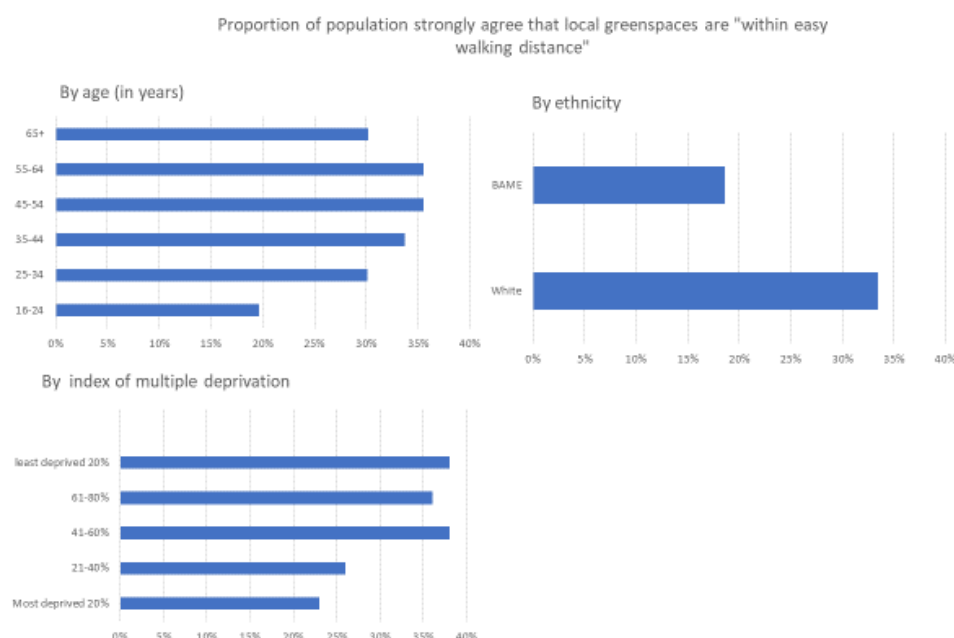


Figure 39: Greenspace within easy reach by different population demographics. Data from MENE survey - ONS and Natural England, using data classifications within this survey

The survey also examined proportions of the population most likely to visit natural spaces. Frequency of visit taking varied between population groups with larger variations by age, ethnicity and socio-economic status (measured using Index of Multiple Deprivation (IMD)) than for other demographics .

Younger people (age 16-24) were the most frequent visitors, compared to other age groups.

The least frequent visitors included those aged 65 and over, populations identifying as black, Asian or from a diverse ethnic population and people living in the most deprived areas.

For Oxfordshire there is some (limited) inequality data available as a combined 2009-2019 analysis of MENE data. This indicates that as for national data, most visits to natural environments are made by wealthier families and those that identify as White.

7.7 Green and Natural Spaces: Children and Young People

Data are available from the MENE survey at a national level, which tell a story of how visits to green and natural environments change with a child's age and by place:

¹⁷⁶ [Monitor of Engagement with the Natural Environment: Headline report and technical reports 2018 to 2019](https://www.gov.uk/government/publications/monitor-of-engagement-with-the-natural-environment-headline-report-and-technical-reports-2018-to-2019) - GOV.UK (www.gov.uk)

- during 2018/19 around two-thirds of children (67%), spent leisure time outdoors at least once a week.
- proportions visiting were highest when children were aged between 6 and 12.
- Frequency of visit taking declined into teenage years while a larger proportion of those aged 16 to 24 spent time outdoors once or twice a month (29%)
- Most children (69%) had visited urban greenspaces in the last month while around a third had visited the countryside (35%) and 16% visited the coast
- While most spent time in natural places in their local area (70%) far fewer (25%) had visited places further afield.
- Just under three quarters of children (71%) had visited the natural environment with adults from their household during the last month 32% took visits with other adults and 17% had spent leisure time outdoors unaccompanied by an adult

7.8 Effects of COVID-19 on use of green and natural spaces


An understanding of the effects of the pandemic (to date) on people's connection to the natural environment at a National level, can be gained from the Natural England People and Nature Survey¹⁷⁷.

Main findings from this show that between April and June 2020 again highlight the inequalities in use of green and natural spaces: adults who have a lower income, lower education levels, who are unemployed, and those living in the most deprived areas are likely to be making fewer visits.

Adults with higher educational attainment are more likely to visit a natural space: 66% of adults with a university degree (or above) made a visit in the last 14 days, compared to 57% of adults with any other qualifications (e.g. A Levels, O Levels, GCSEs, BTEC, Diplomas, Trade Apprenticeships), and compared to 37% of adults with no qualifications.

There is a positive relationship between income and visits; as you earn more you are more likely to get outside in nature. For example, 44% of respondents living in households earning £15,000 or less (below the poverty line) visited a natural space in the last 14 days, compared to 70% of respondents living in households earning £50,000 or above¹⁷⁸.

¹⁷⁷ [The People and Nature Survey for England: Adult Data Y1Q1 \(April - June 2020\) \(Experimental Statistics\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/the-people-and-nature-survey-for-england-adult-data-y1q1-april-june-2020-experimental-statistics)

¹⁷⁸ Sample sizes for the higher income brackets were small, so those earning £50,000 or above are grouped together.  This period includes time when the Government's COVID-19 furlough scheme was in operation. The survey did not ask about whether respondents were on furlough

8 Connections to others and to place

Section Summary

Feeling connected to our communities, family and friends is a fundamental component of mental wellbeing. Evidence links subjective feelings of loneliness to an increased risk of depression and low self-esteem, sleep problems and an increased stress response. The COVID-19 pandemic along with isolation measures have made this an increasingly important issue

Adults

Nationally

- Data from the Office for National Statistics (ONS) shows that before the pandemic, around 5% of the adult population often felt lonely.
- Loneliness needs to be seen as a life course issue: it is an important issue across all ages - adults aged 16-24 years consistently have the highest levels of loneliness of all age groups.
- ONS identified three profiles of adults at particular risk from loneliness:
 - Widowed older homeowners living alone with long-term health conditions.
 - Unmarried, middle-agers with long-term health conditions.
 - Younger renters with little trust and sense of belonging to their area.
- During the COVID-19 pandemic, according to ONS data levels of loneliness have increased from 5.0% of adults to 7.2% of adults between Oct and Feb2021

Across Oxfordshire

- ONS have produced local level estimates of loneliness during the pandemic, and these indicate we need further work to understand the problem within our communities

Children and young people (CYP)

Nationally

- Over 1 in 10 of 10-15 year olds report feeling lonely often
- Greater loneliness at predictable transitions through the education system and moving on from secondary schooling.
- Children receiving free school meals, living in urban areas, with long term illness or disability are more likely to feel lonely CYP described feeling embarrassed about admitting to feeling lonely, and linked it to a possible “failing”
- Barriers (practical, social, emotional, mental) to full participation in social activities can contribute
- CYP who experience multiple issue and triggers or more extreme events (bereavement, disability, being bullied, mental health challenges) may need more help to move out of feeling lonely

Across Oxfordshire

- Children and young people in older years of school report being more lonely as a result of the pandemic in the OxWell school survey

8.1 The importance of social connection to wellbeing and how we describe it

Feeling connected to our communities, family and friends is a fundamental component of mental wellbeing. Increasingly, associations between feeling less connected and both poor physical and mental wellbeing are being understood. For example, evidence links subjective feelings of loneliness to an increased risk of depression and low self-esteem, sleep problems and an increased stress response. In terms of physical health, loneliness has been linked to premature deaths, inactivity, increased smoking, risk of coronary vascular disease and cognitive decline. Feeling lonely can perpetuate isolation through changing our perceptions of others behaviours and increase social anxiety.

