



Advancing our health: prevention in the 2020s

October 2019

About us

The Federation of (Ophthalmic and Dispensing) Opticians – FODO - is the national representative and professional association for community eye health providers, optometrists and opticians in the UK. Our members provide the vast majority of NHS primary eye care in the UK.

Our response

Which health and social care policies should be reviewed to improve the health of: people living in poorer communities, or excluded groups?

As the consultation rightly points out, people often experience “multiple disadvantages” (page 7) and nowhere is this more evident than in poorer communities and excluded groups. Often in poorer or excluded communities, every day survival pressures “just coping” overwhelm long-term needs. This is as true of eye health and quality of life risks as it is of mortality risks, especially when this can be dismissed as somehow ‘normal’ (some ‘kids’ just see better than others, have ‘odd eyes’, or this is ‘just old age’).

Public Health Needs Assessments and Planning

To address this all local joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs) should be required to include an assessment of eye health and hearing needs, including special consideration of the needs in poorer communities and excluded groups and how these might be met.

Healthy and Active Ageing

Age is the major driver of poorer vision and visual impairment. For this reason, there is an urgent need for the government to review and make ‘healthy and active ageing’ and ‘ageing well’ a central part and delivered part of all aspects of public policy. Within this sensory aspects of health and well-being should have much higher priority because unsupported sensory loss has an adverse impact on mental wellbeing, the rate of cognitive decline, falls, employment, earnings, quality of life, and other key detriments of health and wellbeing at population as well as individual levels.

Nowhere is this more important than in poorer communities and for excluded groups. At the heart of local public health strategies should be coordinated plans to tackle avoidable sight and hearing loss, and where people do lose their sight or hearing or both, to ensure they have access to the support and care they need to live independently for longer.

Despite this, as noted above, eye health and hearing needs are often not part of local JSNAs and JHWSs which means people continue to suffer inequalities in access to local care and support. This is one important area where the proposals in the NHS Long Term Plan should bring major measurable benefits.

Homeless People

In this context, the homeless population warrants special consideration. Homeless people have a higher prevalence of eye health issues than the general population, and there is a strong association between visual impairment and lower wellbeing as well as reduced earning potential (1, 2). We very much support NHS England's current work to make minor amendments to the NHS General Ophthalmic Services (GOS) regulations and forms so that homeless people, especially people sleeping rough, can access the eye care they have a right to under the NHS Constitution.

People with Learning Disabilities and Autism

We also very much welcome and support the commitment in the NHS Long Term Plan to improve eye health and hearing services for children and young people in special schools and the collaborative work currently underway to bring this about including the acknowledgment of and investment in clinical and service quality.

References

- (1) Lynne Pezzullo, Jared Streatfeild, Philippa Simkiss and Darren Shickle. The economic impact of sight loss and blindness in the UK adult population. BMC Health Services Research (2018) 18:63
- (2) Sawers, N. The state of ocular health among London's homeless population. Eye 31, 632–635 (2017).

Do you have any ideas for how the NHS Health Checks programme could be improved?

We agree with the principle of “intelligent health checks” – health checks, which are currently variable in terms of uptake and impacts, could instead focus on “supporting people through key changes in their life, in particular thinking about [remaining] healthy and active in older age” (page 17).

In our view there is an urgent need to ensure NHS Health Checks

- target key drivers for health and wellbeing in our ageing population
- help support earlier diagnosis in areas where there are cost-effective interventions that can help make a positive and meaningful difference.

With these criteria in mind, there are important ways in which the NHS Health Checks programme can be improved. We would strongly recommend that as part of an ageing well strategy:

- people should be encouraged to have a NHS sight test as part of the NHS Health Checks programme at age 40 if they have a family history of glaucoma – this is already commissioned and funded via the national GOS contract, but uptake can vary and making people aware of this service could help reduce the risk of sight loss due to glaucoma in our ageing population
- everybody aged 60 and older should be recommended as part of the NHS Health Checks programme to have a sight test – again this is already commissioned and funded as part of the national GOS contract, but most people do not realise that a sight test can help detect multiple health conditions and that early diagnosis can help prevent most forms of sight loss. The National Institute for Health and Care Excellence (NICE) also recommends, in its updated its 'Workplace Health: management practices' guideline, signposting workers to eye examinations (see recommendation 1.6.2) (1) and encouraging more people aged 60 and older will be particularly impactful in our ageing workforce
- provide hearing assessments for people when they are aged 50, 60 and then every five years to help ensure hearing loss is detected early as possible and the impacts of hearing loss – which include social isolation, cognitive decline, reduced quality of life, premature and forced retirement – are minimised. The NICE guideline on the management of hearing loss also shows that the early diagnosis and treatment of hearing loss in our ageing population is very cost effective and therefore recommends promoting the uptake of hearing care (2).

