Tameside Health & Wellbeing Board

Tameside Joint Strategic Needs Assessment

2015/16

Health&Wellbeing
making it happen together in Tameside

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Background

The Tameside JSNA is a shared process that brings challenge and innovation to commissioning and the decision making process for health and well-being.

The Tameside JSNA is an exercise in solving problems together for the benefit of the individuals and our local communities. The JSNA sets the tone of strategic partnerships and provides a shared and robust evidence base to help guide local commissioning and decommissioning decisions as well as a resource allocation for all partners.

This Joint Strategic Needs Assessment (JSNA) has been developed in partnership by the public health team at Tameside MBC, Tameside Metropolitan Borough Council (TMBC) and Tameside & Glossop Clinical Commissioning Group (CCG), with input from other strategic partners and diverse groups and communities.

This report was overseen by the JSNA steering group, which is a sub group of the Tameside Health and Well-being Board, and includes representation from CCG Board Members, TMBC Directors of Adult's and Children's Services, and the Director of Public Health. See Appendix 4 for a full list of steering group members.

The content of the JSNA has been aligned to the indicators from the NHS, Public Health and Adult Social Care Outcomes Frameworks, which the CCG and local authorities are responsible for delivering and its format follows the life course approach of starting and developing well, living and ageing well and ageing and dying well.

The JSNA is a comprehensive description of the current health and wellbeing of the population of Tameside and recommendations for action that will lead to improvements. As a result, it provides the following for Health and Well-being Board local authority and CCG.

- Assurance that current priorities, identified for action, should remain
- Confirmation that some of the longer term priorities should remain. Examples include teenage conceptions, early identification of people with HIV, dementia, reducing falls & their impact in older people, reducing emergency admissions, reducing cancer mortality, increasing breastfeeding, increasing access to rehabilitation etc.
- A benchmarking exercise on a range of areas across the health and social care system that can be used as a reference document around the current position, where progress has been made and recommendations for further action that would improve outcomes. These are wide ranging in nature. This JSNA can then be reviewed at a reasonable interval to determine if measures in place have made a notable difference.
- Gives an overview of the outcomes that public health, social care and the CCG will be specifically responsible for delivering against.
- Provides an outline for a number of thematic areas such as a healthy start in life, support for vulnerable groups, active ageing etc. that could be strands in a life-course approach to commissioning.
- Enables areas across the NHS, social care and public health to be seen as part of a range of measures to improve health and support independence. One example is reducing the number of people in residential and nursing care linked to carer's quality

of life, reducing the impact of falls, incidence of HCAI, preventable sight loss, health related quality of life for older people and proportion of older people offered rehabilitation following hospital discharge. These outcomes provide a framework for working through collaborative approaches to joint working.

- There is a focus on vulnerable groups who have traditionally not had the same level of access to healthcare, employment and other supportive systems. This review enables a number of outcome measures to be viewed together to inform joint working.

- There are some outcome measures on access to health and wellbeing services and interventions that are useful markers.

- There are a number of outcomes where there is limited action in place at the moment but where data indicates there is a higher prevalence which will need to be considered: suicide prevention, hospital admissions as a result of self-harm, children and adults with autism, domestic violence,

The recommendations in the JSNA have influenced the investment priorities for the council and the CCG. For example, previous JSNAs highlighted the issues that underpin the high rates of All Age All-Cause Mortality (AAACM) locally. Summaries and profiles of these health issues were presented to the CCG and Health and Well-being Board (H&WB) and used within their investment and prioritisation processes. As a result, the CCG have approved business cases which enabled investments in programmes, interventions and services which tackle these causes of ill-health and premature mortality.

As part of the JSNA process and in addition to this report a number of other products that inform on the health and wellbeing of Tameside residents are also available. These include ward profiles, bespoke needs assessments and statistical bulletins. All of which are available of both the Tameside council and CCG website.

Population Demographics

Implications for the population's health and well-being

Given that the prevalence of many diseases are age-sensitive, changes in the population and its age distribution will have important implications for the burden of disease and the demand for health services. In addition, an increasingly aged population would be expected to increase the overall prevalence of limiting long term illness or disability within the population and increase the demand for health services and social service interventions.

The age distribution of the Tameside population is shown in Table 1 and Chart 1. Compared to England as a whole Tameside has a slightly lower proportion of people aged 20-39 and a slightly higher proportion of people aged 40-69.

Table 1: Age Distribution of the Tameside Population

	Mid-2013 Tameside Population		
	Males	**Females**	**Persons**
0-4	7,514	7,319	14,833
5-9	6,765	6,561	13,326
10-14	6,254	6,065	12,319
15-19	6,922	6,447	13,369
20-24	6,697	6,849	13,546
25-29	6,888	7,548	14,436
30-34	6,901	7,373	14,274
35-39	6,444	6,649	13,093
40-44	7,919	8,036	15,955
45-49	8,513	8,614	17,127
50-54	7,985	7,786	15,771
55-59	6,605	6,429	13,034
60-64	6,248	6,242	12,490
65-69	6,188	6,190	12,378
70-74	4,173	4,574	8,747
75-79	3,131	3,842	6,973
80-84	1,924	2,794	4,718
85+	1,393	2,815	4,208
Total	108,464	112,133	220,597

Source: ONS, 2015

Chart 1: Age Distribution of the Tameside Population
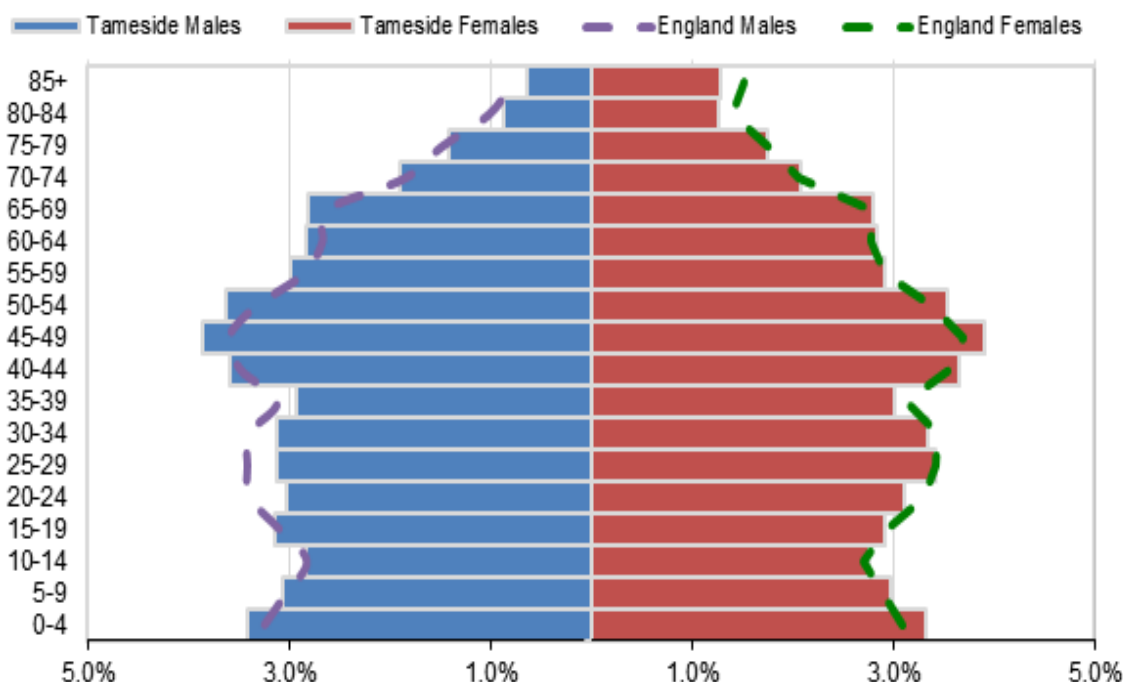
Source: ONS, 2015

The trend in population over the previous 10 years with projections at 5 year intervals to 2035 is shown in Chart 2. The greatest increase in population over the next 20 years is expected to be seen in the 75 and over population, with a 75% increase expected in the population within the age group over the next 20 years. An increasingly aged population is expected to place an increasing burden upon the health and social care economy with an increased incidence of age associated conditions and demand for care home places and interventions to support the elderly in the population.

Chart 2: Population Trend and Projections by Age Band in Tameside
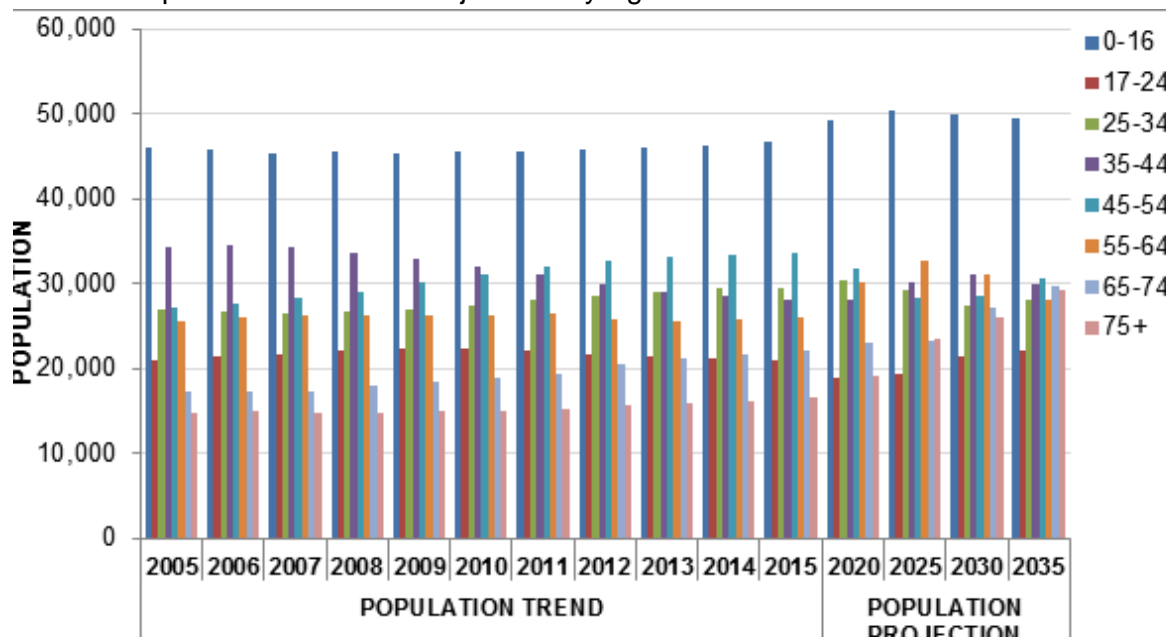
Source ONS, 2015

Deprivation

The prevalence of many diseases and conditions as well as mortality rates varies considerably with the level of deprivation within an area. When considering inequalities in health and wellbeing it is therefore important to consider deprivation as a driver. Just over a third of the Tameside population live in areas that fall within the most deprived 20% of areas nationally, with just 3.2% of the Tameside population living within areas that fall within the least deprived 20% of areas nationally. This means that based upon the level of deprivation in Tameside health inequalities would be expected to exist between Tameside and England as a whole.

The proportion of the population within each national deprivation (IMD2010) quintile are compared between Tameside and its Greater Manchester local authority neighbours and local authorities within the ONS Industrial Hinterlands local authority classification grouping and CIPFA nearest neighbours model in Chart 3. Both the ONS classification model for local authorities and the CIPFA nearest neighbour's model use a collection of socio-economic datasets to group local authorities within similar characteristics together. Compared to its geographical neighbours and other local authorities deemed to be statistically similar, Tameside has a relatively low level of people living within areas designated within the most deprived 20% of areas nationally, although the proportion of people in Tameside living within areas designated within the most deprived 40% of areas nationally is above average.

Chart 3: Proportion of Mid-2013 Population resident in each national deprivation (IMD2010) quintile

Source: ONS, 2015

Chart 4: Proportion of Population within National Deprivation (IMD2010) Quintiles for GM Local Authorities, Industrial Hinterlands and Tameside's Nearest Neighbours
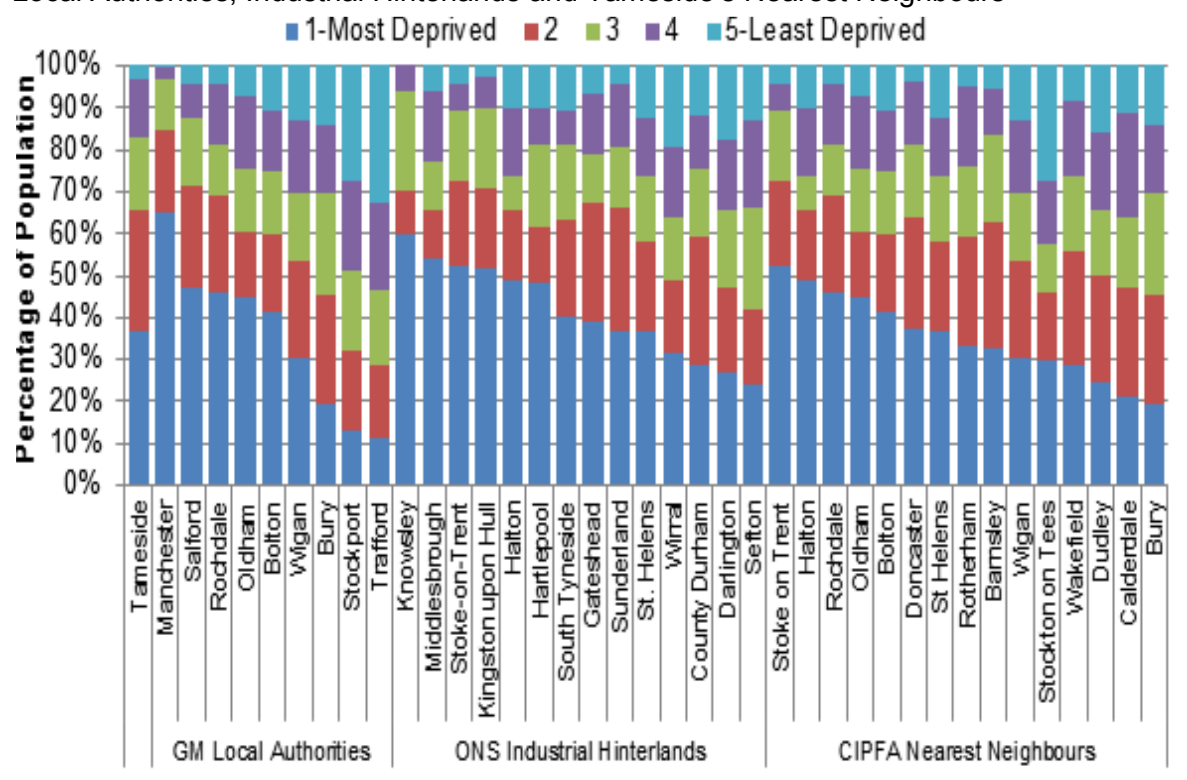
Source: ONS, 2015

Map 1: Deprivation in Tameside and Glossop (IMD 2010)

Tameside Local IMD2010 Quintiles
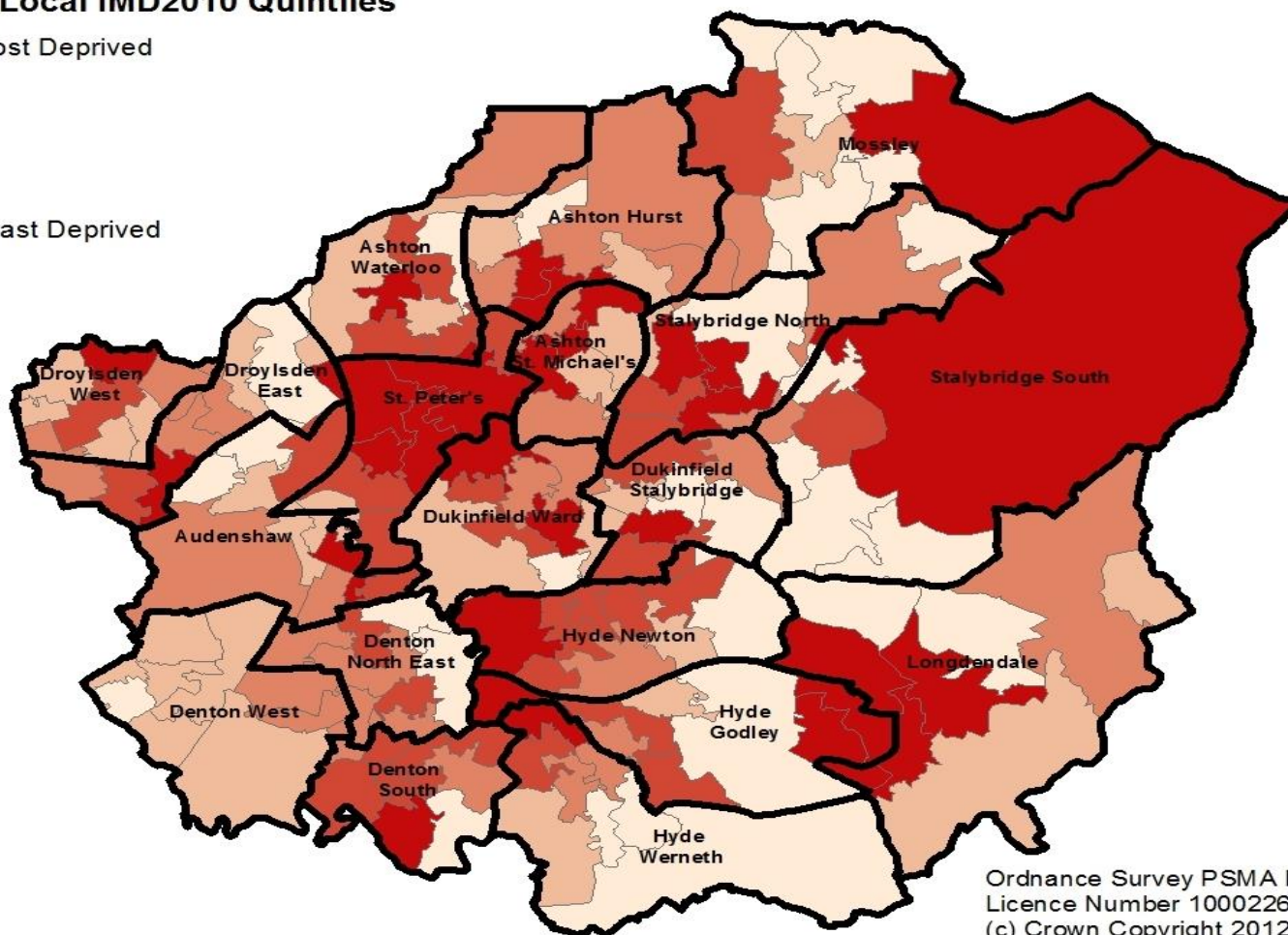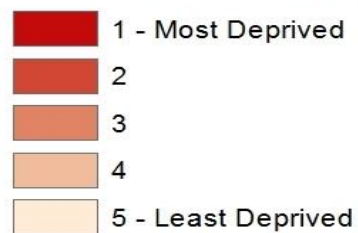
- 1 - Most Deprived
- 2
- 3
- 4
- 5 - Least Deprived

Mossley

Ashton Hurst

Ashton Waterloo

Stalybridge North

Ashton St. Michael's

Stalybridge South

Droylsden West

Droylsden East

St. Peter's

Dukinfield Stalybridge

Audenshaw

Dukinfield Ward

Denton North East

Hyde Newton

Longdendale

Denton West

Hyde Godley

Denton South

Hyde Werneth

Source: Public Health Tameside MBC 2014

Ethnicity

The breakdown of Tameside's population by ethnic group is shown in Table 2. It is important to consider the ethnic breakdown of the local area when planning services, given that different ethnic groups have differing needs. For example, certain chronic health conditions are genetically predisposed in certain ethnic groups. For example, Coronary Heart Disease can be genetically predisposed in those of South-Asian ethnicity. There may also be barriers to accessing services in some ethnic communities due to limited knowledge of English.

The largest ethnic groups within Tameside are the South-Asian ethnicities Indian, Pakistani, and Bangladeshi accounting for 1.7, 2.2 and 2% of the Tameside population respectively. The overall white British population is considerably higher in Tameside at 88.5% compared to the English average of 79.8%.

Table 2: Population Breakdown by Ethnicity in England, the North-West and Tameside

	England (%)	North-West (%)	Tameside (%)
White: English/Welsh/Scottish/Northern Irish/British	79.8	87.1	88.5
White: Irish	1	0.9	0.7
White: Gypsy or Irish Traveller	0.1	0.1	0
White: Other White	4.6	2.1	1.7
Mixed/multiple ethnic group: White and Black Caribbean	0.8	0.6	0.6
Mixed/multiple ethnic group: White and Black African	0.3	0.3	0.2
Mixed/multiple ethnic group: White and Asian	0.6	0.4	0.4
Mixed/multiple ethnic group: Other Mixed	0.5	0.3	0.2
Asian/Asian British: Indian	2.6	1.5	1.7
Asian/Asian British: Pakistani	2.1	2.7	2.2
Asian/Asian British: Bangladeshi	0.8	0.7	2
Asian/Asian British: Chinese	0.7	0.7	0.4
Asian/Asian British: Other Asian	1.5	0.7	0.3
Black/African/Caribbean/Black British: African	1.8	0.8	0.5
Black/African/Caribbean/Black British: Caribbean	1.1	0.3	0.2
Black/African/Caribbean/Black British: Other Black	0.5	0.2	0.1
Other ethnic group: Arab	0.4	0.3	0.1
Other ethnic group: Any other ethnic group	0.6	0.3	0.1

Source: NOMIS, 2015

The ethnic breakdown of the populations of Tameside's wards is detailed in table 3 where higher proportions of Indian and Pakistani populations exist in Ashton Wards, whereas higher proportions of Bangladeshi population exist in Hyde.

Table 3: Ethnic Breakdown of Tameside Ward Populations (%)

	Ashton Hurst	Ashton St Michael's	Ashton Waterloo	Audenshaw	Denton North East	Denton South	Denton West	Droylsden East	Droylsden West	Dukinfield	Dukinfield Stalybridge	Hyde Godley	Hyde Newton	Hyde Werneth	Longdendale	Mossley	St Peter's	Stalybridge North	Stalybridge South
White: Total	85.4	81.0	85.1	93.7	95.5	95.7	95.5	93.3	95.8	94.3	95.8	89.9	93.4	80.5	97.1	96.8	70.3	95.4	95.5
White: English/Welsh/ Scottish/Northern Irish/British	82.8	76.4	82.9	91.6	93.3	93.6	93.2	91.4	94.0	91.9	94.0	87.7	91.4	78.9	95.3	94.6	64.3	93.2	93.4
White: Irish	0.5	0.6	0.5	0.9	0.9	0.9	1.5	1.0	1.0	0.6	0.6	0.6	0.7	0.5	0.9	0.8	0.6	0.4	0.5
White: Gypsy or Irish Traveller	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0
White: Other White	2.0	4.0	1.6	1.1	1.2	1.2	0.8	0.8	0.8	1.8	1.1	1.5	1.4	1.0	0.9	1.4	5.4	1.7	1.6
Mixed/multiple ethnic group: White and Black Caribbean	0.4	0.5	0.5	0.7	0.6	0.8	0.8	0.9	0.9	0.4	0.5	0.5	0.7	0.6	0.6	0.5	0.7	0.4	0.5
Mixed/multiple ethnic group: White and Black African	0.2	0.4	0.4	0.2	0.3	0.3	0.3	0.2	0.3	0.2	0.1	0.2	0.2	0.1	0.1	0.2	0.3	0.3	0.1
Mixed/multiple ethnic group: White and Asian	0.5	0.7	0.7	0.3	0.3	0.3	0.3	0.3	0.2	0.4	0.3	0.3	0.4	0.3	0.2	0.4	0.7	0.3	0.3
Mixed/multiple ethnic group: Other Mixed	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.2	0.2	0.1	0.3	0.2	0.1	0.2	0.3	0.3	0.3	0.1
Asian/Asian British: Indian	5.4	6.4	5.9	0.6	0.6	0.3	0.5	0.9	0.4	1.2	1.1	0.2	0.4	0.6	0.3	0.4	3.7	1.4	1.3
Asian/Asian British: Pakistani	5.2	6.7	4.1	2.0	0.5	0.2	0.8	0.8	0.3	1.1	0.8	0.5	0.6	0.7	0.2	0.0	15.2	0.4	1.2
Asian/Asian British: Bangladeshi	0.5	0.9	1.5	0.3	0.2	0.3	0.2	0.2	0.2	0.4	0.1	6.8	3.0	15.7	0.2	0.6	5.1	0.3	0.1
Asian/Asian British: Chinese	0.3	0.5	0.2	0.7	0.6	0.4	0.5	0.9	0.6	0.5	0.3	0.3	0.3	0.4	0.1	0.2	0.7	0.4	0.4
Asian/Asian British: Other Asian	0.5	1.1	0.4	0.2	0.3	0.3	0.2	0.4	0.1	0.3	0.3	0.1	0.1	0.4	0.1	0.2	0.9	0.2	0.2
Black/African/Caribbean/Black British: African	0.7	0.9	0.4	0.7	0.4	0.7	0.2	1.2	0.7	0.4	0.2	0.4	0.3	0.2	0.5	0.2	1.5	0.5	0.1
Black/African/Caribbean/Black British: Caribbean	0.1	0.2	0.2	0.2	0.1	0.2	0.3	0.3	0.2	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.3	0.1	0.1
Black/African/Caribbean/Black British: Other Black	0.1	0.2	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Other ethnic group: Arab	0.3	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0	0.0	0.1	0.0	0.1
Other ethnic group: Any other ethnic group	0.1	0.2	0.3	0.1	0.1	0.0	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.0

Source: NOMIS, 2015

Migration

Migration is the movement of people from one area of residence to another and can be both internal and international. In 2013, in Tameside there were 630 new migrant national insurance registrations or 4.6 per 1,000 resident working age population, compared to 8.5 and 16.2 per 1,000 resident working age population for the North-West and England respectively. The inflow of international migrants to Tameside is approximate to that of the outflow and therefore net international immigration was therefore small in 2013 in Tameside, compared to England and the North-West, both of which have growing migrant populations. Internal migration (within the UK) in and out of Tameside equates to just over 30 per 1000 mid-2013 resident population. Internal Net Migration in Tameside is slightly negative, with more people moving from Tameside to elsewhere within the UK, than moving to Tameside from elsewhere in the UK.

Table 4: International and Internal Migration Inflows and Outflows within Tameside, England and the North-West

| | Mid-2012 to Mid-2013 | | | | | | | | |
| | Mid-2013 Pop Estimate | Long-Term International Migration | | Internal Migration (within UK) | | Long-Term International Migration | | Internal Migration (within UK) | |
		Inflow	Outflow	Inflow	Outflow	Inflow (Rate per 1000 pop)	Outflow (Rate per 1000 pop)	Inflow (Rate per 1000 pop)	Outflow (Rate per 100 pop)
Tameside	220600	600	600	6900	7300	2.7	2.7	31.3	33.1
England	53865800	449100	274200	98700	104400	8.3	5.1	1.8	1.9
North-West	7103300	40300	30600	106600	115100	5.7	4.3	15.0	16.2

Source: NOMIS, 2015

The proportion of people migrating to Tameside from outside the UK in the year preceding the 2001 census is shown in Table 4. Within the year preceding the 2011 census, the greatest numbers of those migrating to Tameside from outside the UK were white, at 66%. The highest BME group to have emigrated to Tameside was those of Pakistani ethnicity, accounting for 13% of non-UK migration inflow in the year preceding the 2011 census.

Table 5: The Proportion of Persons migrating to Tameside within the previous year from other countries by ethnic group (2011 census)

Ethnic Group	Inflow of Immigrants (Number)	Percentage
All categories: Ethnic group	665	
White	439	66
Gypsy / Traveller / Irish Traveller	0	0
Mixed / Multiple ethnic group	21	3
Asian / Asian British: Indian	18	3
Asian / Asian British: Pakistani	85	13
Asian / Asian British: Bangladeshi	24	4
Asian / Asian British: Chinese	9	1
Asian / Asian British: Other Asian	22	3
Black / African / Caribbean / Black British	35	5
Other Ethnic Group	12	2

Source: NOMIS, 2015

National and local policy context

- Fairer Society, Fairer Lives – Strategic Review of Health Inequalities in England post 2010
- Healthy Lives Healthy People – Our Strategy for Public Health in England – DH 2010
- Our Life in Tameside – Tackling Health Inequalities and Improving Health
- 2009-2019 (Tameside Strategic Partnership)
- My Tameside - Tameside Sustainable Community Strategy 2009-19 (Tameside Strategic Partnership)

Births and Fertility

Outcome Framework
- Public Health Outcomes Framework
- NHS Outcomes Framework (Everyone Counts)
- Social Care Outcomes Framework

Implications for the population's health and well-being

Statistics about births and fertility are an indicator of the health of the general population. Natural Change is the difference between the number of births and the number of deaths each year which, together with migration, are the main components of population change. Monitoring birth and fertility rates is important when considering the future commissioning of services such as health visiting and school provision as well as immunisation programmes and children centre placements.

At Risk and Vulnerable groups

Pregnancy and early years lay the foundations for health, wellbeing, cognitive development and economic security throughout life. The transition through pregnancy, birth and early parenthood is a vital window of opportunity.

A baby born into a home with parents that are well educated and financially comfortable has a better chance of living longer (and without disease and disability) than a baby born into poverty. This is in a large part because the social and economic inequalities in our society are reflected in and help to determine our health and wellbeing outcomes.[1]

Benchmarking

Births

In 2013 there were 2,918 live births to women living in Tameside. Women aged between 20 and 34 years accounted for the highest proportion of births (80%) with births to women aged 35+ accounting for 14% of all births and births to women under the age of 19 having the lowest at 6%

Births in Tameside have fluctuated somewhat over the last few years, but in general the birth rate for Tameside is slightly higher than both the England and North West average. The number and rate of live births varies with the borough of Tameside with the highest birth rate in 2013 being in the ward of St Peters, Ashton (19.4/1000, n=247) and the lowest in the ward of Dukinfield Stalybridge (9.7/1000, n= 105)

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[1] http://www.instituteofhealthequity.org/uk

Chart 5: Crude birth rate per 1000 population for Tameside wards, 2013
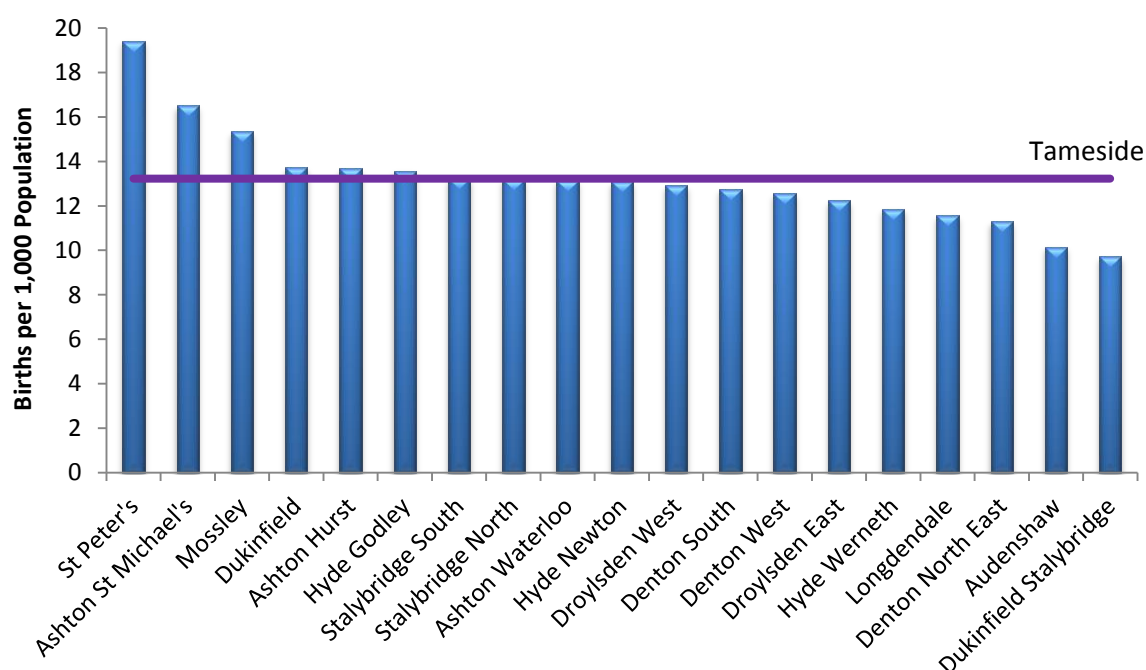
Source: ONS, 2015

The above chart illustrates the crude birth rate in Tameside wards in 2013. It shows that St Peter's has the highest crude rate and above the Tameside average and Dukinfield Stalybridge has the lowest crude rate.

The General Fertility Rate (GFR) is the number of live births per 1,000 females of childbearing age, defined as those aged 15 to 44 years. The GFR for Tameside for 2013 was 68 per 1000 women aged 15-44 years compared to the England and North West averages of 62.4/1000 and 62.6 per 1000 respectively.

Fertility Rate

Chart 6: The average number of children that would be born to a woman over her lifetime (Total fertility rate) 2013

Source: ONS, 2015

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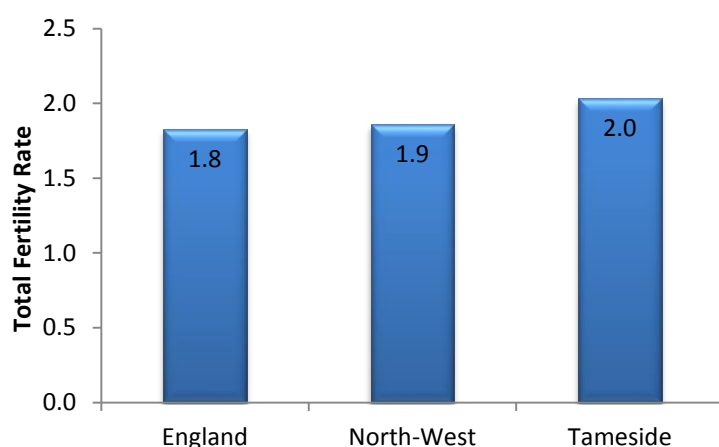
The Total Fertility Rate (TFR) is the average number of children born to a woman in her lifetime. The TFR is influenced by changes in the timing of childbearing within women's lives as well as any changes in final family size. For example, if women start to postpone having children, this will bring down the TFR during that period, but will not necessarily mean that the women in question will have fewer children in total in their lifetime

Policy context

The birth rate is one of the most basic and important measures in demography. But its relevance is not limited to just demographers. Birth rates affect public policy and budgeting for education and health systems, and can have major impacts on the well-being of a community's population. Governments, policymakers, and the news media are concerned about birth rates, because the rates are seen as either being too high or too low.

The birth rate in England has risen by 22% in the last decade and whilst the rate of increase may be slowing, it continues. At the same time the proportion of high risk and complex pregnancies continues to grow due to increased BMI, increased maternal age and a host of long-term conditions that impact onto pregnancy.

Birth rates have implication on population growth, maternity services, housing, health care, education and many other social and economic outcomes.

The foundations of good health and well-being are laid at the start of life in pregnancy, childhood, and in adolescence especially the teenage years.

'What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.' [2]

Evidence demonstrating the impact of positive and negative experiences during pregnancy and the early years of life on a child's health and well-being throughout childhood and into adult life continues to mount.

Key Issues relating to births

Low birth weight is strongly associated with perinatal and infant deaths. Babies just below the low birth weight threshold (2,000 to 2,500 grams) are five times as likely to die as an infant as those of normal birth weight;[3]

Children of mothers who have postnatal depression (PND) are less likely to show secure attachment at 36 months, are more likely to have social, emotional and cognitive problems at age 5[4] and are more likely to experience depression by 16 years. PND affects around 70,000 women per year in England and Wales;

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[2] 'Fair Society, Healthy Lives' (The Marmot Review)
[3] Graham Allen MP and Rt Hon Iain Duncan Smith MP (2008) Early Intervention: Good Parents, Great Kids, Better Citizens. Published jointly by the Centre for Social Justice and the Smith Institute.
[4] Kennedy, I. (2010) Getting it right for children and young people – Overcoming cultural barriers in the NHS so as to meet their needs.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalass et/dh_119446.pdf

Unemployment and Out of Work Benefits

Implications for the population's health and wellbeing

Employment is an important wider determinant of health and wellbeing within the population. It is well known that people in employment have significantly improved mental wellbeing compared to people out of work. Long term unemployment can have a profound effect upon both the mental and physical wellbeing of individuals. The poverty and deprivation resulting from unemployment affect the health and wellbeing of an individual in a multitude of ways. These include not being able to afford a healthy diet, lack of economic security and the health effects of low quality housing. Employment also gives individuals a sense of purpose and achievement which are also important for wellbeing.

Working age benefit claimants at a given time give a snapshot of the needs of the population resulting from unemployment. Many people not in employment are claimants of incapacity benefit or most recently employment support benefit.

At Risk and Vulnerable Groups

People with low levels of education are more likely to be unemployed and areas of deprivation are usually associated with high levels of unemployment.

High levels of unemployment are evident in people with mental health conditions and in people with learning disabilities, despite the majority of people within these groups actually wanting a job.

Benchmarking

The modelled estimate of the unemployment rate in Tameside is benchmarked against England, the North-West and Tameside's ONS Industrial Hinterlands and CIPFA statistical neighbours is shown in Chart 7. At 7% the 2014 unemployment rate in Tameside is approximate to the North-West average. Tameside has the third lowest unemployment rate out of Greater Manchester local authorities, the third lowest out of ONS industrial hinterlands statistical neighbours and the fourth lowest out of Tameside's CIPFA statistical neighbours. Although unemployment remains a significant issue in Tameside, it can be seen that unemployment is much worse in some local authorities with similar socio-economic and demographic profiles to Tameside

Chart 7: Modelled Estimate of Unemployment Rate within persons aged 16-64 (2014)
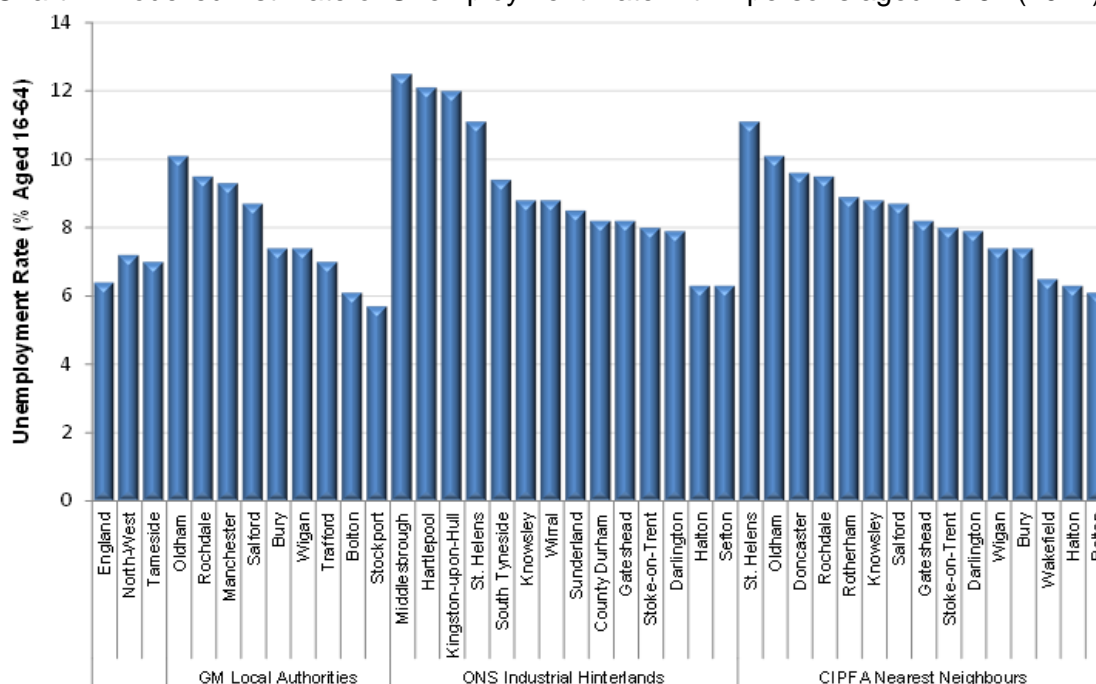
Source: NOMIS, 2015

The working age unemployment rate in Tameside wards derived from the 2011 census is shown in the chart above Note that these ward level figures are not directly comparable to the unemployment rate for local authorities in due the different reference timeframes.