The costs to society of loneliness, have recently been summarised in the Governments loneliness strategy¹⁷⁹, which highlighted that lonely people are more likely to visit a GP or A and E, or enter local authority funded residential care. Loneliness has been estimated to cost the private sector up to £2.5 billion a year in absence and productivity losses.

Our connectedness to others, is described and measured in a number of ways. Key definitions include:

- Loneliness – defined by the ONS and the Government in their strategy as “a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want.”¹⁸⁰
- Social isolation - generally understood as the absence of contact with other people. Loneliness and isolation are often used interchangeably and while they are linked they are not the same. It is possible to be isolated without feeling lonely and vice versa. Isolation is observable and more objectively measured (e.g. counting numbers of relationships someone has or how often they speak to other people). This is compared to loneliness as a subjective perception and experience of isolation or lack of communication with others.

8.2 How is loneliness measured?

The ONS has undertaken a wide consultation on how best to [measure loneliness](#) and recommended a gold standard of using direct and indirect measures of loneliness. They recommended four separate questions to capture different aspects of loneliness, and this approach is used in the English Longitudinal Study of Ageing. In the community Life Survey¹⁸¹, however only a direct question about how often the respondent feels lonely – is used.

8.3 Key National and Local Strategies on loneliness and social connectivity

The Government strategy on loneliness ([here](#)), written in response to the Jo Cox commission on loneliness, highlights the role of local government and public health in reducing loneliness by:

¹⁷⁹ [DDCMS Loneliness Strategy \(publishing.service.gov.uk\)](#)

¹⁸⁰ [Measuring loneliness: guidance for use of the national indicators on surveys - Office for National Statistics](#)

• ¹⁸¹ [Community Life Survey 2018-19 report.pdf \(publishing.service.gov.uk\)](#)

- Embedding tackling loneliness in their strategic planning and decision-making on the wellbeing of their communities
- Recognising the issue through Health and Wellbeing and other boards
- Recognising in (public) health and other public services the importance of people's social wellbeing, and explore how they can identify, refer and better support those at risk of feeling lonely often.
- Working with local communities and civil society bodies, and addressing practical issues around community space and transport.
- Sharing knowledge and best practice for tackling loneliness and improve connections across sectors and the country.

The strategy also highlights the importance of community, family, friends and faith groups and volunteering and the importance of creating opportunities to bring people together.

8.4 The importance of a life course approach and understanding key times of vulnerability

The governments loneliness strategy highlighted a number of areas across the life course, where people are at risk of becoming isolated, due to changes in their lives and circumstances or key transitions. These included:

- Specific experiences across early and childhood/young adult years – family breakdown, key transition points such as changing and/or leaving school (s), bullying, leaving home
- Becoming a parent
- Becoming a carer
- Leaving care
- Moving jobs
- Divorce and relationship breakdown
- Retirement
- Bereavement and losing a loved one

Triggers and actions to reduce loneliness are likely to vary across the life course. Taking a life course approach also enables us identify loneliness at different ages.

8.5 Loneliness: Summary of national Level Data and surveys

Whilst loneliness is undoubtedly something which older generations experience - and especially those who have been isolating or had visiting restricted during COVID – research shows that it is in fact experienced across the life course and affects many children and young people¹⁸². As loneliness is the subjective unwelcome feeling of lack or loss of companionship, it can and does occur even when people are surrounded by others when there is a mismatch between the perceived and desired quality of friendships.

8.5.1 Loneliness in the adult population

In 2018 the ONS issued a National level report¹⁸³ on loneliness in adults in England, based on the 2016/2017 Community Life Survey and also its first report on loneliness in children and young

¹⁸² [Children's and young people's experiences of loneliness - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peopleandpopulation/lifeandevents/articles/childrens-and-young-peoples-experiences-of-loneliness/182)

¹⁸³ [Loneliness - What characteristics and circumstances are associated with feeling lonely? - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peopleandpopulation/lifeandevents/articles/loneliness-what-characteristics-and-circumstances-are-associated-with-feeling-lonely/183)

people. These reports highlighted that 5% of adults in England reported feeling lonely “often” or “always”. Younger adults aged 16 to 24 years reported feeling lonely more often than those in older age groups (figures 40 and 41). Characteristics associated with increased feelings of being lonely in adults in analysis by the ONS included:

- Being female
- Being single or widowed
- Being in poor health or who have conditions they describe as “limiting”
- Being renters compared to homeowners.
- Feeling that they belong less strongly to their neighbourhood
- Having little trust of others in their local area

Analysing the data from the survey, three profiles of adults at particular risk from loneliness were identified ¹⁸⁴:

- Widowed older homeowners living alone with long-term health conditions.
- Unmarried, middle-agers with long-term health conditions.
- Younger renters with little trust and sense of belonging to their area.

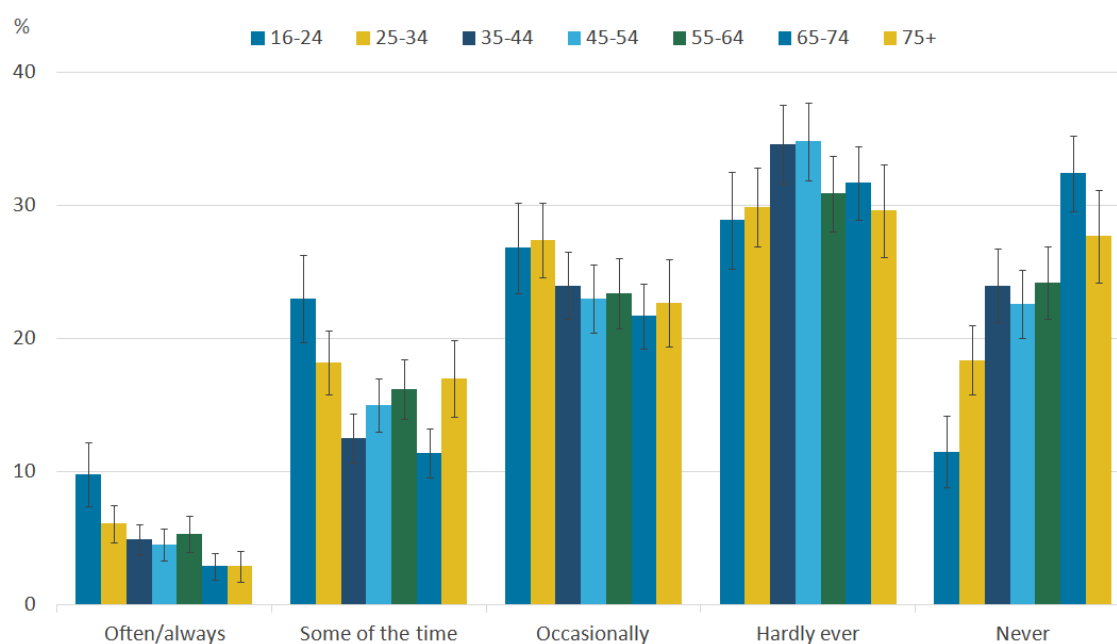


Figure 40: age distribution of % of population feeling often/always lonely, lonely some of the time, occasionally, hardly ever and never. From ONS
<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstances>

¹⁸⁴ [Loneliness - What characteristics and circumstances are associated with feeling lonely? - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstances)