References

(1) Workplace health: management practices NICE guideline (NG13). National Institute for Health and Care Excellence. 2016. <https://www.nice.org.uk/guidance/ng13>

(2) Hearing Loss in adults: assessment and management (NG92), NICE, 2018
<https://www.nice.org.uk/guidance/ng92>

What ideas should the government consider to raise funds for helping people stop smoking?

Smoking is associated with a three-to four-fold increased risk of macular degeneration, a leading cause of sight loss (1). The treatment of macular degeneration is also a major and growing cost for NHS ophthalmology (eye care) services. There are also strong associations between smoking and cataract formation, thyroid eye disease, and diabetic retinopathy (2), which require ongoing NHS funded monitoring and or treatment to reduce the risk of permanent sight loss.

Yet, there is

- limited awareness amongst policymakers about the link between smoking, sight loss and NHS expenditure (for the reasons outlined above)
- limited public awareness about the link between smoking and sight loss – e.g. a study of 402 British adults visiting hospital found that only 9.5% believed that smoking was definitely or probably a cause of blindness, compared with 92.2% for lung cancer, 87.6% for heart disease, and 70.6% for stroke (3).

The government could therefore require tobacco companies to fund independent research, via way of unrestricted grants, into the impacts of smoking on individual eye health and NHS expenditure on eye health services. This research could in turn later help inform the level of taxation on tobacco companies in the UK.

References

- (1) Kelly, S. P., Thornton, J., Lyratzopoulos, G., Edwards, R. & Mitchell, P. Smoking and blindness. *BMJ* 328, (2004).
- (2) Solberg, Y., Rosner, M. & Belkin, M. The association between cigarette smoking and ocular diseases. *Surv. Ophthalmol.* 42, 535–47
- (3) Bidwell, G. et al. Perceptions of blindness related to smoking: a hospital- based cross-sectional study. doi:10.1038/sj.eye.6701955

How can we do more to support mothers to breastfeed?

We do not have a view on this.

How can we better support families with children aged 0 to 5 years to eat well?

We do not have a view on this.

How else can we help people reach and stay at a healthier weight?

Staying healthy and maintaining a healthier weight can help reduce the risk of sight loss due to conditions such as diabetic retinopathy – a leading cause of sight loss in the UK. We therefore support taking action to support people reach and stay at a healthier weight. In order to make a meaningful impact however, the wider determinants of obesity must be tackled and this will require, as has been understood for some time, taking action at all levels – e.g.

- behavioural nudges to encourage/support healthier eating at an individual level – e.g. ‘traffic signal’ coding on packaging
- business rates relief to help businesses promote health and wellbeing for all
- taxation on sugar and other key drivers of obesity

Have you examples or ideas that would help people to do more strength and balance exercises?

Daily activity is key and vision is very much part of this.

Can you give any examples of any local schemes that help people to do more strength and balance exercises?

There are many examples of good fall prevention programmes for people who have already suffered a fall which is secondary prevention. However falls prevention programme focusing on vision, hearing, lighting, trip and slip hazards and daily exercises, muscle strengthening and minor adaptations should be made available to everyone over age 55 both in work and in the community for those who are no longer in work, with particular support for carers.

There are many factors affecting people's mental health. How can we support the things that are good for mental health and prevent the things that are bad for mental health, in addition to the mental health actions in the green paper?

Ageism often results in incorrect assumptions about inevitable decline in older age and, in our view, this contributes to a lack of action on eye health issues and hearing loss in older age. This in turn increases the burden of disease associated mental health issues and widens inequalities.