Chart 8: Working Aged Unemployment Rates for Tameside Wards (2011 census)
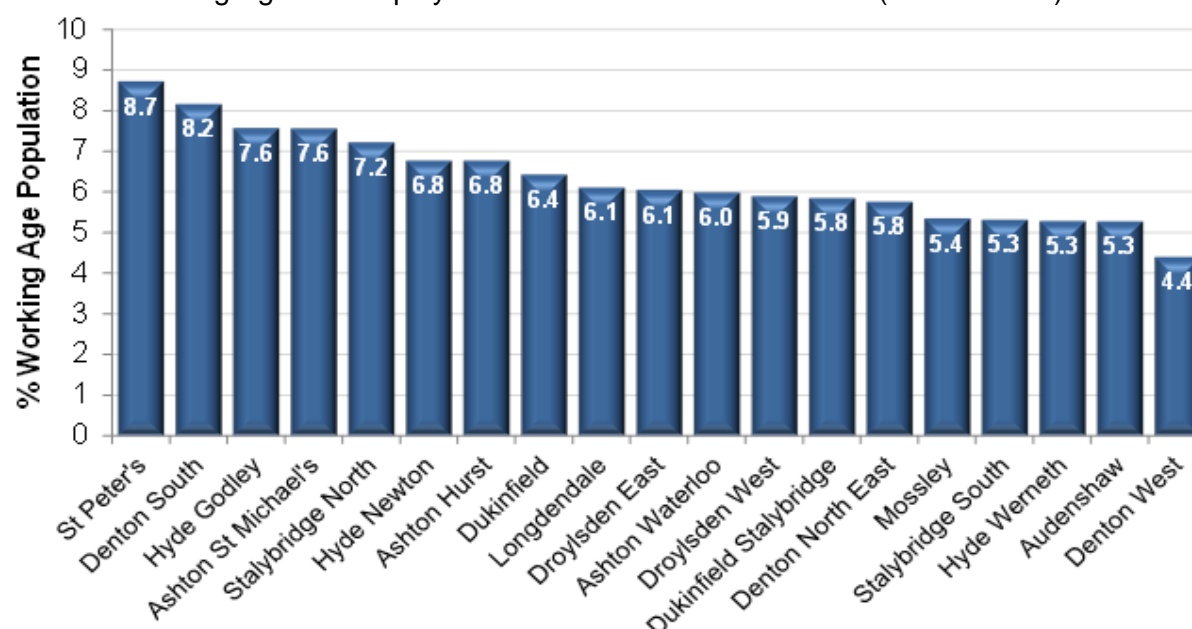
Source: NOMIS, 2015

Chart 8: illustrates a large inequality across wards with respect to unemployment, with the highest rate being observed in St. Peters ward at 8.7%, 4.3 percentage points higher than the lowest at 4.4% in Denton West.

Chart 9: Job Seekers Allowance Claimant Rate
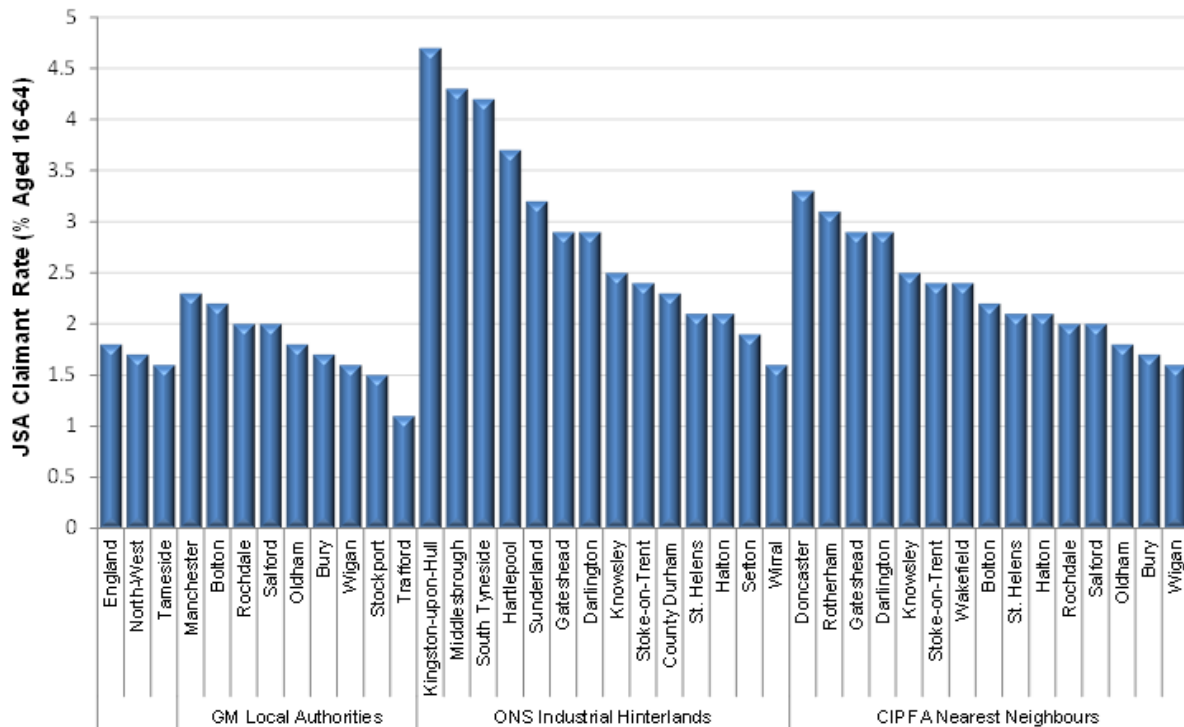
The Job Seekers Allowance (JSA) claimant rate in Tameside is benchmarked against England, the North-West and Tameside's ONS Industrial Hinterlands and CIPFA statistical neighbours are shown in . At 1.6% the 2014 unemployment rate in Tameside is approximate to the North-West average. Tameside has the third lowest JSA Claimant rate out of Greater Manchester local authorities, the lowest out of both ONS industrial hinterlands statistical neighbours and out of Tameside's CIPFA statistical neighbours.

Chart 10: Working Aged JSA Claimant Rates for Tameside Wards

The working age JSA claimant rate in Tameside wards is shown in Chart 8Chart 10 and Chart 11 illustrates a large inequality across wards with respect to unemployment, with the highest rate being observed in St. Peters ward at 2.9%, 2.1 percentage points higher than the lowest at 0.8% in Denton West.
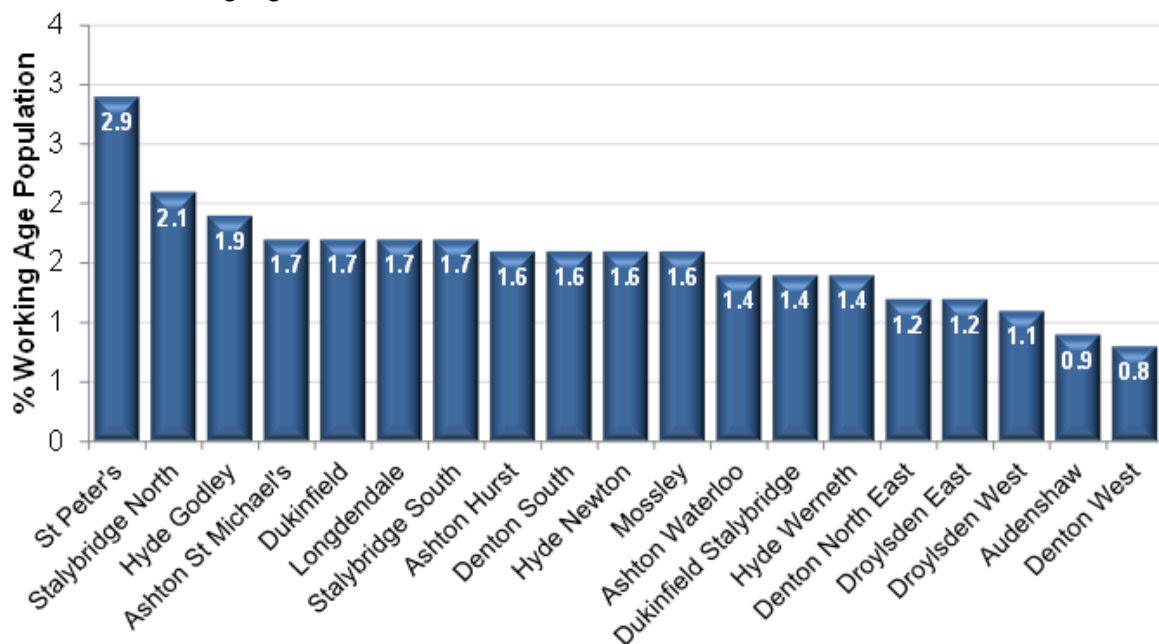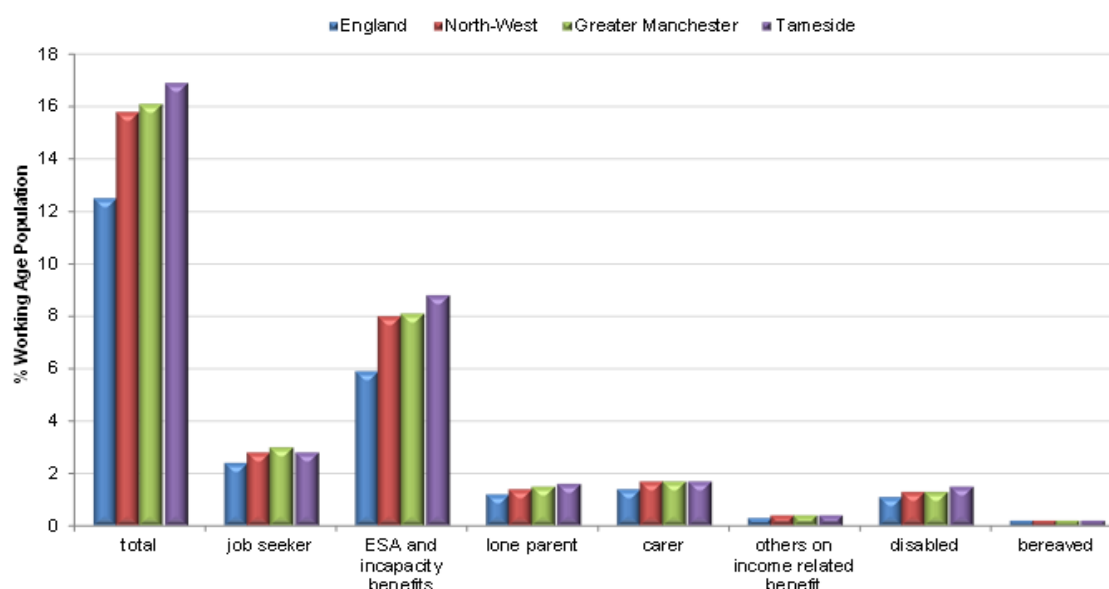
Chart 11: Working age Benefit Claimant Rates by Benefit Category for Tameside compared to England, the North-West, Greater Manchester and Tameside (May 2014)

Source: NOMIS, 2015

The claimant rate of different benefit categories is shown in   for Tameside compared to England, the North-West, Greater Manchester and Tameside for May 2014. There is a large difference in the total rate of working age benefit claimants between Tameside and England. Tameside has a marginally higher working age benefit claimant rate at 16.9% compared to the Greater-Manchester and the North-West. The largest contribution to this discrepancy can be seen in the higher claimant rate for ESA and incapacity benefit in Tameside.

What interventions work? (Relating to all population demographics)

The Marmot Review (2010) recognised and reinforced the approach to reducing health inequalities across the life course and across the social gradient. A life course approach to health and reducing health inequalities focuses on the different elements of the experience of health, from the moment of conception through childhood and adolescence to adulthood and old age.

To improve life expectancy and reduce health inequalities, the causes of premature illness and death (deaths of people aged 75 or under) need to be tackled with a focus on those that have the greatest impact on our population relative to the rest of England and those that disproportionately affect particular communities. It is essential therefore that the causes and how to prevent them are understood. These will relate both to the environment in which people live and closely linked to that, their lifestyle and behaviour.

Lifestyle factors especially smoking, harmful alcohol consumption, poor diet and lack of exercise contribute to these largely preventable diseases. They also contribute to other risk factors including diabetes, high blood pressure, obesity and high cholesterol that have a direct impact on CVD, cancer and respiratory disease.

However lifestyle factors cannot be considered in isolation from the environment in which people live nor the services (including health services) which support communities, families and individuals to better health. Therefore interventions that can significantly reduce an individual's risk of premature illness are central to improving life expectancy rates across Tameside.

The key to ensuring a more healthy population is a significant investment and prioritisation in "wellness" services and flexible personalised services closer to home. This will mean a change in investment profiles and service redesign to ensure a preventative approach to improving health, increasing life expectancy and tackling health inequalities.

Early intervention and prevention is everyone's business and must:

- Facilitate access to universal services

- Build social capital within local communities

- Be embedded in primary and secondary care

- Ensure people have greater choice and control over meeting their needs

What are we doing now?

- Implement robust partnership structures which address the wider determinants of health

- Promoting financial inclusion and tackling income inequalities

- The Workplace Health Improvement Programmes to support people in making healthier choices and in living healthier and longer lives

- Embedding Prevention and Early Intervention into all frontline services

- The Tameside Housing Strategy Action Priorities

- Affordable Warmth Access Referral Mechanism

- Primary Care Services – levelling up quality between practices including early identification of people with risk factors, disease management, expert patient programmes, pathway approach to Long Term Conditions management, vaccination and screening uptake, including dementia screening.

- Lifestyle Very Brief Advice (VBA) and Brief Advice (BA) and Brief Interventions (BI) by frontline practitioners to encourage people to stop smoking, maintain a healthy weight, drink alcohol within recommended levels.

- Provision of Health Improvement and Well-being Services, including:

  - Active Ageing

- Workplace Health Improvement

- Smoke Free

- Stop Smoking Service

- Weight Matters

- Health Trainers/Well-being advisors

- Community Health Development and Community Engagement

- Oral Health Promotion

- Physical activity and active recreation

What needs to happen next, and by whom?

- A strategic shift towards and investment in early intervention and prevention

- The development and implementation of Health and Well Being Strategies across Tameside , through effective engagement with a wide range of partners and Council departments to improve health and life expectancy

- Social Marketing and Community Engagement Campaign

- Development and implementation of a Healthy Schools Programme

- Effective working at Neighbourhood level and building strong relationships with communities

- Programme of Health Equity Audit (HEA) to ensure different population groups get the services they need

- Wide use of the JSNA by all commissioners to identify health needs and work towards more effectively meeting those needs

- On-going commitment to improving access to health services and improving outcomes for all

- Refreshed focus on early years maximising appointments to engage with families antenatal and in pre-school years.

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Life Expectancy and Mortality

Implications for the population's health and well-being

Outcomes Framework

- Public Health 0.1 Increased Healthy Life Expectancy
- Public Health 0.2 Reduced differences in life expectancy and healthy life expectancy between communities
- NHS 1b Life Expectancy: Males and Females

Life expectancy at birth is considered an indication of the overall mortality experience and health status of the population and is one of several indicators used to highlight the existence of inequalities in overall health across different geographical areas and population groups. The Marmot Review 2010 'Fair Society, Healthy Lives' outlines the inequality in life expectancy across socio-economic groups and sets out potential strategic solutions to narrowing the gap in life expectancy between the poorest and most affluent in society.

The causal effects of public health interventions targeted across the life-course may take a long time to be realised within life-expectancy figures, which are driven by the rate of mortality within specific age ranges of the population. It should therefore be recognised that life-expectancy figures, although considered a good indication of the overall health status of the population, may not provide a good representation of recent public health activity. Positive life-style changes within the population as a whole may take several years to be realised in positive effects upon life-expectancy.

Trend in Life Expectancy at Birth

The rolling trend in life expectancy across twenty years in Tameside, Greater Manchester, the North-West and England is shown in Chart 12 and Chart 13 for males and females respectively. Although life expectancy in males has increased relatively steadily in Tameside by 5 years in males and 2.5 years in across the timescale presented, the gap in life expectancy between England and Tameside has increased by 1 and 1.6 years in males and females respectively. This suggests that inequalities in life-expectancy at national and regional levels are worsening, and that although the overall health of Tameside's population is improving, improvements have been realised at a higher level nationally.

Chart 12: Trend in Male Life Expectancy at Birth
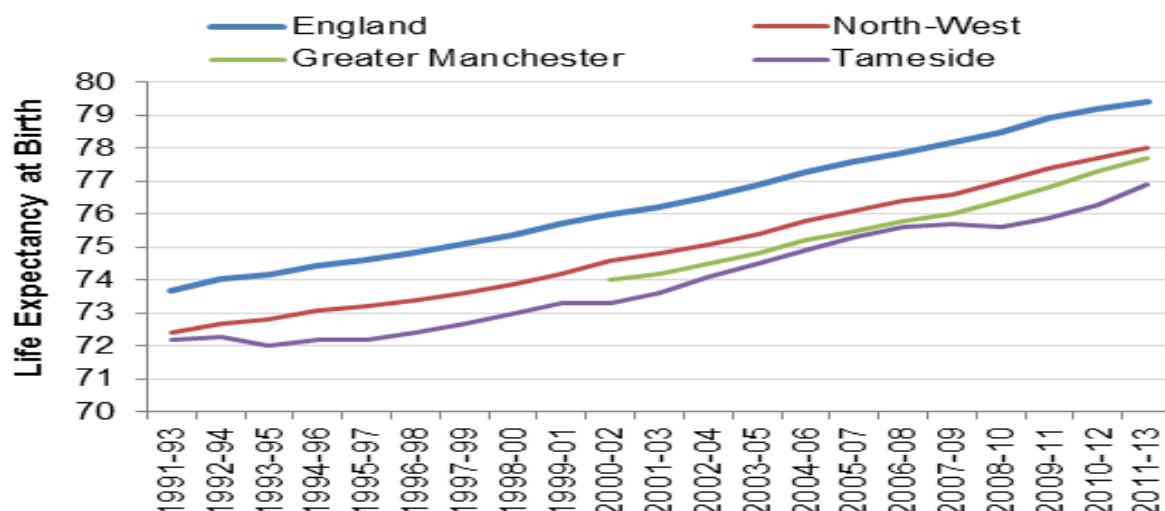
Source: ONS, 2015

Chart 13: Trend in Female Life Expectancy at Birth
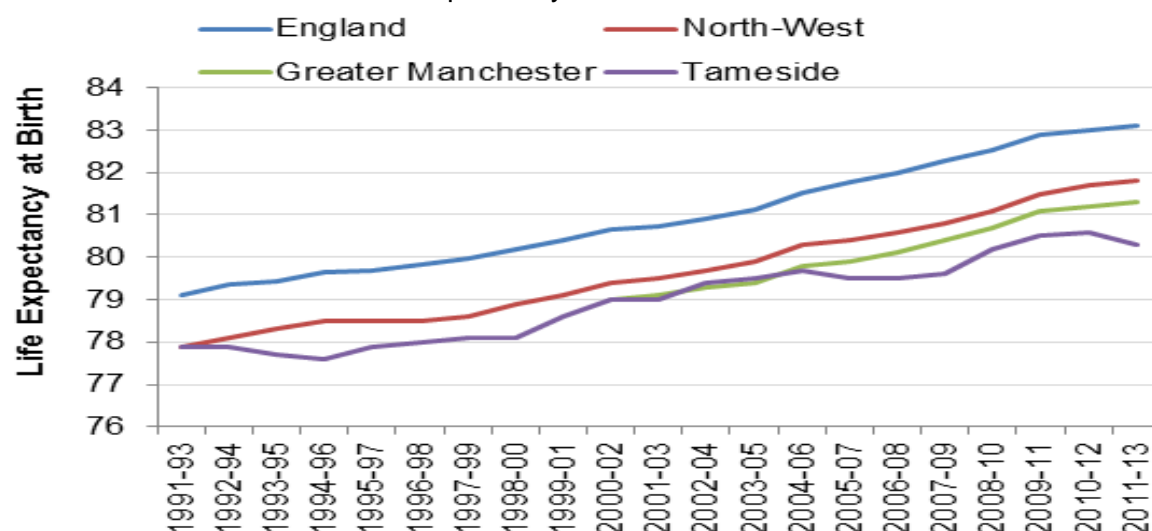
Source: ONS, 2015

Benchmarking of Life Expectancy

Life expectancy based upon mortality data for the period 2011-2013 is compared between Tameside and its Greater Manchester local authority neighbours and local authorities within the ONS Industrial Hinterlands local authority classification grouping and CIPFA nearest neighbour's model and in Chart 14 and Chart 15 for males and females respectively. Both the ONS classification model for local authorities and the CIPFA nearest neighbour's model use a collection of socio-economic datasets to group local authorities with similar characteristics together.

Male life expectancy for the period 2011-2013 in Tameside is the 3rd lowest out of ten Greater Manchester local authorities, 6th lowest out of 17 ONS Industrial Hinterlands local authorities and 4th lowest out of 16 CIPFA nearest neighbours.

Chart 14: Benchmarking of Male Life Expectancy (2011-2013)
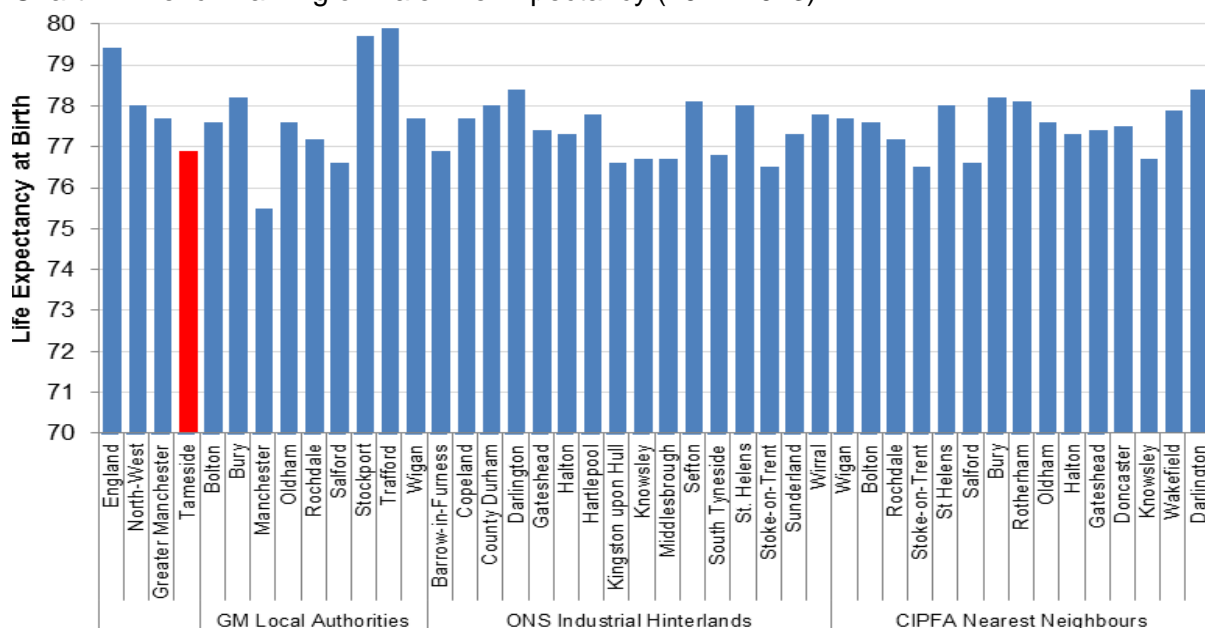
Source: ONS, 2015

Life expectancy is comparatively low in Tameside when viewed against its geographical local authority neighbours and statistically similar local authorities, which is especially true for life expectancy in females.

Chart 15: Benchmarking of Female Life Expectancy (2011-2013)
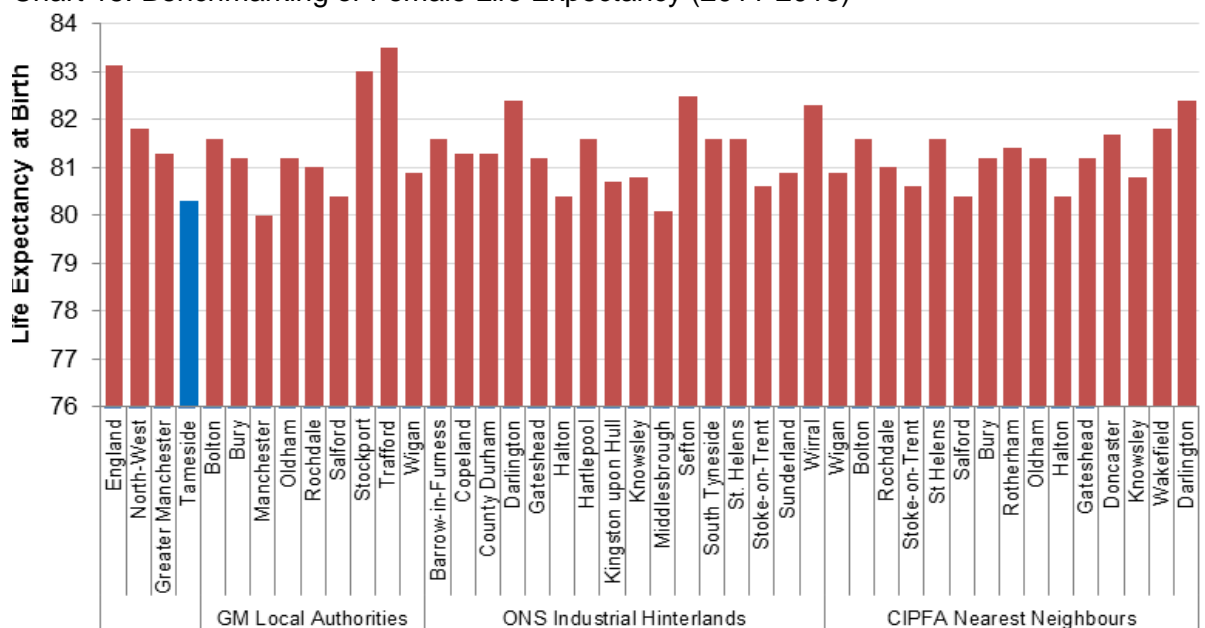
Source: ONS, 2015

Female life expectancy for the period 2011-2013 in Tameside is the 2nd lowest out of ten Greater Manchester local authorities, 2nd lowest out of 17 ONS Industrial Hinterlands local authorities and the lowest out of 16 CIPFA nearest neighbours.

Life expectancy at birth figures for Tameside wards for the period 2009-2013 are shown in Chart 16. Life expectancy ranges by 8.4 years and 7.4 years in males and females respectively across all Tameside wards.

Life expectancy at birth for Tameside local quintiles of the Index of Multiple Deprivation (IMD2010) are shown in Chart 17. Across the deprivation quintiles the gap in life expectancy is 7.9 years for males and 7.3 years for females. It can be seen from the life expectancy figures for Tameside wards and deprivation quintiles that there is a significant inequality in life expectancy within the Tameside population.

Chart 16: Life Expectancy at Birth by Tameside Ward (2009-2013)
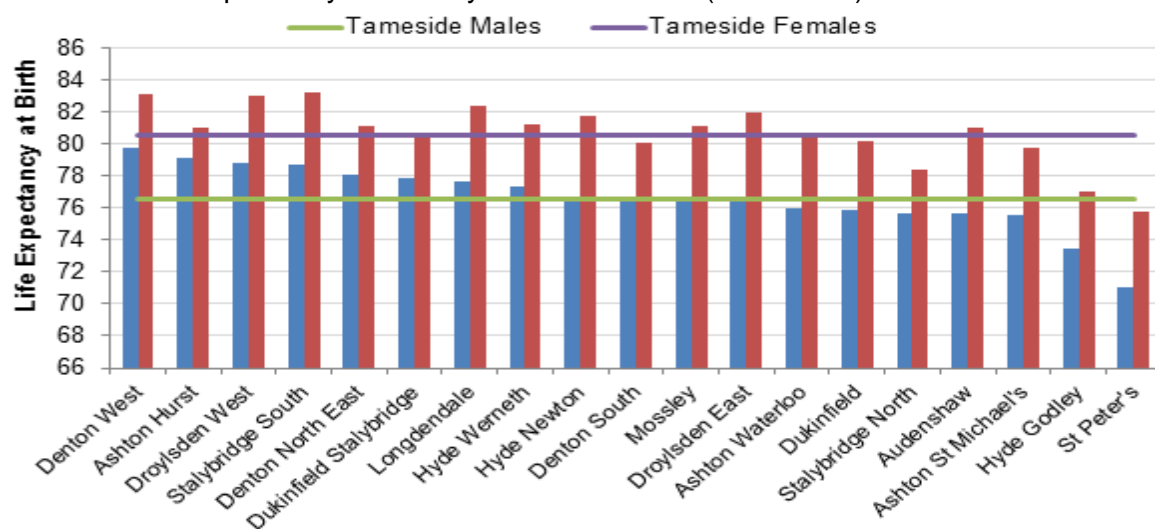
Source: PCMD and ONS mid-year populations, 2015

Chart 17: Life Expectancy at Birth 2009-2013 by Local Quintiles of IMD2010
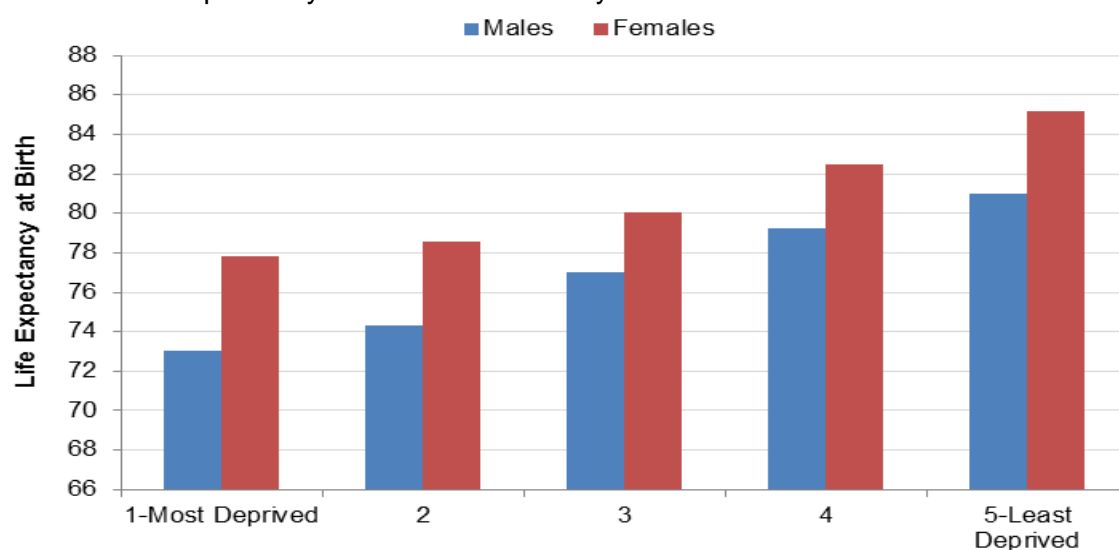
Source: PCMD and ONS mid-year populations, 2015

Life Expectancy at Age 65

Implications for the population's health and well-being

Life expectancy at age 65 gives an indication of how long individuals can expect to live on average having reached the age of 65, which in turn is a barometer of the health status of the population aged 65 and over. In addition, increasing average life-spans of the population may be considered from the perspective of increased demand for services providing care for the elderly and potentially increasing rates of limiting long term illness or disability.

Trend in Life Expectancy at Age 65

The rolling trend in life expectancy at age 65 across twelve years in Tameside, Greater Manchester, the North-West and England is shown in Chart 18 and Chart 19 for males and females respectively.

Life expectancy at 65 in Tameside males increased by 2.4 years between the periods 2000-02 to 2011-13, which is in line with increases in male life expectancy at 65 for England.

Life expectancy at 65 in Tameside females increased by just 0.8 between the periods 2000-02 to 2011-13, with the gap in life expectancy at 65 between England and Tameside females increasing from 1.1 to 2.2 years.

Whilst the inequality in the health of the over 65 male population between Tameside and England has remained relatively constant over the timescale presented, the inequality in the health of the over 65 female population between Tameside and England has increased over the timescale presented.

What is also illustrated in the charts below is that since 2009/11, life expectancy for both males and females has started to plateau. This plateau is more obvious in female life expectancy at 65 years than males. For Tameside there is an obvious decrease in life expectancy at 65 years for females. The plateau could be a blip and may start to rise again in the coming years; however it is important that we continue to monitor these trends.

Chart 18: Trend in the Gap in Life Expectancy at age 65 between England and Tameside *(Males)*
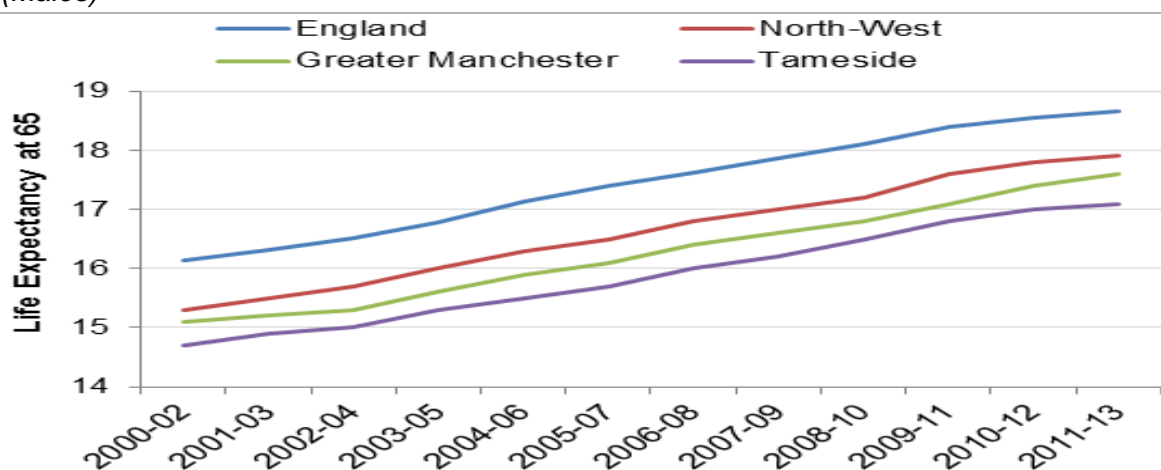
Source: ONS, 2015

Chart 19: Trend in the Gap in Life Expencacy Age 65 between England and Tameside
(Females)
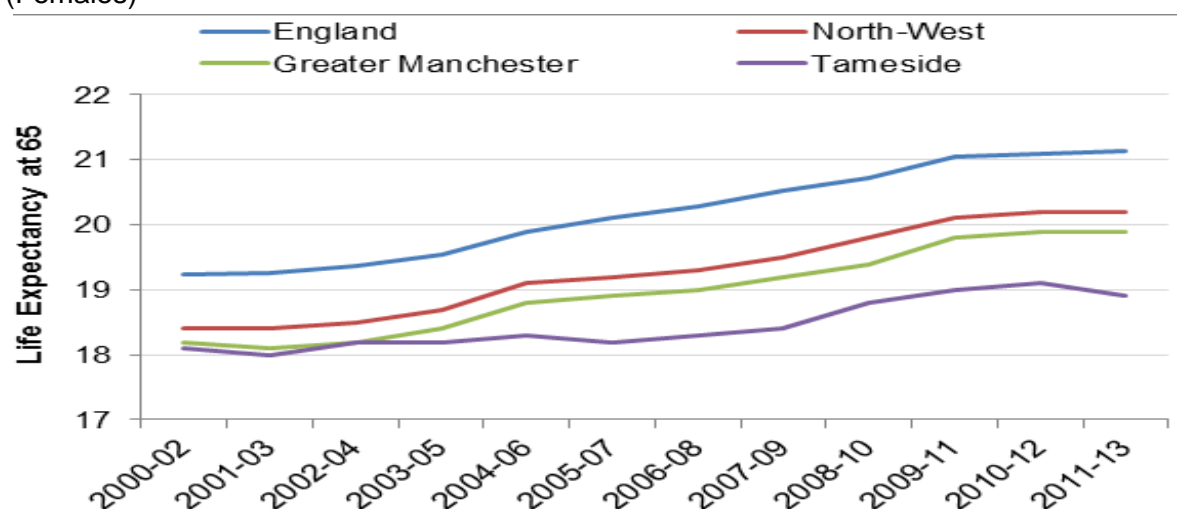
Source: ONS, 2015

Benchmarking of Life Expectancy at 65

Life expectancy at age 65 based upon mortality data for the period 2011-2013 is compared between Tameside and its Greater Manchester local authority neighbours and local authorities within the ONS Industrial Hinterlands local authority classification grouping and CIPFA nearest neighbour's model in Chart 20 and Chart 21 for males and females respectively.

Both the ONS classification model for local authorities and the CIPFA nearest neighbour's model use a collection of socio-economic datasets to group local authorities within similar characteristics together.

Male life expectancy at age 65 for the period 2011-2013 in Tameside is the 2nd lowest out of ten Greater Manchester local authorities, 4th lowest out of 17 ONS Industrial Hinterlands local authorities and 2nd lowest out of 16 CIPFA nearest neighbours.

Chart 20: Benchmarking of Male Life Expectancy at age 65 (2011-2013)
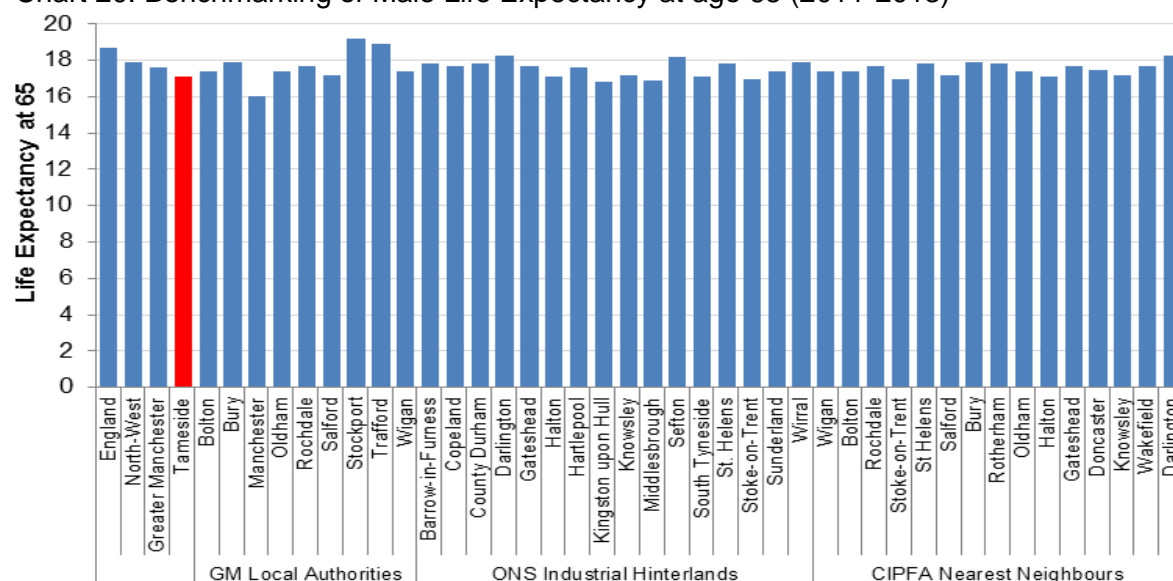
Source: ONS, 2015

Female life expectancy at age 65 for the period 2011-2013 in Tameside is the lowest out of ten Greater Manchester local authorities, 2nd lowest out of 17 ONS Industrial Hinterlands local authorities and the 2nd lowest out of 16 CIPFA nearest neighbours. Life expectancy at age 65 is comparatively low in Tameside when viewed against its geographical local authority neighbours and statistically similar local authorities.