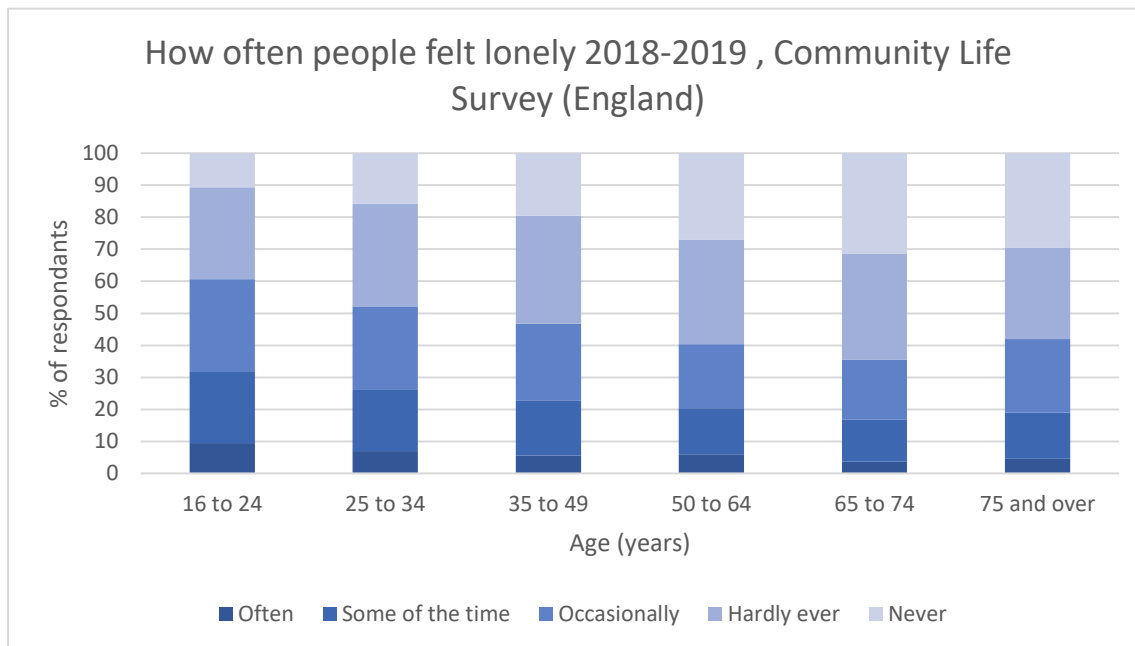


Figure 41: % of respondents feeling lonely often, some of the time, occasionally, hard ever and never by age. Source Community Life Survey (ONS)

In 2019, the Health Foundation undertook an analysis of UK household longitudinal study *Understanding society*¹⁸⁵, which used new indirect measures of loneliness. These data indicated that potentially a much higher proportion of the population is lonely (as many as 13%) and also a steeper rise in feeling lonely in those over 80 years¹⁸⁶.

Mapping of areas of concern for adults has also been undertaken recently by the Oxfordshire Community Foundation.¹⁸⁷

8.5.2 Oxfordshire Data: older adults

Age UK, have constructed loneliness heat maps, for residents across local areas over 65 years of age. These are shown in figure 41 below and bring together data across four domains from the 2011 Census, which together predict 20% of the loneliness observed amongst older people age 65 and over as measured in the English Longitudinal Study of Ageing (ELSA). These four domains are:

- Marital status
- Self-reported health status
- Age
- Household size

¹⁸⁵ [Understanding Society – The UK Household Longitudinal Study](#)

¹⁸⁶ [The missing lonely | The Health Foundation](#)

¹⁸⁷ [Needs-Analysis-Report-Community-Friendship-April-2019.pdf \(netdna-ssl.com\)](#)

The 2021 Oxfordshire JSNA used this to map the predicted prevalence of loneliness across all LSOA's in Oxfordshire, using loneliness rankings from all LSOA's nationally. From this, the areas in Oxfordshire which are in highest risk quintile (ranked amongst of all neighbourhoods in England) were:

- Cherwell: Banbury, Bicester Town
- Oxford: Blackbird Leys, Wood Farm, Barton, St Clements, Jericho, Cowley
- South Oxfordshire: Didcot South

These are also shown on figure 42 below (areas at highest risk of loneliness in the over 65s are indicated in purple shading).

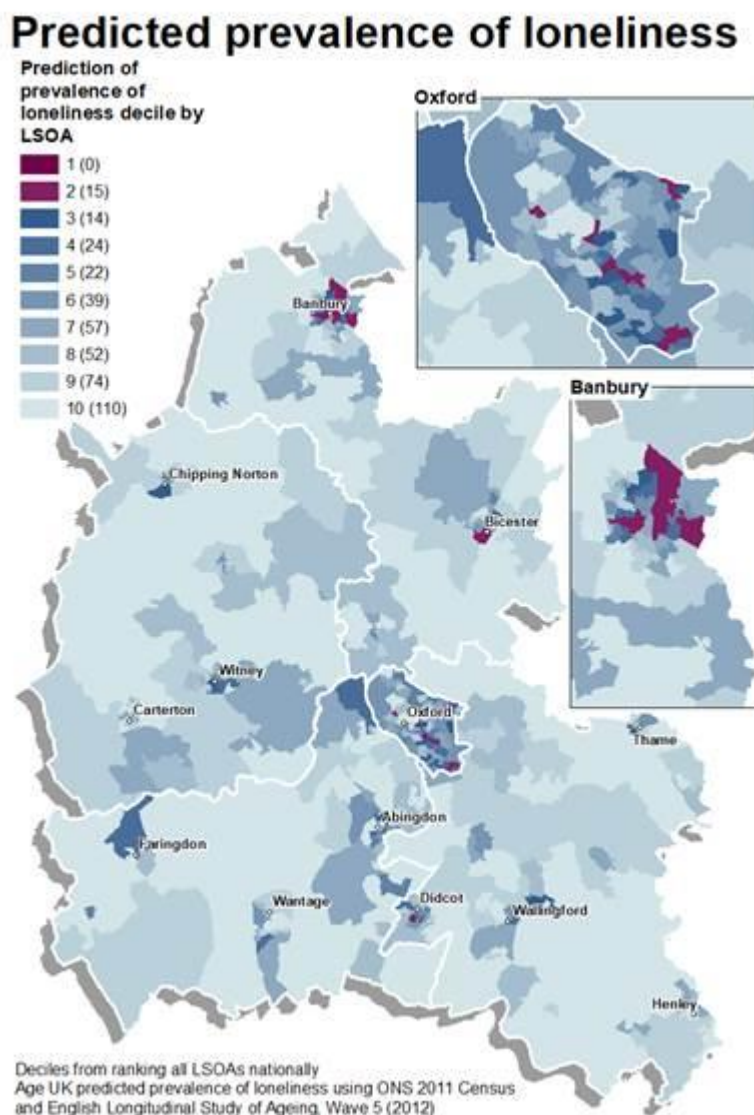


Figure 42: Predicted Prevalence of loneliness. [JSNA](#)

8.6 Oxfordshire Social Isolation

PHE fingertips pulls together data on social isolation in adult carers, from the Adult Social Care Survey. In 2019/2020, only 44% of carers over the age of 18 in Oxfordshire had as much social contact as they would like (compared to 45.9% nationally) and only 39.1% of adult social care users had as much social contact as they would like (compared to 43.4% nationally).