To tackle the root cause of issues like these there is now an urgent need to take healthy and active ageing seriously and to stop considering ageing as a 'public health burden' or 'demand' and 'risk' driver but, instead, to view ageing as one of the major public health achievements of the 20th Century and something to celebrate and do well. This perspective shift will also make clearer the many cost-effective, sustainable and unobjectionable opportunities that exist to improve mental health and wellbeing in the population.

For example, when we think about ageing well and preventing avoidable mental health issues, the early diagnosis and management of sight threatening conditions can help prevent sight loss or minimise the impact this has on individuals, families and wider society. This has a profound and positive impact on mental wellbeing and independence, yet mental health initiatives, as in this green paper, seldom touch on the importance of maintaining good sensory health or supporting those with sensory loss. This is a serious shortcoming given that high-quality evidence which shows

- depressive symptoms are highly prevalent in people experiencing sight loss and will likely affect rehabilitation outcomes (1) - e.g. older people with sight loss are almost three times more likely to experience depression than people with good vision (2)
- people with dementia are more likely to experience visual misinterpretations and hallucinations. Sight loss exacerbates the symptoms of dementia, impairing orientation,

cognition and communication. Sight loss decreases quality of life and increases the care needs of this group

- people with cognitive impairment may be less likely to be aware that they have problems with their sight. The same applies to hearing loss
- people with cognitive impairment and dementia do not always get access to care the care they need to ensure that they can see and hear as well as possible. This not only leads to loss of social functioning and confusion (affecting the ability of individuals to recognise people, enjoy TV, eat, hear requests, instructions, conversations and jokes) but correlates strongly with depression, cognitive decline and loss of independence. Vision, eye health and hearing assessments should therefore be mandated elements of all cognitive assessments and care plans.

We therefore welcome the recent profile given to ophthalmology as a hospital capacity and waiting times issue but this is addressing a symptom rather than a cause. We therefore urge the DHSC, Public Health England and NHS England to give greater relative priority to sight, hearing and other sensory loss than currently given the rapidly rising age profile of the population and the urgent need to tackle the institutional biases which wrongly assume that sensory decline and its associated impacts are an inevitable part of ageing, as this is not the case. There is so much more that can be done, as NICE evidence demonstrates, to help prevent sight loss, support hearing loss and improve mental health and wellbeing in our ageing population.

It is also important to note the importance of ensuring that people with sensory loss have access to emotional support and rehabilitation services from the point of diagnosis onwards as this can have a major and positive impact on their long-term mental health and independent living (3).

References

- (1) Horowitz A, Reinhardt J & Boerner K. (2005) The effect of rehabilitation on depression among visually disabled older adults. *Aging and Mental Health* 9(6), 563-570.
- (2) Evans, J. R., Fletcher, A. E. & Wormald, R. P. L. Depression and Anxiety in Visually Impaired Older People. *Ophthalmology* 114, 283–288 (2007).
- (3) RNIB. Sight Loss: A public health priority. 1–20 (2014). Available at: http://www.rnib.org.uk/sites/default/files/Sight_loss_a_public_health_priority.pdf and NHS England and Department of Health, Action Plan on Hearing Loss (2015)

Also – see NICE

- Age-related macular degeneration. NICE guideline (NG82). NICE. January 2018
- Glaucoma: diagnosis and management. NICE guideline (NG81). NICE. November 2017
- Cataracts in adults: management. NICE guideline (NG77). NICE. October 2017

Have you examples or ideas about using technology to prevent mental ill-health, and promote good mental health and wellbeing?

We would like to see an exploration of whether local weather apps and forecasts by national broadcasters could be effective in encouraging people of all ages to get out into the day light and fresh air and be more active – e.g. in green spaces especially for any activity which involves mobility and socialising with other people.

We recognise that sleep deprivation (not getting enough sleep) is bad for your health in several ways. What would help people get 7 to 9 hours of sleep a night?

We would like to see much more exploration of/research into the effects on sleep

- of light and noise pollution in towns and cities
- light-based distractions in bedrooms such as TVs, mobile phones and other screen-based devices for both adults and children
- modern work patterns, multiple jobs filling and the 'gig economy'
- nocturnal continence management for older age groups
- the effects of polypharmacy and medicines management.

Have you examples or ideas for services or advice that could be delivered by community pharmacies to promote health?