Chart 21: Benchmarking of Female Life Expectancy at age 65 (2011-2013)
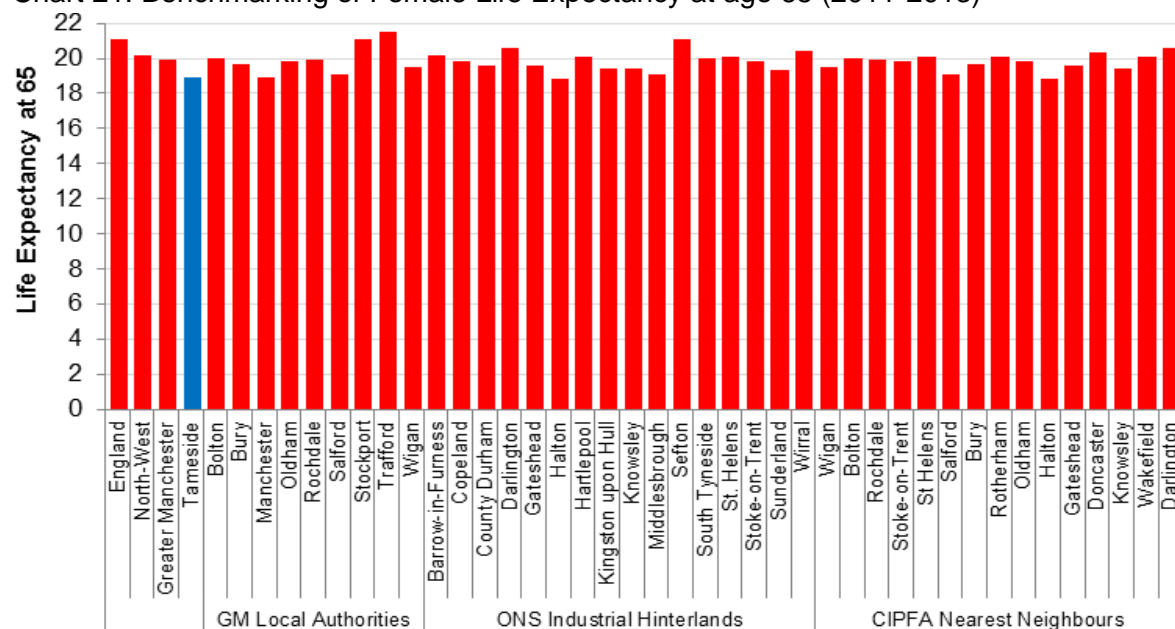
Source: ONS, 2015

Life expectancy at 65 figures for Tameside wards for the period 2009-2013 are shown in Chart 23. Life expectancy at age 65 ranges by 5.9 years and 5.5 years in males and females respectively across all Tameside wards.

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Life expectancy at age 65 for Tameside local quintiles of the Index of Multiple Deprivation (IMD2010) are shown in Chart 23. Across the deprivation quintiles the gap in life expectancy at age 65 is 4.5 years for males and 4.7 years for females.

Chart 22: Life Expectancy at age 65 by Tameside Ward (2009-2013)
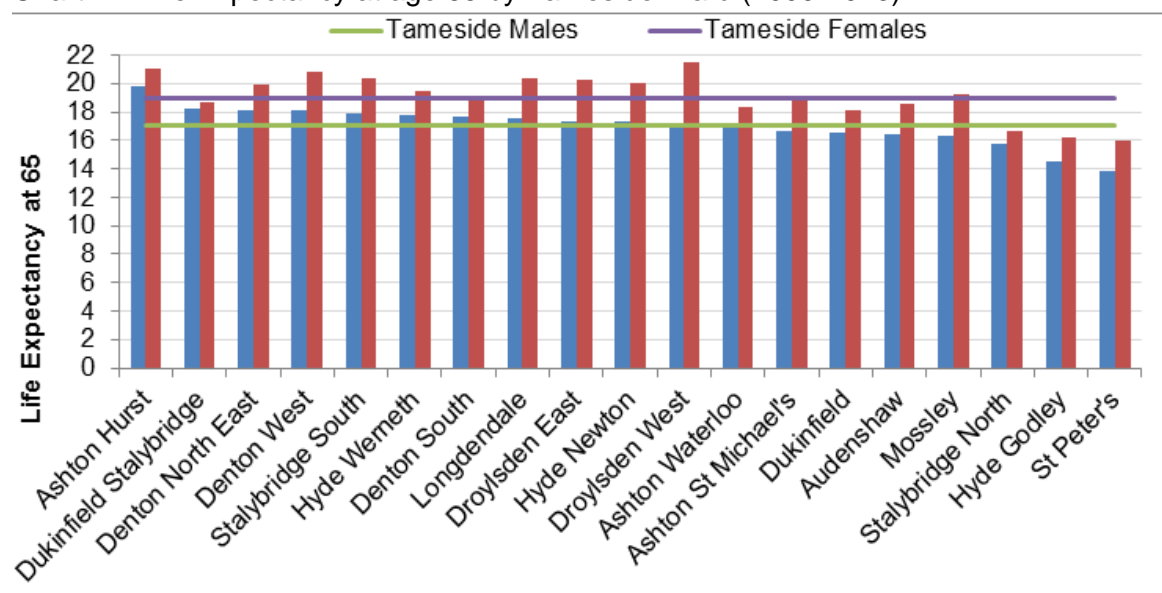
Source: PCMD and ONS mid-year population, 2015

Chart 23: Life Expectancy at age 65 Birth 2009-2013 by Local Quintiles of IMD2010
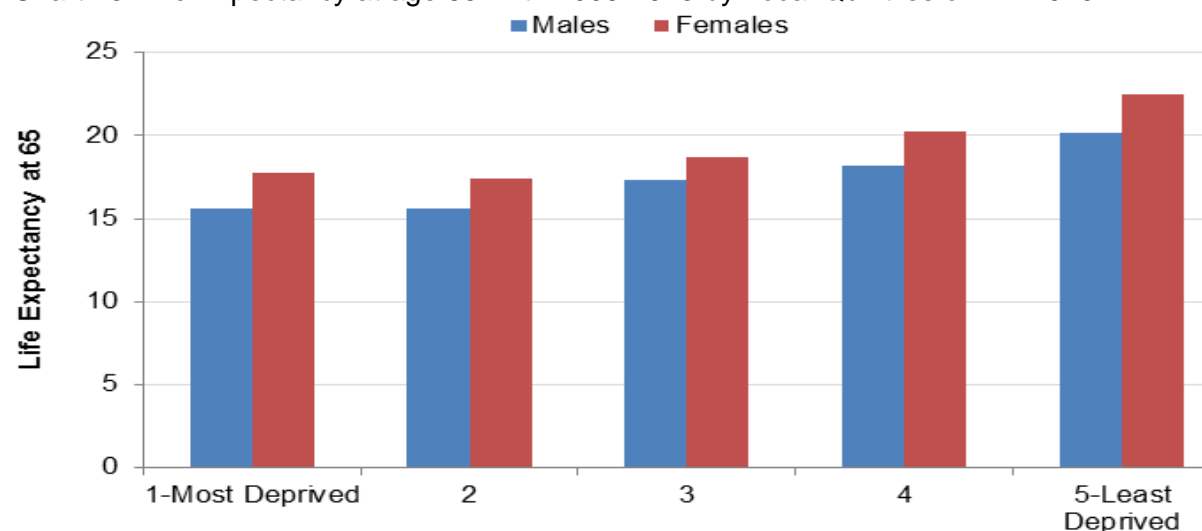
Source: PCMD and ONS mid-year populations, 2015

Healthy Life Expectancy at Birth

Implications for the population's health and well-being

Healthy life expectancy (HLE) as defined by the office of National Statistics (ONS) is the number of years of life an individual can expect to live in 'Very Good' or 'Good' health based upon how individuals perceive their health.

With the state pensionable age rising to 65 for both males and females in 2018 and then higher still in subsequent years, a significant proportion of the working age-population may be unfit for work. This may have a significant effect upon the economy and raise the number of Employment and Support Allowance claimants.

The burden of ill-health upon health care services will also increase with a low HLE and an increasingly aging population. This would also be a factor in the provision of social services needed to cope with the needs of an increasingly ailed population.

Benchmarking of Healthy Life Expectancy

Healthy Life Expectancy (HLE)for the period 2010-2012 is compared between Tameside and its Greater Manchester local authority neighbours and local authorities within the ONS Industrial Hinterlands. HLE.is comparatively low in Tameside when viewed against its geographical local authority neighbours and statistically similar local authorities In addition, healthy life expectancy in Tameside is significantly lower than the state pension age of 65.

Both the ONS classification model for local authorities and the CIPFA nearest neighbours' model use a collection of socio-economic datasets to group local authorities within similar characteristics together.

Male Healthy Life expectancy for the period 2010-2012 in Tameside is the 2nd lowest out of ten Greater Manchester local authorities, 3rd lowest out of 15 ONS Industrial Hinterlands local authorities and 2nd lowest out of 16 CIPFA nearest neighbours. Female Healthy Life Expectancy for the period 2010-2012 in Tameside is 2nd lowest out of ten Greater Manchester local authorities, lowest out of 15 ONS Industrial Hinterlands local authorities and the 2nd lowest out of 16 CIPFA nearest neighbours. Healthy life expectancy is comparatively low in Tameside when viewed against its geographical local authority neighbours and statistically similar local authorities. In addition, healthy life expectancy in Tameside is significantly lower than the state pension age of 65.

Chart 24: Benchmarking of Male Healthy Life Expectancy at Birth (2010-2012)
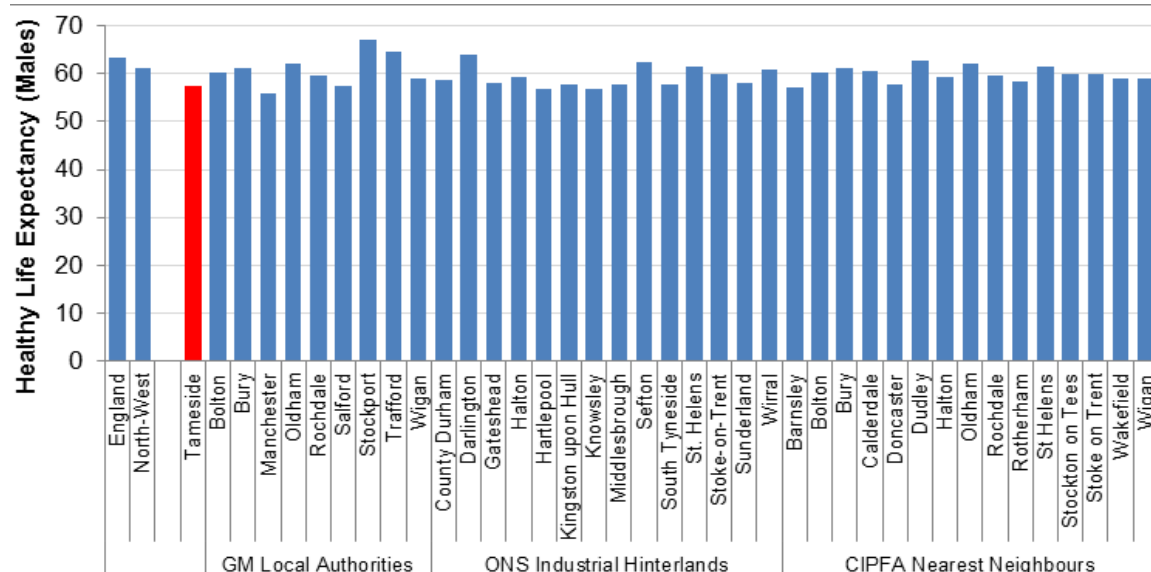
Source: ONS, 2015

Considering healthy life expectancy as a proportion of life expectancy at birth, gives an indication of the proportion of life that an individual can expect to live in 'good' health and thus the burden of ill-health in the elderly and the potential implication for effects of an aging population upon demand for health services.

Tameside males can expect to live on average 75.2% of their lives in good health, whereas Tameside females can expect to live 70.2% of their lives in good health. Compared to geographical neighbours in Greater Manchester and its statistical nearest neighbours, Tameside has a comparatively low proportion of life expected to be spent in good health in both males and females.

Chart 25: Benchmarking of Healthy Life Expectancy as a percentage of Life Expectancy in Males (2010-2012)
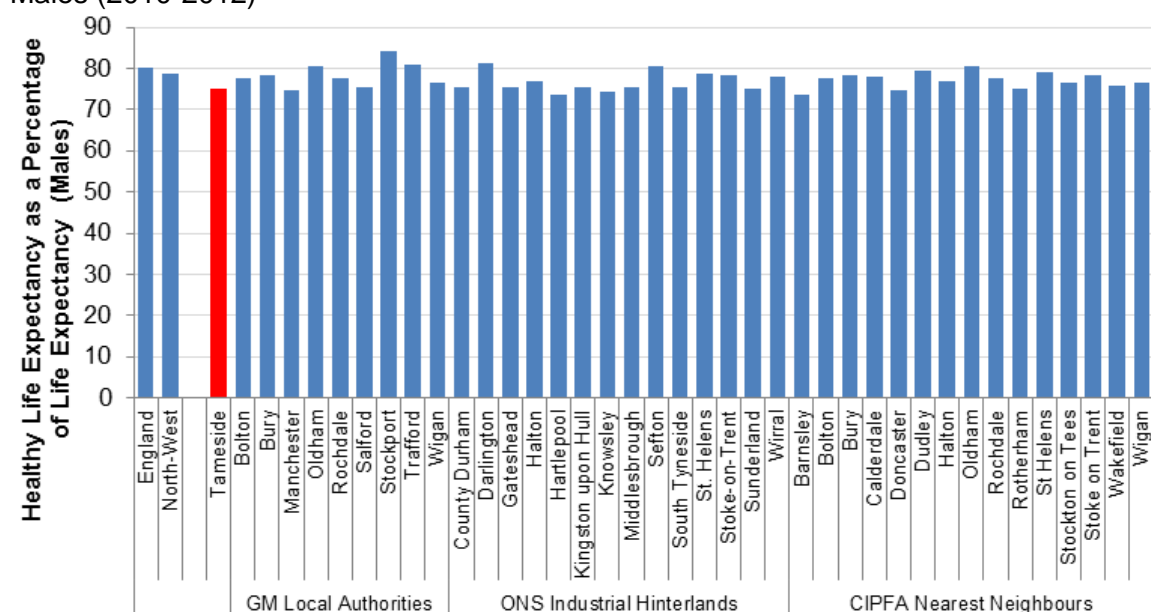
Source: ONS, 2015

Chart 26: Benchmarking of Female Healthy Life Expectancy at Birth (2010-2012)
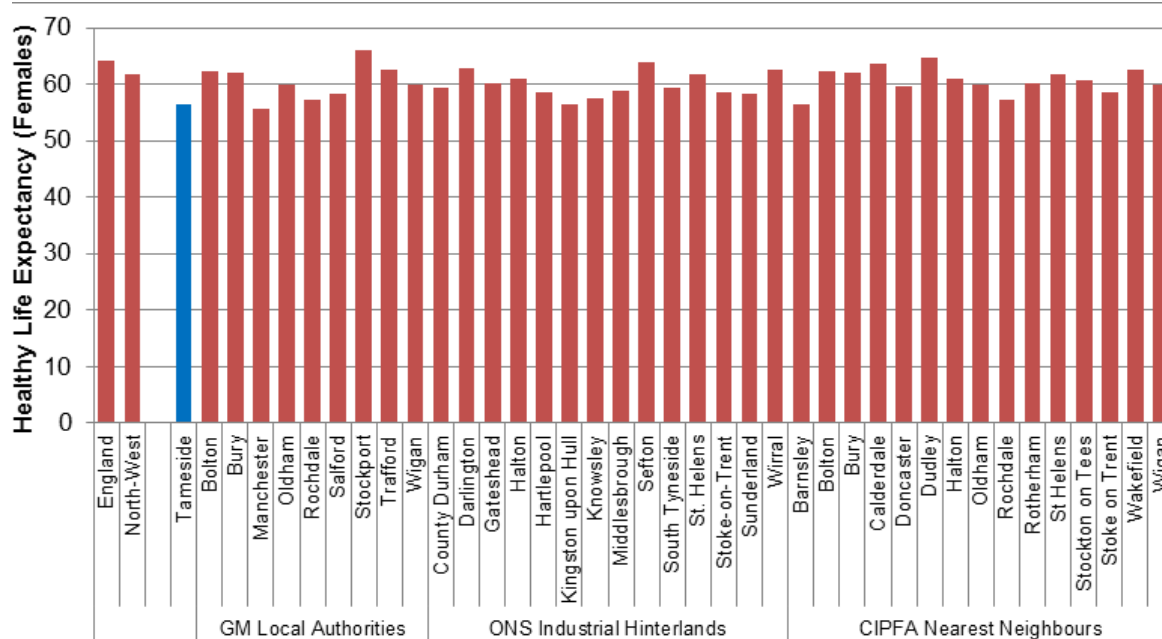
Source: ONS, 2015

Chart 27: Benchmarking of Healthy Life Expectancy as a percentage of Life Expectancy in Females (2010-2012)
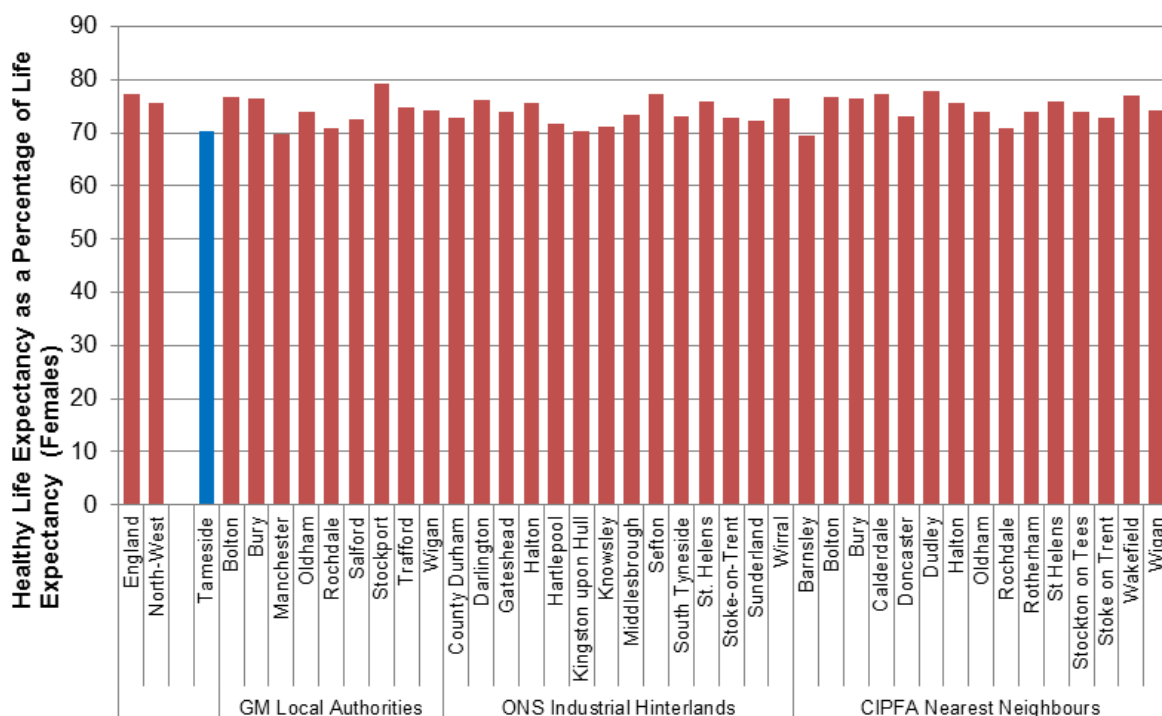
Source: ONS, 2015

Average Lifespan and Life Expectancy

The mean and mode averages of age at death and life expectancy are shown for males and females respectively in charts 28 and 29. The most common age at which people die is the called the mode age of death, the mean age of death is also known as the average age a person might die. Although life expectancy is considered a good indication of the overall health of the population, it is affected disproportionately by deaths at younger ages and therefore a more accurate reflection of the age people can be expected to live to can be better given by the most common age of death occurring in a population; otherwise known as the mode age of death, which is predominately affected by deaths in older age groups. The charts (28 and 29) illustrate that the most common age of death in Tameside for males is 83 years within the period 2011-2013, whereas for females the mode age of death for 2011-2013 is 90 years. The mean or average age of death, is approximately 3 years lower than the life expectancy at birth in males and 1 year lower than the life expectancy in females.

Chart 28: Male Life Expectancy and the average Male Lifespan
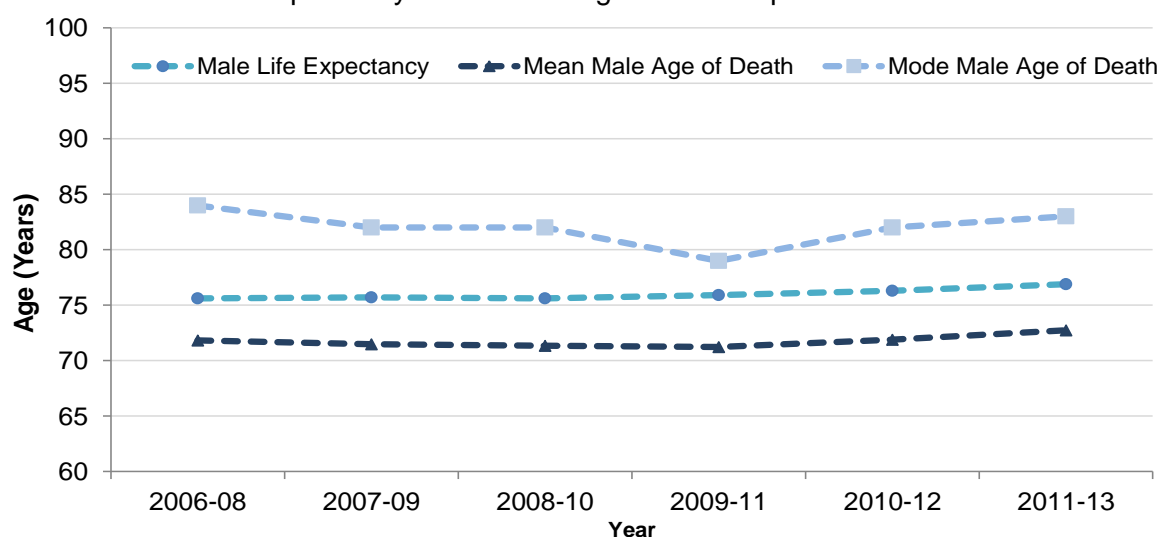
Source: ONS, 2015

Chart 29: Female Life Expectancy and the average Female Lifespan
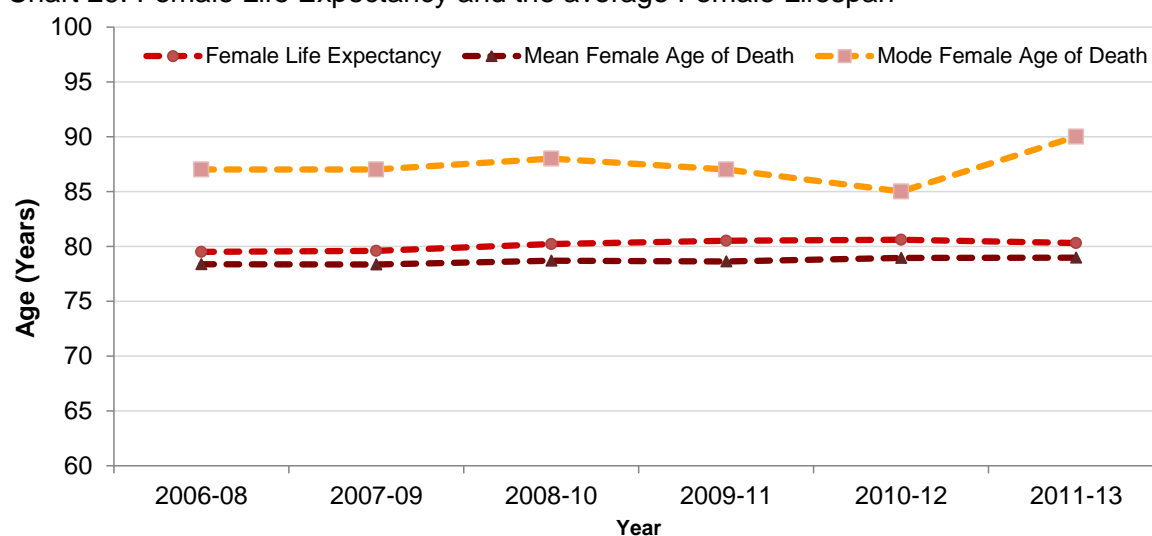
Source: ONS, 2015

Top 10 causes of death and premature death (under 75) in Tameside 2014

Examination of the most common causes of death gives an indication of the major burdens of life threatening disease within the population and where death is due to potentially preventable causes, where public health intervention would be expected to have the largest impact upon premature mortality and extension of life expectancy. Although analysis of premature mortality may yield the greatest impact in terms of life extension, many potentially preventable diseases contribute to mortality at all ages.

The most common causes of death in Tameside in 2014 and the proportion of these with respect to the overall number of deaths in 2014 are shown for males in Chart 30. Ischaemic heart diseases are the most common cause of overall mortality in Tameside males accounting for just over a fifth of Tameside male deaths in 2014. Lung cancer is the second highest cause of death in males accounting for approximately a tenth of total male deaths,

Chart 30: Most Common Male Cause of Death in Tameside,2014

■ Heart Disease

■ Cancer of the Digestive Organs

■ Lung Cancer

■ Mental health and Dementia disorders

■ Stroke

■ Chronic lower respiratory diseases

■ Cancer of the male genital organs

■ Influenza and pneumonia

■ Other
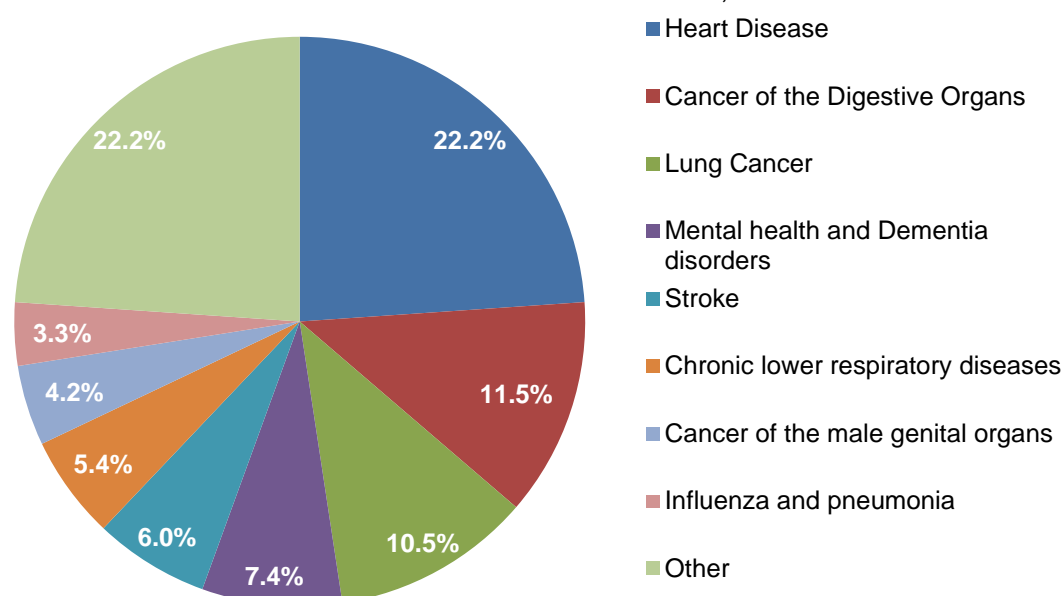
Source: Primary Care Mortality Database (PCMD), 2015

The most common causes of death and the proportion of these with respect to the overall number of deaths are shown for females in Chart 31. Similarly to all-cause mortality in males, ischemic heart disease is the largest killer in females, contributing 13.5% of female deaths. An organic mental disorder, which includes all forms of dementia, is the second largest cause of death in females. Lung cancer contributes a lower proportion to overall female deaths than males, being the third highest cause of death in females at 7.4%.

Chart 31: Most Common Female Causes of Death in Tameside, 2014
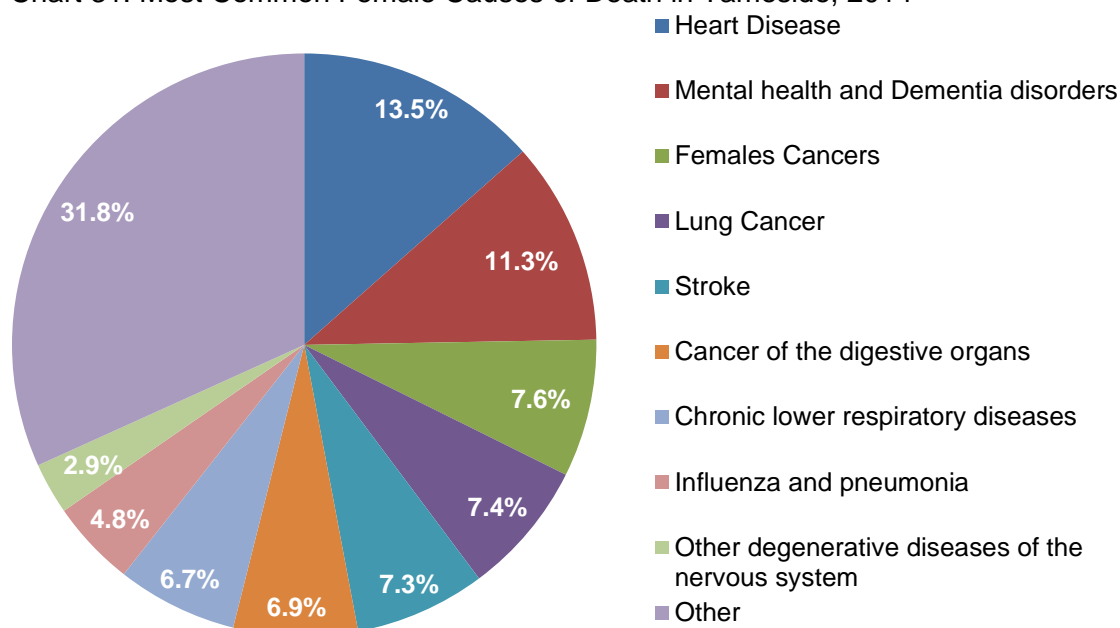
Legend:
- Heart Disease
- Mental health and Dementia disorders
- Females Cancers
- Lung Cancer
- Stroke
- Cancer of the digestive organs
- Chronic lower respiratory diseases
- Influenza and pneumonia
- Other degenerative diseases of the nervous system
- Other

Pie chart values: 13.5%, 11.3%, 7.6%, 7.4%, 7.3%, 6.9%, 6.7%, 4.8%, 2.9%, 31.8%

Source: Primary Care Mortality Database (PCMD), 2015

The most common causes of premature death and the proportion of these with respect to the overall number of premature deaths are shown for males in Chart 32. Although, ischemic heart diseases are the most common more specific cause of premature mortality in males, as a whole, cancer is the largest contributor of premature mortality in males, with lung cancer being the second most common cause of male premature death at 14.9% of male premature deaths in 2014.

Chart 32: Most Common Male Premature (under-75) Causes of Death in Tameside, 2014
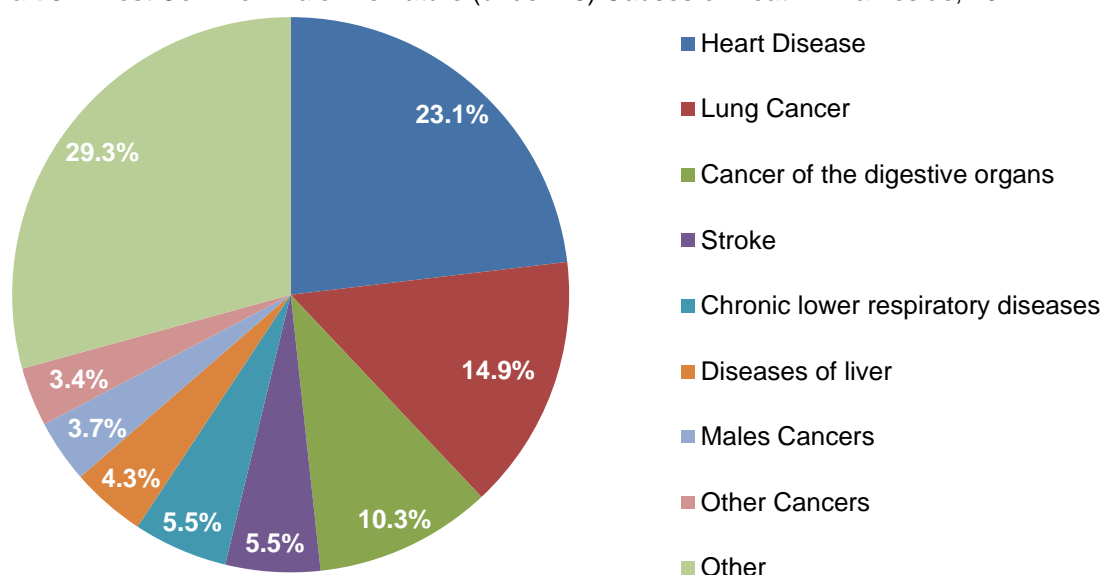
Legend:
- Heart Disease
- Lung Cancer
- Cancer of the digestive organs
- Stroke
- Chronic lower respiratory diseases
- Diseases of liver
- Males Cancers
- Other Cancers
- Other

Pie chart values: 23.1%, 14.9%, 10.3%, 5.5%, 5.5%, 4.3%, 3.7%, 3.4%, 29.3%

Source: Primary Care Mortality Database (PCMD), 2015

The most common causes of premature death and the proportion of these with respect to the overall number of premature deaths are shown for females in Chart 33. Lung cancer is the most common cause of premature death in females accounting for 11.1% of premature female deaths.

Chart 33: Most Common Female Premature (under-75) Causes of Death in Tameside, 2014
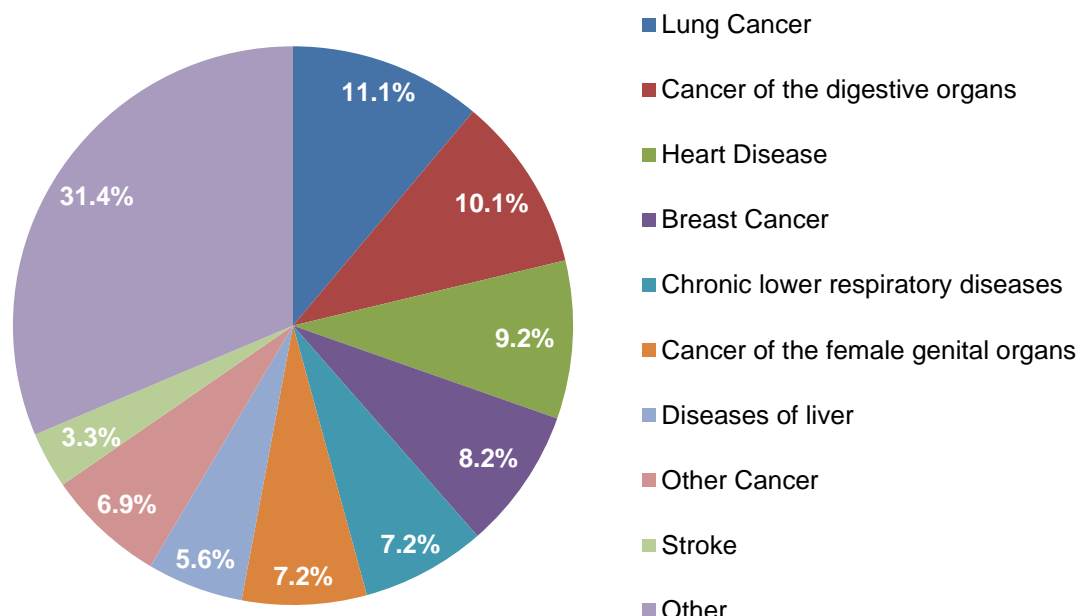
Source: Primary Care Mortality Database (PCMD), 2015

Implications for the population's health and well-being

Many of the most common causes of death are contributed to by modifiable lifestyle factors that are responsible for a considerable proportion of the mortality burden. The most common cause of death and premature death in both males and females are ischaemic heart diseases such as Coronary Heart Disease (CHD). Most cases of premature mortality from heart disease are completely preventable by leading a healthy lifestyle. Public health interventions that promote healthy lifestyles play an important part in reducing mortality rates from circulatory diseases such as CHD.

Cancer remains one of the most preventable causes of death with a large proportion of cases being caused by modifiable lifestyle factors such as diet, physical activity, alcohol consumption and tobacco use. Lung cancer deaths are one of the most preventable causes of death with an estimated 85% of all cases due to exposure to tobacco smoke.[5] In addition to changes in modifiable lifestyle risk factors, early diagnosis of cancer significantly improves survival rates and therefore screening programmes are critical to the reduction of cancer mortality rates.

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[5] Cancer Research UK, 2015

Health Protection

Population vaccination coverage

Outcomes framework: Public Health 3.3

Implications for the population's health and well-being:

Immunisation plays a critical role in preventing ill health and helping people to lead healthier lives. Serious complications, disability and deaths, from vaccine preventable diseases such as measles, whooping cough, meningococcal serogroup C, tetanus and influenza have been greatly reduced since the implementation of routine immunisation programmes. The national immunisation programmes aims to protect individuals before birth and throughout the life course. Achieving high levels of vaccination not only benefits the individuals having the vaccination but can also provide indirect benefits to people not immunised via herd immunity. The higher the proportion of the population vaccinated against an infection, the lower the proportion at risk of becoming infected and the lower the chance of spread. High coverage is key to reducing demand on preventable causes of hospital admissions.

The immunisation programmes are dependent upon systematic relationships between stakeholders, which include but are not limited to, vaccine suppliers, GP practices, School Nurses, Health Visitors, Secondary care providers, NHS England (NHSE), Child Health Information Systems, CCGs, and Local Authorities. All these stakeholders have a vital role to ensure that inter organisational systems are in place to maintain the quality of the immunisation pathways. The Public Health England (PHE) Screening and Immunisation team (SIT), embedded into NHS England (NHSE) is expected to take the lead in ensuring this quality is maintained. Accurate recording of all vaccines given and good management of all associated documentation is essential, so a vital element is for the patient's medical records and Child Health Information Systems (CHIS), Personal Child Health Record (Red Book) to have robust systems for updating with key information.

Key priorities for all the programmes are:
• To achieve and maintain high levels of coverage
• Transfer of commissioning arrangements from NHSE to Local Authorities - 2015
• On-going provision of appropriately trained workforce with capacity to deliver current programmes and future extensions
• Accurate recording and reporting systems across all stakeholders
• Making every contact count as an opportunity to assess/provide immunisations
• Increasing public belief in the safety and effectiveness of immunisations
• Linking vaccination with Greater Manchester and local outbreak plans

At risk and vulnerable groups:

People who are at risk of, or particularly vulnerable to, vaccine preventable diseases include:
- People who are more likely to come into contact with the disease (for example because they are born in a country which has a higher rate of the disease in question)
- They have other conditions or circumstances which means they are more likely to experience complications if they get the disease
- They are from a group within the population that is known to have lower rates of vaccination uptake, often due to difficulties in accessing services
- People who have close contact with others who are particularly vulnerable to complications if they get the disease i.e. carers and health and social care workers

Targeted immunisation programmes exist for hepatitis B and tuberculosis (TB) providing vaccination to infants and children at risk of TB and to babies and young children born to mothers who are chronically infected with the hepatitis B virus or who have had the disease during pregnancy.

Groups that tend to have low vaccination uptake include traveller families, asylum seekers, people who are homeless, children from multiple child families, children of lone or teenage parents, looked after children, those in non-English speaking families, those with physical or learning disabilities and those not registered with a GP.

Policy context:

On 1st April 2013 NHS England Local Area Teams became responsible for commissioning immunisations programmes. In Greater Manchester this function is delivered by Greater Manchester Screening and Immunisation Team (GMSIT), whose staff are employed through Public Health England. Local Authorities have a role in scrutinising and challenging the arrangements for commissioning and providing immunisation programmes. There will be a transfer of commissioning arrangements for early years to Local Authorities in 2015.

The national routine vaccination programme covers childhood vaccinations against diphtheria, tetanus, pertussis (whooping cough), *Haemophilus influenzae* type B, polio, meningococcal serogroup C, rotavirus, influenza, measles, mumps, rubella (MMR), pneumococcus, human papilloma virus (HPV), and adult vaccinations against influenza, pneumococcal disease, shingles and pertussis for those at risk.