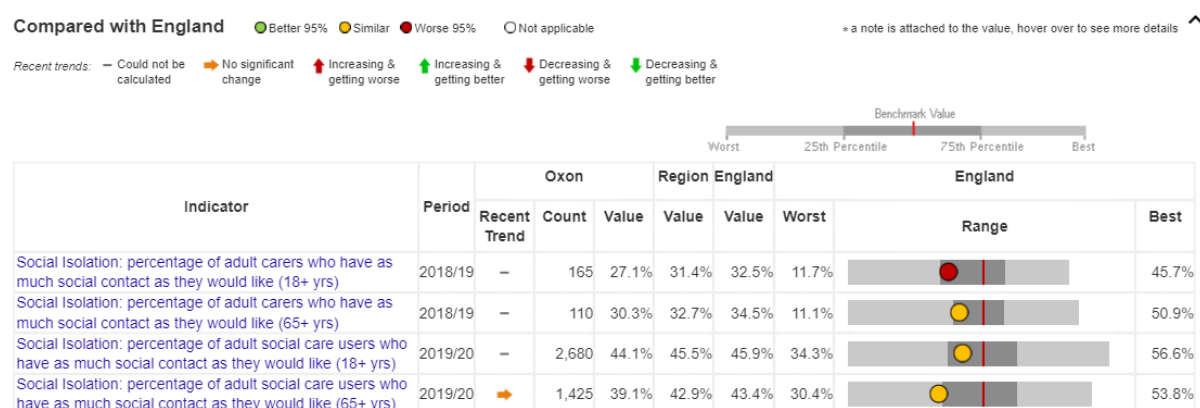


Figure 42: proportion of adult carers who do not have as much social contact as they would like. Data from PHE fingertips : [Public Health Profiles - PHE](#). Indicator from NHS digital [Adult Social Care User Survey](#)

8.7 Connection to place : the Community Needs Index (Civic assets, connectedness and active and engaged community)

Given the importance of feeling connected to local communities, information from the Community Needs Index is also summarised. The score is a composite measure based on 19 indicators over three areas: Civic Assets, Connectedness and Active and Engaged Community¹⁸⁹, compiled by the

¹⁸⁹ The index covers 19 indicators, across three domains;

- Civic Assets: Measures the presence of key community, civic, educational and cultural assets in close proximity of the area. These include pubs, libraries, green space, community centres, swimming pools – facilities that provide things to do often, at no or little cost, which are important to how positive a community feels about its area.
- Connectedness: Measures the connectivity to key services, digital infrastructure, isolation and strength of the local jobs market. It looks at whether residents have access to key services, such as health services, within a reasonable travel distance. It considers how good public transport and digital infrastructure are and how strong the local job market is.

Oxford Consultants for Social Inclusion (OCSI) and Local Trust. It was developed to identify areas experiencing poor community and civic infrastructure, relative isolation and low levels of participation in community life (further details about the index can be found [here](#)¹⁹⁰). A higher Community Needs Score indicates greater need. Below, results by districts and city for 2019 are summarised.

- In Cherwell, the average score across all MSOAs was 48.81.
 - Areas with highest Community Needs Index were Banbury (Banbury Hardwick – score 99.2, Banbury Ruscote – score 83.6, Banbury Neithrop score 56.4) and Bicester (especially Bicester North – score 67.41)
- Oxford the average score across all MSOAs was 26.38
 - Areas with highest Community Needs Index were Oxford Central (LSOA score- 81.84) and Blackbird Leys (LSOA score 66.17)
- South Oxfordshire the average score across all MSOAs was 52.98
 - Areas with highest Community Needs Index were Didcot West (score - 76.41), Didcot South (score - 81.34), Thame South (score - 107.78), Thame North (score - 107.76), Henley North (score – 73.93) Henley South (score – 73.93)
- Vale of the White Horse the average score across all MSOAs was 57.96
 - Areas with highest Community Needs Index were Farrington & Stanford (MSOA score- 108.83) and Abingdon Northcourt & Peachcroft (MSOA score-79.01)
- West Oxfordshire the average score across all MOSAs was 50.48
 - Areas with highest Community Needs Index were Chipping Norton (score- 81.84), Carteton North (score – 100.40), Carteton South (score 93.54), Whitney West (score – 101.84)

At a national level, information on from the community life survey also gives a picture of social cohesion, community engagement and social action.¹⁹¹

8.8 Loneliness and Social Isolation in Children and Young People

Data on loneliness and social isolation in children and young people show the need to consider this as a life-course problem and one that is important across all ages.

ONS national data¹⁹² indicates:

- Even before the pandemic, 11.3% of 10-15 year olds and around 9.8% of 16-24 year olds reported feeling lonely often (compared to 6% of adults overall)

-
- Active and Engaged Community: Measures the levels of third sector civic and community activity and barriers to participation and engagement. It shows whether charities are active in the area and whether people appear to be engaged in the broader civic life of their community.

¹⁹⁰ [Left behind? Understanding communities on the edge - Local Trust](#)

¹⁹¹ [Community Life Survey 2018-19 report.pdf \(publishing.service.gov.uk\)](#)

¹⁹² [Children's and young people's experiences of loneliness - Office for National Statistics \(ons.gov.uk\)](#)

- If these national figures are applied to the Oxfordshire population, this equates to:
 - 5,672 of 10-15 year olds across Oxfordshire feeling lonely often and
 - 8,085 of 16-24 year olds feeling lonely often
- There are ages with higher proportions of young people feeling lonely : 16% of 12 year olds and 13% of 18 year olds and 21 year olds said they often felt lonely. These are aligned with a range of predictable transitions through the education system and moving on from secondary schooling.

Associations between the children's environment and feeling lonely were identified:

- 27.5% of children receiving free school meals reported "often" being lonely compared to 5.5% who were not
- Children living in urban areas were more likely to feel lonely (19.5% of children living in cities compared to 5% in rural areas reported often feeling lonely)
- Children who had "low " satisfaction with relationships with family and friends were more often lonely (34.8%, 41.1% respectively)
- Young people (16-24 years) were less likely to feel lonely if they didn't have a long term illness or disability (44.8% of 16-24 year olds with no disability/illness said they were " hardly ever lonely", compared to 18.2% with a disability).
- Young people (16-24 years) living in single adult households were more likely to feel lonely

Importantly the report also summarised qualitative findings. Namely that:

- CYP described feeling embarrassed about admitting to feeling lonely, and linked it to a possible "failing"
- Barriers (practical, social, emotional, mental) to full participation in social activities can contribute to loneliness
- CYP who experience multiple issue and triggers or more extreme events (bereavement, disability, being bullied, mental health challenges) may need more help to move out of feeling lonely

8.9 The impact of COVID-19 on our social connections

According to the ONS Levels of loneliness have increased since spring 2020.

Between April and May 2020, 5.0% of adults (older than 16 years) said that they felt lonely "often" or "always"¹⁹³. However, from October 2020 to February 2021, during the COVID-19 pandemic results from the Opinions and Lifestyle Survey (OPN) show that proportion increased to 7.2% of the adult population¹⁹⁴.

ONS have mapped these recent loneliness findings from between October and February 2021¹⁹⁵. Areas with a higher concentration of younger adults (aged 16-24) and areas with higher rates of unemployment tended to have higher rates of loneliness (October 2020 to February 2021). The results of this for Oxfordshire across districts and for Oxford city are shown below (figure 43) . However, these results are based on small numbers and cannot be used to directly compare areas:

¹⁹³ [Coronavirus and loneliness, Great Britain - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peopleandplaces/population/loneliness/articles/coronavirusandlonelinessgreatbritain)

¹⁹⁴ [Mapping loneliness during the coronavirus pandemic - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peopleandplaces/population/loneliness/articles/mappinglonelinessduringthecoronaviruspandemic)

¹⁹⁵ [Mapping loneliness during the coronavirus pandemic - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/peopleandplaces/population/loneliness/articles/mappinglonelinessduringthecoronaviruspandemic)

rather than being taken as a definitive result should be seen as an indication that further work to understand this across Oxfordshire is needed.