Pharmacies are well placed to raise awareness of eye health and signpost people to local eye care services in primary care settings, reducing pressure on GPs and hospitals and more importantly helping ensure timely diagnosis and management of eye conditions in order to prevent permanent sight loss.

This would be simple to achieve by explicitly including referral for a sight test within the NHS 'Make Every Contact Count' initiative.

This is important because people value their sight more than any other sense (1) and any level of sight loss, including uncorrected refractive error, can reduce quality of life (2). Diseases of the eye have a particular public health importance because they occur in otherwise healthy and active people and are usually asymptomatic until permanent, extensive and irreversible damage has occurred. Regular sight tests and early intervention significantly reduce these risks.

Simple low-cost sign-posting to primary eye care could help reduce the major economic impacts associated with avoidable sight loss (3).

References

- (1) The College of Optometrists. Britain's eye health in focus: A snapshot of consumer attitudes and behaviour towards eye health. (2013).
- (2) Cumberland, P. M. & Rahi, J. S. Visual Function, Social Position, and Health and Life Chances. JAMA Ophthalmol. (2016). doi:10.1001/jamaophthalmol.2016.1778

(3) Wittenborn, J. & Rein, D. Cost of Vision Problems: The Economic Burden of Vision Loss and Eye Disorders in the United States. (2013).

What should the role of water companies be in water fluoridation schemes?

We do not have a view on this.

What would you like to see included in a call for evidence on musculoskeletal (MSK) health?

It is important to consider the impacts of sensory health and sensory acuity (both vision and hearing) on MSK health. For example, the Chief Medical Officer notes that sensory disability, including hearing loss and visual impairment, is estimated to be responsible for 7–10% of all years lived with disability among those aged 70 or over in the UK (1).

Sight loss is closely linked to falls – e.g. 3.8% of falls resulting in hospital admission can be directly attributed to visual impairment, costing 10% of the total cost of treating accidental falls (2). Unsupported hearing loss is also associated with falls and the associated costs (3).

References

- (1) Annual Report of the Chief Medical Officer: Surveillance Volume, 2012: On the State of the Public's Health. Department of Health and Social Care. March 2014
- (2) Boyce, T. Falls—costs, numbers and links with visual impairment. (2011).
- (3) Joint Strategic Needs Assessment Guidance: Guidance for Local Authorities and NHS commissioners on assessing the hearing needs of local populations. Office of the Chief Scientific Officer. June 2019

What could the government do to help people live more healthily: in homes and neighbourhoods; when going somewhere; in workplaces; in communities?

Given that our population is experiencing longer life and that, with changing pension entitlements remaining in the workplace for longer, it is now more important than ever that the government takes the issue of ageism seriously in all aspects of public policy and action. Ageism is already a discriminatory issue, but it has not yet received the policy priority it deserves.

In particular the NHS and wider society perspectives, facilities and professional training must now address this if the government is to have a meaningful impact on helping people live more healthily in homes and neighbourhoods; when going somewhere; in workplaces; and in communities.

For example, too often opportunities to support people age well are missed or ignored because policymakers and commissioners wrongly assume that sensory loss is an inevitable side effect of growing older. These biased assumptions are directly contradicted by the evidence from NICE and other respected, evidence-based sources, yet they still persist in the NHS at all levels (1-4). These misconceptions are similar to those about gender or race and similarly have no place in a society that is committed to treating people equally.

Policymakers and commissioners are often also unaware that unsupported sensory loss can significantly increase the risk of social isolation, loneliness, cognitive decline, unemployment and reduce quality of life in other areas they are seeking to address, yet all of these risks can be prevented or mitigated by early diagnosis, treatment and support. The key preventive measure here is regular sight testing.

We therefore urge the government to tackle ageism head on as it has other forms of discrimination in access and care. It is now more important than ever to challenge the status quo by taking healthy and active ageing seriously and seeing ageing as something to celebrate and to do well.

This should involve changing the terminology of ‘burdens’ and the professional focus away from what older individuals ‘cannot do’ to what they ‘can do’. Greater profile and public officials’ training in the Public Sector Equality Duty would assist policymakers and commissioners better to realise the multiple cost-effective, sustainable and positive opportunities that exist to improve health and wellbeing in the population.