Recent changes additions to the childhood vaccination schedule since 2013 include:
- Rotavirus vaccine was introduced 2013.
- MenC vaccine was reduced from 3 to 2 doses in the 0 to 5 year schedule. The third dose was moved to be included in the school age programme in 2013.
- Seasonal influenza vaccine for 2 and 3 year olds introduced in 2013
- Seasonal influenza vaccine for 4 year olds introduced in 2014.
- Recent changes to the programme: the additional does of Meningitis C vaccine at 14 years of age was added in 2014.

- In September 2014 the Human Papilloma Virus (HPV) programme changed from a three-dose to a two-dose schedule. This change has also been implemented in other countries.
- Shingles vaccine was introduced into the schedule in 2013 for adults aged 70 with a catch up aged 79 years.

On the horizon is the inclusion of MenB vaccine into the schedule.

'Immunisation against infectious disease', also known as the Green Book, has the latest information on vaccines and vaccination procedures in the UK. Updates on the Green Book can be found on the www.gov.uk website.

Vaccine update newsletters cover developments in the field and updates to the Green Book. See the latest vaccine uptake guidance and statistics at https://www.gov.uk/government/collections/immunisation. Public Health England (2013) also has the "The Complete Routine Immunisation Schedule 2014".

Benchmarking:

A range of performance and monitoring data is available for screening and immunisation programmes from Public Health England website, IMMFORM and the Cover of Vaccination Evaluated Rapidly (COVER) data.

Childhood Immunisation Programme

Coverage data from the childhood immunisation programmes are reported at ages 12 months, 24 months and 5 years. The data is collected through the UK COVER (Cover of Vaccination Evaluated Rapidly) collection by Public Health England. These aggregated data are collected from Child Health Information Services (CHIS) which are computerised systems storing clinical records supporting health promotion and prevention activities for children, including immunisation. In England, COVER14 data for 2014-15 has been collected for Upper Tier Local Authorities (LAs) and former Primary Care Trusts (PCTs).

Chart 34: Coverage reported at 24 months: Tameside and Glossop 0 to 5 years immunisations – coverage reported at 24 months. Target 95%
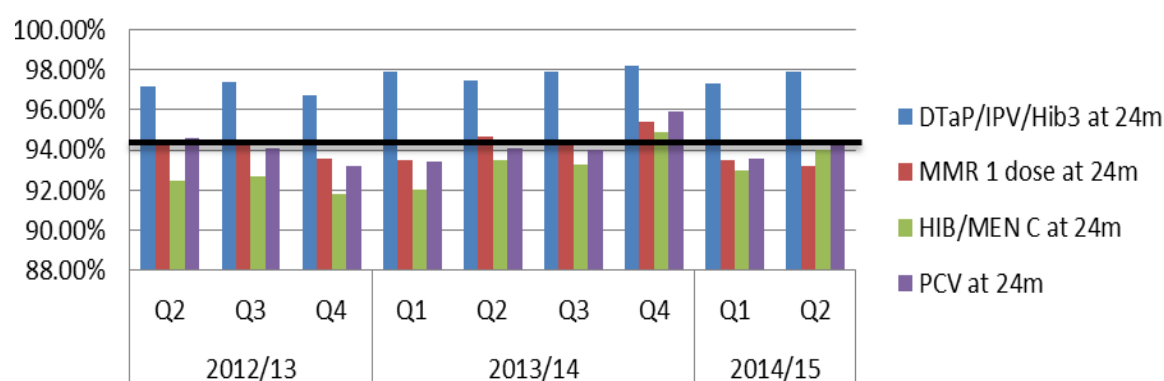
Source: COVER, 2015

The above chart illustrates the Vaccine coverage protecting against Diptheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus influenza, and Meningococcal group C and Pneumococcal diseases 2012/13 -Q2 2014/15 and shows that Tameside and Glossop have consistently achieved the 95% target for vaccination coverage against Diphtheria, Tetanus and Polio. The target has only been achieved for Measles, Mumps and Rubella (MMR) and Pneumococcal diseases in one quarter over the last 2 years. The target has not been achieved for Haemophilus influenza or Meningococcal group C diseases (given as one vaccine)

Chart 35: Coverage reported at 5 years: Tameside and Glossop 0 to 5 years immunisation programmes coverage reported at 5 years
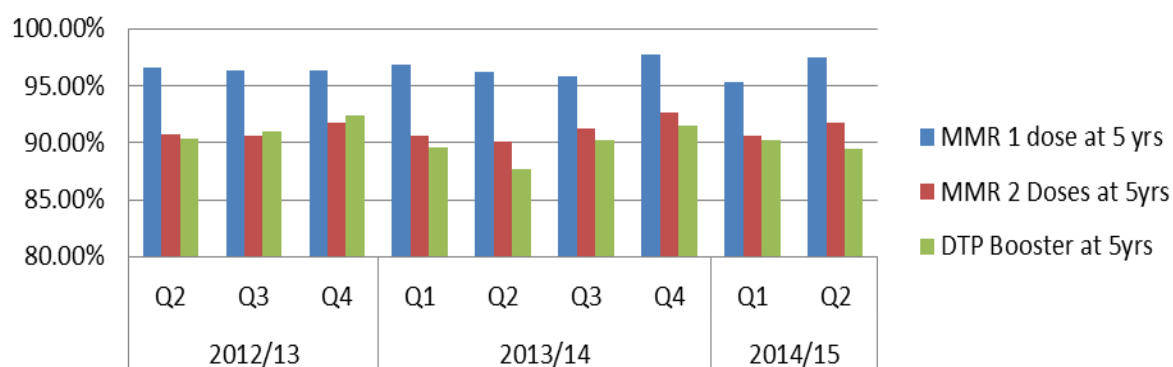
Source: COVER, 2015

The above chart shows the Vaccine coverage protecting against Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps and Rubella at 5 years: 2012/13 -Q2 2014/15

Tameside and Glossop has achieved vaccination coverage target for Measles, Mumps and Rubella. The target is 95% for the first dose of vaccine and 90% for the second vaccination. The vaccination coverage target of 90% for the booster protection against Diphtheria Tetanus, Pertussis and Polio has been achieved intermittently.

Human Papillomavirus Vaccine (HPV)

HPV immunisation is important because it is has been estimated that this programme will prevent 400 women each year from developing cervical cancer.

The objective of the HPV immunisation programme is to provide two doses of HPV vaccine at least six months apart to females before they reach an age when the risk of HPV infection increases and puts them at subsequent risk of cervical cancer. Prevention of HPV infection in those eligible for vaccination and in others outside of the routine programme should include advice on safer sex. All women, whether vaccinated or not, should be strongly encouraged to attend routine cervical screening at the scheduled age. HPV vaccines are over 99% effective in preventing cervical abnormalities associated with HPV types 16 and 18 in women who have not already been infected by these types. There is no uptake target for this programme.

The national immunisation programme began in 2008 using a vaccine (Cervarix) against HPV 16 and 18. In 2012, the programme changed to use a vaccine (Gardasil) which in

addition to protection against the two high-risk HPV types (16 and 18) protects against HPV types 6 and 11 that cause the majority of genital warts. The HPV vaccine Gardasil is offered routinely to girls aged 12 to 13 years (school year 8) and any girl in school years 8, 9, 10 and 11 regardless of date of birth who has not had HPV immunisation.

Chart 36: HPV Uptake Year 8 Schoolgirls 2013/14
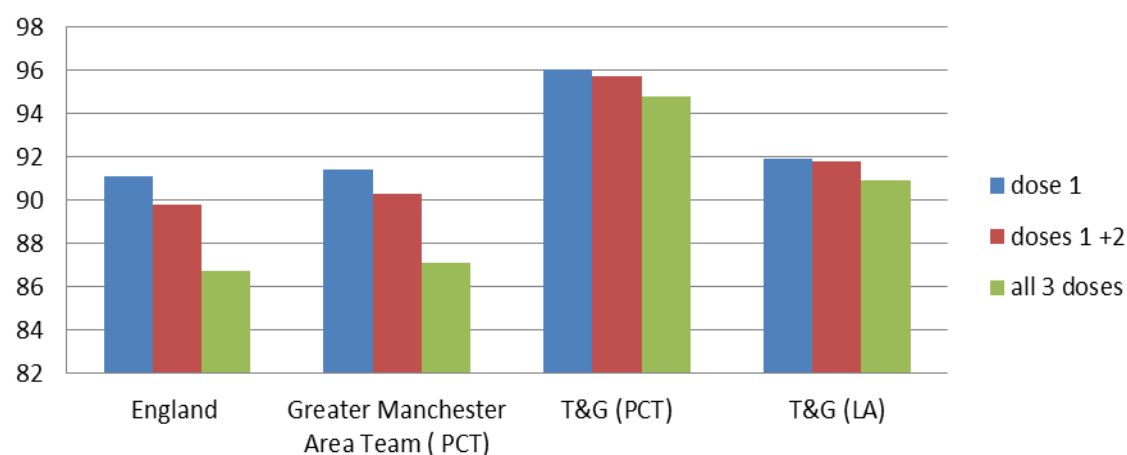
Source: IMMFORM, 2015

N.B. Tameside and Glossop data is different depending on whether looking at data on a PCT or LA footprint.

Tameside and Glossop coverage in 2013/14 is greater compared to England and Greater Manchester averages.

School Leaver Booster

The school leaver booster continues the protection against Tetanus, Diphtheria and Polio (Td/IPV) and Meningococcal infection (MenC). The intention of these immunisations is to increase the longevity of protection offered by the same immunisations which are given as part of the routine childhood programme. There are currently no formal targets for the uptake of these vaccinations but an aspirational Greater Manchester wide target of 90% has been agreed. As there is no formal, national system the data presented in this section provides a snapshot from informal local reporting. Tameside and Glossop uptake for 2013/14 for the school booster at 14 years was 88%. Data for the recently introduced Men C vaccine at 14 years also shows a figure of 88%.

Adults: Shingles

Shingles is caused by the reactivation of a latent varicella zoster (chicken pox) virus infection. The risk and severity of shingles increases with age, and can lead to post herpetic neuralgia which can require hospitalisation. It is estimated that, in people aged 70 years and over, around one in 1000 cases of shingles results in death. The aim of the national shingles immunisation programme is to lower the incidence and severity of shingles in older people. It is a one off immunisation offered to people aged 70 years .There is also a catch up programme offered at 79 years of age. There is no uptake target for this programme

Table 6: Summary of Performance Uptake of the Shingles Vaccine in Tameside and Glossop

uptake of Shingles Immunistion	2013/14 annual data		Nov 2014 monthly data	
	aged 70 years	aged 79 years	aged 70 years	aged 79 years
Greater Manchester	50.4%	46.5%	37.3%	36.5%
T&G	37.8%	41.2%	40.5%	41.3%

Source: IMMFORM, 2015

Uptake of the shingles vaccine in Tameside and Glossop appears to be improving.

Adults: Pneumococcal immunisation

Invasive pneumococcal disease is a major cause of morbidity and mortality. The aim of the programme is to protect all of those for whom pneumococcal infection is likely to be more common and/or serious, these include people aged 65 years and over, who are offered a one off immunisation. The vaccine (PPV) which is effective for older age group is different to the vaccine (PCV) which is used for children. There is no minimum standard for uptake. The data collection for adults is on IMMFORM.

Data for 2013/14 indicates T&G had uptake of 68.5% against a GM background uptake of 68%. This snapshot indicates a slight decline from the 69.4% uptake for 2012/13 annual figure.

Season influenza vaccination uptake 2013/14

Monitoring flu vaccination uptake involves immunisers recording activity on the national IMMFORM system. Annual flu vaccination is offered to all those over age 65, children (currently those aged 2, 3 and 4 years) and to adults and children who are particularly at risk of experiencing complications if they get flu. These at risk groups include pregnant women and those with other underlying health conditions. Carers and health and social care workers are also recommended to have the flu vaccination every year. There were 48,923 seasonal influenza vaccinations recorded and administered to GP registered patients across all target populations in 2013/14. Tameside and Glossop CCG achievement was similar or higher to the national uptake for all eligible groups during 2013/14. Across the CCG the 75% target for those aged 65 was reached and the target for healthcare workers was nearly reached (and was reached by Tameside Hospital Foundation Trust). Performance for eligible groups is summarised in Table 7 below. Local performance is better than national figures.

Table 7: Local and national influenza vaccine uptake by eligible cohort 2013/14

Eligible cohort	Target	Tameside CCG	England
Patients aged 65 years or older	75%	76%	73.2%
Patients aged six months to under 65 years in risk groups (excluding pregnant women without other risk factors)	- (EU target is 75%*)	59.1%	52.3%
Chronic liver disease	-	-	42.9%
Immunosuppression	-	-	54.7%
Chronic neurological disease	-	-	49.2%
Pregnant women	-	49.3%	39.8%
2 year olds (including at risk groups)	-	43.7%	42.6%
3 year olds (including at risk groups)	-	46.6%	39.6%
long-stay residential care homes	-	unknown	unknown
Carers	-	51.2%	44.8%
Healthcare workers	75%	72.3%	54.8%

Source: IMMFORM, 2015

However, this translates into approximately 24,000 eligible people that were not vaccinated in Tameside and Glossop; and less than half of pregnant women and children aged two and three were recorded as receiving their flu vaccination. This is a national pattern seen with the flu programme where less than half of those with chronic liver disease, and less than half of those with chronic neurological disease were vaccinated.

What interventions work?

Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people under 19 years https://www.nice.org.uk/guidance/ph21. Note resources for professionals are now available from new Department of Health pages at http://www.dh.gov.uk/en/Publichealth/Immunisation/index.htm and for parents, carers and patients at http://www.nhs.uk/livewell/childhealth1-5/pages/childimmunisation.aspx

Immunisation itself is a central public health intervention but to be successful a high proportion of the eligible population must be offered and take up the vaccinations.

Effective and cost effective interventions for maximising uptake include:
- tailored invitations and reminders for 'Did Not Attends' by text or telephone
- improved access to clinics e.g. extended times, weekends
- school based programmes and venues for vaccination
- access to health professional to discuss concerns
- dissemination of good practice
- domiciliary and outreach services
- brief advice and referral
- opportunistic vaccination
- appropriately trained and up to date staff
- ensure staff in place to monitor uptake
- tailored information and support
- immunisation status checks at first health assessment for Looked After Children

- targeted promotional campaigns (social marketing techniques) including benefits/risks
- immunisation checks at entry to school, nursery, play groups; Sure Start Centres, school transfer

What are we doing now?

- Tameside Council, Tameside and Glossop CCG and GMSIT have worked with a wide range of organisations to promote the seasonal flu vaccination campaign 2014/15. Flu vaccination has been made available to at risk groups via pharmacies in Greater Manchester in order to promote improved access.
- Guidance on provision of flu vaccination for social care staff and people living in residential care has been included in care home contracts.
- Flu vaccination was chosen a subject for the Greater Manchester Sector Led Review process in June 2014. A Greater Manchester Action Plan was issued in August 2014 and it contained recommendations that were considered for local application with the Flu Planning Group for Tameside.

What needs to happen next, and by whom?

- Greater Manchester Screening and Immunisation Team (GM SIT), Tameside and Glossop CCG and Public Health will work together to identify strategies to increase access, information and choice, in particular for disadvantaged communities.
- The GM SIT now has access to robust routine immunisation uptake data by locality on a quarterly basis. The next step is to identify the reasons for the variation in uptake and subsequently to agree a series of actions aimed at reducing inequalities in access and uptake with our partner agencies in each locality.
- The GM SIT has identified a programme–lead for the routine 0-5 years immunisation programme.
- To monitor uptake and quality in GP practices and other providers using a standardised GM wide criteria. This work will be led by Screening and Immunisation Coordinators who will work closely with GP practices, NHSE, CCG's and local Public Health colleagues.
- To play a role in delivering training sessions, high quality training for staff in GP Practices as providers of immunisation and screening programmes is central to the provision of a high quality service.

Treatment completion for tuberculosis (TB)

Outcome Framework: Public Health 3.5

Implications for Population Health:

Tuberculosis (TB) has re-emerged nationally as a serious public health threat. Following major declines in the incidence of TB during most of the 20th century, the incidence of TB in England increased steadily from the late 1980s to 2005, and has remained at relatively high levels ever since. The incidence of TB in England is higher than most other Western European countries. Trends in England are in marked contrast to some comparable countries that have achieved consistent reductions by concerted approaches to TB prevention, treatment and control.

TB is a communicable disease caused by bacteria belonging to the mycobacterium tuberculosis complex. TB usually affects the lungs but can affect other parts of the body (extra-pulmonary). TB is curable with a combination of specific antibiotics, but treatment must be continued for at least six months. In the UK there are around 9,000 cases of TB reported each year and there are approximately 350 deaths. Most cases occur in major cities. TB incidence in the North West Region is strongly linked to deprivation.

Timely treatment for TB is essential to saving lives and preventing long-term ill health as well as reducing the risk of new infections and development of drug resistance.

Preventing the development of drug resistant TB is important as it has more severe health consequences and is more expensive to treat. People with untreated pulmonary TB are an infection risk to others. Incomplete treatment is associated with the development of drug resistant TB which is more difficult and more costly to treat.

At risk groups or vulnerable groups:

- Close contacts of an infectious case
- People from ethnic minority groups, immigrants from high-prevalence countries, particularly South Asia and Sub-Saharan Africa
- People who have lived in, travelled to or received visitors from places where TB is prevalent
- People who are immune-compromised including those with HIV
- Prisoners
- Homeless people
- People dependent on drugs and alcohol

Benchmarking:

In 2013, there were 7,290 TB cases reported in the UK, an incidence of 13.5 cases per 100,000 population. Although there has been a small decline in incidence in the past two years, it is too early to tell whether this is the start of a downward trend.

Greater Manchester has the highest TB incidence rate in North West England, with 424 cases of tuberculosis reported to ETS in 2013 (data provided by Public Health England Field Epidemiology Service (Liverpool)). The number of reported cases has followed by a

downward trend since 2011, similar to the national trend, but similarly it's difficult to know whether this will be a sustained decrease.

In 2013 Greater Manchester had an incident rate of 15.6 cases of TB per 100,000 population, which was a decrease from the 2012 rate of 16.9 new cases of TB, but is above the national average.

Chart 37: Tuberculosis case reports and rates by region, England, 2010
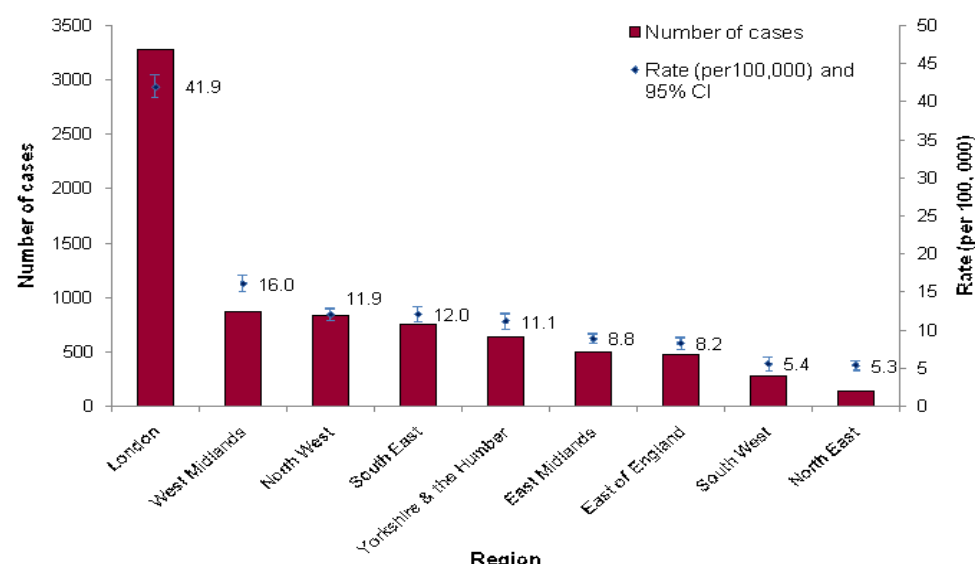
Sources: Enhanced Tuberculosis Surveillance, Office for National Statistics mid-year populations estimates: TB Section - Health Protection Services, Colindale

Chart 38: Incidence of Tuberculosis in the North West, 2008 – 2010

2008-2010 Incidence of Tuberculosis - North West
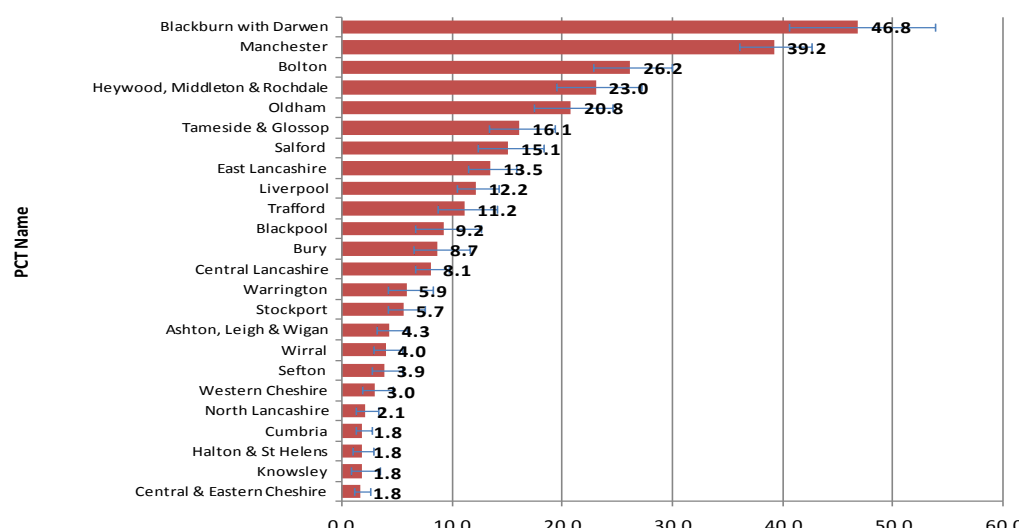
Sources: Enhanced Tuberculosis Surveillance, Office for National Statistics mid-year populations estimates: TB Section - Health Protection Services, Colindale

The above chart illustrates that Tameside and Glossop have the sixth highest incidence of TB in the North West between 2008 and 2010

Policy context:

- [TB action plan and toolkit](#) published by the Chief Medical Officer (CMO)
- NICE Guidance includes a TB Pathway; TB Clinical Guideline (CG117); and Guidance on Hard to Reach Groups (PH 37).
- Collaborative Tuberculosis Strategy for England 2015 to 2020 published by the PHE and NHSE (2015)Greater Manchester 3-5 Year TB Strategy – prepared by the Greater Manchester Collaborative Programme Board (remains in draft form, expected to be signed off April 2015)

What interventions work?

- Patients should be involved in making decisions about their treatment.
- Patients should undergo a risk assessment for treatment adherence and people with adverse factors on their risk assessments should be considered for directly observed therapy (DOT).
- Clinicians should consider how to mitigate the adverse social factors.
- Patients should have a named key worker and know how to contact them.
- The key worker should promote treatment adherence, considering use of the following approaches to improve adherence to treatment:
  - reminder letters;
  - health education counselling;
  - home visits;
  - patient diaries;
  - objective monitoring e.g. urine testing; information about help with paying for
  - prescriptions;
  - help accessing benefits, housing and social services.

What are we doing now?

- Consultants in Communicable Disease Control and specialists working within the Public Health England Greater Manchester Health Protection Team work closely with TB Services and Health Protection Leads in local authorities to ensure TB control at a local authority level. The Health Protection Team has a public health leadership and co-ordination role in the timely investigation and management of community TB incidents.
- Oldham CCG co-ordinate the TB agenda on behalf of Greater Manchester, and convene the TB collaborative Forum, which manages the governance processes and ensures good communication between the Greater Manchester TB commissioners.
- The North West has implemented a TB Cohort Review. The group meet quarterly and systematically review the case management and contact investigation of every case of TB reported over the 3 month period.
- NHS North West works with local Directors of Public Health to ensure the various aspects of the TB summit are implemented with partners in the local authorities and local health providers.
- Tameside Foundation Trust manages the TB Specialist Service which is commissioned on a GM level. A GM level service specification was introduced into GM acute trust contracts for12/13.

- The Local Authority has undertaken research on acceptability of TB communications in an area of Tameside.

What needs to happen next, and by whom?

Local Strategy

A local 3-5 year GM TB Strategy is in development and will focus on the specific needs within Greater Manchester. The aim is for the 2 strategies to sit side-by-side, and the aims and resultant outcomes from the strategies will be consistent. The local strategy was shared at the last DsPH meeting, and should be formally signed off soon when further amendments have been made.

North West TB Control Board

A North West Regional TB Control Board is to be created. Exact arrangements are yet to be finalised, but the aspiration is to provide a staffed control board from April 2015 who can then begin to implement the national TB programme going forward.

Work is underway to address the immediate clinical issues that need to be addressed with;

- A work stream of the TB Summit is looking how to improve capacity in the TB specialist workforce. Tameside is currently under capacity. Tameside and Glossop CCG is the accountable commissioner.
- Tameside Hospital Foundation Trust has a key role in ensuring that the Greater Manchester TB specification is implemented locally. This will benefit both hospital TB specialist services and wider communities by having an education and training programme for professionals and community groups.
- The NICE Guidance (PH 37) "Identifying and managing tuberculosis among hard to reach groups" recommendations will require a comprehensive overview by health and social care commissioners at the Tameside Health Protection Group.

Low birth weight

Outcomes framework: Public Health 2.01

Indicator Name: Low birth weight of term babies

Implications for the population's health and well-being:

Low birth weight reflects the health of mothers and babies and is associated with poor outcomes for babies including increased infant mortality. Good maternity and infant health care can make a significant difference, as can good social and family support.

At risk or vulnerable groups:

There is a strong social gradient for low birth weight, with lower income groups more likely to have babies with low birth weight. There is also variation between ethnic groups.

Benchmarking:

Low birth weight is less common in Tameside than in the North West (NW) and England and improved from 2010.

Chart 39: Percentage of all births (live and still births) where the baby has a low birth weight 2012

Percent of live births recorded with birth weight under 2500g*
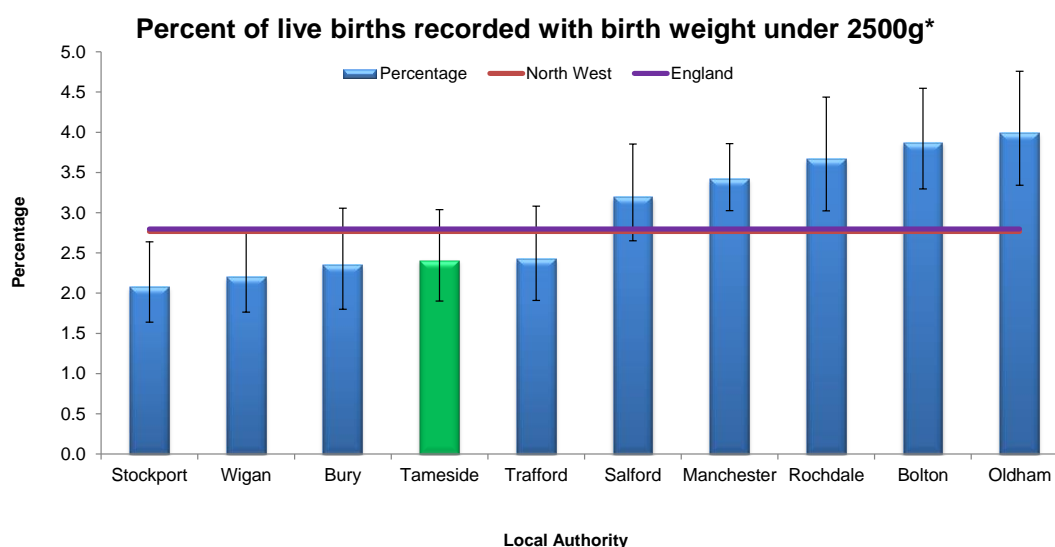
Source: HSCIC, 2014

Policy Context:

Low birth weight is highlighted by the [Marmot Review](#) as an important indicator of population health.

What interventions work? (Including those from outside of Public Health & the Local Authority)

Good maternity and infant health care can make a significant difference, as can good social and family support. NICE have produced detailed guidance for [maternity care](#) and the [Healthy Child Programme](#) and [National Service Framework for Children](#) provide extensive evidence-based framework for maternal and infant care.

Reducing smoking in pregnancy will help to reduce the percentage of babies born with low birth weight. The Children's Centre offer initiatives to reduce domestic violence, enhance maternal health, reduce child poverty and increase family income through access to work and benefit entitlements can all make important contributions. General improvements in the determinants of health will be reflected in improvements in maternal and child health.

What are we doing now?

Local women have good access to maternity services from Tameside Hospital, with additional support for vulnerable women. Stop Smoking Services are tailored to support pregnant women (for more information see the Indicator relating to smoking). Children's Centre core offer services are available in priority areas.

What needs to happen next and by whom?

1. It is vital that current local services for pregnant women that meet NICE guidelines continue to be available and readily accessible, and that the Health Child Programme and Children's Centre services are provided in line with national guidance.
2. Continued action to reduce smoking at the time of delivery (SATOD)

Infant Mortality

Indicator Name: including Infant mortality rates and Neonatal mortality (0 to 27 days)

Implications for the population's health and well-being:

Deaths in children are rare, and in most years there are less than 20 child deaths in Tameside of which about half are infant deaths. For children over 1 year injuries, infections, cancers and complications of long term conditions including birth anomalies are all important.

At risk or vulnerable groups:

It has been clear for over 100 years that infant mortality rates in England follow a social gradient: rates are lowest in the most advantaged families, highest in the most disadvantaged.

Large inequalities in infant mortality rates exist between White and ethnic minority groups in England and Wales.

Benchmarking:

Infant mortality for Tameside is below the NW and England averages. Small numbers make the trend difficult to sensitive to small variations. The trends for very early deaths (perinatal and neonatal) are of improvement from 2003, but no change for the first year of life (infant mortality).

Chart 40: Infant mortality, Crude rates (all maternal ages), Infants <1 year, 2011-13 (Pooled) per 1,000 live births
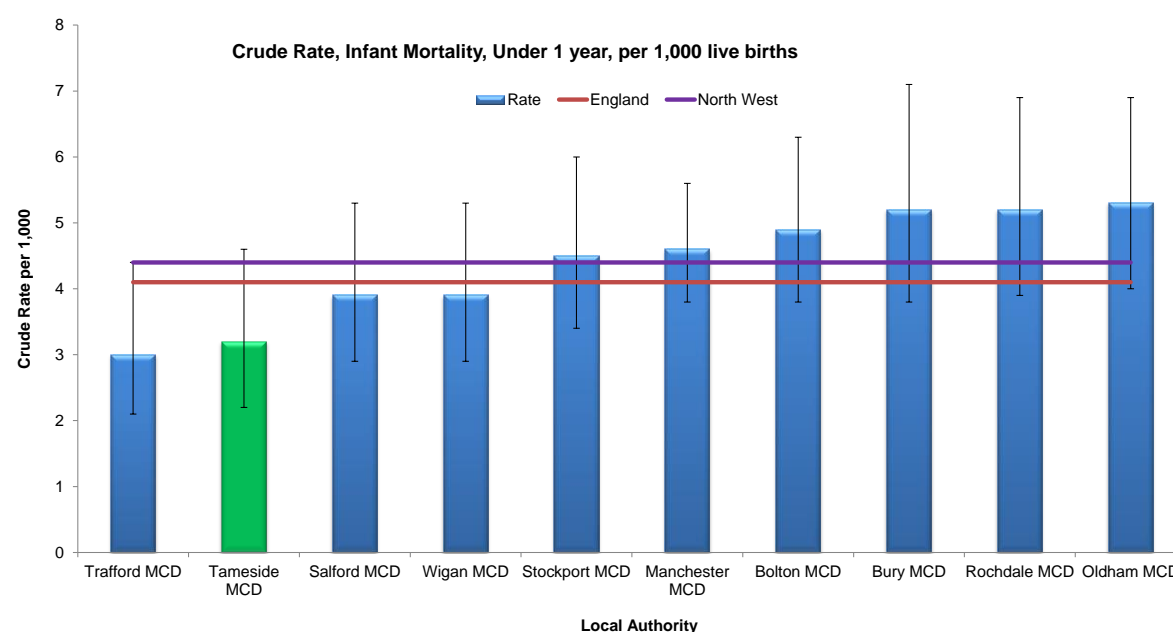
Source: Health and Social Care Information Centre (HSCIC), 2015

Chart 41: Infant, neonatal and perinatal* mortality rates** per 1000 live births, 2003-2005 to 2010-2012
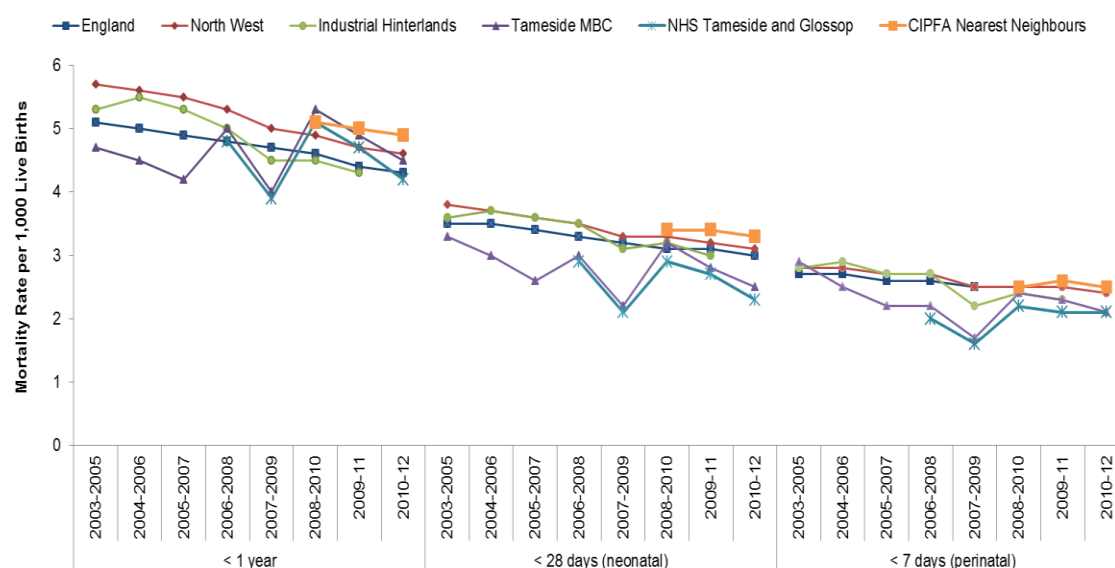
Source: HSCIC, 2015

The chart above illustrates [*including still births] [**each age group excludes the deaths from the younger age groups]. It shows that for Tameside the rate per 1,00 0 live births has fallen for each age group since 2009-2011.

Policy Context:

All child deaths are reviewed by a local Child Death Overview Panel that reports to the Local Safeguarding Children Board. The Stockport, Tameside and Trafford Panel review all local deaths and present an Annual Report with recommendations for action. National guidance to Panels defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Local maternity services are overseen by the Tameside and Glossop Maternity Services Liaison Committee. The GM New Delivery Model for Early Years will enhance support to pregnant women and infants.

What interventions work? (Including those from outside of Public Health & the Local Authority)

Good maternity and infant health care can make a significant difference, as can good social and family support. NICE have produced detailed guidance for maternity care and the Healthy Child Programme 0-5yrs and 5-19yrs and National Service Framework for Children, Young People and Maternity Services provides provide extensive evidence-based framework for maternal and infant care.

What are we doing now?

Local women have good access to maternity services from Tameside Hospital, with additional support for vulnerable women. Stop Smoking Services are tailored to support pregnant women (for more information see the Indicator relating to smoking). Children's Centre core offer services are available in priority areas.

What needs to happen next and by whom?

- It is vital that current local services for pregnant women that meet NICE guidelines continue to be available and readily accessible, and that the Health Child Programme and Children's Centre services are provided in line with national guidance.
- Continued action to reduce smoking at the time of delivery (SATOD)

The Stockport, Tameside and Trafford Child Death Overview Panel (CDOP) Annual Report 2013/14 included a recommendations to review current work address low birth weight, prematurity and maternal smoking and associated issues of hypertension, diabetes and obesity

Breastfeeding at 6 to 8 weeks

Outcomes framework: Public Health 2.02

Indicator Name: including Breast feeding initiation and Breast feeding at 6 to 8 weeks

Implications for the population's health and well-being:
Breastfeeding provides massive short and long term health benefits to both the mother and the baby, including promoting the emotional attachment between them both; and contributes significantly to reducing health inequalities.

For breastfeeding to be viewed as the conventional way to feed a baby, a social culture needs to be established in order that families feel comfortable and encouraged to breastfeed from family, friends, professionals and wider society alike.

The Department of Health recommend exclusive breastfeeding for the first 6 months as providing optimum nutrition for babies with the gradual introduction of solid food after this time in tune with the baby's developmental progress.

Parents require proactive, early, evidence based information in order to enable them to make an informed infant feeding choice and proactive, intensive, early skilled support in breastfeeding management in order to help prevent the problems that lead to mothers stopping breastfeeding earlier than they or their baby would have wished.

At risk or vulnerable groups:

The National Infant Feeding Survey 2010[6] found that the highest incidences of breastfeeding were found among mothers who are aged 30 or over (87%), are from minority ethnic groups, mothers who left education aged over 18 (91%), in managerial and professional occupations (90%) and living in the least deprived areas (89%). Whilst mothers of first babies are more likely to start breastfeeding than mothers of second or later babies (84% compared with 78%), those who have previously breastfed a baby for at least six weeks are more likely to start breastfeeding.

Teenage mothers and mothers of lower socioeconomic status are least likely to breastfeed (NICE 11 2008.). Evidence also points to specific groups being at greater risk of early 'drop-off' regardless of initial intention to initiate breastfeeding. These include women who have had complex deliveries such as a caesarean section, and women who are obese.

There is a strong social gradient for initiation and continuation of breastfeeding. Current local priority areas in Tameside are Ashton Hurst, Ashton St Michael's, Ashton St Peter's, Denton South, Hyde and Hattersley.

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[6] Information Centre for Health and Social Care (2011). *Infant Feeding Survey 2010: Early Results.* London: Information Centre. Available at:
https://catalogue.ic.nhs.uk/publications/public-health/surveys/infa-feed-serv-2010-earl-resu/infa-seed-serv-2010-earl-resu-rep.pdf

Breastfeeding mums can be vulnerable to discrimination, particularly when trying to feed in public.

Benchmarking:

Breastfeeding initiation and continuation rates across Tameside despite having improved greatly over the last 10 years are currently static and still remain low in comparison to National and Regional rates. For the complete year 2013/14, breast feeding initiation in Tameside was 61% compared to the England rate of 74%. In 13/14 Breast feeding at 6 to 8 weeks in Tameside was 29.6% compared to the England average of 45.8%

Chart 42: Breastfeeding Initiation Rates, Tameside, 2009/10 to 2013/14
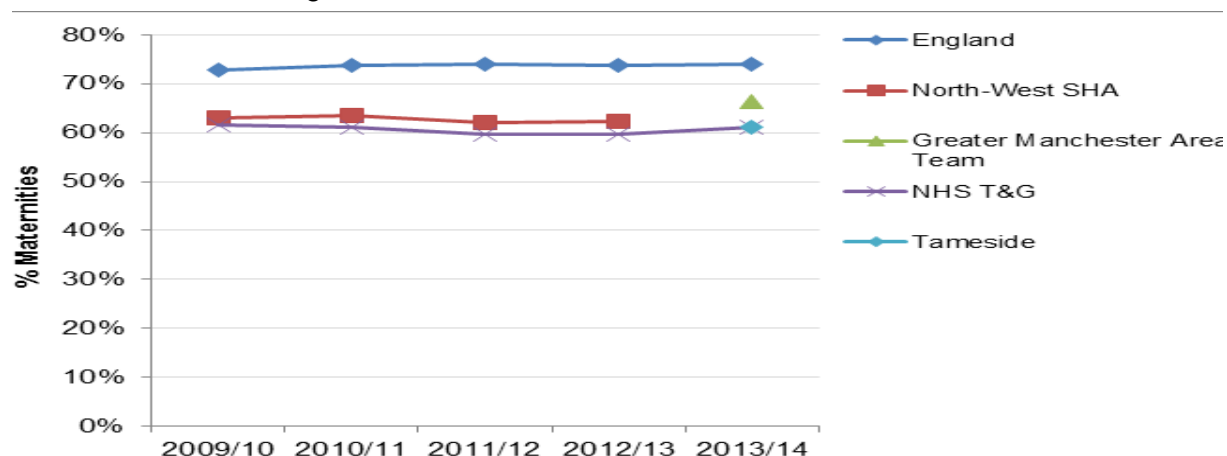
Source: NHSE, 2015

The above chart (chart 43) illustrates that the Breastfeeding Initiation rates for Tameside and Glossop have remained fairly consistent. The 0- 5 years commissioning responsibility will move to the local authority in 2015 so figures will be reported as Tameside Local authority level and not Tameside and Glossop.