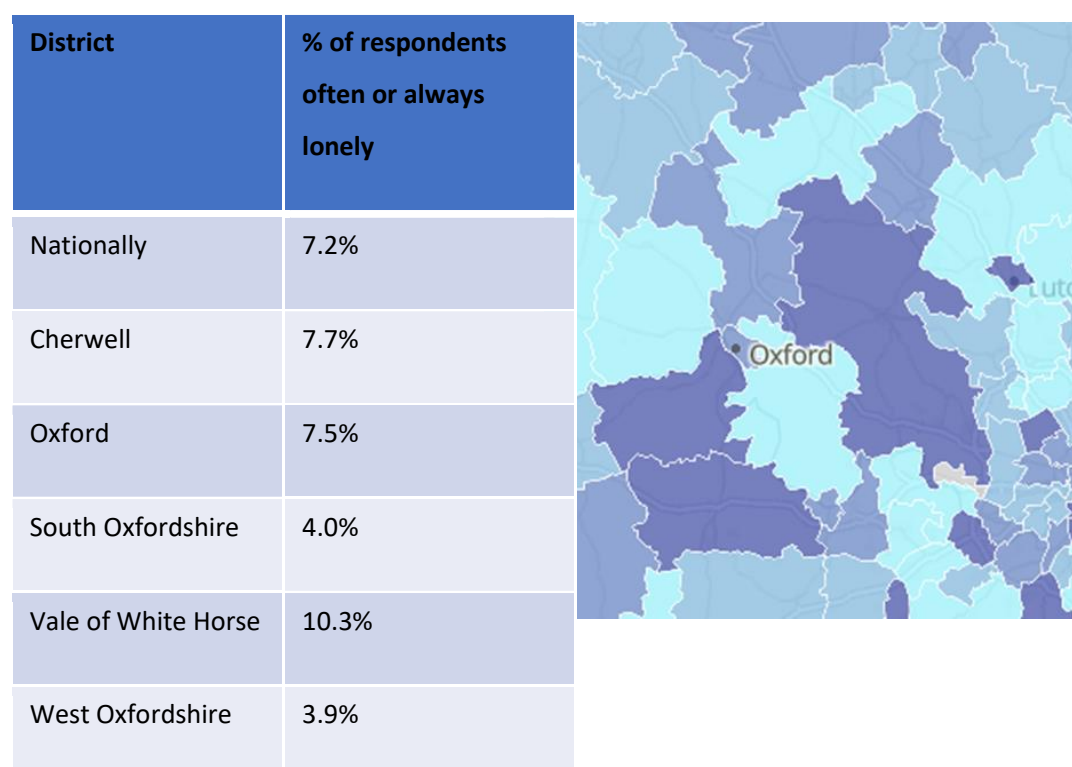


Figure 43: Proportion of survey respondents feeling lonely often or always. Data source: ONS [Mapping loneliness during the coronavirus pandemic - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/lonelinessduringthecoronaviruspandemic/1)

The Public Health England Wider Impacts of COVID on Health tool (WICH tool) has also compiled data on loneliness and by different inequalities¹⁹⁶, illustrating that loneliness has affected different groups unequally and during the pandemic. A more detailed discussion of academic research on loneliness during the pandemic has been produced by PHE¹⁹⁷.

From discussions with local partners, loneliness has affected many residents who have been accessing support in this time.

For older adults, age UK have investigated the effects of lockdown and isolation^{198 199} and reported the social, cognitive and physical effects which now present a number of challenges. The internet has also been a vital tool for many in keeping in touch with friends, family and some online activities and although many older adults are digitally connected, a significant proportion are not and have

¹⁹⁶ [Wider Impacts of COVID-19 on Health - PHE](https://www.phe.org.uk/publications/wider-impacts-of-covid-19-on-health)

¹⁹⁷ [3. Measures of anxiety, depression, loneliness and life satisfaction - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/3-measures-of-anxiety-depression-loneliness-and-life-satisfaction)

¹⁹⁸ [the-impact-of-covid-19-on-older-people_age-uk.pdf \(ageuk.org.uk\)](https://ageuk.org.uk/research/the-impact-of-covid-19-on-older-people)

¹⁹⁹ [Age UK research on impact of the pandemic on our older population's health](https://ageuk.org.uk/research/age-uk-research-on-impact-of-the-pandemic-on-our-older-population-s-health)

been more vulnerable to isolation: nearly two million over-75s in England are still digitally excluded²⁰⁰.

For children and young people locally, the OxWell survey data reports the impact of COVID-19 on school pupils feelings of isolation and having people to talk to.

Across Oxfordshire, 48% of girls and 50% of boys felt they had less people to talk to and 17% of girls and 19% of boys had more people to talk to during lockdown. The pattern varied with age (figure 44) Having no-one to talk to was highly and significantly correlated with mental wellbeing in both primary and secondary phases.

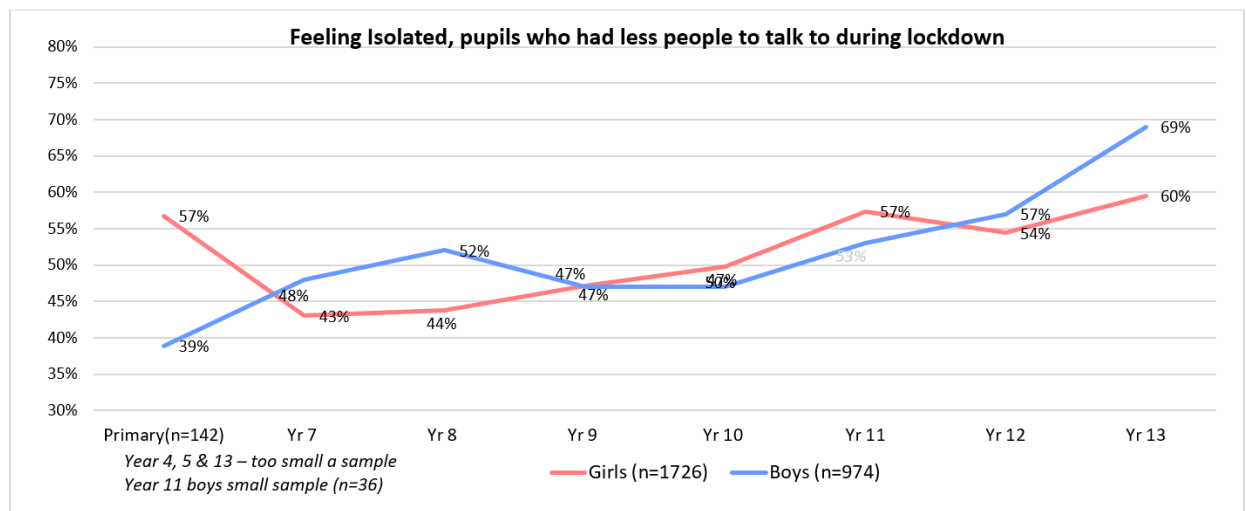


Figure 44: % of respondents who had less people to talk to during lockdown. OxWell 2020 survey

²⁰⁰ [Nearly two million over-75s in England are still digitally excluded in a COVID-19 world | Press release | Age UK](#)

9 Recommendations

Given the broad nature of this assessment, many recommendations that are made apply across different areas. However, we do also highlight specific areas for further work, or sections of the population likely to be at increased risk of poor mental wellbeing. This is intended to better inform decision making and action.

9.1 Taking a systems approach to mental wellbeing

This assessment has highlighted the broad range enablers and environments that affect mental wellbeing across the life course and the need for a whole systems-based approach to mental wellbeing. That is to say, mental wellbeing needs to be considered as “everyone’s business” and a wellbeing in all policies approach is necessary.