We, with the National Community Hearing Association (NCHA), stand ready to help and would welcome the opportunity, with our sector partners from eye and hearing health, to work with the government in delivering a more effective healthy and active ageing programme.

References

- (1) Age-related macular degeneration. NICE guideline (NG82). NICE. January 2018
- (2) Glaucoma: diagnosis and management. NICE guideline (NG81). NICE. November 2017
- (3) Cataracts in adults: management. NICE guideline (NG77). NICE. October 2017
- (4) Hearing loss in adults: assessment and management. NICE guideline (NG98). NICE. June 2018

What is your priority for making England the best country in the world to grow old in, alongside the work of Public Health England and national partner organisations?

- **Support people with staying in work**
- **Support people with training to change careers in later life**
- **Support people with caring for a loved one**
- **Improve homes to meet the needs of older people**
- **Improve neighbourhoods to meet the needs of other people**
- **Other, please specify**

Other – tackling ageism

As above the single biggest priority to make England the best country in the world to grow old in will be tackling ageism so that policymakers, commissioners and wider society see ageism as something that is just as unacceptable as racism, sexism and other behaviours – be they implicit or explicit – and in contravention of the Equality Act 2010.

As we have pointed out to other questions, this would enable government and health and care authorities to give higher priority to eye health and hearing in planning and, by doing so, prevent many more cases of avoidable sight loss. This would

- help people gain employment and stay in work for longer
- enable people to change careers in later life
- help people with caring for a loved one
- make everyone think more carefully about accessibility needs – sensory – to meet the needs of older people.

Taking this approach will also allow see that, despite an increasing proportion of our population living with multiple long-term conditions and, regardless of age, we can still ensure people can still

- *see*
- *hear*
- *eat*
- *communicate*
- *smile*
- *move*

as well as possible, as these are the keys to inclusion, independent living and the antidotes to loneliness, depression and cognitive decline.

The barriers to success include

1. the NHS and care system still dealing with health and disability issues in isolation. The reasons for this are historical and cultural and are rarely down to contractual issues despite the readiness of this as an excuse for inaction. Alternatives can always be implemented where there is leadership and will. In order to support active ageing the NHS and care system should be honest and transparent about what will and will not be provided so people can make informed decisions about what they might need to age well. Currently many services/devices to enable active ageing are implicitly rationed to control NHS and social care expenditure, yet people have the right to information about what works and what they might benefit from.
2. employers and wider society are often overlooked as wider determinants of health and by focusing overly on the NHS and care system, we miss major opportunities to keep people active and well and in work for longer. Improving access to sight and hearing tests for older people in the workforce can help keep people in work for longer.

It is only when seeing the individual – and their health and support issues – in the round with all services, professionals and sectors focusing on holistic care and healthy and active lifestyles, that individuals will feel empowered to welcome and take on a fuller role in their ageing well programme.

What government policies (outside of health and social care) do you think have the biggest impact on people's mental and physical health? Please describe a top 3

The following three priorities, outside of health and social care, are likely to have the biggest impact people's mental and physical health:

- Give every child the best start in life
- Create fair employment and good work for all
- Create and develop healthy and sustainable places, dwellings and communities

These have been selected, informed by evidence of what works to reduce inequalities in the social determinants of health, as identified by the Marmot Review (1).

References

(1) Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010. Institute of Health Equity 2010. Available at: <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

How can we make better use of existing assets – across both the public and private sectors – to promote the prevention agenda?

It is vital that funding reaches the frontline where it will have the most impact on prevention. In order to achieve this, it is crucial that we make better use of existing assets and infrastructure across both the public and private sector – e.g. it is important to avoid building additional capacity in costly secondary care settings where care can be delivered using more accessible and lower cost primary care infrastructure which already exists.

This is particularly true in the eyecare sector, where people are unnecessarily losing their sight because of a lack of capacity in secondary care, and where NHS commissioners have been far too slow to make better use of capacity and capabilities in primary eyecare to reduce pressure on hospital services and to prevent sight loss. This is sometimes exacerbated by commissioner ignorance and weakness and professional and institutional protectionism (sometimes masquerading as non-evidence-based concerns about safety).