Chart 43: 6-8 Week Breastfeeding Prevalence, Tameside, 2009/10 to 2013/14
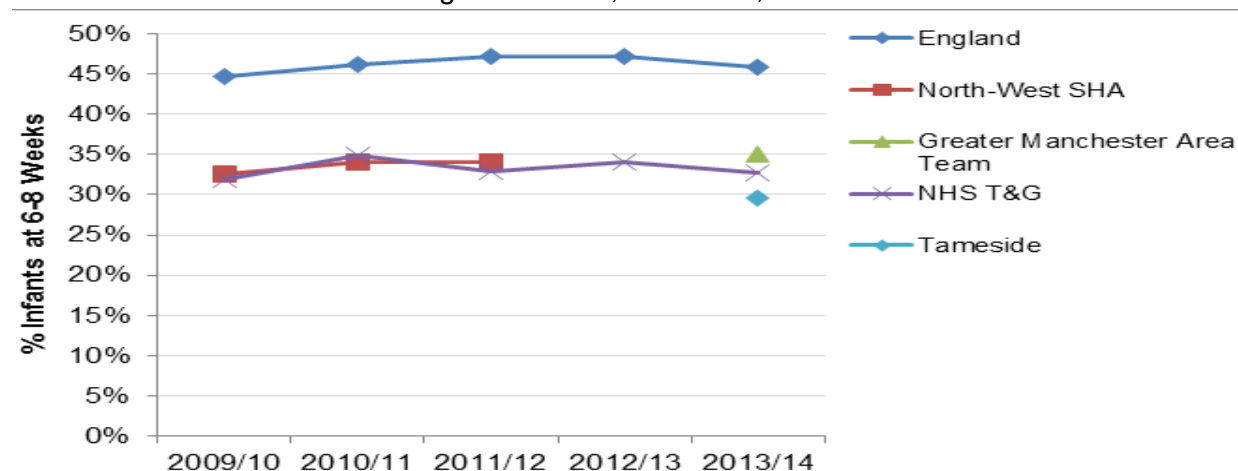
Source: NHSE and Stockport FT, 2015

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Policy Context:
Current DH policy is to promote exclusive breastfeeding for the first 6 months, continuing for as long as the mother and baby wish while gradually introducing a more varied diet. Promotion of breastfeeding is part of the national and local Healthy Child Programme. Local strategy reflects the recommendations of the NW Breastfeeding Strategy.

The Department of Health supports the National Institute for Health and Clinical Excellence (NICE) guidance that recommends NHS facilities achieve the World Health Organization/UNICEF UK Baby Friendly Initiative accreditation as a minimum standard. This includes training and education of frontline staff to achieve appropriate standards of care. Tameside Community Services, Children's Centres and Hospital are fully accredited at Stage 3.

Key guidance can be seen in the list below:

- Fair Society Healthy Lives: Marmot Review (2010)
- Commissioning local Breastfeeding Support Services (2009)
- NICE guidance 11; improving the nutrition of pregnant and breastfeeding mothers and children in low income households (2008)
- Healthy Weight, Healthy Lives: A cross government strategy for England (2008)
- The Healthy Child Programme-Pregnancy and the First Five Years of Life (2008)
- Addressing Health Inequalities: A NW Breastfeeding Framework for Action (2008)
- A NW Framework to achieve healthy weight for children and families (2008)
- Maternity Matters; Choice, access and continuity of care in a safe environment (2007)
- NICE Postnatal Care Guidelines (2006) updated December 2014
- NICE Support for Commissioning Post Natal Care July 2013

What interventions work?

The evidence points to a number of successful interventions which can increase initiation and duration of breastfeeding and support mothers to overcome some of the difficulties they face. In developed countries, specific interventions are known to be useful in promoting breastfeeding[7] including

- Informal group based education delivered during the antenatal period.
- One to one education and support in both the antenatal and post natal period.
- Packages which include media campaigns combined with structural changes to the health sector (Baby Friendly Initiative)
- Programmes intended to support changes to the environment in which mothers live to enable them to feel comfortable breastfeeding whenever and wherever they need to (Breastfeeding Friendly/Welcome Scheme).
- Peer supporter programmes delivered in the antenatal and postnatal period

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[7] *Health Technology Assessment* 2000; Vol. 4: No. 25

What are we doing now?

- We have Infant Feeding leads in both Stockport FT and Tameside FT
- Improvement is driven by the Infant Feeding Management Group who coordinate the delivery of a Borough action plan
- Auditing staff knowledge and client satisfaction with the HV service to maintain the UNICEF baby Friendly standards
- Breastfeeding Peer Support Programme in place, including support groups
- Underway in 2014, the Council launched the Breast Milk Its Amazing Social Marketing campaign in light to increase initiation of breastfeeding and promote a breastfeeding culture in Tameside. With this a website, smart phone application and a suite of resources has been launched.
- In 2014 Baby Welcome and Baby Welcome Plus Award scheme for businesses and community venues was launched in hope to support and encourage breastfeeding mums to breastfeed in public.
- Lactation Clinic in community for more complex feeding issues.
- Training of Health Visitors as Lactation Consultants
- Health visitor antenatal contacts to promote sensitive and responsive parenting and increase breastfeeding initiation

What needs to happen next and by whom?

- Improving data quality and produce a Tameside Profile to inform future commissioning priorities
- Further develop the Breast Milk Its Amazing Social Marketing Campaign with view to evaluate to progress and success of the first year – providing recommendations for the second year of the campaign.
- Continue to enrol business and community venues on to the Baby Welcome and Baby Welcome Plus Award Schemes
- Promotion of breastfeeding in schools and colleges
- Multi-agency approach to early antenatal programme to include fathers and to support responsive and sensitive parenting and optimum infant feeding choices

Children in Poverty

Outcomes framework: Public Health 1.1

Implications for the population's health and well-being:

Child Poverty is currently defined by the national child poverty measure: the percentage of children who live in families in receipt of out-of-work benefits or in working families with income less than 60% of the median national income. The wider determinants of poverty include a range of social and economic factors and are currently being reviewed under the banner of 'life chances' and 'social mobility'.

The consequences of allowing a child to grow up in poverty are severe, not only for the child but for the family, for society and for the wider economy. For a child, consequences can be wide ranging and can affect Health, Education, Employment, Behaviour, Finance, Relationships and well-being.

A child growing up in poverty has a greater likelihood of experiencing health problems from birth and of accumulating physical and mental health problems throughout life. Poverty and inequalities proportionately increase the chances that someone will develop a disability or life limiting illness and ultimately decrease their life expectancy.

At risk or vulnerable groups:

Though poverty can affect anyone, a number of groups are more at risk than others. These include, children in care, teenage parents, asylum seekers, single parents and particular ethnic groups.

Benchmarking:

Levels of Child Poverty in Tameside are higher than both the North West and England (national Child Poverty Data from 2011). Local data had indicated that the levels of poverty had climbed over the past 4-5 years. Local data is no longer comparable due to welfare changes. National data from HMRC continues to be available but in arrears. This data indicates a relatively static position in the percentage of children in poverty in Tameside.

Chart 44: Percentage of children living in poverty, Greater Manchester local authorities 2011
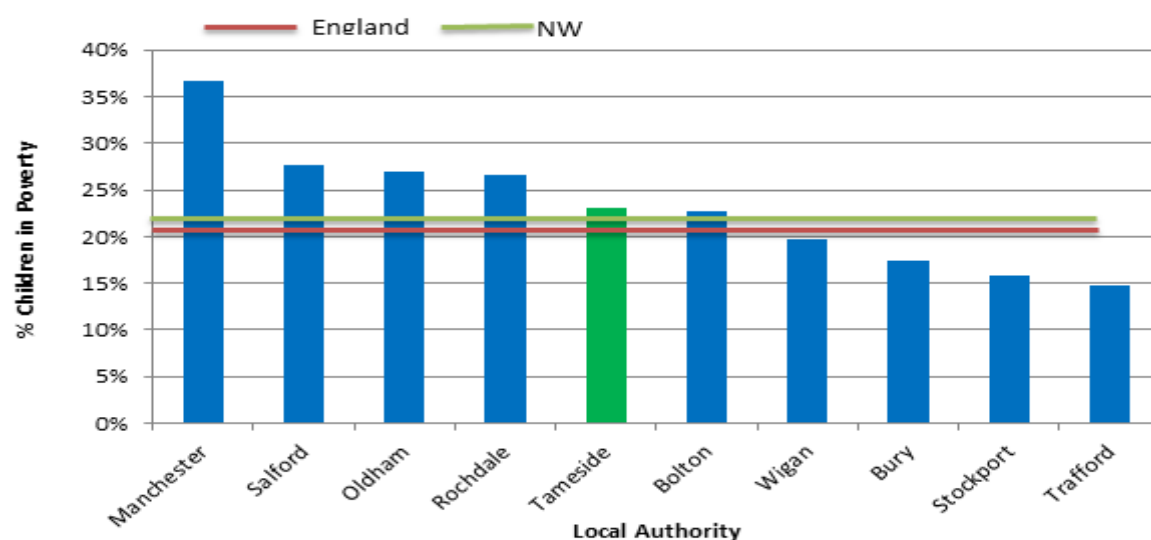
Source: HMRC, 2011

The above chart illustrates that Tameside has the fifth highest percentage of children living in poverty within the Greater Manchester local authorities. This figure is higher than both the North West and England averages.

Chart 45: Percentage of children living in poverty, Tameside, 2006-2012
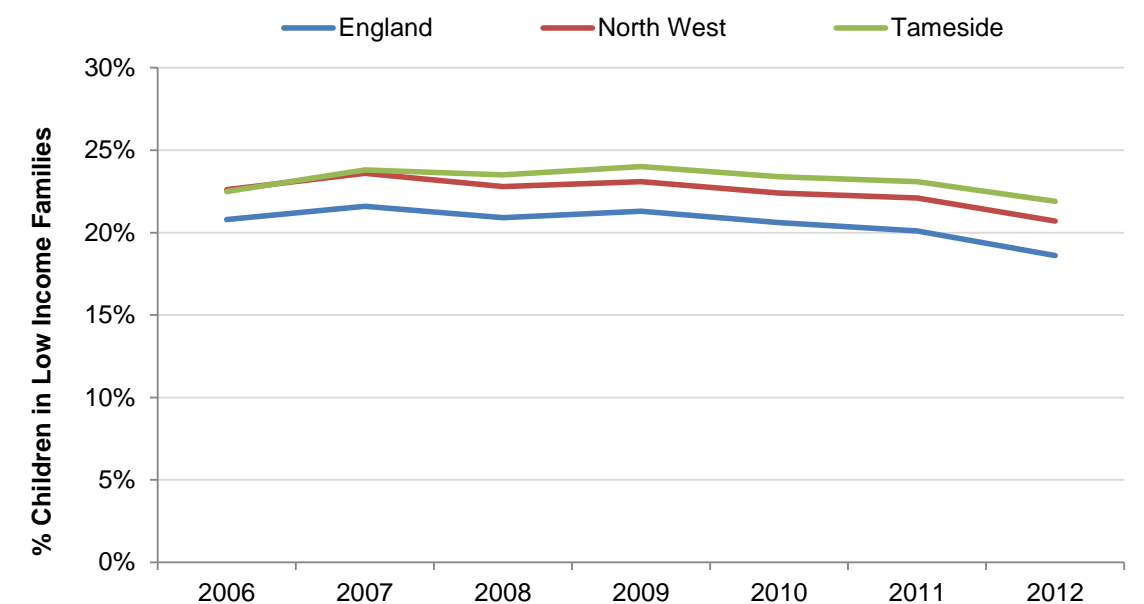
Source: HM Revenue and Customs 2015

The above chart illustrates the percentage of children living in poverty compared to the North West and England over time. It shows that although the percentage is reducing, the gap between the North West and England is actually getting wider.

Policy Context:

The approach to tackling child poverty has shifted emphasis in-line with reductions in public spending and changes to public services. National Government are due to release a new National Child Poverty Strategy by early March 2014.

What interventions work?

The Government's child poverty strategy places less emphasis solely on income instead focusing on 'strengthening families, encouraging responsibility, promoting work, guaranteeing fairness and providing support to the most vulnerable'. It is this approach combined with welfare reform, the work programme and the complex families and community budgets programme which now encapsulates the child poverty agenda.

What are we doing now?

An assessment of child poverty in the borough was carried out in 2011 looking at the characteristics and needs within the borough. Tackling poverty is integral to the 'people' work strand of the economic strategy and action plan as well as the work of the Children's Trust and Health and Well-being Board.

What needs to happen next and by whom?

A wider 'all ages' anti-poverty strategy is now being finalised and will bring together all actions to tackle poverty in the borough into a single plan.

Emotional well-being of looked-after children

Outcomes framework: Public Health 2.8

Implication for the population's health & well-being:

Looked after children and young people share many of the same health risks and problems as their peers, but to a greater degree; they often enter care with a worse level of health, in part due to the impact of poverty, abuse and neglect. Good physical and emotional health and well-being are key contributors to broader outcomes such as improved learning and achievement and to the long-term prospects of young people as they move into adulthood.

It is the responsibility of the local authority to make sure that every child it looks after has a health plan which forms part of the overall care plan. CCGs must work with their local authority to ensure that their health plans are effective.

The number of looked after children continues to rise, there were 68,840 looked after children at 31 March 2014 in England, an increase of 1% compared to 31 March 2013 and an increase of 7% compared to 31 March 2010. The number of looked after children has increased steadily over the past five years and it is now higher than at any point since 1985.

Much of the increase in 2014 was due to the rise in the number of children aged 16 and over who started to be looked after. In the year ending 31 March 2014, 4,510 children in this age group started to be looked after, representing an increase of 21% from 2013.

In part the increase relates to government legislation. Statutory guidance was issued on 1st April 2010 to local authorities jointly by the Secretary of State for Children, Schools and Families and the Secretary of State for Communities and Local Government. It provides revised guidance for children's services, authorities and local housing authorities about their respective duties under Part 3 of the Children Act 1989 and Part 7 of the Housing Act 1996 to secure or provide accommodation for homeless 16 and 17 year old children, following the judgment by the House of Lords in the case of R (G) v London Borough of Southwark (2009).

Like most statutory guidance and legislation the full impact on local authorities is only just being felt and this in some way contributes to the rise in the 16+ looked after population.

The mental health needs of children were further impacted upon by central government withdrawal of funding to CAMHS. Two-thirds of councils have been unable to supplement the withdrawal of funds to mental health services since 2010. Data obtained under the Freedom of Information Act by mental health charity Young Minds revealed that two-thirds of local authorities have been unable to replace the withdrawn funds for child and adolescent mental health services (CAMHS)

At risk or vulnerable groups:

All looked after children are vulnerable and should their emotional wellbeing be poor it impacts on all areas of their and their ability to achieve best outcomes into adulthood. The child's journey includes the needs to achieve educationally to ensure economic security.

- Looked-after children have poorer educational outcomes than non-looked-after children. High proportions have special educational needs and their emotional and behavioral health is often a cause for concern.

Benchmarking:

Table 8: (All Data as at 31/12/14 unless indicated otherwise)

Total number of Looked After Children (LAC) in Tameside	408
Number of LAC placed in Tameside (from other areas)	318 – 30.11.14
Number of LAC placed in other areas by Tameside	126
% of LAC with up to date health and dental checks	85.6%
% of LAC who are looked after for more than 12 months with an SDQ completed	94.7%

Source: Tameside MBC data – accurate as at 13th January 2015

Policy context:

- Children Act 1989 and 2004
- Statutory Guidance Promoting the Health and Well-being of Looked After Children (April 2013) http://media.education.gov.uk/assets/files/pdf/s/promotinghealth.pdf
-

The above guidance places emphasis on agencies working together in a co-ordinated manner to focus on identification and early intervention to support children and families.

Local guidance can be found in the Corporate Parenting Strategy 2012 – 15 (currently under review) http://www.tameside.gov.uk/lac/strategy/1215.pdf

What interventions work?

Early intervention and support for vulnerable children placed in care.
- Children's services should actively engage and support schools in developing knowledge and skills related to promoting good mental health, early identification and to support children's emotional well-being
- School should adopt a systematic approach to assessing and meeting the needs of children and young people
- Identification of children and young people who need referral for specialist individual interventions
- Systematic monitoring of children and young people's outcomes
- Promotion and delivery of individual mental health support to children through the social work and family intervention worker targeted support

What are we doing now?

Since central governments withdrawal of funding for LAC specific CAMH services the local authority and health have been exploring effective interventions to ensure appropriate services are available from tier one to four of need ensuring the most vulnerable receive services whilst the frontline staff are equipped with the skills to work effectively to promote emotional and physical health of our children.

A co-commissioned bid has been successful to look at working across tiers. A position has been created and is currently being recruited to for a Project Manager to support the implementation of a multi- agency approach to early identification of emotional needs and the training of significant front line staff to ensure early identification and skill base to work with the young person and family with guidance, support and access to specialist mental health service when identified as a need.

We continue to target support for children and young people at risk of developing mental health problems: The formulation 12 months ago of a through care team and through care support team where support workers, often with long stating relationships with young people change role to one of PA at the LAC review prior to their sixteenth birthday ensures the knowledge and history of that young person is known and changes in behaviours and presentation is identified early.

The recruitment in social care of a 16+ worker who function is twofold, to support the young people highlighted in paragraph 4 to, where safe to do so, re-unite families to prevent isolation which often leads to mental health issues, supporting young people where, unable to live with family into supported lodgings where they continue to live in a family environment and when appropriate and safe into independence in suitable accommodation with established support again to minimise mental health issues. They will advocate for the young person to ensure housing offered is appropriate and meet the young person needs re support networks.

As named health professionals, School Nurses and Health Visitors play an active role in working with looked after children and work with them and their carers to carry out health assessment reviews and develop a health action plan and work is currently underway to ensure that all GP with looked after children on Care Plan, have all the information they need to ensure that health needs are met and that they can contribute to any health plan for the child.

What needs to happen next, and by whom?

All looked after children must have a good quality health assessment and health plan which ensures individual health needs are met. Emotional and mental health elements need to be fully assessed, captured within the health plan intervention, offered as required and outcomes monitored.

Tooth decay in children aged 5

Outcomes framework: Public Health 4.02

Indicator Name: including
Tooth decay in children aged 5 years, Mean DMFT in 5 year olds & 10 year olds
Tooth extraction in children under 5,
% of children with DMFT in 5 year olds & 10 year olds.

Implications for the population's health and well-being:

- Tooth decay causes pain, sepsis, loss of appearance and confidence, loss nights' sleep, missed school, and required avoidable and unpleasant dental treatment including extractions under general anaesthetic which represent an avoidable risk to life.

- Good oral health in five year olds is an indicator of healthy infant feeding and nutrition.

- Decay levels in five year olds are a good indicator of oral health of the population as a whole.

- Decay in five year olds is an indicator of future tooth decay and oral health.

At risk or vulnerable groups:

Inequalities exist between communities in Tameside and Glossop, with the severest of decay existing in areas of highest socio-economic deprivation including Ashton St Peters, Hyde North, Hyde Werneth and Hattersley.
Ethnicity - The highest decay levels (severity and prevalence) were found in Bangladeshi children. More than 70% of Bangladeshi children examined had some decay with an average of nearly four teeth affected. Pakistani children also show higher decay levels than white children and other ethnic groups (over 60% of Pakistani children affected with an average of nearly 3 teeth decayed).

Benchmarking:

Every four years a nationally co-ordinated survey of the oral health of five year old children's teeth is carried out. The sampling frame is children attending mainstream schools who are five years old at the time of the survey. Calibrated examiners examine children and record the number of decayed (d), missing (m) and filled (f) primary teeth making up the dmft index.

Overall the level of dental caries in 5 year old children in Tameside is lower than that of most other local authorities in Greater Manchester and compares favourably to England and North-West averages. In most indicators presented an improvement has been observed between the 2007/08 and 2011/12 survey.

Chart 46: Mean DMFT per child aged 5 years (2007/08 and 2011/12)
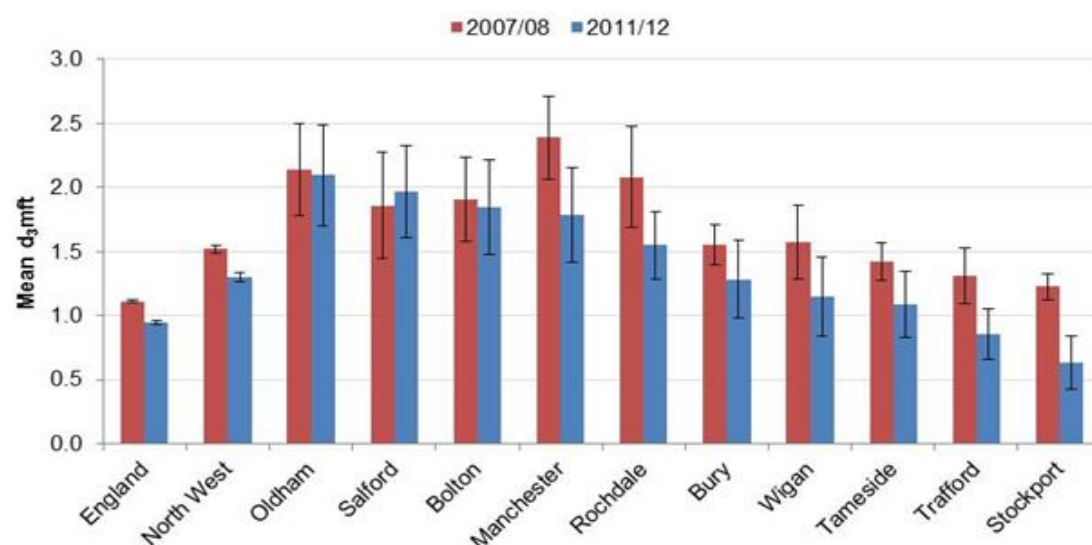
Source: NWPH, Dental Survey of Children, 2011/12

Chart 47: % DMFT > 0 (2007/08 and 2011/12)
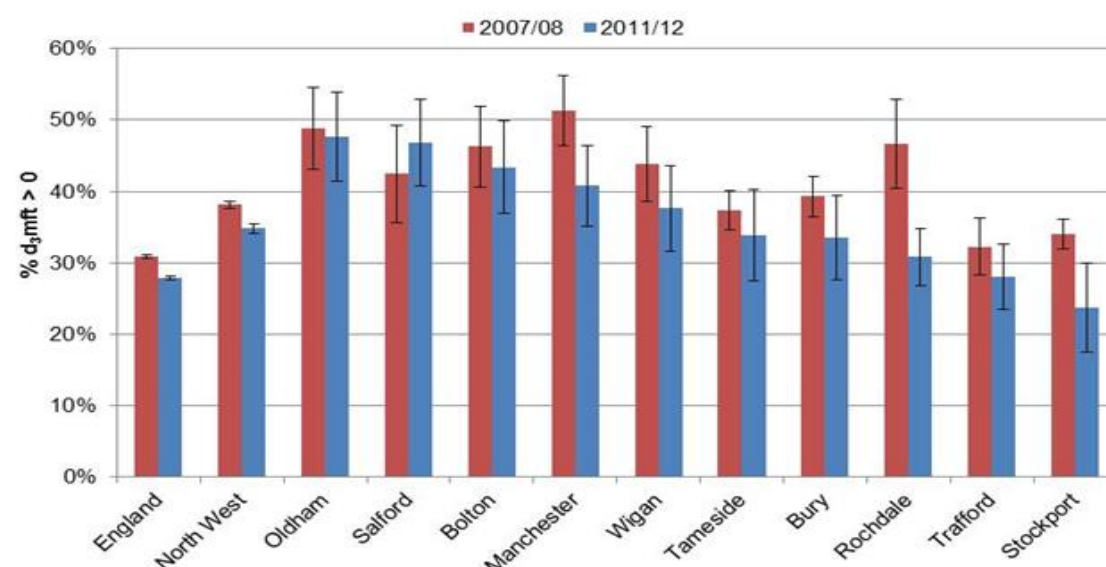
Source: NWPH, Dental Survey of Children, 2011/12

Policy Context:

Local authorities improving oral health: commissioning better oral health for children and young people: An evidence-informed toolkit for local authorities

Delivering better oral health: an evidence-based toolkit for prevention

What interventions work? (Including those from outside of Public Health & the Local Authority)

Relevant NICE guidance:

[Oral health: approaches for local authorities and their partners to improve the oral health of their communities](#)

[Obesity: working with local communities](#)

[Maternal and child nutrition](#)

What are we doing now?

- All 6 month babies receive toothbrush and paste. Those most at risk (Looked after Children, Hyde Bangladeshis, medically compromised) receive additional support and advice.
- Health visiting team give brush, paste and advice at 12 month check. Bangladeshi parents may be referred to the bi-lingual advisor.
- Cost price brushes and paste are sold through children's centres, family support, and home start and supported housing schemes.
- School nurse assistants deliver oral health sessions to children and parents in reception class.
- Under-fives child care providers get a nutrition and oral health award if they fulfil criteria.
- Training and resources are provided to all the teams who work with Early Years and vulnerable families including pre-school, child-minders, and general dental practitioners.
- Fluoride varnish scheme for 3-6 year olds attending Hyde primary schools.
- Bi-lingual oral health advisor in Hyde supporting healthy weaning through home visits.
- Oral health support for Cornerstones, very vulnerable families.
- Supporting oral health advice in vaccination and immunisation sessions in pilot practices.

What needs to happen next and by whom?

Tameside has a strong record in partnership working to deliver evidence based strategies to improve health and address inequalities. The effectiveness of this approach has been shown in the recent improvements. Current initiatives are targeted at improving diet and reducing sugar intake and to increase tooth brushing with family strength fluoride toothpaste from when teeth come through. In order to reduce inequalities between Tameside children and those in England as a whole, and those within Tameside this programme must be maintained and strengthened.

There is a particular need to address inequalities relating to ethnicity and socio-economic deprivation – maintaining Tameside-wide initiatives while extending targeted work including fluoride toothpaste schemes and bi-lingual weaning support and home visit to Ashton.

Excess weight in children

Outcomes Frameworks:
- Public Health: 2.06 - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds
- Public Health: 2.12 - Excess Weight in Adults
- Public Health: 2.13- Percentage of physically active and inactive adults
- NHS Outcomes Framework: 1b Life expectancy at 75

Implications for the population's health and well-being:

In the last twenty years there has been an unprecedented increase in obesity in the UK, and this trend is predicted to continue due to a wide range of factors related to modern day living including our diets, levels of physical activity and inactive leisure pursuits.

In 2013 about one sixth (15.2%) of children under 16 in England were obese. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults. Children of parents who are obese (particularly mothers) are more likely to be overweight or obese. Therefore child obesity is a whole family and whole community issue and has to be addressed on a multitude of levels and not just at the level of the individual child. Childhood obesity cannot be looked at in isolation from adult obesity, family lifestyles and the obesogenic environment.

In England, around a quarter of adults in 2013 were obese, (26 per cent of men and 24 per cent of women). Being overweight was more common than being obese and 41 per cent of men and 33 per cent of women were overweight, but not obese. Both BMI and waist circumference contribute to the National Institute for Health and Care Excellence (NICE) calculation of health risk caused by overweight and obesity. By these definitions, more than half of men and women were in the increased, high or very high risk categories.

People who are overweight or obese are at a greater risk of type 2 diabetes, cardiovascular disease and cancer. On average obesity reduces life expectancy by 11 years. The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Foresight 2007). These factors combine to make the prevention of obesity a major public health challenge.

At risk or vulnerable groups:

- Children from low income families
- Children with obese parents
- Young parents (<21) & single mothers
- People living in areas of deprivation
- Adults who are unemployed or in semi-routine & routine occupations
- Individuals with a physical or learning disability
- Individuals with a mental health condition
- Looked After Children (LAC)/ Care Leavers
- Older People

National and local policy context

- [DH, Healthy Lives, Healthy People: A call to action on obesity in England (2011)](#)
- [Healthy Weight, Healthy Lives (2008)](#)
- [Foresight report – Tackling obesities: Future choices (2007)](#)
- The Tameside and Glossop Healthy Weight Strategy (2010 -2015)

NICE guidance

- Managing overweight and obesity among children and young people: lifestyle weight management services (PH47) October 2013
- Managing overweight and obesity in adults – lifestyle weight management services (PH53) May 2014
- Maternal and child nutrition (PH11) March 2008
- Obesity (CG43) December 2006
- Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (CG189) November 2014
- Prevention of cardiovascular disease (PH25) June 2010
- Weight management before, during and after pregnancy (PH27) July 2010

Benchmarking:

Excess weight children

Within the 2013/14 academic year 13.6% of reception year children within Tameside were categorised as overweight but not obese, which is similar to both North-West and England averages. The prevalence of obesity in Tameside reception year children was 10.8% in the 2012/13 academic year, which was similar to the North-West average and just slightly higher than the England average.

In the 2013/14 academic year, the proportion of Year 6 children categorised as overweight but not obese was 13.6%. This was similar to the England and North-West averages. The prevalence of obesity in Year 6 children within the 2013/14 academic year was 19.7% which was similar[8] to both England and North-West averages.

In Tameside levels of obesity have been slightly above or below 10% in Reception Year and have been between 19% and 21% in Year 6 since 2008/9 (see Chart 48 and Chart 49 below)

Chart 48: Prevalence of obese children in reception, Tameside, 2008/09 to 2013/14

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[8] Not statistically different to.
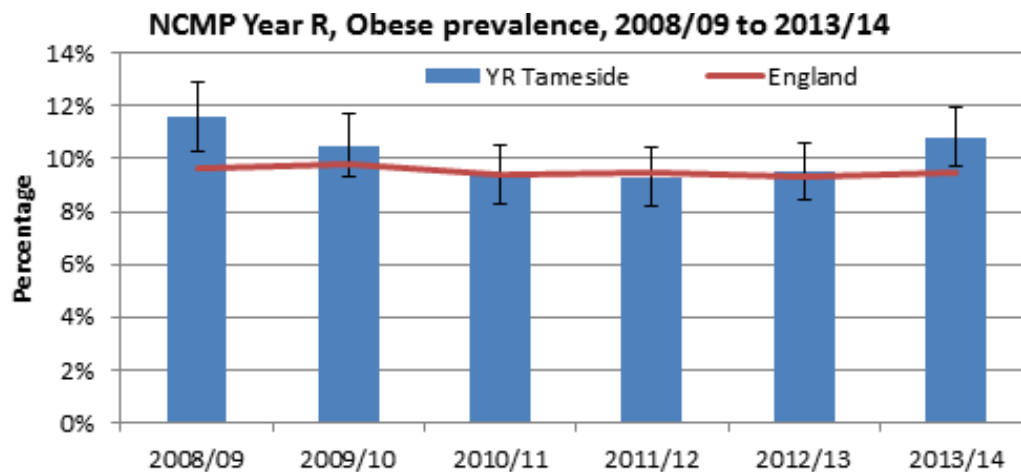
Source: NCMP, 2014

Chart 49: Prevalence of obese children in year 6, Tameside, 2008/09 to 2013/14
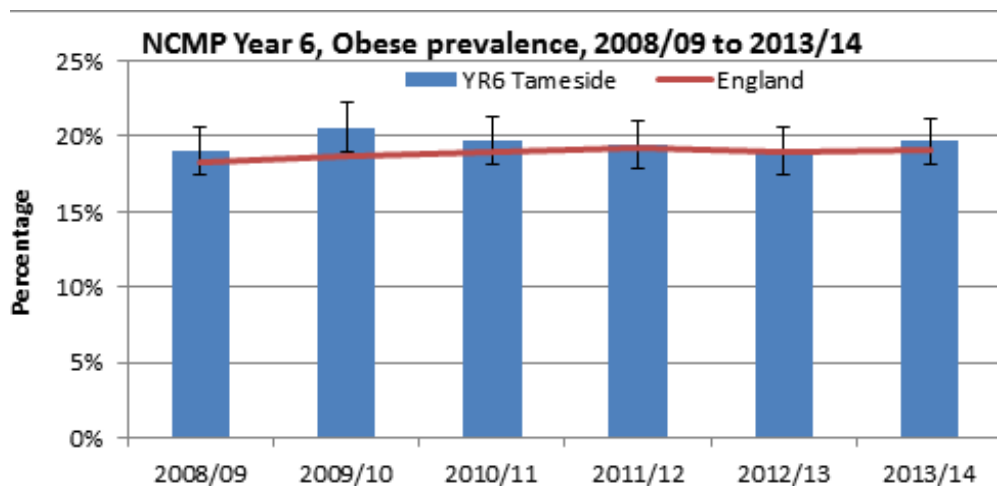
Source: NCMP, 2014

The data for Reception Year and Year 6 in the graphs above give an overall picture for Tameside. However in order to understand how obesity affects children in the Borough it is important to look at ward data.

Map 2: Percentage of Reception Year Children Classified as Obese by Tameside Ward, Three year rolling average 2010/11-2012/13
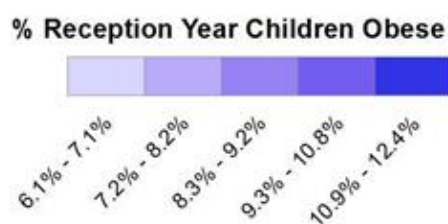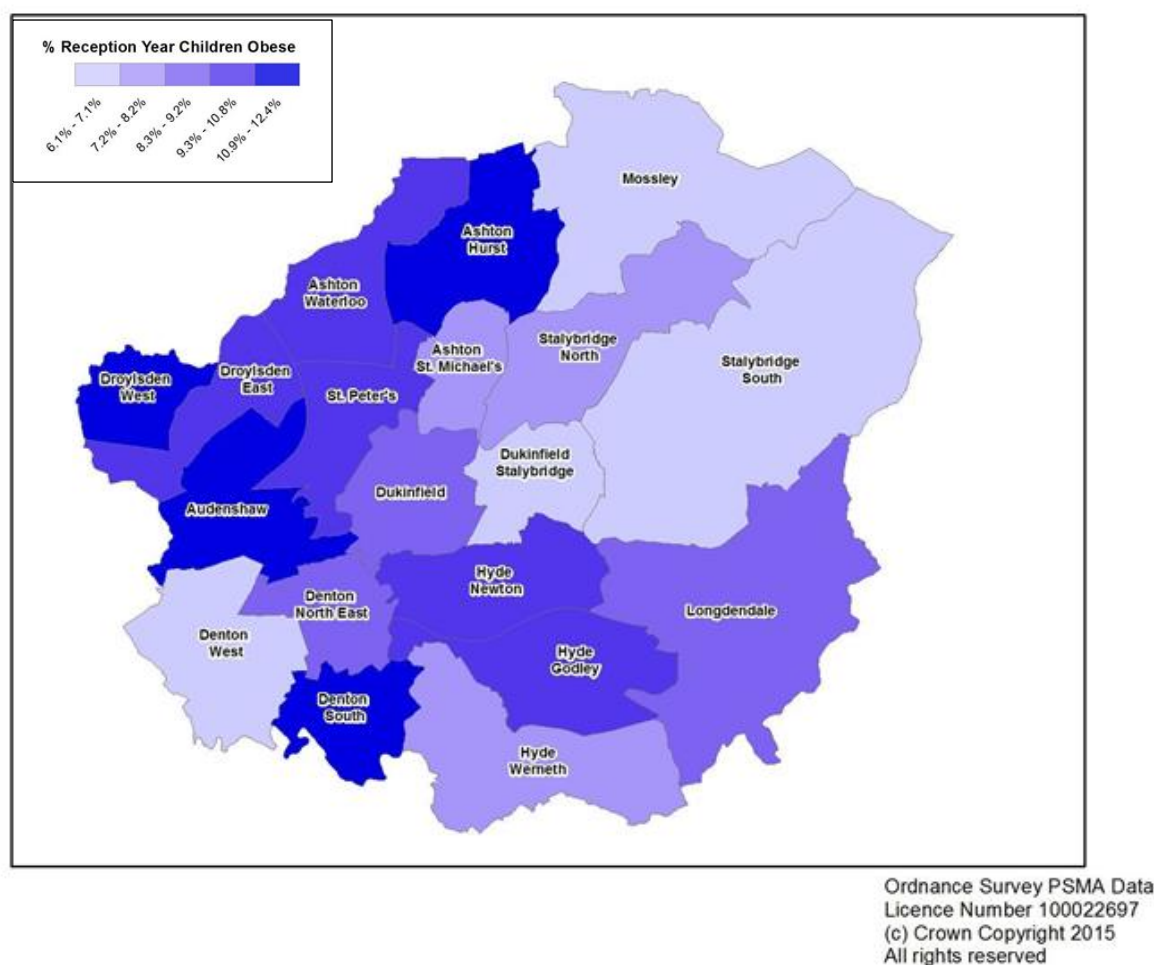
The maps Map 2: Percentage of Reception Year Children Classified as Obese by Tameside Ward, Three year rolling average 2010/11-2012/13above show the three year averages for obesity data for each ward. Although this picture may change with time, this latest data suggests that Ashton Hurst, Droylsden West, Audenshaw and Denton South have particularly high levels of obesity in Reception Year children. It also suggests that obesity in Year 6 pupils is particularly high in Ashton Hurst, Ashton St Michaels and Droylsden West.

What interventions work?

The 2007 Foresight report on obesity stated that

- The obesity epidemic cannot be prevented by individual action alone and demands a societal approach.
- Tackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national.

Some local actions which will contribute to the prevention and reduction of obesity are:
- Support breastfeeding
- Increase access to and opportunities for physical activity and healthy food, for example provision of and access to green open space and opportunities for play and food growing.
- Improve availability of unstructured opportunities for physical activity, such as access to parks and open spaces and safe play areas for children and young people.
- Support initiatives in schools and communities to improve children's wellbeing and self - esteem through physical activity and healthy eating.
- Ensure that health and wellbeing are prioritised and integrated throughout the planning system.
- Encourage the provision of healthier and more sustainable catering.
- Limit the easy accessibility of unhealthy food choices, for example by working with existing hot food take-aways and sandwich shops to reformulate their menus to reduce the sugar, salt and fat content of food and to provide healthier options.
- Consider controlling the proliferation of hot food takeaways in specific areas, such as near schools.
- Conduct health impact assessments to ensure that all parties think about proposed developments from a health perspective, specifically the impact on levels of physical activity and healthy food choices.
- Support, develop and encourage active travel and in doing so also reduce carbon dioxide emissions and improve road safety.
- Implement lower speed limits in residential streets. Speeds above 20 mph discourage active travel and deter parents from allowing children to play on their streets.
- Encourage through appropriate commissioning access to and facilities for structured leisure programmes.
- Ensure all opportunities are accessible to people with limited mobility, including those who are obese.
- Promote the value and benefits (health and otherwise) of an active lifestyle.
- Promote and encourage the use of existing green spaces.

What are we doing now?

- Promoting breastfeeding
- Promoting Healthy Start
- Family Health Mentors
- Delivery of the mandatory National Child Measurement Programme
- Children's nutrition programme

- School Sports Partnership
- Health and well-being clubs in secondary schools
- Living Streets has engaged with over 50 schools in the borough to organise park and stride and active travel days.
- Health trainers
- Adult weight management services
- Workplace health scheme
- Physical activity opportunities in sports centres and green spaces
- Community Health Checks

Service user or public engagement or consultation:

In a 2014 a TMBC consultation asked Tameside residents what would help their health and wellbeing. Getting fitter, losing weight and eating healthy were the three themes with the highest responses from the 701 people that participated.

What needs to happen next and by whom?