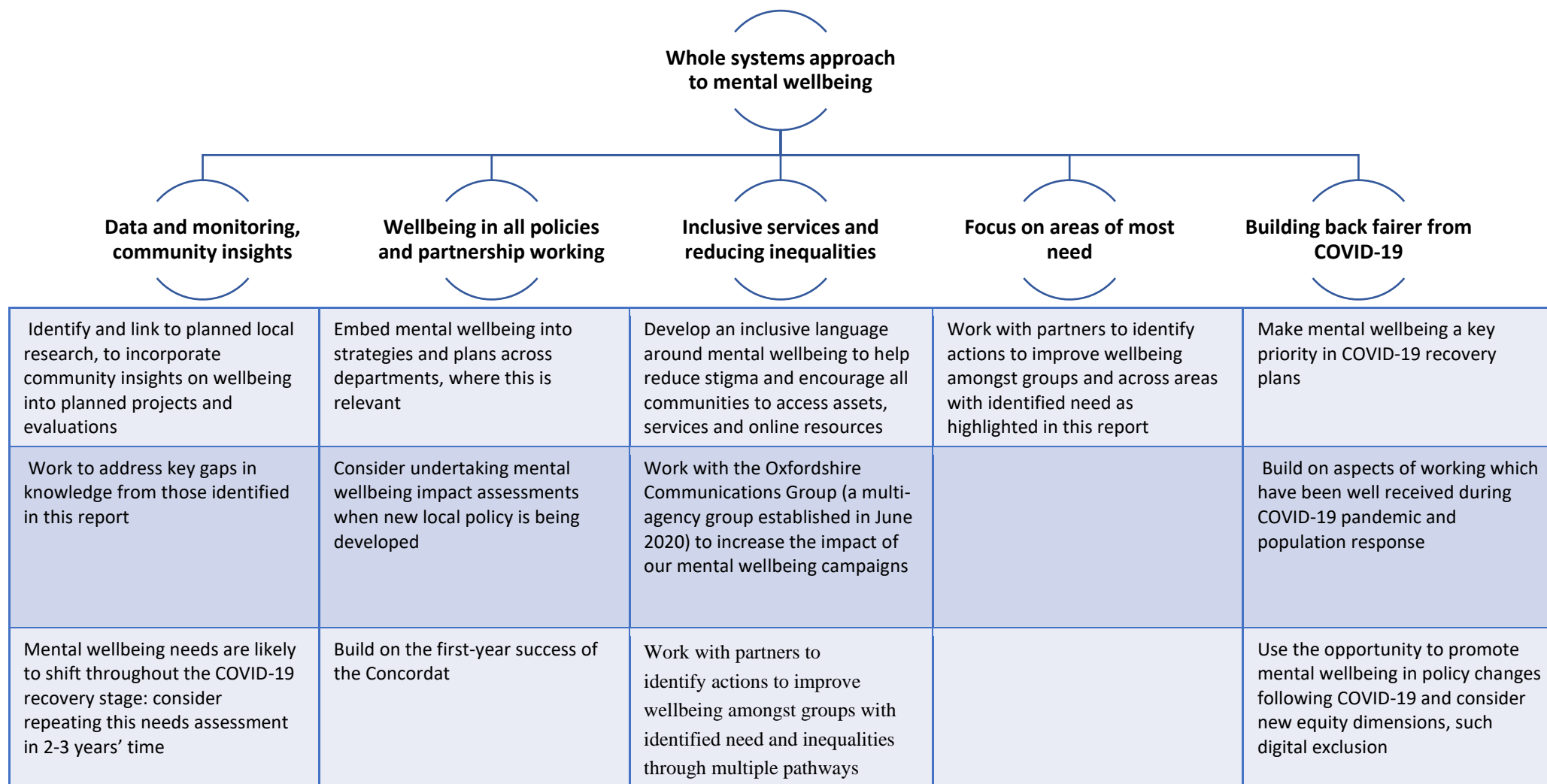
Under the overall approach of whole systems working, further recommendations have been divided into 5 themes (figure 45):

- **Data - surveillance, evaluation, and community insights:** work to address gaps in knowledge and understand wellbeing through a variety of data gathering approaches
- **Wellbeing in all policies and partnership working:** working with a range of partners to improve across mental wellbeing through different pathways: make wellbeing “everyone’s business”
- **Inclusive services and reducing inequalities:** developing inclusive language and services and acting to reduce inequalities
- **Prioritising areas of identified need**
- **Building back fairer from COVID-19:** making wellbeing a priority in the recovery from COVID-19 and learning from the lessons and opportunities identified in this needs assessment.

Each of these areas is explored in more detail over the following pages, along with supporting rationale for the recommendations.



Figure 45: Recommendation themes



New strategy for social prescribing to be cascaded widely through the system to understand any gaps in provision	Within commissioning, consider primary prevention and mental wellbeing across the patient journey	Maximise opportunities to promote mental wellbeing across diverse settings and outside of formal healthcare, e.g links with partners across settings such as community centres, faith settings, community ladders and schools		
	Share widely the findings from this needs assessment, so that results can inform strategy development and can be embedded widely into planning across different areas	Identify opportunities for training in wellbeing support, for example amongst those who people turn to for initial help with mental wellbeing and the experience from our communities		

9.2 Data: surveillance and evaluation and community insights - improving our understanding of mental wellbeing in our communities

Rationale

We've identified a number of gaps in our knowledge and understanding of mental wellbeing across Oxfordshire, which act as barriers to understanding areas of need and levers for intervention.

Key areas which stand out for further work include:

- Understanding **where people turn to for help and what help communities would like** - to better inform opportunities for action
- **Improved community insight: specifically around lived experience of residents.** In particular for those at higher risk of poor mental wellbeing and amongst certain groups identified in this report

Improved understanding of

- **Social isolation and loneliness** across the **whole life course**, and needs of different populations emerging from the COVID-19 pandemic
- Understanding of **access and use of green and natural spaces by different communities** and links to wellbeing in Oxfordshire
- **What help specific populations want to improve wellbeing:** in terms of types of support, location of support, language around support and access.
- **Perinatal wellbeing** and mental wellbeing in families with early years children, as these areas were not explored in this report
- **Local inequalities in mental wellbeing**

Improved understanding of wellbeing at **certain life stages:**

- **Perinatal mental wellbeing and wellbeing at the transition to parenthood**
- **Wellbeing in 0-5s and family focused aspects of wellbeing**
- Wellbeing and its determinants for children and young people – for example **at transitions** to teenage years and between leaving school/full time education and moving to employment
- **Mental wellbeing in older age** – e.g. transition to retirement, loss of independent living and specifically with groups where loss of wellbeing and independence may have been triggered by COVID-19 and associated control measures. The impact of digital exclusion in this age group.

Improved quantitative data on:

- **Sleep** in the adult population, stress, creativity, volunteering
- **Specific inequalities in Oxfordshire** (much data is only available at a national level)

9.2.1 Identify and link to planned local research, to incorporate community insights on wellbeing into planned projects and intervention evaluations

- For example: work with teams who are currently developing research on healthy weight to understand links between mental wellbeing, healthy weights and place in our communities.
- **Evaluations of planned local interventions to include impact measures for effects on mental wellbeing** (where this is an anticipated benefit)
 - Agreeing a **joined-up approach to these measurements with partners** (e.g., agreeing on common wellbeing questions and measurements included in local surveys -e.g. short version of the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS)). This would allow more consistent data collection
 - Inclusion of qualitative research around wellbeing in planned evaluations of interventions

9.2.2 Work to address key gaps in knowledge from those identified in this report

- This will require **a range of approaches** – for example to improve community insight, participatory approaches to research and use of community researchers should be considered.
- **Specific areas to address** are included in the rationale paragraph above, for example
 - **understanding loneliness and social isolation** in greater depth and across the life course, an improved understanding of perinatal wellbeing locally
 - Specifically, **working with different populations to understand what help and support would be useful** and accessible to them (for example, outside standard care settings) is key
 - **Understanding of combinations of issues** facing residents at certain **life stages**: e.g. for 16-24 year olds, what help is accessed and what they would like for wellbeing, understanding lived experience of loneliness, impact of financial uncertainty in this group disproportionately affected by unemployment in COVID-19
 - Understanding **inequalities and lived experience** of these at local levels across protected characteristics
 - Understanding local access to natural spaces and inequalities in this
- **Mapping the range of assets or services that are available in a local area** or to a particular community when planning further service delivery. This was outside the scope of the needs assessment and would need to be tailored to groups of interest due to the wide range of services available.