For example, the All-Party Parliamentary Group (APPG) on Eye Health and Visual Impairment has reported that the eye health system in England is “failing patients on a grand scale” (1), and research has shown that up to “22 people per month are permanently losing sight due to delayed and cancelled hospital appointments for conditions like wet age-related macular degeneration (AMD), glaucoma and diabetic eye disease”(2).

This crisis represents how prevention efforts are thwarted due to a lack of leadership in commissioning, even when the major eye health charities and sector experts agree on what the problems are and now hold to solve them. The RNIB Chair, Eleanor Southwood recently described the problem succinctly:

“Nobody should lose sight from a treatable condition simply because their eye clinic is too busy to provide care in a clinically appropriate timescale.

“Implementing the recommendations [in the APPG] report will help to meet the increasing demands for eye care services, deliver strategic and joined up eye care, and reduce the numbers of patients losing sight because of delays” (3)

There is now an urgent need to transform eye care services at scale in England as they trail significantly behind Scotland and Wales where pressure on hospitals has been reduced and preventable causes of sight loss are more effectively managed. We would welcome a meeting, along with sector partners, to set out how we can make better use of existing assets and current commissioning models to minimise poor eye health and prevent sight loss whilst minimising NHS costs and service disruption.

References

- (1) APPG, See the Light, 2018, <https://www.rnib.org.uk/sites/default/files/See%20the%20light%20Improving%20NHS%20eye%20care%20capacity%20in%20England.pdf>
- (2) Foot B. MacEwen C. (2017) “Surveillance of sight loss due to delay in ophthalmic treatment ore review: frequency, cause and outcome”. Eye, 31: 771-775 (British Ophthalmological Surveillance Unit)
- (3) RNIB, Report warns of crisis in eye clinic capacity as cancelled appointments risks patients’ sight, <https://www.rnib.org.uk/who-we-are/media-centre/latest-media-releases/report-warns-crisis-eye-clinic-capacity-cancelled>

What more can we do to help local authorities and NHS bodies work well together?

We need to ensure that people with long-term health issues can see, hear, eat, communicate, smile, have their medicines reviewed frequently and, ideally, are continent and can move physically. These are the keys to effective social functioning, independent living at all ages and the antidotes to loneliness, depression and cognitive decline in older age.

Despite this, local eye health and hearing needs are often not part of local joint strategic planning and there is an urgent need to ensure that local JSNAs and JHWSs include an assessment of eye health and hearing needs to ensure this happens.

In addition, training for all staff working with people with complex needs should embed multi-disciplinary working, personal responsibility within the team for holistic care, and an approach that makes things happen for individuals rather than preventing things happening for individuals. This is largely a matter of culture – and often professional cultures. Although there can be contractual and management issues that need to be addressed, they are a ready excuse, usually over-stated and can invariably be overcome if the culture is right.

What are the top 3 things you'd like to see covered in a future strategy on sexual and reproductive health?

We do not have a view on this.

What other areas (in addition to those set out in this green paper) would you like future government policy on prevention to cover?

Preventing sight loss.

Sight loss has a very significant impact on wider health and wellbeing – it can increase the risk of social isolation, cognitive decline, unemployment, and reduce independent living and quality of life. Undiagnosed eye conditions can lead to sight loss, but in most cases can be prevented through regular sight testing, early diagnosis and treatment.

Sensory disability, including hearing loss and visual impairment, is estimated to be responsible for 7–10% of all years lived with disability among those aged 70 or over in the UK (1). By 2050, it is projected that one in four people in the UK will be aged 65 years and over – an increase from approximately one in five in 2018 (2). Unless more is done to tackle sensory disability it will increase disproportionately with population projections over the next 10 years.

To address this, we propose that sensory functions should have their own focus, work stream and programme within the future prevention strategy. This will ensure that quality of life is not sacrificed to quantity of life and drowned out by the focus on major killers. Both need to be prioritised equally. If as a result of this consultation, quality of life (including sensory issues) is given parity of esteem in prevention strategies, just as mental and physical health are being equalised, prevention will have taken a major step forward in meeting the challenges of the 21st Century as hoped and one FODO can wholeheartedly support.

References

- (1) Annual Report of the Chief Medical Officer: Surveillance Volume, 2012: On the State of the Public's Health. Department of Health and Social Care. March 2014
- (2) Overview of the UK population: Office for National Statistics (ONS) August 2019 - <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/august2019>