The Tameside Healthy Weight Strategy Group is committed to the delivery of the local strategy. Some of the key areas which more work needs to happen include:

- Improving the quality of the breastfeeding data that is collected.
- Increasing the 6-8 week breastfeeding rates.
- To reduce internal inequalities in child obesity by directing services and resources to communities where rates are highest.
- Teenage healthy weight pathway
- Increased co-ordination of support available to schools to promote healthy eating and physical activity.
- Increased support to parents and carers to develop a healthy diet and activity levels for the whole family.
- Active travel programme to promote walking and cycling
- Review of the maternal weight management pathway
- Development of supplementary planning guidance (controlling takeaways etc) and promotion of healthy environment
- Social marketing campaigns
- Importance of healthy weight built into all care pathways
- Better recording and access to data on adult prevalence of overweight and obesity

School Readiness

Outcomes Framework: Public Health 1.2

Implications for the population's health and well-being:

School readiness focuses on whether a child is ready for school based on a range of skills including literacy, numeracy, physical health, social and emotional adjustment, the child's approach to learning and their level of language, cognition and general knowledge. Young children's earliest experiences and environments set the stage for future development and success and can influence their life chances.

At risk or vulnerable groups include:

- Looked after children
- Children who receive Free school meals
- Children with SEND (Special Educational Needs and Disabilities)
- Children for whom English is an additional language

Benchmarking:

The Early Years Foundation Stage Assessment has been used to measure this outcome. The EYFS has the previous measure of 'good development' was defined as achievement of at least 78 points across the EYFS, with at least 6 points in each of the scales in Personal, Social and Emotional Development and Communication, Language and Literacy. This has now been adapted to fit with the new framework as such 2013 data is not necessarily comparable with previous years, but can be compared with figures going forward.

In 2013, following the new EYFS assessment framework, 42% of children were said to have achieved a 'good' level of development OR to be 'ready for school'.
Rates in School readiness had been increasing in Tameside up until 2013 when the new framework was introduced.

2014 school readiness figures in Tameside demonstrate an improvement in this figure to 52%, whilst national figures increased to 60% and statistical neighbours at 55%. Current trend shows that Tameside is improving its rates, but that there is increase required to catch up with England figures and to further decrease the gap to our statistical neighbours. The following tables and graph demonstrates comparisons with England, North West and our statistical neighbours and GM local authorities in 2014, and Tameside performance from 2009-2014

Chart 50: Number & Percentage of children achieving at least the expected level across the specific areas of Learning by gender and local authority, 2014
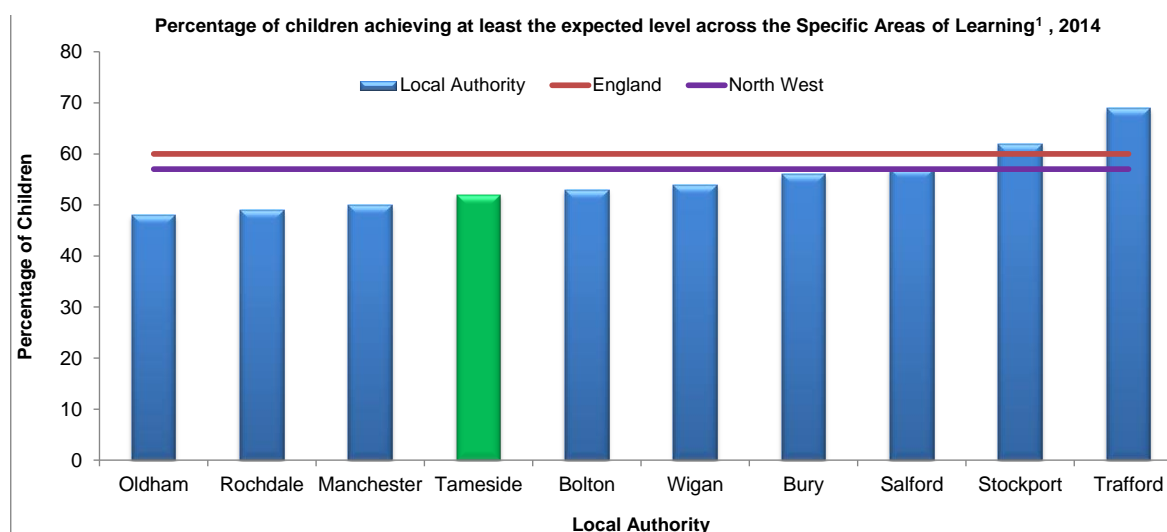
Percentage of children achieving at least the expected level across the Specific Areas of Learning[1] , 2014

Source: Department for Education/Tameside MBC, 2014.

The above chart illustrates that Tameside has the fourth lowest percentage of children who achieve specific areas of Learning, across all the Greater Manchester local authorities. They fall below the averages for both the North West and England

Chart 51: Children achieving a Good level of development at Foundation Stage Profile.
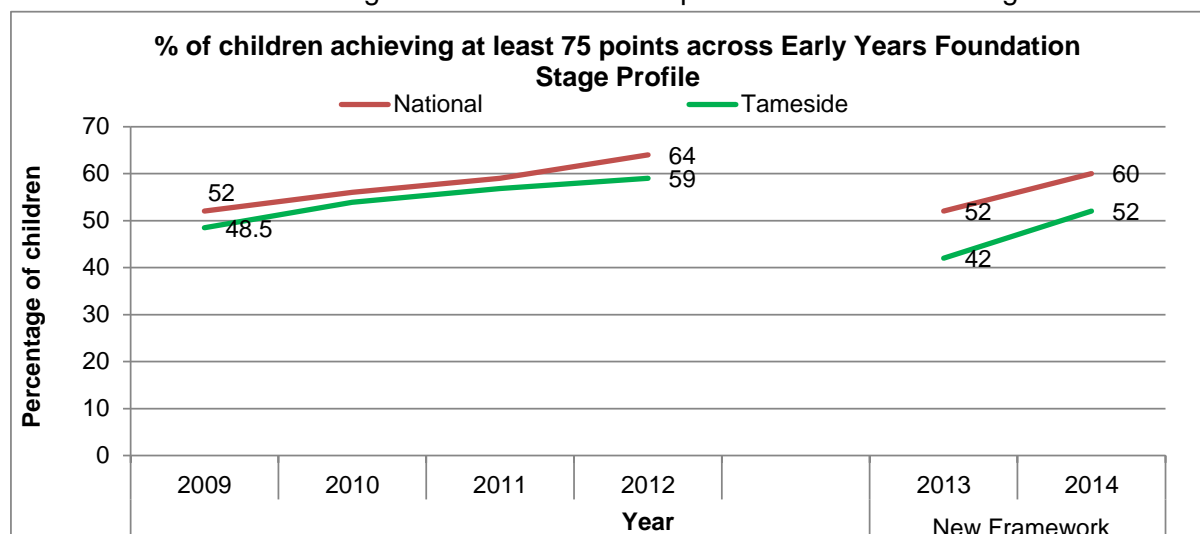
% of children achieving at least 75 points across Early Years Foundation Stage Profile

Source: Department for Education/Tameside MBC, 2014.

The above chart illustrates that the percentage of children in Tameside who achieve at least 75 points across the Early Years foundation stage profile is below the England average, for both the previous framework and the new framework started in 2013.

Policy context:

- **Early Years Foundation Stage Handbook 2014:**
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249995/Early_years_foundation_stage_profile_handbook_2014.pdf

- **PSR Early Years Theme:**
Association of Greater Manchester Authorities

What interventions work?

High quality home visits by trusted professionals, a menu of evidence based interventions for families requesting additional support and evidence based parenting programmes.

What are we doing now?

As part of the Early Years theme of Public Service Reform we are now working with AGMA to roll-out our new Early Years Delivery Model across Tameside.

Our new delivery model consists of:

1. A shared outcomes framework across all local partners;

2. A common assessment pathway across Tameside: eight common assessment points for an integrated ('whole child' and 'whole family') assessment at key points in the crucial developmental window, using expanded existing assessment points, and with the remaining Healthy Child Programme visits to continue as standard;

3. Evidence-based assessment tools to identify families reaching clinically diagnosable thresholds for intervention or having multiple risk factors as early as possible;

4. Needs assessment triggers referral into an appropriate evidence-based targeted intervention;

5. A suite of evidence-based interventions is being developed, to be sequenced alongside other public service interventions as a package of transformational support to families, with appropriate step-down packages of support;

6. Ensuring better use of day-care: new 'contract' with parents eligible for targeted twos day-care to drive engagement in education/employment/training/volunteering, and introducing new common terms and conditions to drive improvement in all day-care settings;

7. A new workforce approach, to drive a shift in culture: enabling frontline professionals to work in a more integrated way in support of the 'whole family' and with other services to collectively reduce dependency and empower parents;

8. Better data systems to ensure the lead professional undertaking each assessment has access to the relevant data to see the whole picture, to reduce duplication and confusion, to track children's progress and in particular support the most vulnerable and disadvantaged;

9. Long-term evaluation to ensure families' needs are being addressed and adds to national evidence for effective early intervention.

What happens next and by whom?

We have been working within two areas in the borough over the last 12 months to adopt this model, and are currently in the process of evaluating the programme locally. Learning from the early adopter sites will be taken forward and used to inform the roll out of the new delivery model across Tameside in Health Visiting and Children's Centre teams over the next year. Alongside this, work is being progressed with our Private Voluntary and Independent sector to extend the offer of day care to our targeted 2 year olds, and to engage them in the new delivery model. Work with schools, and the school improvement team to extend the model into nursery and reception classes is a further area of development.

A comprehensive work force development programme is underway to increase our staff skills and knowledge in delivering a package of evidence based assessment and interventions for children aged 0-5.

Absence from School

Outcomes Framework: Public Health 1.3

Implications for the population's health and well-being:

Poor school attendance impacts on pupil's attainment, future life opportunities and earnings as an adult as well as being an indicator of possible safeguarding concerns.

Absence from school is measured by the percentage of half days missed by pupils due to overall absence, which includes both authorised and unauthorised absence. An alternative measure is the percentage of children who are persistent absentees i.e. they miss more than 15% of school time. The persistent absence percentage is being re calculated to 10% from the beginning of the academic year 2014/2015.

At risk or vulnerable groups:

The statistics also show that children on free school meals (FSM), or those with special educational needs (SEN), were around three times more likely to be persistently absent. The overall absence rates have decreased nationally from 6.0% to 4.4%.

Chart 52: Absence rate for children on free school meals, nationally, 2009/10 to 2013/14
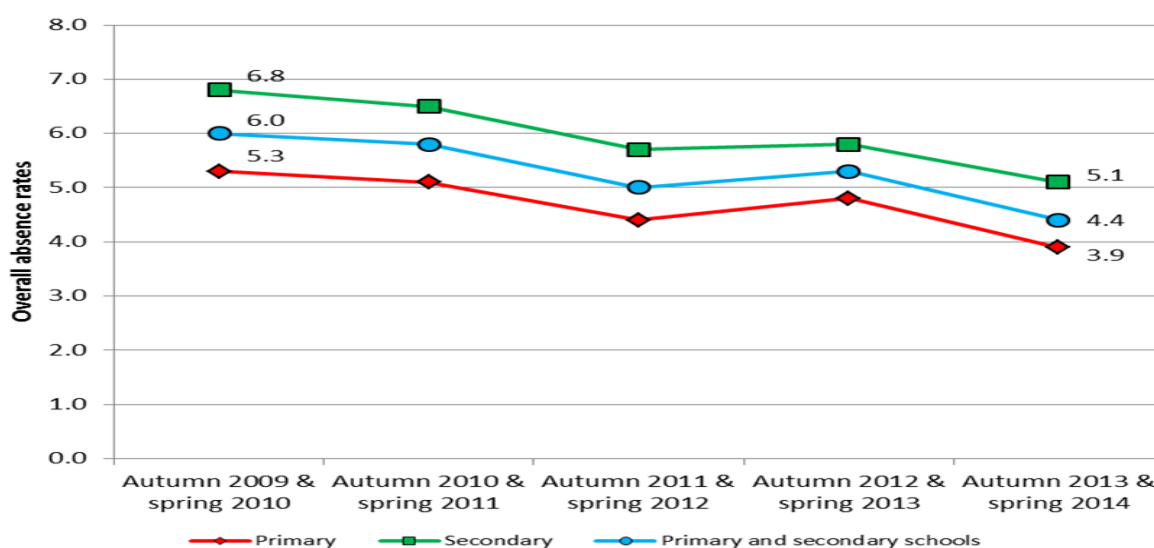
Source: Statistical First Release - Pupil absence in schools in England, including pupil characteristics, May 2014

From the data from the statistical first release May 2014 it shows that Tameside's current overall absence is 3.5 % which compares well with the North West currently 3.7% and with the National figure of 4.4 %.

What interventions work?

Ensuring Children's Right to Education determines that early intervention and use of CAF (Common Assessment Framework) provide an appropriate framework for identifying and resolving attendance issues.

What are we doing now?

- Education Welfare Officers are working with early help teams, schools health and participating in direct work; they raise awareness and contribute to the skill base in other agencies.
- Traded Services are embedded to ensure that schools who wish to enhance their attendance work with additional resources are able to do so.
- Central and Statutory Services are there to ensure that the Local Authority is able to maintain an overview and to identify any schools or areas where additional support is required. The team complete annual register checks
- School Nurses support parents and school to maximise school attendance.

What needs to happen next, and by whom?

- In the context of the changing role of the LA, schools should ensure that their systems for early intervention and action are in place and effective.
- The Attendance Strategy and the Children Missing Strategy are being reviewed to reflect the changing roles and responsibilities of the range of agencies which have an impact on school attendance.
- Education Welfare has developed and delivers training to schools on Strategies to monitor vulnerable group's attendance.
- Early access to data needs to be available in order to identify emerging issues and trend changes which may require remedial action.

16-18 Year Olds Not in Education, Employment or Training (NEETs)

Outcome Framework: Public Health 1.5

Implications for the population's health and well-being:

It is generally accepted that young people in Education, Employment and Training (EET) are less susceptible to poor health, effects of poverty, involvement in crime and negative measures of well-being. Evidence shows that long term NEET membership can cause a life-time 'scar' – with consequential impact on health indicators, lower income earning aspiration and less positive participation in community life.

- The Local Authority commissions the Career Guidance & Support Service (formally Connexions Service) to work with young people from vulnerable groups to promote EET (generally) and address NEET (specifically). Programme spend for 2013 -14 = £450,000
- A European Social Fund (ESF) NEET contract, held by Rathbone UK, directly benefits residents with Tameside postcodes. A proportion of the total spend is dedicated to reducing 16-18 NEET. Programme spend is £930k across 2011-14
- Other programmes (e.g. Early Intervention Foundation Learning, Looked After Children) contribute indirectly to NEET reduction

At risk or vulnerable groups:

- Those young people in areas of high multiple deprivation (Smallshaw Hurst, Hattersley, Denton South, St Peter's)
- Vulnerable groups designated as LLDD (**Learner with Learning Difficulties or Disabilities**), Teenage Parents, Looked After Children and Care Leavers, Special Educational Needs (SEN), Youth Offenders, those with mental health problems.

Benchmarking:

Tameside's Area Agreement uses local residency information as a measure which is felt to be more accurate than the national descriptor. Information is provided by the CCIS (Client Caseload Information System) with quarterly updates and an annual validation. NEET performance tends to be cyclical – for example, higher figures in September, October until the system 'tracks' where post 16 learners are registered.

NEET has been reducing since 2006 (8.6%) to a static 4.6% (as of Q3 2014/15). The current economic situation is directly affecting NEET and deterioration might be expected in the data. Unemployment evidence (Department of Work and Pensions) appears to indicate, however, that the greatest impact is on the 18-24 age group rather than 16-18.

Area	2011	2012	2013
Tameside	2.10	3.60	4.90
North West	5.70	6.60	5.90
Statistical Neighbours	5.86	5.21	6.12
England	9.40	10.80	9.20

Source: www.education.gov.uk

Chart 53: Percentage of NEET population in Tameside from 2009/10 to 2011/12
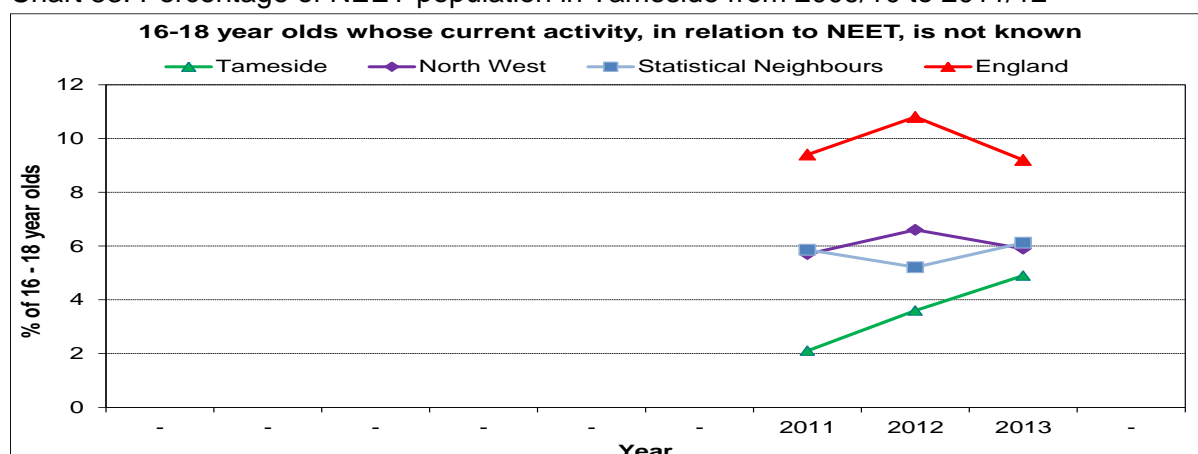
Source: Tameside MBC 2015 & Department of Education 2015

N.B The National Data on the proportion of 16-18 year olds NEET is published annually by Department of Education, but are not directly comparable with LA figures due to differences in definitions used.

The above chart illustrates that the percentage of 16 to 18 year olds who are currently not in education or employment has risen since 2011, in comparison to England where the percentage has reduced.

Policy context:

Positive Participation and Youth Unemployment are high on the national policy and governmental agenda. Various local, regional and national support programmes are available to support NEET reduction: Youth Contract, Youth Commitment, Apprenticeship grants and incentives for employers. The Council's Leader, Chief Executive and senior management are committed to TMBC being instrumental in supporting measures to reduce youth unemployment through increasing apprenticeship opportunities and improved post 16 educational participation. We recognise that working in wider partnership is crucial successful positive outcomes.

What interventions work?

- Increasing apprenticeship opportunities (16-18 apprenticeships in learning currently 20.4% (2011) against a baseline of 13.8% (2008))

- Increasing post 16 education participation (currently 86% (2011) against a baseline of 74% (2005). Overall EET stands at 90% (2011)
- Bespoke programmes for re-engagement in learning, personal development programmes, pre-vocational learning, supported employment for LLDD (**Learner with Learning Difficulties or Disabilities**).
- Bespoke cohort programmes for designated vulnerable groups (e.g. LAC EET (69% (2011) compared to 43% (2009)

What are we doing now?

- Employer engagement in apprenticeship provision - supported work experience, financial incentives, brokerage, awareness raising etc.
- Revised TMBC service unit focus on designated vulnerable groups only (see above)
- Strategic focus on locality based interventions in a holistic context – Family Intervention teams, Local Integrated Service Pilots, Youth and Family teams
- Jobs pledges aimed at supporting young people
- Shaping/influencing GM policy for Apprenticeships and FE restructures that work better for Tameside
- A newly established employment and skills team

What needs to happen next, and by whom?

- Continuation of the above
- Increased focus on Tameside post 16 retention in education
- Increased focus on small and medium employers to engage in apprenticeships in local key sectors
- Direct intervention work with vulnerable groups
- Reduction in teenage pregnancy
- Reduction in alcohol and drug misuse – particularly Alcohol
- Linking / integrating the education/learning and business relationship better so that skills supply meets skills demand now and in the future.

Under 18 conceptions

Outcomes Framework: Public Health 2.4

Implications for the population's health and well-being:

Teenage Parents can be and often are excellent parents, but sometimes young people are not ready to become parents, did not plan to become parents and do not have the systems in place to support them to be good parents

- Around three quarters of teenage pregnancies are unplanned and half end in an abortion.
- 15 per cent of all NEETs are teenage mothers or pregnant teenagers.
- Teenage mothers are a fifth more likely to have no qualifications by the age of 30.
- They are also 22 per cent more likely to be living in poverty at 30.
- The rate of post-natal depression is three times higher among teenage mothers
- Children of teenage mothers have a 63 per cent increased risk of being born into poverty and are more likely to have accidents and behavioural problems.
- The infant mortality rate for babies born to teenage mothers is 60 per cent higher.
- They are three times more likely to smoke throughout their pregnancy and 50 per cent
- less likely to breastfeed.

Young mothers can also experience poor maternal emotional health and well-being and can find it difficult to progress their education or find childcare to enable their participation in education, training or employment. These issues mean that there are increased chances of both teenage parents and their children living in poverty, which contribute to health inequalities and on-going child poverty.

At risk or vulnerable groups:

Young people:

- living in and leaving care
- with low educational attainment
- with poor attendance and a dislike of school
- in contact with the police
- poor emotional health and mental health

Benchmarking:

Tameside's under-18s conception rate has fallen significantly over recent years and halved over a five year period. In 2013 (latest data available)comparatively we have a rate very close to the Greater Manchester average but higher than the national average TMBC are responsible for provision in Glossopdale until 2015 and continue to secure geographical coverage. However, under-18 conception data is restricted to authority boundaries.

Key Points:

- The under 18 conception rate for Tameside fell from 32.7 per 1,000 15-17 year old women in 2012 to 29.1 per 1,000 in 2013
- Over a three year period 2011-2013 we have collectively achieved a 16.1 rate reduction.

Table 9: Under 18 conception rates, 2013

Under 18 conceptions (rate/1,000 population)	2011	2012	2013	Rate change 2011-2013
ENGLAND	**30.7**	**27.7**	**24.3**	**-6.4**
NW	**35.3**	**31.6**	**27.6**	**-7.7**
Nearest statistical neighbours (mean)	**37.5**	**33.7**	**32.9**	**-4.6**
GM	**37.8**	**33.3**	**28.2**	**-9.6**
Bolton	39.6	30.3	27.7	**-11.9**
Bury	32.9	32.6	26.7	**-6.2**
Manchester	52.5	45.0	36.5	**-16**
Oldham	36.5	33.1	30.6	**-5.9**
Rochdale	31.7	35.0	26.1	**-5.6**
Salford	41.9	37.9	30.4	**-11.5**
Stockport	28.4	26.8	25.9	**-2.5**
Tameside	45.2	32.7	29.1	**-16.1**
Trafford	24.2	20.2	15.6	**-8.6**
Wigan	34.7	32.0	27.1	**-7.6**

Source: Chimat, 2015

Policy context:

The Department of Health produced "A Framework for Sexual Health Improvement for England" in March 2013 adding to the national teenage pregnancy strategy update in 2010 'Teenage Pregnancy Strategy: Beyond 2010'. The Local Government Association clarified the emerging roles of the local authority in 'Tackling teenage pregnancy Local government's new public health role'

The local 2011-13 Sexual Health Strategy includes reducing teenage conceptions as one of the key areas for attention. A strategy refresh will be written during 2014.

The public health outcomes framework provides us with a challenge to: Reduce under-18 conceptions

What interventions work?

The 2010 national strategy update recommends two factors for which the evidence of impact on teenage pregnancy rate reductions is strongest:

- The delivery of comprehensive Sex and Relationship Education (SRE) programmes which can be effective in delaying initiation of sex as well as increasing condom and/or contraception use.
- The provision of accessible, young people-centred contraceptive and sexual health (CaSH) services to enable increased access and use of contraception.

What are we doing now?

- Week day drop in provision at centrally located sexual health services.
- YOUthink is a prevention service provided by TMBC. The team consists of Family Planning Agency (FPA) trained youth workers that deliver brief interventions, sexual health awareness and prevention sessions and promote local services. This includes offering all schools sexual health workshops for year 10 pupils and targeted support for vulnerable or high risk young people.
- YOUthink also train frontline staff that work with children and young to have the skills and feel confident to discuss sex, relationships and sexual health with young people, and promote local sexual health services.
- An interagency pathway for teenagers who are pregnant.
- We have added a youth *Have Your Say performance indicator to our main service to ensure young people get to feed in to the service about their experiences.*
- Sexual health Advice For Everyone (SAFE) promotion campaign is being delivered to raise awareness of sexual health information and local services.
- Young women that have undergone a pregnancy termination are given targeted support and contraception advice to help them avoid the need for additional terminations in the future.
- We have a better offer of LARC in general practice.
- We are consulting young people about condom access.
- We have doubled the access to FREE emergency hormone contraception in pharmacy in 2013
- The sexual health service has rebranded www.theorangerooms.co.uk

What needs to happen next?

- Senior leadership & champions as a commissioning organisation.
- Senior leadership & champions from clinicians

- A better understanding of the SRE offer to pupils and partnership support to schools.
- Focus on those most vulnerable & come out of the clinic to reach those most vulnerable.
- Consult with young people
- Extend the contraception offer to young people
- Challenge ourselves – What are we doing to help raise aspirations?

Teenage Mothers

Outcomes Framework: Public Health

Implications for the population's health and well-being:

During 2013 there were **163** births to women under the age of 20 in Tameside; about 60 of those births were amongst young women who conceived between the ages of 15-17.

The majority of young people, who become young parents cope, they become good parents and go on to provide for their children as best they can.

Being a young parent can be very challenging, parents are much low likely to be living below the poverty threshold, more likely to have left education early and be living in difficult circumstances.

Chart 54:Under 18 Maternity Rates, per 1,000, Tameside,(& comparators) 2009 to 2013
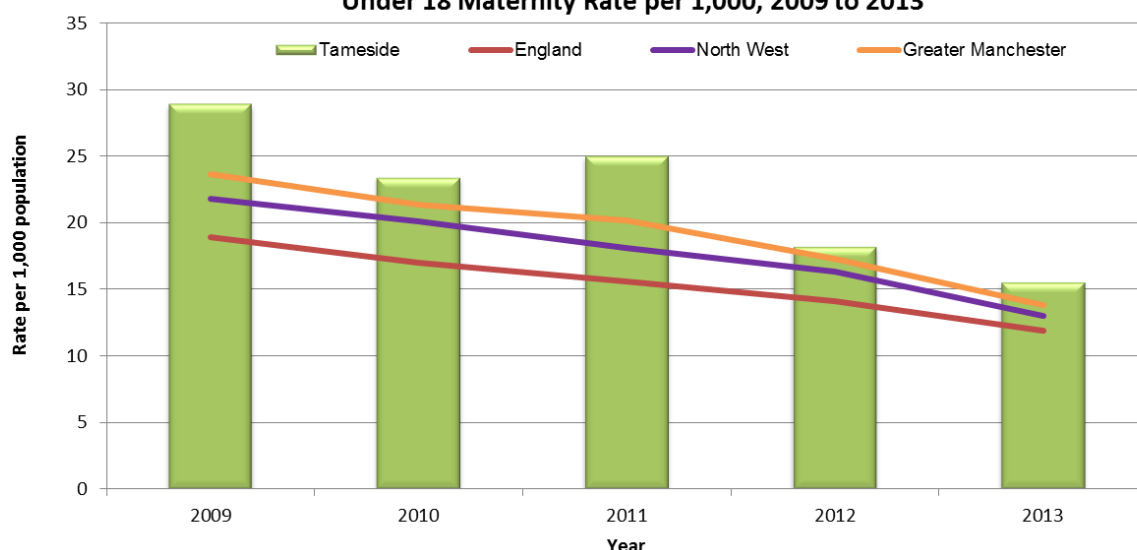
Source: HSCIC, 2015

Teenage parent comparison figures across Greater Manchester conurbation are unavailable at this time. Births data amongst 15-17 years old is available and as of 2012 and 2013 we are similar to the GM average but we have more births in young women than the national average.

Factors which impact on teenage parents

- *63% higher risk for children to be born in poverty amongst women under 20.[9]*

- Rates of adolescents not in education, employment or training (NEET) *21% of the estimated number of female NEETs aged 16-18 are teenage mothers. [10]*

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[9] *1. Child poverty:* Mayhew E and Bradshaw J 'Mothers, babies and the risks of poverty', Poverty, 121 (2005). Consultation on Child Poverty Strategy 2014-17 HM Government. (2014).

- *41% higher risk of infant mortality for babies born to women under 20.* [11]

- *25% higher risk for babies born to women under 20.* [12]

- *Mothers under 20 are twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout pregnancy.* [13]

- *Mothers under 20 are third less likely to initiate breastfeeding and half as likely to be breastfeeding at 6-8 weeks.* [14]

- Mothers under 20 suffer from poorer mental health in the three years after birth compared with older mothers - with a 30% higher level of mental illness two years after the birth [15]

Key Points: What are we doing now?

1. Smoking cessation
   It is important that teenage parents consider the impact of smoking on both their own health and that of their children's. We aim to ensure that our smoking cessation service is accessible to teenage parents.

2. Children's centres
   Children's centres throughout Tameside offer a wide range of support.
   www.tameside.gov.uk/surestart/contactdetails

3. Midwifery
   Specialist midwife support is available to teenage mums in Tameside.

4. FNP
   Tameside's Family Nurse Partnership is now available in Tameside, offering a wide range of support to young parents up to the age of 19   http://fnp.nhs.uk/young-mums

5. Parenting
   Tameside offer a range of Parenting support opportunities including a weekly support group for young parents www.tameside-sid.org.uk/listing-details.asp

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[10] *NEET*: National Client Caseload Information System (NCCIS), DfE 2013. NB: These data were collected by local authorities. Although national guidance is provided, accuracy can be affected by issues such as local arrangements for information sharing.

[11] I*nfant mortality rate*: Childhood, Infant and Perinatal Mortality in England and Wales, 2012. ONS, February 2014.

[12] *Low birth weight:* Botting B, Rosato M and Wood R (1998) Teenage mothers and the health of their children. Population Trends 93)

[13] *Maternal smoking prevalence:* Infant Feeding Survey, 2010.

[14] *Breastfeeding initiation and prevalence at 6-8 weeks:* Infant Feeding Survey, 2010

[15] *Mental health.* Long-term consequences of teenage births for parents and their children. Teenage Pregnancy Research Programme briefing. Teenage Pregnancy Unit, Department of Health. 2004.

What interventions work?

- For many pregnant young women/young mothers, disengagement from education occurred prior to pregnancy. Difficulty with work, bullying from pupils and staff, and a sense of failure often led attendance being poor.
- Improved attendance and engagement with education can follow pregnancy, especially if offered appropriate non-judgmental support.
- Different forms of educational provisions during and following pregnancy is influenced by a range of factors including; the young woman's health, her previous educational experiences, her relationships with peers, the setting's ability and willingness to accommodate her changing needs and recognise her new status a mother.
- Young women with positive school experience and regular attenders, with good academic achievements pre-pregnancy, were more likely to be met by a supportive attitude by their schools.
- Young women who had been poor attendees or excluded prior to pregnancy benefited from attending specialist units and education other than school provisions.
- Specialist provision is most likely to lead young women to continue with her education post 16, and improved attendance during and after pregnancy.
- The features of specialist units which were cited as of particular importance include: the onsite childcare facilities; work, practical and emotional support; the locations are often set up to deal with post- birth issues: and to where staff were respectful.
- A lack of affordable and accessible childcare is a barrier to continuing education and young parents want their babies to be near at hand, especially if breast-feeding.
- Care to Learn funds childcare for school age mothers, although the cost and travel often mean additional barriers to cost exist, see Care to Learn https://www.gov.uk/care-to-learn
- The impact of raising the Participation age (RPA) legislation on pregnant pupils/ teenage parents is an area for continued consideration. https://www.gov.uk/government/collections/raising-the-participation-age
- Young fathers in compulsory education are invisible and paternity leave rights are not guaranteed http://www.youngfathers.info/engaging/schoolage_question.htm

Policy context:

The Department of Health produced "A Framework for Sexual Health Improvement for England" in March 2013 adding to the national teenage pregnancy strategy update in 2010 'Teenage Pregnancy Strategy: Beyond 2010'.

The Local Government Association clarified the emerging roles of the local authority in 'Tackling teenage pregnancy Local government's new public health role'

The local 2015-17 Sexual Health Strategy includes reducing teenage conceptions as one of the key areas for attention.

Chlamydia diagnoses (15-24 year olds)

Outcomes Framework: Public Health 3.2

Implications for the population's health and well-being:

Chlamydia is a bacterial infection and is the most common Sexually Transmitted Infection (STI) in the UK. Chlamydia infection is normally easily treated with antibiotics; non-treatment of the infection can lead to infertility, as well as pelvic inflammatory disease (PID) and ectopic pregnancy in women, and epididymitis in men.

Locally, the NHS spends around £160,000 each year on delivering the National Chlamydia Screening Programme (NCSP), which specifically targets young people under 25 years. Residents can be screening in GP practices, Genitourinary Medicine (GUM) clinics, Community Contraception, Sexual Health (CaSH) services and other non-clinical youth settings.

At risk or vulnerable groups:

Chlamydia is most common in sexually active young people under the age of 25 years, although people of any age may acquire chlamydia infection if they are sexually active and not practising safer sex. Locally we must ensure that we are tailoring the Chlamydia screening offer to young people who face additional challenges and access barriers into services. Young people who are in looked after circumstances, not in employment or education, within the criminal justice system or facing other challenges need extra focus.

Benchmarking:

The PHO indicator requires that we aim to achieve a Chlamydia Diagnosis rate of 2,300 per 100,000 (15-25 year olds) which means that we need to find approximately 800 young people who have acquired the infection during 2014. In 2013 Tameside and Glossop was one of four Greater Manchester localities to achieve reaching the indicator.

A new diagnosis based target is being introduced for 2012/13: 2,400 to 3,000 diagnoses per 100,000 young people aged 15-24 years. Applying 2011/12 data to this new target, gives a local rate of 3,150, which again is the highest in Greater Manchester. Whilst this indicates good access to screening opportunities, it also indicates that there are high levels of chlamydia infection amongst local young people.

Chart 55: Reduced Late Diagnosis, Chlamydia, Local Authority,

Reduced Late Diagnosis, Chlamydia, Local Authority, 2012
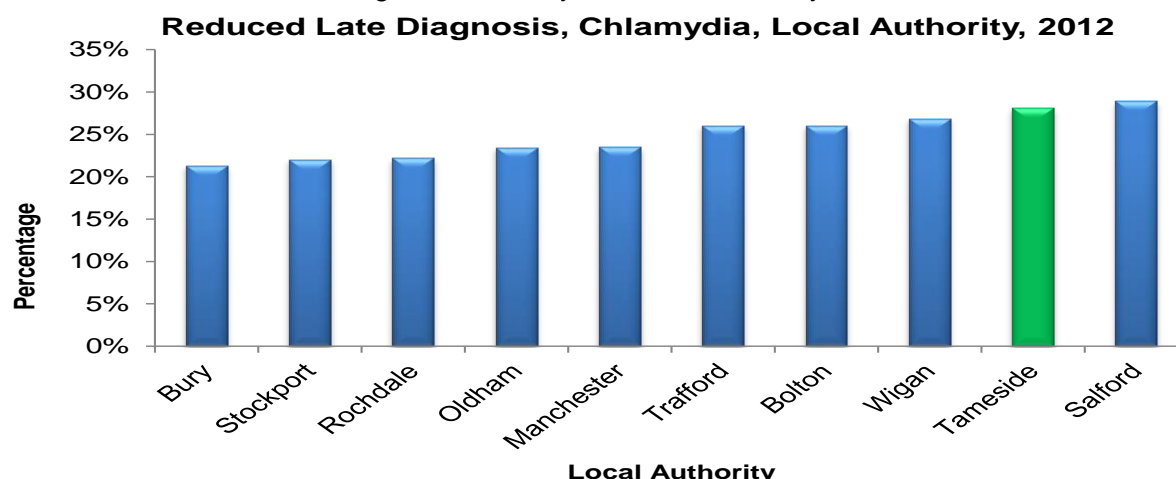
Source: January-December 2012 CTAD ctadlink, 2015

Table 10: Chlamydia screening coverage

Total Chlamydia Testing Data			15-24 Year Old Population Estimates (n)
Percent of population tested	Percent of tests positive	Diagnosis rate per 100,000	
28.1%	8.8%	2,474	27,733

Policy context:

The Department of Health produced "A Framework for Sexual Health Improvement for England" in March 2013. The local 2011-13 Sexual Health Strategy includes reducing teenage conceptions as one of the key areas for attention. A strategy refresh will be written during 2014.

The public health outcomes framework provides us with a challenge to: Diagnose 2,300 cases per 100,000 (age15-25)

The local 2011-13 Sexual Health Strategy includes the Chlamydia diagnosis indicator. A strategy refresh will be written during 2014.

What interventions work?

Screening should be embedded in the normal healthcare that young people receive when accessing health services, e.g. GPs, pharmacies, CaSH and Termination of Pregnancy (TOP) services. The opportunistic screening of young people, who are sexually active. Outreaching to marginalised groups and taking opportunities to screen e.g. repeat oral contraception review.

What are we doing now?

- We commission: triage, postal and the training offer collaboratively across GM via RUClear www.ruclear.co.uk
- YOUthink is a sexual health outreach team jointly commissioned by the local authority and NHS, which delivers sexual health workshops in schools and colleges and delivers more targeted work with vulnerable young people. YOUthink promote, and carry out, screening.
- The Lesbian and Gay Foundation promote Tameside and Glossop sexual health services so local young people know where to access quality services.
- The Tameside Pregnancy Advisory Service (TPAS) based at Tameside General Hospital only performs TOP treatment if chlamydia screening has been carried out.
- A SAFE (Sexual health Advice for Everyone) delivers new campaigns each year *CHLAMYDIA_2013*.
- A GP lead will be championing sexual health within primary care.

What needs to happen next, and by whom?

- The payment system for screening in primary care needs to be reviewed.
- We need to support colleagues who work with marginalised young people to offer the screen e.g. probation.
- NHS Clinical Commissioning Groups (CCGs), local authority and Public Health need to ensure that all young people receive quality information, advice and support about good sexual health.
- To ensure high diagnosis rates, frontline practitioners need to effectively promote and target screening to vulnerable and at risk groups.

Hospital admissions caused by unintentional and deliberate injuries to children aged 0-14 years, 0-4 years and 15-24 years.

Outcomes framework: Public Health 2.7i, 2.ii

Implications for the population's health and well-being

Injuries are a leading cause of hospitalisation, death, disability and ill health among children. The World Health Organisation (WHO) predicts that by 2020, injury will be the biggest single cause for loss of healthy human life years. The NHS spends around £131 million a year on emergency hospital admissions due to injuries among children.

This a 'Stay Safe' indicator defined as 'The number of finished in-year emergency admissions of children and young people to hospital as a result of unintentional and deliberate injury per 10,000 children and young people.

Childhood Injuries are the cause of 20% of all child deaths in UK. From the local child death overview panel report 2013/14, 34% of all child deaths were in the age group 5 to 17 years with 12% of these deaths due to trauma and 12% due to medical or surgical emergencies.

The most common cause of hospital episodes for childhood unintentional injury (ages 0-14) is falls, accounting for around 45% of episodes

By contrast, the most common cause of death from an unintentional injury among those aged 0-14 years is from a road traffic accident. [16]

In a study of childhood deaths from injury in England and Wales, the rate of death for children of parents classified as never having worked or as long-term employed were compared with those classified as higher managerial or professional occupations. Rates were: 20.6 times higher for pedestrian deaths; 27.5 times higher for cyclist deaths; 37.7 times higher for fire-related deaths; and 32.6 times higher for deaths of undetermined assault.

Benchmarking:

Different data sources use different age brackets when presenting data (Public Health Outcomes Framework use 0-4, 0-14 and 15-24, the Health and Social Care information centre use <5, 5-14 and 15-64). The most useful age brackets and data sources, to tell the Tameside story have been selected for presentation here.

More children in Tameside are admitted to hospital because of unintentional and deliberate injuries than in England or Greater Manchester. This is true across all the age ranges, but the difference is wider in the 0-4 age group. Falls are the greatest cause of hospital admission in all age groups and genders, apart from in 15-19 year old female group where deliberate self-harm is the single greatest cause of admission. Burns and accidental

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[16] Childhood Injuries. A review of Evidence for Prevention, (2010) S Wood, M.A Bellis, E Towner, A Higgins

poisonings are a feature of admissions in the younger age group. This is in line with national trends, and has been identified in NICE guidance.