9.2.3 New strategy for social prescribing to be cascaded widely through the system to understand any gaps in provision

- The development of a social prescribing strategy is currently being undertaken within the CCG. This can be used to understand different opportunities for social prescribing – e.g. green prescribing and thinking of the diversity of settings in which social prescribing occurs

- 9.2.4 Mental wellbeing needs are likely to shift throughout the COVID recovery stage: consider repeating this needs assessment in 2-3 years time
- At the time of writing, the COVID-19 pandemic is ongoing and many effects are yet to be fully experienced or understood. It is likely to change the landscape of mental wellbeing and delivery of support and services. Therefore **repeating this needs assessment in 2-3 years time** to take account of the changes and emerging needs amongst our residents is recommended.

9.3 Wellbeing in all policies approach and partnership working

Rationale

The importance of primary prevention and wider determinants of wellbeing have been demonstrated, through the data and literature presented. However, improving mental wellbeing through these different pathways and reducing inequities will only be achieved through a joined up and systems wide approach. This includes working to raise the profile of mental wellbeing and working with partners to ensure strategies and plans across all areas consider impacts on mental wellbeing.

- 9.3.1 Embed mental wellbeing into strategies and plans across departments, where this is relevant
- For example in active travel policies and evaluations, linked into healthy place shaping, sustainability plans and into local plans at district and city level
 - This is especially relevant for work with our 10 most deprived wards, for example through the Health and Wellbeing Partnerships working in these areas
- 9.3.2 Consider undertaking mental wellbeing impact assessments when new local policy is being developed
- For example, in policies relating to green and natural spaces, transformation of ways of working post COVID-19 (e.g., consider differential effects of remote working and online support groups in different populations).
- 9.3.3 Build on the first-year success of the Concordat
- **Broadening of membership** to include members from areas currently not represented. For example, extending membership to include organisations working on green and natural spaces
 - **Continued sharing of best practice and learning through quarterly Concordat meetings**
- 9.3.4 Within commissioning, consider primary prevention and mental wellbeing across the patient journey

9.3.5 Communicate the findings of this needs assessment widely, to stakeholders and public so that findings can be embedded widely into planning and strategies across different areas

- For example: create a story board of reports findings to highlight key messages and present findings widely to varied audiences and stakeholders

9.4 Inclusive language, services and reducing inequalities

Rationale

This report highlights a number of areas we can build upon to improve wellbeing across Oxfordshire – both in terms of inequalities and areas of need.

It highlights the importance of an inclusive and shared language in allowing communities to engage with activities and specific support for mental wellbeing. Data on where people turn to for help with wellbeing, highlights the diversity of partners and resources that people turn to for support, and the many opportunities to improve mental wellbeing before people access formal health care. Working to address these will not only reduce inequalities in positive mental health, but also in physical health.

9.4.1 Develop an inclusive language around mental wellbeing to help reduce stigma and encourage all communities to access assets, services and online resources

9.4.2 Work with the Oxfordshire communications group (a multi-agency group established in June 2020) to maximise the effectiveness of campaigns by:

- Considering the language we use around mental wellbeing, and work to ensure messages we use around mental wellbeing are **non-stigmatising and inclusive** to all communities
- **Developing a communications plan for this year** promoting different aspects of wellbeing which builds on the findings of this report
- Exploring **different ways of raising awareness around mental wellbeing and available support**, e.g. consider the full range of media used by children and young people, such as short form video content

9.4.3 Work with partners to identify actions to improve wellbeing amongst groups with identified need and inequalities through multiple pathways and settings:

- **Work with partners across the prevention Concordat and more widely to improve and promote mental wellbeing across a number of settings and different communities, outside of the formal healthcare setting**
 - E.g. messaging and support for mental wellbeing **within increased community settings**, such as **community centres, faith settings, settings where people access other support (such as community larders, food banks), libraries, schools**
 - **Identify opportunities to train those who people turn to for initial support** - friends and family and community leaders/champions - in mental

- wellbeing support.** This should also include volunteers in settings where people turn to for other support, such as community food larders.
- **Develop support with input and insight of lived experience of our communities**
 - **Increasing wellbeing through continued partnership working:** for example, inclusion of partners working on green and natural spaces within the Mental Health Prevention Concordat (as above) and also public health representation in Local Nature Partnerships.
- There are already many great examples of partnership working across Oxfordshire which have been used to increase wellbeing through different pathways, approaches and with diverse communities (see also partnership working above) . The following are some illustrative (not comprehensive) examples of where this approach has been taken:
 - Partnership between Public Health Oxfordshire, PHE South East and Banbury Madni Mosque for an “Every Mind Matters” [mental health campaign](#)²⁰¹
 - The Ways to Wellbeing project, [Style Acre](#), delivering a buddying programme to adults with learning disabilities. Trained employees in mental health first aid and to promote wildlife & nature activities, working with Element 6 and the Wildlife Trust & Sustainable Wantage.
 - Growing Well Together project [Oxford City Farm](#) delivering farming volunteer sessions for all adults. Trained staff in mental health first aid and employed a project worker to target engagement with underrepresented ethnic minority communities Read more [here](#).
 - Active Reach Residents from Blackbird Leys and Greater Leys were supported throughout COVID-19 to keep physically active. Partners include Access Sport, Age UK Oxfordshire, Aspire Oxford, KEEN, Oxford Hub, Oxfordshire Mind, OXSRAD and Oxfordshire Youth. Read more [here](#)
 - Move Together: a project co-ordinated by Active Oxfordshire, in collaboration with the District Councils who are providing local place-based expertise to support individuals into appropriate activity and help them move more, to improve their health. Read more [here](#).
 - Partnership between Cherwell District Council, Oxfordshire Mind and Resilient Young Minds, working with Year 5 and 6 students to help them understand more about stress, anxiety and self-esteem . See [here](#).

²⁰¹ [Local mosque leaders supports ‘Every Mind Matters’ mental health campaign \(oxfordshire.gov.uk\)](#)

9.5 Focusing on areas of most need

Rationale

Although improved data is needed in many areas, this assessment has identified areas of inequality and specific challenges faced across different ages. Work with partners to begin to address these challenges and identify potential interventions and actions.

9.5.1 Work with partners to identify actions to improve wellbeing amongst groups with identified need as highlighted in this report

There are cross-cutting themes across all stages of the life course. For example, this assessment has demonstrated the increasing need to consider loneliness and isolation across all ages, especially in the context of the COVID-19 pandemic and associated control measures. It has highlighted the need for actions across all wider enablers to mental wellbeing and to consider the known drivers of inequality (such as financial circumstances and deprivation) in considering mental wellbeing.

For each broad life course, areas of most need are summarised in figure 46 below to inform action.