Chart 56: Top 5 Injury Admissions by Gender in 0-4 year olds (2011-12 to 2013-14)
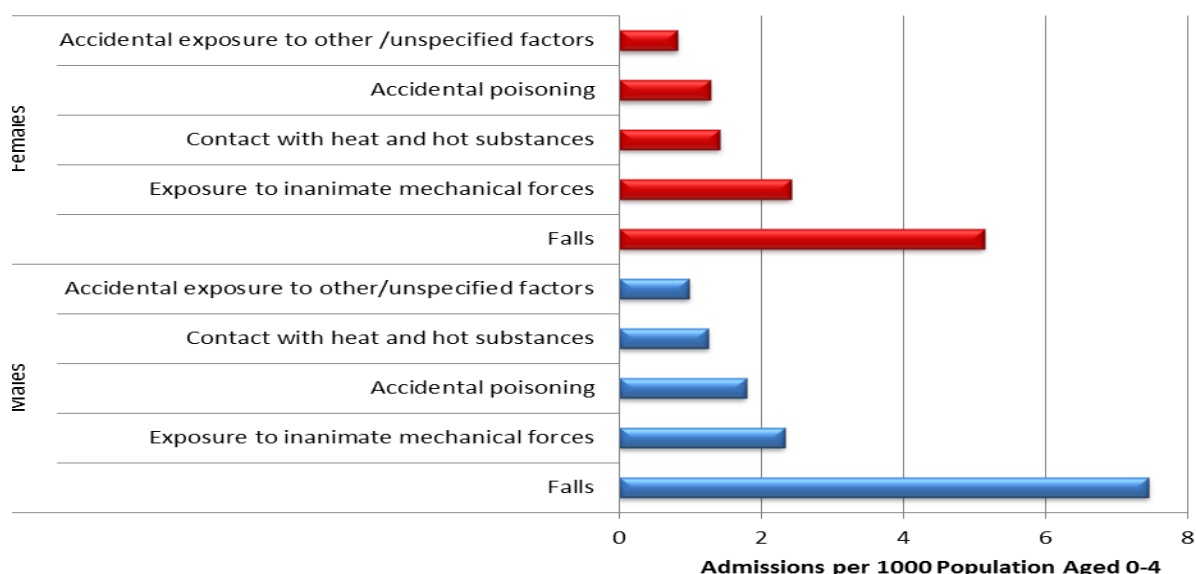
Source: Secondary User Statistics (SUS)-HSCIC

The chart above illustrates that for 0-4 year olds Falls are the most significant childhood injury for this age group. The chart below illustrates that for children aged 5 – 9 years again falls are the most significant childhood injury.

Chart 57: Top 5 Injury Admissions by Gender in 5-9 year olds (2011-12 to 2013-14)
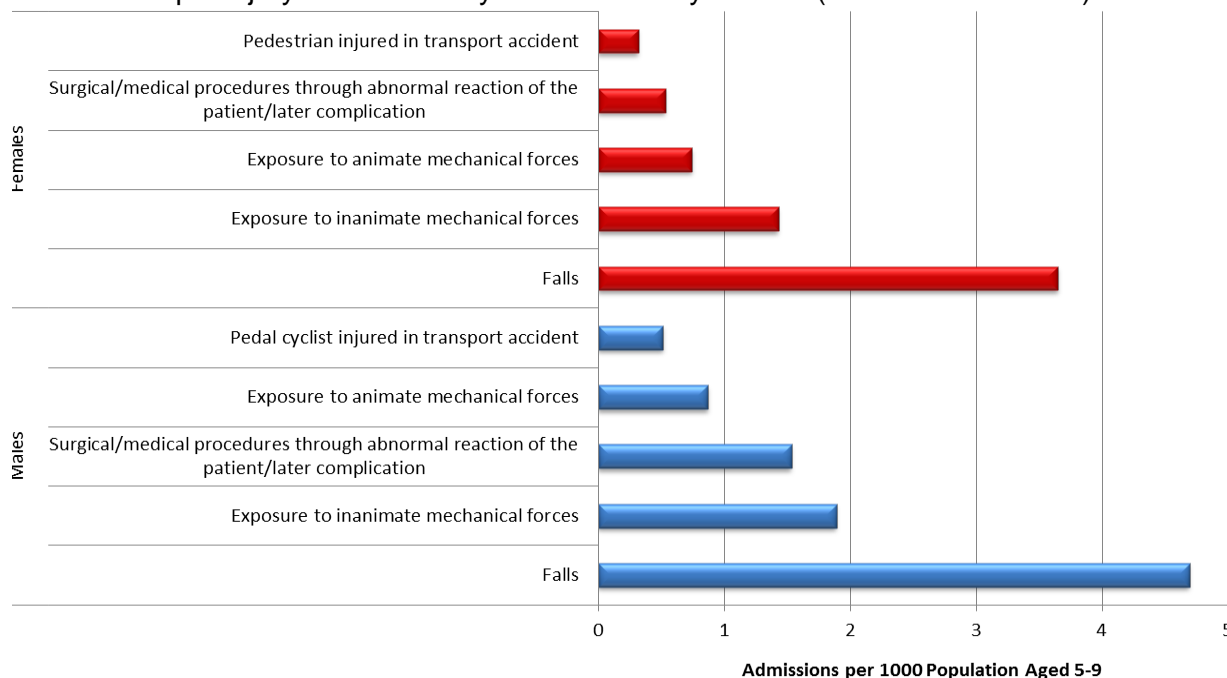
Source: Secondary User Statistics (SUS)-HSCIC

Chart 58: Top 5 Injury Admissions by Gender in 10-14year olds (2011-12 to 2013-14)

Females

Category	
Drugs, medicaments and biological substances causing adverse effects in therapeutic use	
Exposure to animate mechanical forces	
Exposure to inanimate mechanical forces	
Falls	
Intentional self-harm	

Males

Category	
Exposure to animate mechanical forces	
Surgical/medical procedures through abnormal reaction of the patient/later complication	
Exposure to inanimate mechanical forces	
Pedal cyclist injured in transport accident	
Falls	

Admissions per 1000 Population Aged 10-14

Source: Secondary User Statistics (SUS)-HSCIC

The chart above illustrates that for females aged 10-14 years, hospital admissions for self-harm are highest followed closely by falls. For males in this age category falls are the most significant childhood injury. The chart below illustrates that again for females self-harm is the most significant hospital admission and for males falls are highest.

Chart 59: Top 5 Injury Admissions by Gender in 15-19 year olds (2011-12 to 2013-14

Females

Category	
Assault	
Surgical/medical procedures through abnormal reaction of…	
Exposure to inanimate mechanical forces	
Falls	
Intentional self-harm	

Males

Category	
Surgical/medical procedures through abnormal reaction of…	
Intentional self-harm	
Assault	
Exposure to inanimate mechanical forces	
Falls	

Admissions per 1000 Population Aged 15-19
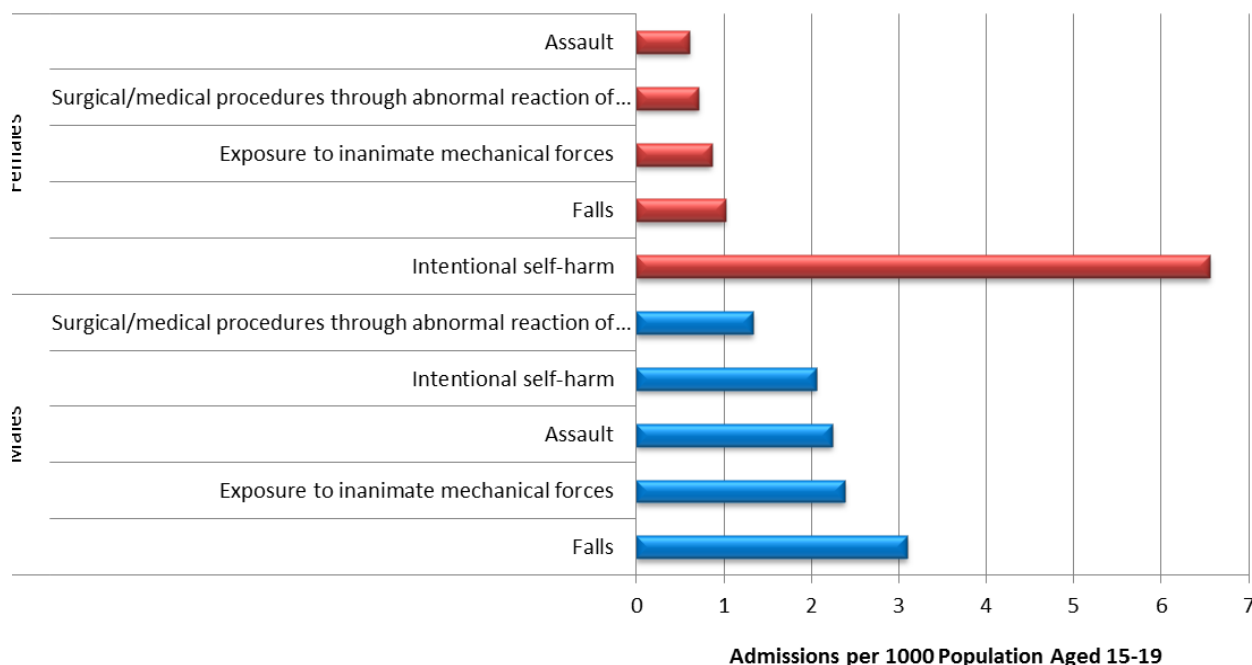
Source: Secondary User Statistics (SUS)-HSCIC

At risk or vulnerable groups:

The burden of injury on children is unequal. Children in poorer communities and those from poorer families in better-off areas are the most vulnerable. More than 95% of all child injury deaths occur in low-income and middle-income communities. Although the child injury death rate is much lower in high-income areas, injuries still account for about 40% of all child deaths in these communities.[17]

In all age groups, up to the age of 15, more boys are admitted to hospital following deliberate and unintentional injury than girls. The majority of admissions take place following falls, with deliberate self-harm taking over from falls in the 10-14 and 15-19 female categories as the leading cause of admission.

Chart 51: Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 resident population
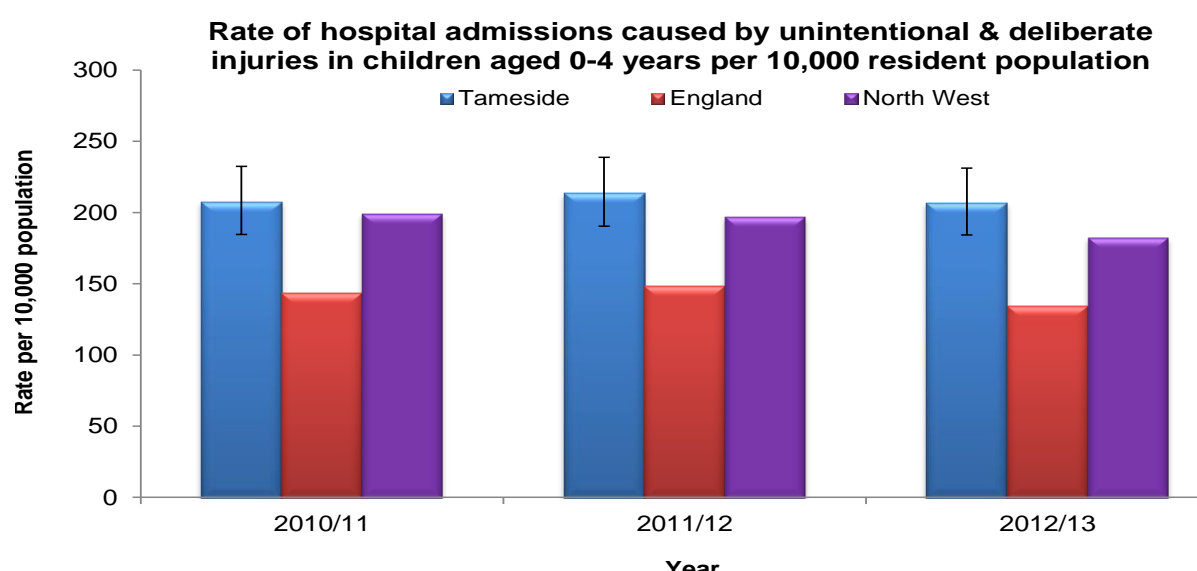
Source: Public Health England: Knowledge and Intelligence Team (South West), 2015

The charts above and below illustrate that Tameside have higher admission rates for unintentional and deliberate injury than both the England and North West averages.

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[17] http://www.who.int/ceh/capacity/injuries.pdf

Chart 61: Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years per 10,000 resident population
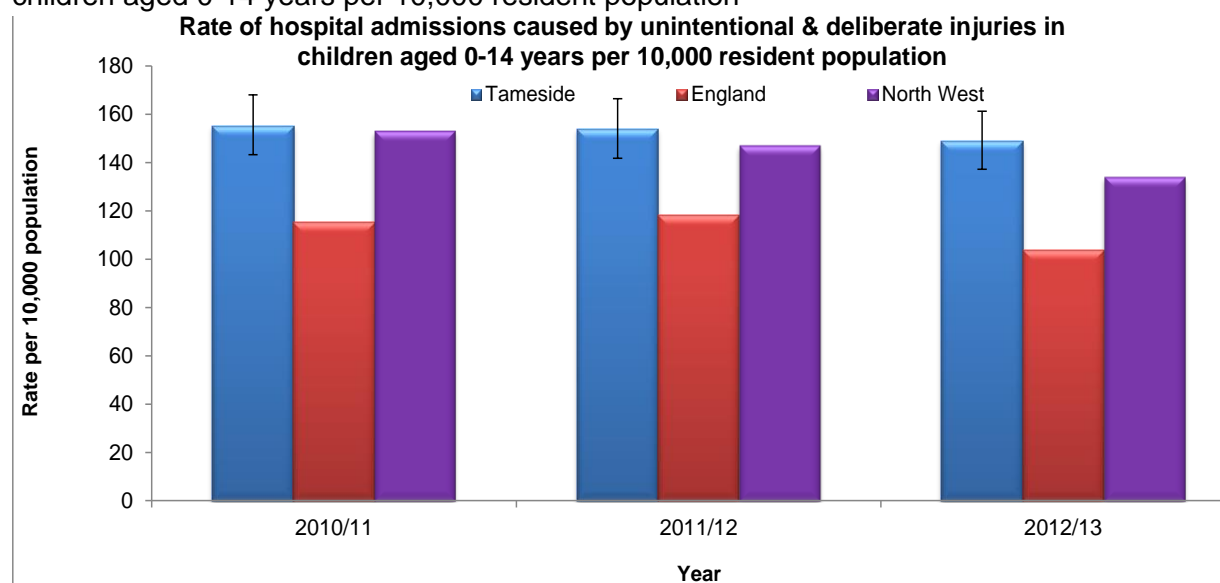
Source: Public Health England: Knowledge and Intelligence Team (South West), 2015

Chart 62: Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 15-24 years per 10,000 resident population
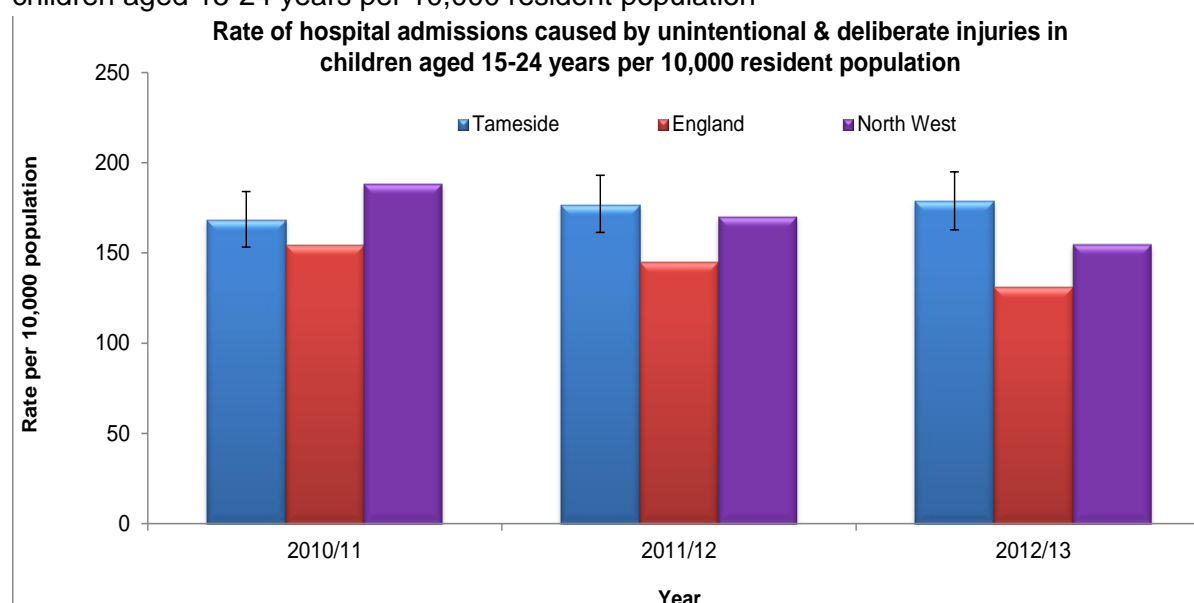
Source: Public Health England: Knowledge and Intelligence Team (South West), 2015

The chart above illustrates that for the age group 15-24 years, Tameside's admission rate as increased since 2010 giving Tameside a significantly higher admission rate than both the England and North West average in 2012/13.

Policy context:

NICE guidance, published in 2010 looks at three separate areas for injury minimisation:

- [General strategies to prevent unintentional injuries among under 15s](#)
- [Home safety assessments & provision of home safety equipment](#)
- [Road design-making routes safer](#)

It has been recognised that there appears to be a high number of hospital admissions of children and young people to Tameside Hospital. The available data has been reviewed, and work is on-going to unpick the coding issues identified. This is being supported by the Greater Manchester Public Health Network. Data quality issues have been recognised at a Greater Manchester level

What interventions work?

The published national guidance (see above) gives recommendations across five key areas:

General measures-planning & co-ordination:

- Local plans should commit to preventing injuries among under-15s, focusing on those most at risk
- Trained child and young person injury prevention coordinator in each locality
- Provide the wider childcare workforce with access to injury prevention training

Home safety:

- Identify and prioritise households most at risk and offer home assessments
- Ensure the assessment, supply and installation of equipment is tailored to need and includes the provision of information and advice
- Provide practitioners who visit children and young people at home with mechanisms for sharing information

Outdoor play:

- Ensure a prevention policy is in place which balances fun, physical activity and learning
- Encourage cycle training and promote use of cycle helmets
- Conduct local injury prevention campaigns for all events where fireworks may be used

Road safety:

- Partnerships: Maintain road safety partnerships to help plan, coordinate and manage road safety activities

Speed reduction:
- Engineering measures to reduce speed in streets primarily residential or where pedestrian and cyclist movements are high
- Introduction of [20 mph zones](#)

What are we doing now?

The Council has commissioned Greater Manchester Fire and Rescue (GMFRS) in partnership with Health Visitors and Children Centres to pilot an equipment scheme in Denton South, Stalybridge North, Ashton St Michaels and Ashton St Peters (areas known to have high A&E attendance amongst the 0-5yr olds). GMFRS will install equipment including stair gates, door stoppers and hair straightener covers, with flexibility to meet other safety needs, as well as providing home safety advice to parents of children under 5. This work will be evaluated, and if it is deemed successful rolled out to the rest of Tameside.

Funding from ROSPA has allowed a Task and Finish Group to create Home Safety Bags – 10 in each of the 7 main children centres (aimed at parents with children under 5) to provide advice, tips and education around preventing) injuries that occur in the home setting. These bags include – activities for child, educational booklet, pull out poster and an evaluation form. 40 front line workers have received Child Home Safety Training by ROSPA.

Childhood accident prevention requires a collaborative approach to make a difference. We are working together with the CCG and partners at a greater Manchester level to improve data quality. The current data means it is not possible to tell if we have a higher number of accidents that our statistical neighbours or an over reliance on A and E and a corresponding lower threshold for admission.

Once quality data is available, and needs assessment will be developed with key stakeholders to inform an injury prevention strategy for Tameside.

The 20 is plenty, road speed awareness campaign continues. .

What needs to happen next and by whom?

- Needs Assessment for the 0-18 population, with individual focus on appropriate age groups that best represent the different ages and stages of our population and the different injuries that affect them

- Agreement of a two year action plan, and engagement with stakeholders.

- Continued development of a GM level approach to childhood injury reduction, and improvement of data.

- Continued work with Tameside Hospital and the CCG to improve local data.

- Continued training for front line staff to improve information and support given to parents and families of children in Tameside.

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s and emergency admissions for children with lower respiratory tract infections

Outcomes frameworks:
- NHS 2.3ii: Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s
  NHS Operating Framework PHQ16: Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s
- NHS 3.2: Emergency admissions for children with lower respiratory tract infections

Implication for the population's health and well-being:

Having long term conditions such asthma, diabetes and epilepsy as a young person can have a far reaching impact on a young person's well-being throughout adolescence and into adulthood. These include increased rates of depression, increased dependence on parents, poor vocational education, lower employment rates and negative self-image. The care and support young people receive can influence the prevalence and impact of the health outcomes. Health care providers play important roles in the lives of young people with chronic illnesses.

For children and young people with chronic health conditions, the aim of their treatment and care is to manage their illness in such a way that they are able to achieve their full potential. In order for this to be achieved, children, young people and their families should have access to services that help them to develop the self-confidence and self-management skills, needed to deal with the impact of their condition upon themselves, their family or carers.

Current models of health service delivery are unlikely to cope with future demand. Inadequate and fragmented services for chronic illness contribute to unnecessary and costly hospital admissions and inconvenience for patients.

Note: The true prevalence of asthma admissions is difficult to determine due to the lack of a single objective diagnostic test and different methods of classification of the condition.

At risk or vulnerable groups:

There is a significant relationship between deprivation and child emergency hospital admissions for both asthma and epilepsy across England: as deprivation increases, admission rates increase. However, there is no such relationship between deprivation and child emergency hospital admissions for diabetes.

Benchmarking:

Benchmarked information is available on all three conditions as detailed in the following charts.

Chart 63: Rate of emergency hospital admissions for asthma, diabetes and epilepsy (<19 years) per 100,000 population 2013/14.
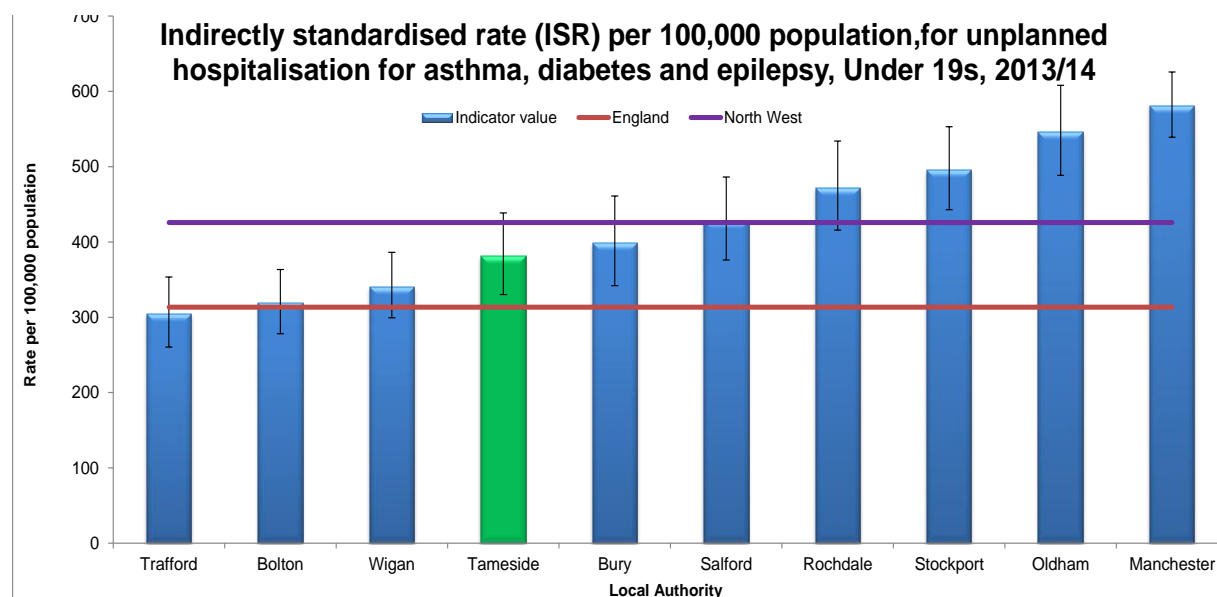
Source: Health and Social Care Information Centre, (HSCIC), 2015

Chart 64: Rate of emergency hospital admissions lower respiratory conditions (<16 years) per 100,000 population 2013/14.
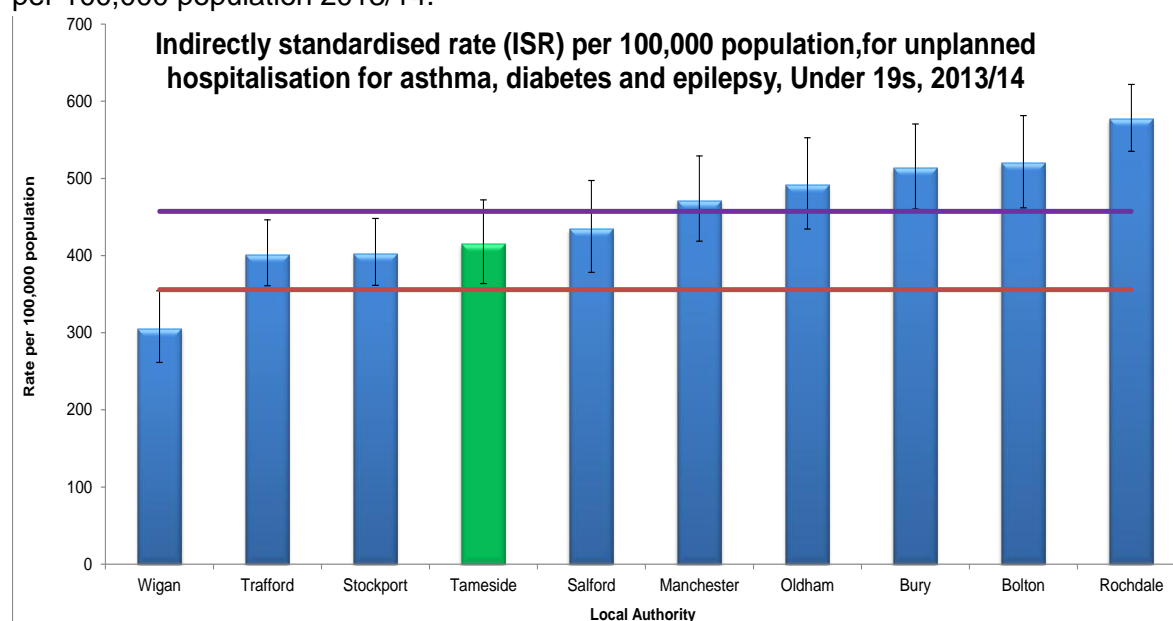
Source: Health and Social Care Information Centre, (HSCIC), 2015

Policy context:

- [NICE Guidance - TA 133 Asthma Uncontrolled](#)
- [NICE Guidance – IPG419 Bronchial theromoplasty for severe asthma](#)
- [NICE Pathway - Epilepsy](#)

- NICE Guidance – The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care
- NICE Guidance – Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults
- NICE Guidance CG69 - Prescribing of antibiotics for self-limiting respiratory tract infections in adults and children

What interventions work?

- Public health interventions that may mitigate disease progression including reducing tobacco use, alcohol consumption, and illicit drug use, obesity, increasing physical activity.
- Prevention, early identification and management of risk factors, including high cholesterol and blood pressure, diabetes and chronic kidney disease.
- Better management of the condition in the community could reduce the number of emergency admissions for asthma.

What are we doing now?

The roles and responsibilities for proactively managing long term conditions lie within primary care and community health services, supported by paediatrics. Evidence based pathways need to be developed locally to ensure that all services are equipped to play their part.

Asthma: The NHS Clinical Commissioning Group (CCG) has prioritised action on asthma. The following plan is underway:
- Full data analysis of activity over last five years
- Repeat admissions identified and case notes scrutinised
- Local pathway developed to cover primary and secondary care and the community, notably in schools.
- Clinical guidance developed as required

Diabetes: The CCG is working with providers to ensure that the paediatric diabetes standards are met and from this developing a service specification for the Paediatric Diabetes Service in line with the forthcoming Best Practice Tariff.

We have higher emergency admissions for chronic ambulatory care sensitive conditions, where unplanned hospitalization could be avoided than both the England and Cluster average.

We will continue to reduce admissions both for adults and children through more proactive diagnosis and management across primary and community care. We have trained School Nurses in Asthma and are empowering carers and nurses to feel confident in recognising and managing common Adverse Drug Reactions (ADRs).

In particular we are developing our urgent and ambulatory care system and focussing the Epilepsy Nurse Specialist on home and school assessment and support.

We are developing Diabetes and Epilepsy services for patients who are moving out of childhood into adulthood and THFT are extending the paediatric service to young people up to their 19th birthday. We are also currently reviewing Transition policy, training and competencies of school staff, with increased links with school nurses and undertaking a review of NICE guidance and development of system to ensure effective implementation of pumps.

What needs to happen next and by whom?

Plans for 15-16 to deliver on improvement include the review of urgent care as part of the Care Together programme. New models of care will be developed for children and young people via the proactive prevention, urgent care, and women & children Care Design Groups.

First-time entrance to the youth justice system

Outcomes framework: Public Health 1.4

Indicator Name: First time entrants to youth justice system

Implications for the population's health and well-being:

Children in, or close to, the Youth Justice System have far more unmet health needs than other children of their age and face a range of other difficulties including school exclusion, substance misuse, speech and language difficulties, fragmented family relationships and unstable living conditions. In addition, organisational and attitude problems can be barriers to progress.

An offence is defined as a first offence if it results in the offender receiving their first Youth Caution, Youth Conditional Caution or conviction i.e. they have no previous criminal history recorded on the Police National Computer (PNC). Offences resulting in further Cautions or convictions are known as further offences since the offender already has a recorded criminal history.

At risk or vulnerable groups:

Research shows that there are a number of characteristics that are more frequently and regularly present in the offending population than the general population. These include social deprivation, poor housing, substance use, peers who offend, problems with school (exclusions and poor attendance), parental conflict, lack of parental boundaries, experience of neglect, emotional, physical or sexual abuse, and parents with mental health issues and / or substance use issues.

Young people entering the youth justice system for the first time will often have some of the aforementioned characteristics present in their lives and may have low aspirations, lacking in their own self-belief and unable to picture a positive future.

Benchmarking:

Table 11: Number of first time entrants by area, 2009 to 2014

	2009	**2010**	**2011**	**2012**	**2013**	**2014**
Local	215	179	168	131	92	108
Regional	9180	7027	5269	4059	3046	2636
National	67898	48916	38668	38019	22996	20461

Source: Youth Justice Board Quarterly Review for Tameside

As the figures show, there continues to be a decline in the numbers of young people entering the youth justice system and this is evident across the country. The last period (October 2013 – September 2014) saw a slight rise locally in the numbers of young people entering the system but it is not anticipated that this is the start of an upward trend.

Policy Context:

Troubled Families agenda and the move towards a model of working that is more aligned with early intervention and prevention.

What interventions work? (Including those from outside of Public Health & the Local Authority)

The Youth Offending Team are targeting young people at the first available opportunity and trying to engage with them on a voluntary basis in order to ensure that they do not progress through the system and to try and identify any unmet need at an early stage. This would include assessments around a young person's general health, as well as more specific assessments in relation to speech and language and mental health, where deemed necessary.

All young people coming into contact with the Youth Offending Team are routinely screened for substance use and appropriate interventions delivered or referrals made where a need is identified.

There is currently a push to ensure that more young people who may have a learning need, mental health concern, communication problem or other circumstance heightening their vulnerability, are presented to the mentally vulnerable offenders panel and thus dealt with by means of interventions that suit their vulnerability whilst also addressing the presenting problematic behaviour.

Young people are also supported to access universal health services and where necessary accompanied to meet with their own GP.

The You Think sexual health team engage with a number of young people around contraception, safe sex and sexual health.

What are we doing now?

Engaged with young people at an early intervention stage through the grant funded Youth Justice Liaison and Diversion (YJLD) team that consist of a speech and language therapist and a mental health practitioner, both part time workers. These workers identify any need and either delivers a short piece of intervention work or signpost and direct to mainstream services.

Working closely alongside the Branching Out Young People's Substance Misuse team to support young people and educate them into desisting from using substances or at least to use them in a safe and controlled manner.

Work is also being delivered to promote a healthier diet amongst young people and this can include practical support with cooking and food preparation, alongside budgeting.

What needs to happen next and by whom?

- All agencies need to intervene early to address emerging health and well-being needs to preventing offending, with clear pathways into health provisions.

- Ensure that the YJLD Health Team based within the Youth Offending Team is funded from another source once the current grant funding finishes in March 2016

- Health professionals based within the Youth Offending Team must continue to work alongside Greater Manchester Police to ensure that young people who are considered to be 'mentally vulnerable' are diverted away from the criminal justice system and dealt with in a way that is more tailored to their specific needs and aimed at preventing a re-occurrence of the problematic behaviours

- There needs to be an expansion and development of targeted youth support services for young people aged 10 – 17 who need some additional support and guidance in order to achieve better outcomes

Mortality in under 16 and under 19 year olds

Outcomes framework:

Indicator Name: including
Child deaths in under 16 years
Child deaths in under 19 years

Implications for the population's health and well-being:

Deaths in children are rare, and in most years there are less than 20 child deaths in Tameside of which about half are infant deaths (See Infant Mortality Section).

For children over 1 year injuries, infections, cancers and complications of long term conditions including birth anomalies are all important. For older teenagers self-harm and injuries, especially road traffic accidents are significant.

Mortality is highest in infancy, dropping to very low rates in the middle childhood years, before rising again in adolescence.

Patterns of mortality vary with age and sex; perinatal and congenital causes predominate in infancy, with acquired natural causes (for example infections or neurological, respiratory and cardiovascular disorders) becoming prominent in later childhood and adolescence. More than 50% of adolescent deaths occur from external causes, which included traffic deaths, non-intentional injuries (for example, falls), fatal maltreatment and death from assault, suicide and deliberate self-harm. Deaths of children diagnosed with life-limiting disorders (disorders that are likely to reduce a child's lifespan) might account for 50% or more of all child mortality in England and Wales.

At risk or vulnerable groups:

There is strong social gradient for child deaths with the most deprived groups experiencing the highest mortality.

Benchmarking:

The small number of deaths each year makes the trend in local deaths sensitive to small variations between years. As half of deaths occur in the first year, changes in birth rate also influence the rates. The trend graphs suggest that:
- The rate of child deaths for Tameside has been decreasing over the past 20 years, and generally below that for the NW and in line with England.

Chart 65: Deaths in under 16s Annual Trend (DSR per 100,000 population)
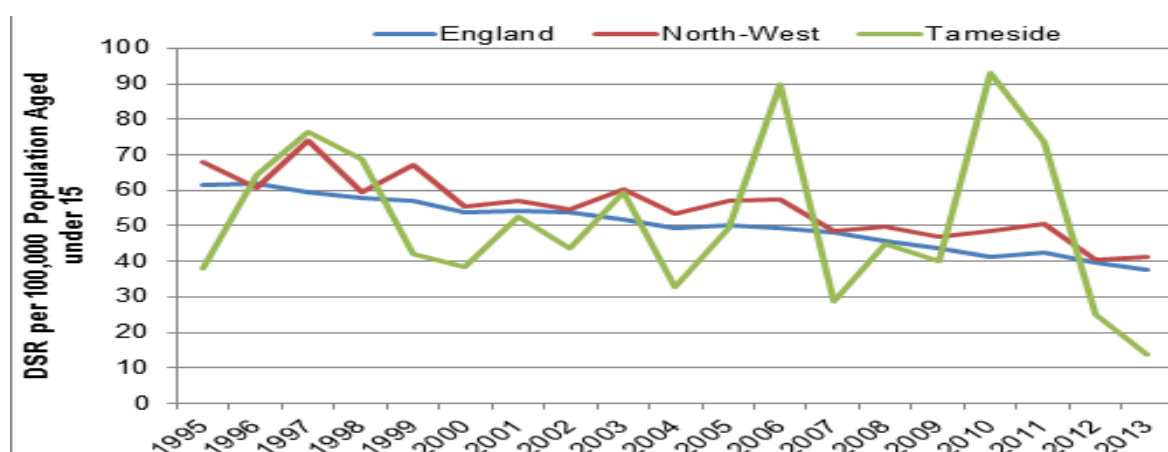
Source: HSCIC, 2015

During the five years 2008-2013 the rate increased and was above the England and NW rates, but then fell below both. This was during a period of increased local birth rate.

Chart 52: Deaths in Under 16s Rolling 3-Year Average (DSR per 100,000 population)
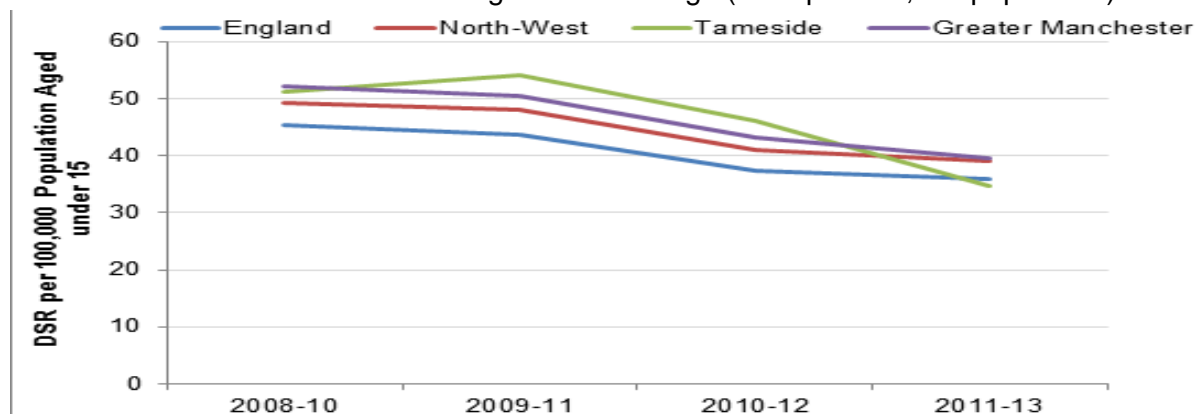
Source: HSCIC, 2015

The rate of deaths for Under 19s is generally a little lower than for Under 16s.

Chart 67: Under 19 Deaths, Tameside, 2006-08 to 2011-13
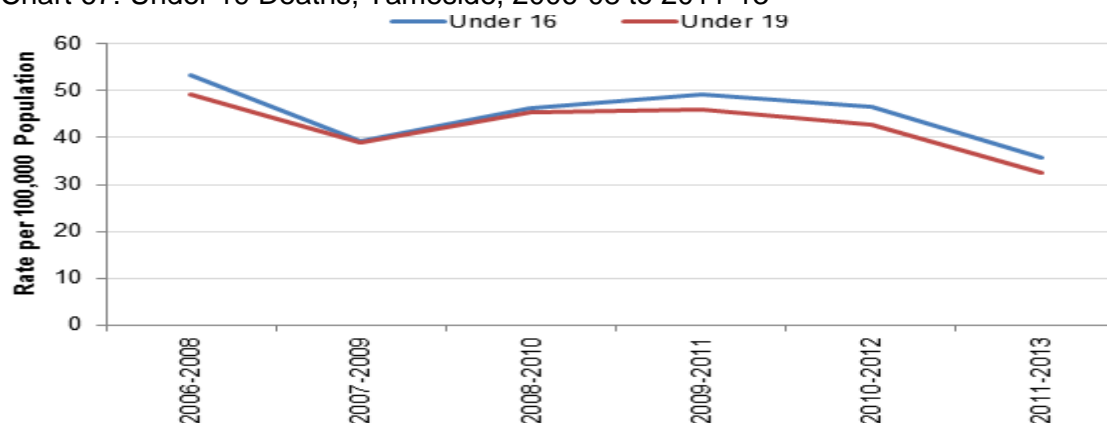
Source: PCMD, 2015

Policy Context:

All child deaths are reviewed by a local [Child Death Overview Panel](#) that reports to the Local Safeguarding Children Board. The Stockport, Tameside and Trafford Panel review all local deaths and present an Annual Report with recommendations for action. National guidance to Panels defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

What interventions work? (Including those from outside of Public Health & the Local Authority)

Good engagement with good antenatal services, health visiting and other early years services is important to both establish a good start in life that minimises the risk of life threatening illness or injury. Good attachment and emotional health are vital to the development of stable behaviour and family life which reduce the risk of injury and self-harm.