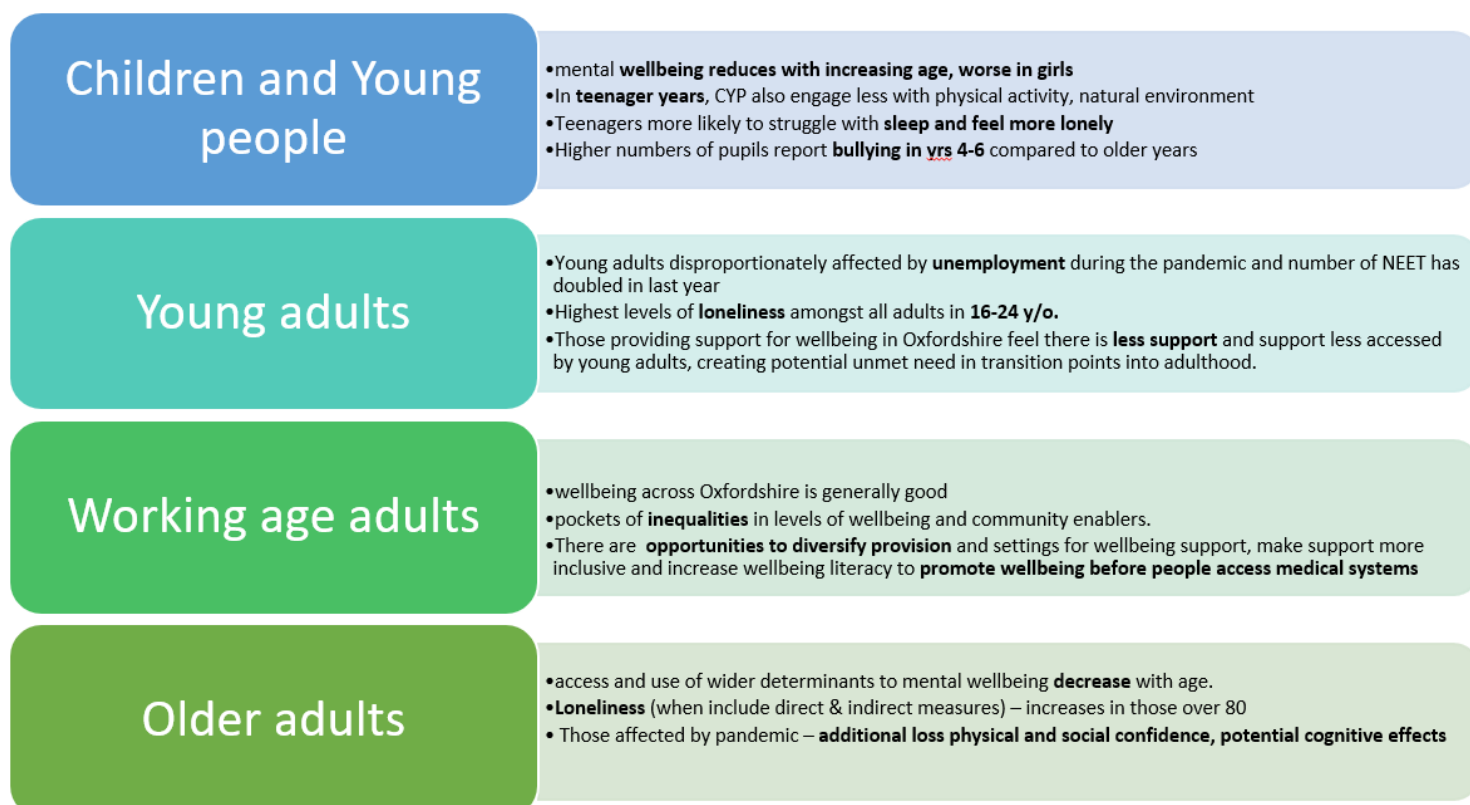


Figure 46: Summary of key challenges at different ages

9.6 Taking forward lessons learnt and building back fairer from COVID-19

Rationale

Although COVID-19 and its associated control measures have negatively impacted on the mental wellbeing and health of so many, there have been a number of very positive examples locally of adapting ways of working, innovative projects, for example bringing together community hubs offering holistic support to residents and the rapid transformation of many services to support people through online and digitally, when face to face interactions have been limited.

9.6.1 Make mental wellbeing a key priority in COVID-19 recovery plans

9.6.2 Build on the aspects of working during COVID-19 which have been positively received
Specific examples - community support hubs, grass roots volunteering, increased time spent in green and natural spaces and new ways of delivering services e.g. digital access to support groups have removed barriers for some to attend (reduced stigma, reduced travel and expense), though not in all cases

9.6.3 Consider mental wellbeing impact in any policy changes following COVID-19 : Use the opportunity to promote mental wellbeing in policy changes following COVID-19 and consider new equity dimensions, such digital exclusion

Specific examples – remote working and online groups have worked well for some, but for other they have removed important contact. Taking up digital offers of support is not always possible for those who are digitally excluded or whose home environment does not allow this

Table 7: Summary of recommendations

Area	#	Recommendation	Responsibility
Data and monitoring	1	Identify and link to planned local research, to incorporate community insights into mental wellbeing into planned projects - ensure this includes community participation	OCC Public Health, Mental Health Concordat
	2	Work to address key gaps in knowledge from those identified in this report	OCC Public Health, Mental Health Concordat
	3	Mental wellbeing needs are likely to shift throughout the COVID recovery stage: consider repeating this needs assessment in 2-3 years time	OCC Public Health
	4	New strategy for social prescribing to be cascaded widely through the system to understand any gaps in provision	CCG
Mental wellbeing in all policies and partnership working	5	Embed mental wellbeing into strategies and plans across departments, where this is relevant	All relevant departments, district and city councils
	6	Consider undertaking mental wellbeing impact assessments when new local policy is being developed	All working, educational environments, organisations etc.
	7	Build on the first-year success of the Concordat	Mental Health Concordat
	8	Within commissioning, consider primary prevention and mental wellbeing across the patient journey	All commissioners of services
	9	Share widely the findings from this needs assessment, so that results can inform strategy development and can be embedded widely into planning across different areas	OCC public health
Inclusive services and reducing inequalities	10	Develop an inclusive language around mental wellbeing to help reduce stigma and encourage all communities to access assets, services and online resources	Mental Health Concordat and Oxfordshire communications Group
	11	Work with the Oxfordshire Communications Group (a multi-agency group established in June 2020) to increase the impact of our mental wellbeing campaigns	Mental Health Concordat, Oxfordshire communications Group

	12	Work with partners to identify actions to improve wellbeing amongst groups with identified need and inequalities through multiple pathways	Mental Health Concordat
	13	Maximise opportunities to promote mental wellbeing across diverse settings and outside of formal healthcare, e.g links with partners across settings such as community centres, faith settings, community ladders and schools	Mental Health Concordat, OCC public Health, Health and Wellbeing Partnerships
	14	Identify opportunities for training in wellbeing support, for example amongst those who people turn to for initial help with mental wellbeing and the experience from our communities	Mental Health Concordat, OCC public Health, Health and Wellbeing Partnerships
Focus on areas of most need	15	Work with partners to identify actions to improve wellbeing amongst groups and across areas with identified need as highlighted in this report	Mental Health Concordat,
Lessons learnt and building back from COVID-19	16	Make mental wellbeing a key priority in COVID-19 recovery plans, specifically amongst groups who have been most affected	All organisations e.g. OCC, schools. Work places,
	17	Build on the aspects of working during COVID-19 which have been positively received	All service providers
	18	As we shift to new ways of working, evaluate the impact of remote and digital provision on services to different communities (e.g. considering digital poverty, social exclusion)	All service providers