The Healthy Child Programme [0-5yrs](#) and [5-19yrs](#) provides a universal and targeted approach to supporting children's development and reducing child deaths.

Creation and maintenance of safe home, public and play environments are essential to reduce deaths from injuries.

What are we doing now?

- The various elements of the local Healthy Child Programme are commissioned by Tameside and Glossop CCG, Tameside Council and NHS England.

What needs to happen next and by whom?

The Stockport, Tameside and Trafford Child Death Overview Panel (CDOP) Annual Report 2013/14 included recommendations to:
- assess the work currently in place to target vulnerable groups
- analyse the injury admissions with a view to identifying any correlation with the CDOP data
- 5 years 'snapshot' is under taken across the 3 Authorities and GM to evaluate CDOP data in more detail

Living and Working Well

Diet and nutrition

Outcomes Framework:

Public Health 2.02 - Breastfeeding
Public Health 2.06 - Excess weight in 4-5 and 10-11 year olds
Public Health 2.12 - Excess Weight in Adults
Public Health 2.17 - Recorded diabetes
Public Health 4.02 - Tooth decay in children aged 5
Public Health 4.04 - Under 75 mortality rate from all cardiovascular diseases
Public Health 4.05 - Under 75 mortality rate from cancer

Implications for the population's health and well-being:

Poor diet and nutrition are recognised as major contributory risk factors for ill health and premature death. One study found that the burden of food related ill health measured in terms of death and ill health is similar to that attributable to smoking[18].

Over the last few decades food availability, commercialisation, patterns of retailing, a preference for convenience, pricing, a higher frequency of eating outside of the home, more frequent snacking, less home cooking and increased portion sizes for both adults and children have led to a greater consumption of foods high in fat, sugar and salt.

Because of these changes in dietary and lifestyle patterns, chronic diseases such as obesity, diabetes, cardiovascular disease (CVD), hypertension and stroke, and some types of cancer are becoming increasingly significant causes of disability and premature death. Overall, scientists estimate that about a third (32%) of 13 of the most common cancers in the UK could be prevented through improved diet, physical activity and body weight[19]. Levels of sugar consumption and snacking contribute to the gum disease and tooth decay particularly in young children.

Recorded diabetes, excess weight in adults and under 75 years death rates from cardiovascular disease and cancer are all significantly higher in Tameside than the England average. In terms of tooth decay in 5 year olds (2012 data) Tameside is slightly below the average for the North West, but remains above the average for England. The North West is the worst region of England for tooth decay. These could all be reduced significantly if the population's diet improved.

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[18] Rayner M & Scarborough P(2005) J Epidemiol Community Health 2005;59:1054–1057. doi: 10.1136/jech.2005.036491
[19] http://www.wcrf-uk.org/uk/preventing-cancer/cancer-preventability-statistics

Other diet related health problems include osteoporosis, anaemia, and vitamin D deficiency. Under nutrition or malnutrition can still occur, even in children or adults who are not underweight.

For diet, recommendations for populations and individuals should include the following:
- achieve energy balance and a healthy weight
- limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and towards the elimination of trans-fatty acids
- increase consumption of fruits and vegetables, and legumes, whole grains and nuts
- limit the intake of free sugars
- limit salt (sodium) consumption from all sources and ensure that salt is iodized

Food and nutrition needs will change and develop throughout life; from breastfeeding being the recommended nutrition for the first six months of life, to weaning, infant foods and appropriate nutrition and portion sizes for a growing child. Achieving and maintaining a healthy weight may become more of a challenge throughout adulthood and older people will often have specific dietary needs.

Competitive markets along with new technology have enabled the food industry to produce food cheaply and in high quantities to meet consumer demand. This has led to an increased production of processed food and ready meals, with many of these being high in fat, sugar and salt. Fatty and sugary foods are also heavily advertised and marketed which has increased consumer demand. Portion sizes of products high in fat, sugar and salt have also increased over recent years. These trends have contributed to people consuming too much saturated fat, sugar and salt and not enough fruit and vegetables.

Eating practices can also be influenced by access to affordable healthy food, social and psychological stress, the levels of skills, knowledge and confidence in cooking and preparing food, cultural traditions, food poverty and fuel poverty.

Food and nutrition as a topic has links with the environment, sustainability and community. Climate change and water supplies globally affect food supply and prices, and communities may wish to take action on their local food situation and get involved in growing, selling and cooking food.

Improving dietary habits is a societal, not just an individual problem. Therefore it demands a population-based, multi-sectoral, multi-disciplinary, and culturally relevant approach.

At risk or vulnerable groups:

- Children and adults in low income families
- Children with obese parents
- Young Parents (<21) & single mothers
- Adults who are unemployed or in semi-routine & routine occupations
- Individuals with a physical or learning disability
- Individuals with a mental health condition

- Looked After Children (LAC)/ Care Leavers
- Older People
- People who live in 'food deserts' i.e. where there is a lack of access to affordable healthy food.
- People in food poverty or fuel poverty.

Policy context:

The main local policy which considers food and nutrition is the Tameside and Glossop Healthy Weight Strategy (2010 -2015).

- Choosing Health (2004)
- Foresight report – Tackling obesities: Future choices (2007)
- Healthy Weight, Healthy Lives (2008)
- DH, Healthy Lives, Healthy People: A call to action on obesity in England (2011)
- NICE Clinical Guidelines 43 (2006)
- NICE Guidance PH12 (2008)
- NICE Guidance – Maternal and Child Nutrition (2008)
- Choosing a better diet: A food and health action plan (2005)
- Tameside Poverty Strategy 2014-17
- Tameside Affordable Warmth Strategy 2009-12
- My Tameside - The Sustainable Community Strategy 2012-22

Benchmarking:

The findings from the latest National Diet and Nutrition Survey (NDNS) report show that 70% of adults aged 19-64 are still not eating enough fruit and vegetables. They also show that most people are still eating too much saturated fat, added sugar and salt and not enough dietary fibre.

The NDNS data for 2008 to 2012 shows[20]:

- Sugars (non-milk extrinsic sugars (NMES), also referred to as 'added sugars'): average intakes exceeded the recommendation of no more than 11% food energy for all age groups, most notably for children aged 4 to 10 and 11 to 18 years where average intakes provided 14.7% and 15.6% food energy respectively.
- Saturated fat: average saturated fat intakes in all age groups exceeded the recommended level of no more than 11% food energy. For example, average saturated fat intake for adults aged 19 to 64 years was 12.6% food energy. Intake of trans fats by all age groups met recommendations.
- Salt: average salt intake for older adults aged 65 years and over was 7.2g/day, above the recommended maximum daily limit of 6g/day. Average salt intake in children aged 4 to 18 years also exceeded the SACN recommendations for each age group except for children aged 7 to 10 years. Salt intake for adults aged 19 to 64 years was published in 2012.

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[20] https://www.gov.uk/government/news/new-national-diet-and-nutrition-survey-shows-uk-population-is-eating-too-much-sugar-saturated-fat-and-salt

- Fruit and vegetables:
  - adults aged 19 to 64 years consumed on average 4.1 portions per day and adults 65 and over consumed 4.6 portions. 30% of adults and 41% of older adults met the "5-a-day" recommendation.
  - boys and girls aged 11 to 18 years consumed on average 3.0 and 2.7 portions per day respectively. 10% of boys and 7% of girls in this age group met the "5-a-day" recommendation.
- Oily fish: average consumption of oily fish was well below the recommended one portion (140g) per week in all age groups.
- Vitamin D: blood analyses showed evidence of low vitamin D status in 23% of adults aged 19 to 64 years and 22% children aged 11 to 18 years over the year as a whole. This increases to 40% for both in the winter months.
- Iron: 46% of girls and 23% of women had low iron intakes.

A national report on Family Food[21] notes that there have been significant upward trends in household expenditure on total fats and oils, butter, sugar and preserves, fruit and fruit juice, soft drinks and beverages. It also stated that household purchases of vegetables (excluding potatoes) were highest in the South West and lowest in the North West (1,201 and 980 grams per person per week respectively). The report also illustrated the nation's diet compared to the proportions of food groups recommended by the eatwell plate[22] (see chart 68 below).

Chart 68: Eatwell plate comparison for households, 2012

Eatwell plate comparison for low income and all households
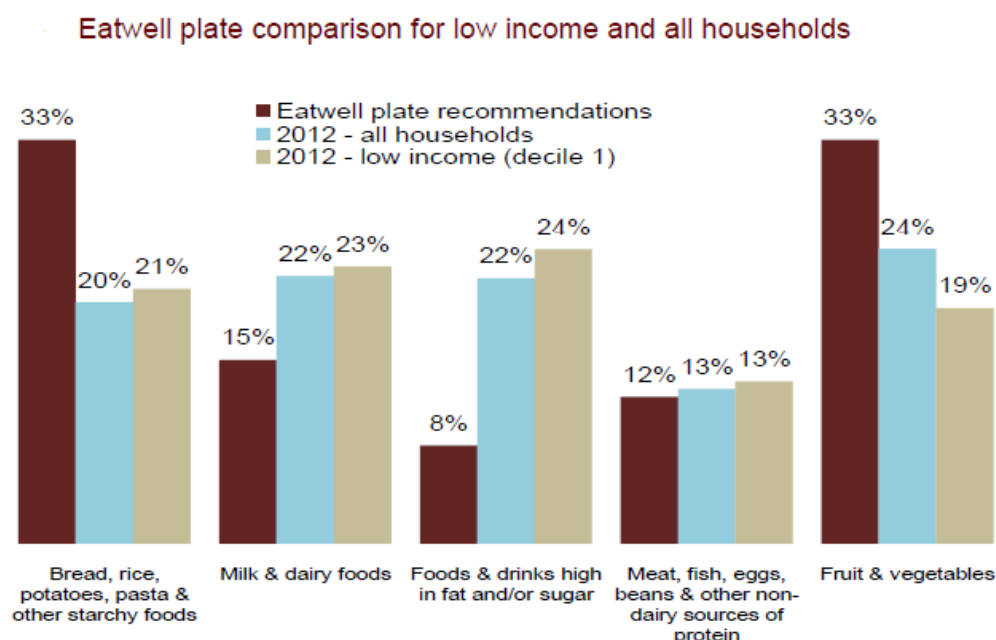
Source: Family Food 2012, Department for Environment, Food and Rural Affairs, 2013.

[21] Family Food 2012, Department for Environment, Food and Rural Affairs, 2013.
https://www.gov.uk/government/publications/family-food-2012
[22] http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx

Chart 68 illustrates that neither low income households nor all households are close to the eatwell plate as a whole. For non-dairy sources of protein, both low income and all households are close to the eatwell plate ideal. Both low income households and all households have a relatively similar diet when compared to the eatwell plate. The main difference between low income households and all households is in fruit and vegetable purchases where low income buys less.

What works?

Evidence from research on social marketing suggests that it is unlikely that the type of public information campaigns that urge people to avoid certain foods and to exercise more frequently will be enough to adequately address the problem of obesity. Interventions that go beyond information campaigns to simultaneously inform, shift motivation and provide the necessary skills are more likely to lead to behaviour change.[23]

Actions that local partners can take include:

- Ensure that everyone has access to healthy, competitively priced food.
- Tackle food poverty
- Promote and support breastfeeding
- Support all organisations to provide healthy food including nurseries, schools and colleges.
- Support residents to increase their knowledge, skills and confidence in understanding and making healthier food choices.
- Ensure that healthy food provision is prioritised and integrated throughout the planning system.
- Use supplementary planning guidance to restrict further increase in the number and density of hot food takeaways.
- Encourage the provision of healthier and more sustainable catering.
- Limit the easy accessibility of unhealthy food choices, for example by working with existing hot food take-aways and sandwich shops to reformulate their menus to reduce the sugar, salt and fat content of food and to provide healthier options.
- Conduct health impact assessments to ensure that all parties think about proposed developments from a health perspective, specifically the impact on levels of healthy food choices.

What are we doing now?

- Promoting breastfeeding e.g. Baby Friendly Initiative
- Promoting Healthy Start scheme
- Prevention programme e.g. healthy lifestyle courses focussing on children aged 18 months to 5 years and their families
- Promoting evidence based infant feeding, weaning and pre-school nutrition
- Early Years Food and Nutrition Training
- Nutrition and Oral Health Award Scheme for under 5s child care providers
- Child and family weight management courses

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[23] Foresight: Tackling obesities – Future Choices (2007)

- Primary school family 'cook and be active' programmes at school sites
- Nutrition and activity sessions in schools for Year 5 pupils
- Ready, Steady Cook and Eat courses in primary schools
- Food for Life school food award scheme for schools
- Weight management service in GP practices
- Weight Matters weight management programme for adults
- Community dieticians offer 1-1 appointments for the following:
  - Patients with a BMI > 30 who have other co-morbidities or with a BMI > 40 with no other co-morbidities.
  - Women who are pregnant and underweight or with high BMI (> 30).
- Casserole club
- Diggin' Tameside

Service user or public engagement or consultation:

Healthy diet was endorsed as a priority for both Tameside Health and Wellbeing Strategy during public consultation in 2013 and also during a consultation in 2014 where residents were asked what would contribute to their health and well-being.

What needs to happen next, and who needs to do it?

The Tameside Healthy Weight Strategy Group is committed to the delivery of the local strategy. There is need for continued commitment from partners and for a more holistic approach to promoting and enabling healthy eating. Public Health and partners are currently in the process of developing an integrated wellness service for adults that will provide support in improving diet and nutrition.

Actions that would contribute to improving diet and nutrition are:

- Development of a food and nutrition strategy that sets out actions for all stages of life and for all organisations and communities in Tameside.
- Increase breastfeeding rates and good nutrition during early years.
- Support nurseries and schools to have a food policy and to provide healthy food and snacks at all times.
- Work with partners to reduce food and fuel poverty.
- Encourage all partners to get involved in campaigns such as change4life and GULP (Give Up Loving Pop).
- Development of supplementary planning guidance (controlling takeaways etc) and promotion of healthy environment
- Support residents to increase their knowledge, skills and confidence in understanding and making healthier food choices.
- Support community food growing schemes.

Outcomes Frameworks:
- Public Health: 2.06 - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds
- Public Health: 2.12 - Excess Weight in Adults
- Public Health: 2.13- Percentage of physically active and inactive adults
- NHS Outcomes Framework: 1b Life expectancy at 75

Implications for the population's health and well-being:

In the last twenty years there has been an unprecedented increase in obesity in the UK, and this trend is predicted to continue due to a wide range of factors related to modern day living including our diets, levels of physical activity and inactive leisure pursuits.

In England, around a quarter of adults in 2013 were obese, (26 per cent of men and 24 per cent of women). Being overweight was more common than being obese and 41 per cent of men and 33 per cent of women were overweight, but not obese. Both BMI and waist circumference contribute to the National Institute for Health and Care Excellence (NICE) calculation of health risk caused by overweight and obesity. By these definitions, more than half of men and women were in the increased, high or very high risk categories.

People who are overweight or obese are at a greater risk of type 2 diabetes, cardiovascular disease and cancer. On average obesity reduces life expectancy by 11 years. The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Foresight 2007). These factors combine to make the prevention of obesity a major public health challenge.

In 2013 about one sixth (15.2%) of children under 16 in England were obese. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.

As obesity and the factors that lead to obesity can begin in childhood, it is important that the whole picture is addressed to prevent overweight and obesity in current and future generations.

At risk or vulnerable groups:

- People living in areas of deprivation
- Adults who are unemployed or in semi-routine & routine occupations
- Individuals with a physical or learning disability
- Individuals with a mental health condition
- Young parents (<21) & single mothers
- Older People
- Looked After Children (LAC)/ Care Leavers
- Children from low income families
- Children with obese parents

National and local policy context

- [DH, Healthy Lives, Healthy People: A call to action on obesity in England (2011)](#)
- [Healthy Weight, Healthy Lives (2008)](#)
- [Foresight report – Tackling obesities: Future choices (2007)](#)
- The Tameside and Glossop Healthy Weight Strategy (2010 -2015)

NICE guidance

- Managing overweight and obesity among children and young people: lifestyle weight management services (PH47) October 2013
- Managing overweight and obesity in adults – lifestyle weight management services (PH53) May 2014
- Maternal and child nutrition (PH11) March 2008
- Obesity (CG43) December 2006
- Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (CG189) November 2014
- Prevention of cardiovascular disease (PH25) June 2010
- Weight management before, during and after pregnancy (PH27) July 2010

Benchmarking:

Excess weight adults:

Just over one in four (26.7%) adults in Tameside is obese (Active People Survey 2012). Whilst this is not significantly different from the England average it still represents a serious health risk to the population. Just under half (49.6%) of adults are physically active. This means about one in two adults are inactive and will have increased risk of ill health that is linked with a sedentary lifestyle, for example studies have linked excessive sitting with being overweight and obese, type 2 diabetes, some types of cancer, and premature death (http://www.nhs.uk/Livewell/fitness/Pages/sitting-and-sedentary-behaviour-are-bad-for-your-health.aspx

Chart 69: Percentage of population aged 16+ classified as obese (BMI>30)
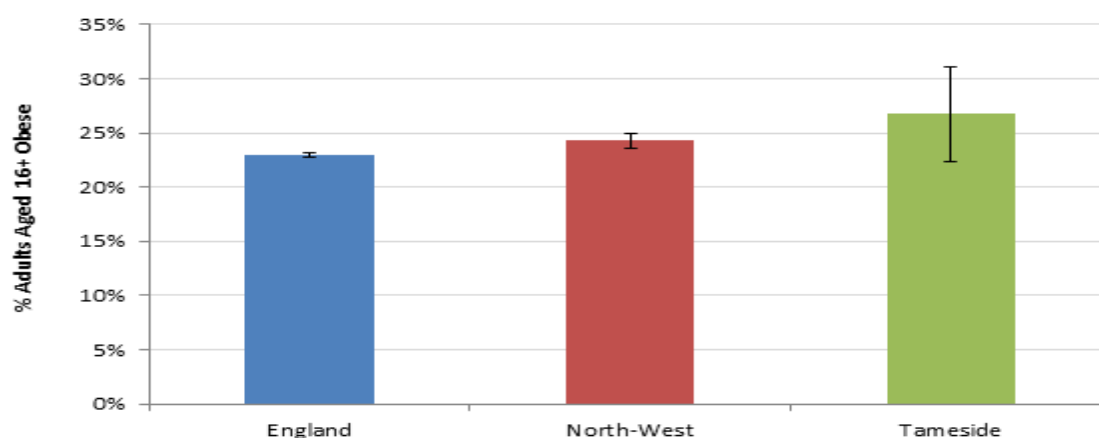
Source: Sport for England (Active People Survey 2012)

What interventions work?

The 2007 Foresight report on obesity stated that

- The obesity epidemic cannot be prevented by individual action alone and demands a societal approach.
- Tackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national.

Some local actions which will contribute to the prevention and reduction of obesity are:

- Increase access to and opportunities for physical activity and healthy food, for example provision of and access to green open space and opportunities for play and food growing.
- Ensure that health and wellbeing are prioritised and integrated throughout the planning system.
- Encourage the provision of healthier and more sustainable catering.
- Limit the easy accessibility of unhealthy food choices, for example by working with existing hot food take-aways and sandwich shops to reformulate their menus to reduce the sugar, salt and fat content of food and to provide healthier options.
- Consider controlling the proliferation of hot food takeaways in specific areas, such as near schools.
- Conduct health impact assessments to ensure that all parties think about proposed developments from a health perspective, specifically the impact on levels of physical activity and healthy food choices.
- Support, develop and encourage active travel and in doing so also reduce carbon dioxide emissions and improve road safety.
- Implement lower speed limits in residential streets. Speeds above 20 mph discourage active travel and deter parents from allowing children to play on their streets.
- Encourage through appropriate commissioning access to and facilities for structured leisure programmes.
- Improve availability of unstructured opportunities for physical activity, such as access to parks and open spaces and safe play areas for children and young people.
- Ensure all opportunities are accessible to people with limited mobility, including those who are obese.
- Promote the value and benefits (health and otherwise) of an active lifestyle.
- Promote and encourage the use of existing green spaces.
- Support initiatives in schools and communities to improve children's wellbeing and self - esteem through physical activity and healthy eating.
- Support breastfeeding

What are we doing now?

- Adult weight management services
- Health trainers
- Workplace health scheme
- Physical activity opportunities in sports centres and green spaces

- Community Health Checks
- Delivery of the mandatory National Child Measurement Programme
- Promoting breastfeeding
- Promoting Healthy Start
- Family Health Mentors
- School Sports Partnership
- Children's nutrition programme
- Health and well-being clubs in secondary schools
- Living Streets has engages schools in the borough to organise park and stride and active travel days.

Service user or public engagement or consultation:

In a 2014 a TMBC consultation asked Tameside residents what would help their health and wellbeing. Getting fitter, losing weight and eating healthy were the three themes with the highest responses from the 701 people that participated.

What needs to happen next and by whom?

The Tameside Healthy Weight Strategy Group is committed to the delivery of the local strategy. Some of the key areas which more work needs to happen include:

- Active travel programme to promote walking and cycling
- Importance of healthy weight built into all care pathways
- Better recording and access to data on adult prevalence of overweight and obesity
- Development of supplementary planning guidance (controlling takeaways etc.) and promotion of healthy environment
- Review of the maternal weight management pathway
- Teenage healthy weight pathway
- Social marketing campaigns
- Increased co-ordination of support available to schools to promote healthy eating and physical activity.
- Increased support to parents to develop a healthy diet and activity levels for the whole family.
- Improving the quality of the breastfeeding data that is collected.
- Increasing the 6-8 week breastfeeding rates.
- To reduce internal inequalities in child obesity by directing services and resources to communities where rates are highest.

Physically active and inactive adults

Outcomes framework: Public Health 1.10 / 2.13

Indicator Name: including
Utilisation of green spaces for exercise / health
Proportion of physically active / inactive adults
Participants in moderate physical activity (no x 30 mins per week)

Implications for the population's health and well-being:

The national cost of physical inactivity in England is £8.2 billion a year and is the fourth leading risk factor for premature mortality. Recent research suggests that the cost to Tameside of physical inactivity is £5.3m in health cost and over £21.5m when costs to the wider community are included

Physical activity provides important health benefits across the life-course helping to prevent and manage over 20 chronic conditions including, coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. Participation in sport and active recreation during youth and early adulthood can lay the foundation for life-long participation in health-enhancing sport and wider physical activity. There is a clear relationship between the amount of physical activity people do and all-cause mortality.

Physical activity has not just been shown to prevent and manage chronic condition there are many other social, individual and emotional reasons to be active. Physical activity has been shown to:
- Play a key role in brain development in early childhood
- Improve long term educational attainment
- Boost workplace productivity and reduce sickness absence
- Reduce levels of crime and antisocial behaviour.

More people taking part in sport and physical activity at all levels will bring a number of benefits and there is strong, systematic evidence of a direct link between regular physical activity and improved health for people of all ages. A 10% increase in adult activity would prevent around 6,000 premature deaths not to mention bringing economic benefits worth at least £2 billion a year.

At risk or vulnerable groups:

It is important that all groups have the opportunity to be physically active in order to achieve a population shift in participation. There is a significant reduction in participation post 16 with levels of physical activity declining with age in both genders, with women and girls being less physically active than men at all ages. Certain groups within communities are less likely to participate in sufficient physical activity. The prevalence of engaging in physical activity has been identified as being lower among females, older adults, people from deprived backgrounds, and people from ethnic minority groups

Benchmarking:

Across Tameside around 35% of people aged 16 and over participate in sport, similar to the England average and around 47% of the adult population that are physically active, is significantly lower than the England average[24,14] However there are around 38% of the adult population who are physically inactive which is significantly higher than the England average (29%)[25]

The map below shows sports participation across the wards of Tameside and it illustrates that the lowest rates of participation are in and around the wards of St. Peter's and Longdendale, with less than 15% of people in these areas participating in sport or active participation.

Map 3: Three times a week sport and active participation (Oct 2011-Oct 2012)
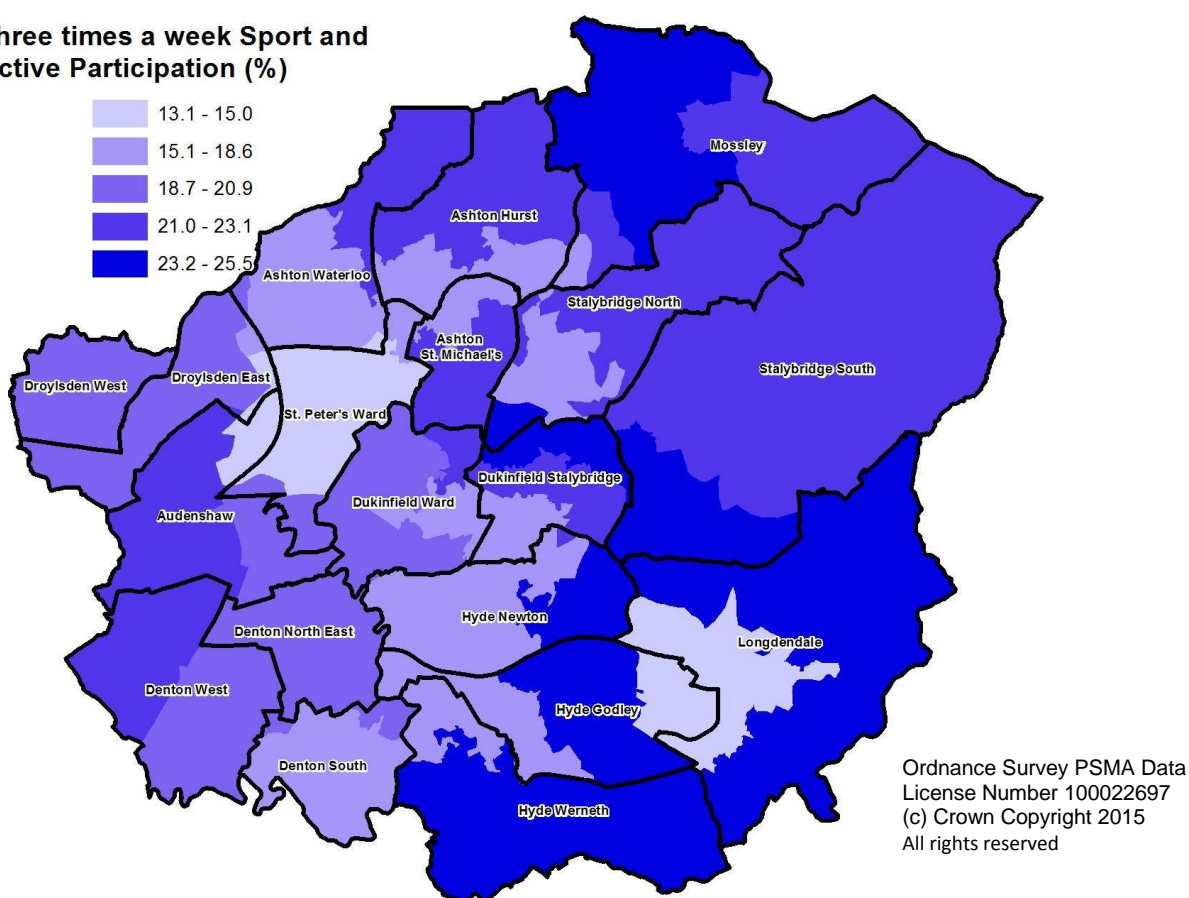
Source: Sport for England, 2015

Policy Context:

Everybody Active, Every Day: An Evidence-Based Approach to Physical Activity was released by Public Health England (PHE) in October 2014. In it the call for there to be

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[24] http://www.sportengland.org/our-work/local-work/local-government/local-sport-profile/
[25] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000002/are/E06000008

culture change with physical activity being made easy, fun and affordable, with exercise and active recreation become available to all, in every community across the UK.

To deliver this vision the paper calls for actions across four areas, at national and local level:

1. Active society: creating a social movement
2. Moving professional: activating networks of expertise
3. Active environments: creating the right spaces
4. Moving at scale: scaling up interventions that make us active

The document includes 5 steps for local areas to support change:

1. Teach every child to have and enjoy the skills to be active every day
2. Create safe and attractive environments where everyone can walk or cycle, regardless of age or disability
3. Make every contact count for professionals and volunteers to encourage active lives
4. Lead by example in every public sector workspace
5. Evaluate and share the findings so the learning of what works can grow

The 2012-17 Youth and Community Strategy for Sport England 'Creating a Sporting Habit for Life' was launched in January 2012 by the Department for Culture, Media and Sport (DCMS). The strategy aims to increase the proportion of people regularly playing sport, in particular, the proportion of 14-25 year olds who play sport and to establish a lasting network of links between schools and sports clubs in local communities so that young people keep playing sport up to and beyond the age of 25.

The DCMS and Sport England aim to do this by:
- Building a lasting legacy of competitive sport in schools
- Improving links between schools and community sports clubs.
- Working with the sport's governing bodies: focusing on youth
- Investing in facilities
- Communities and the voluntary sector

Start Active Stay Active: A report on physical activity for health from the four countries Chief Medical Officers (2011), set out the recommended amounts of activity across the life course. The guidelines highlight that physical activity should be encouraged across the population and that the risks of poor health resulting from inactivity are high, with a clear link between physical activity and chronic disease. The report also highlight the emerging evidence that sedentary behaviour is an independent risk factor and effort should be made to reduce this.

Locally the 'Get Active, Be Healthy, Enjoy and Achieve' Sport and Physical Activity Strategy for Tameside 2010-2020 highlights the need to support people to start being more physically active and to create more accessible opportunities for all to stay active and succeed through the achievement of personal goals.

What interventions work? (Including those from outside of Public Health & the Local Authority)

Activities that promote physical activity either through recreation, sport or as a means of transport, will improve the health and well-being of communities, encouraging social interactions, contributing to improved physical and mental health. Alternatively, activities that result in a loss or reduction of green space and recreational facilities, reducing opportunities of physical activity will have a negative impact on health.[26]

Physical activity should not be mistaken for sport; physical activity is any bodily movement produced by the skeletal muscles that uses energy. This includes sports, exercise and other activities such as playing, walking, doing household chores or gardening.

Current recommendations are that adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

- Early intervention and prevention models that encourage people to be more regularly active that provides outcomes around positive mental health and well-being and maintaining healthy weight.

- Interventions that reduce barriers to participation. Provision tailored to local need using market segmentation data, widen access and entry level provision available to new starters at affordable cost to encourage regular participation, effective marketing campaigns including the use of social media, providing expertise and resources to pump prime and sustain voluntary groups/clubs who provide sport and physical activity opportunities.

- Investment in Active Travel as a mode of transport. Improvement in infrastructure to make it easier for people to walk and/or cycle as a mode of transport and interventions designed to support people in the behaviour change have both been shown to be exceptionally cost effective.

What are we doing now?

- We are currently working with Active Tameside to:
  - develop an exercise referral scheme, this will allow people in the borough who are inactive and suffer from a long term condition to have a safe an effective pathway to become more active.
  - strengthen the existing offer to 0-5 and ensuring exercise is embedded from a young age
  - improve the offer for older people, with a focus on falls prevention
  - Helping to reshape the organisation into a community focused organisation with a goal of getting people active
  - Develop the quantity and quality of low cost exercise sessions based in communities
- TMBC is currently working with a group of volunteers to establish a Parkrun event at Stamford Park/Silver Springs

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[26] The Solid facts WHO report on the social determinants of health

- Active Tameside have been awarded funding from TfGM to deliver an Active Outdoors project where they will be looking to increase participation in outdoor physical activity including the Walking for Health walks, led cycle rides and the Green space volunteering scheme
- Development of cycling strategy, starting with audit of cycling facilities which will be complete early 2015

What needs to happen next and by whom?

- The re-establishment of the Sport & Physical Activity Alliance (SPAA) which engages providers to ensure limited resources are targeted effectively, using best practice models to ensure maximum impact and value for money. The SPAA would enable a strategically coordinated approach to delivery and intervention avoiding duplication and identify effective commissioning opportunities.
- A refresh of the existing physical activity strategy led by the new SPAA taking into to account Public Health England new physical activity strategy, [Everybody Active, Every Day](#).
- Engagement with GPs and their practice staff around physical opportunities
- The Sports Trust to work with National Governing Bodies of Sport, sports clubs, community groups and health organisations to develop programmes which contribute to the DCMS 'Creating a Sporting Habit for Life' strategy.
- Development of the Tameside built environment to facilitate an increased take up of sport and physical activity, including establishing the urban parks as activity hubs and encouraging the development of walking and cycling routes to increase the number of journeys made by walking and cycling.

Smoking prevalence

Outcomes Framework:
- Public Health 2.01 Low birth weight of term babies
- Public Health 2.03: Smoking status at time of delivery
- Public Health 2.09: Smoking prevalence in 15 year olds
- Public Health 2.14:Smoking prevalence in adults (over 18)
- Public Health 2.14 Smoking prevalence in adults (over 18 - routine and manual)
- NHS Outcomes Framework: 1b Life expectancy at 75 i Males ii Females
- NHS Outcomes Framework: 1c Neonatal mortality and stillbirths

Implications for the population's health and well-being:

- 22.4% of adults in Tameside smoke (about 39,750 people); this is higher than North West (20.1%) and England (18.4%).
- Each year smoking costs Tameside £65.4 million
- Smoking caused 1,391 deaths between 2011and 2013.
- Smoking was the cause of 2,964 hospital admissions in 2013-4 at a cost of £6,769,977.
- Smoking-related deaths are a major contributor to the low male and female life expectancy in Tameside.
- 17.8% of pregnant women in Tameside smoke compared to an England average of 12%.

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy; contributing to 40% of all infant deaths, 12.5% increased risk of premature birth and 26.3% increased risk of intrauterine growth restriction (DH, 2009).

At risk or vulnerable groups:

Smoking accounts for half the difference in life expectancy between social class 1 and 5 (ASH, 2008), and helps to perpetuate poverty, deprivation and health inequality. In Tameside, those most exposed are; men from low socio-economic or routine and manual groups, children and unborn babies exposed to second hand smoke (SHS), and those with existing health conditions, e.g. Mental Health problems, CVD, COPD.

Children exposed to SHS are at much greater risk of cot death, meningitis, lung infections and ear disease. Children from more deprived households are more likely to be exposed to SHS. If both parents smoke children are four times more likely to start smoking than if neither parent smokes.

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of respiratory conditions; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes.

Smoking during pregnancy is strongly associated with age and social economic position. Pregnant women from unskilled occupation groups are five times more likely to smoke than professionals, and teenagers in England are six times more likely to smoke than older mothers. Infants born to smokers are much more likely to become smokers themselves, which perpetuates cycles of health inequalities (ASH: Smoking In Pregnancy – a call to action http://ash.org.uk/files/documents/ASH_893.pdf)

Benchmarking:

22.4% of adults in Tameside smoke (about 39,750 people); this is higher than the North West (20.1%) and England (18.4%). This has fallen from 32% in 2006/07, but the gap between Tameside and England as a whole has not been closed. The graph below shows the Tameside smoking prevalence in red dots and the England prevalence in black dots.

Chart 70: Smoking prevalence (I.H.S. data)
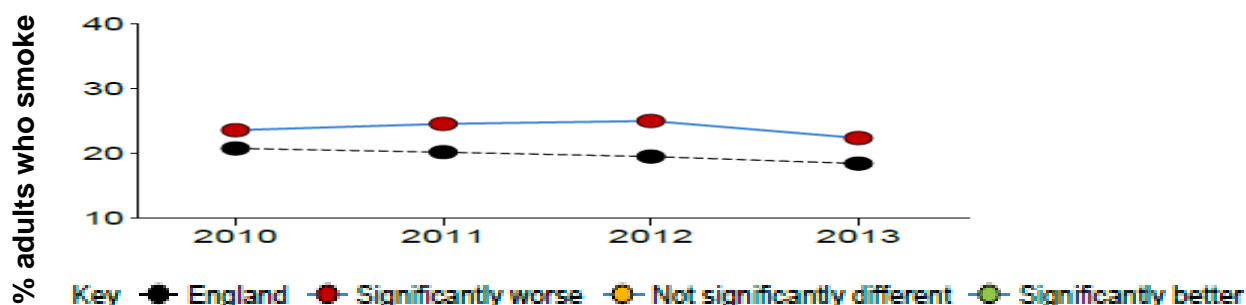
Source: Local Tobacco Profiles, 2015

There are approximately 39,750 smokers in Tameside. The ambition is to for Tameside to work towards being smoke free. However, in order for Tameside just to have the same rate as England for smoking, we would need an estimated 7100 smokers need to quit.

In 2013/14 an estimated 17.8% (461) of pregnant women in Tameside smoked at the time of delivery (SATOD). This is the second highest rate in Greatest Manchester, and much higher than England (12%). Although the data suggests a falling trend and slight closing of the gap with England (see below), there are concerns nationally regarding the robustness of this data. The graph below shows the Tameside smoking prevalence during pregnancy in red dots and the England prevalence in black dots.

Chart 71: Smoking status at time of delivery, 2010/11 to 2013/14

Source: Local Tobacco Profiles, 2015

Policy context:

- [DH Healthy Lives; Healthy People](): a tobacco control plan for England
  - o To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% by 2015
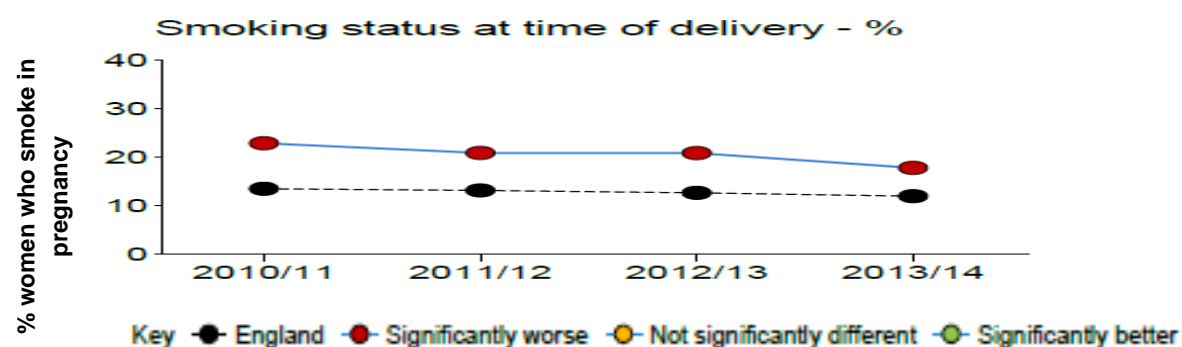 - o To reduce rates of regular smoking among 15 year olds in England to 12% 2015
  - o To reduce rates of smoking throughout pregnancy to 11% by 2015
- [Tameside Tobacco Control Strategy]()

NICE guidelines

- Brief interventions and referral for smoking cessation (PH1) March 2006
- Identifying and supporting people most at risk of dying prematurely (PH15) September 2008
- Preventing the uptake of smoking by children and young people (PH14) July 2008
- Quitting smoking in pregnancy and following childbirth (PH26) June 2010
- School-based interventions to prevent smoking (PH23) February 2010
- Smokeless tobacco cessation: South Asian communities (PH39) September 2012
- Smoking cessation in secondary care: acute, maternity and mental health services (PH48) November 2013
- Smoking cessation services (PH10) February 2008
- Tobacco: harm-reduction approaches to smoking (PH45) June 2013
- Workplace interventions to promote smoking cessation (PH5) April 2007

What interventions work?

The six internationally recognised strands of tobacco control are:

- Stopping the promotion of tobacco;
- Making tobacco less affordable;
- Effective regulation of tobacco products;
- Helping tobacco users to quit;
- Reducing exposure to second-hand smoke; and
- Effective communications for tobacco control.

There is a range of evidence advising what works in different settings, including

- Advise all patients (including pregnant women and people with smoking-related diseases) who smoke to quit, and refer those who want to stop to NHS Stop Smoking Services
- Local mass-media campaigns can prevent the uptake of smoking among young people
- Integrate information on smoking into school curriculum, and deliver anti-smoking activities as part of Personal, Health and Social Education (PHSE).
- Effective enforcement to prevent the sale of illicit tobacco and underage sales of tobacco products reduces the opportunities to start smoking for children and young people.
- Smoke-free homes and cars reduce exposure to SHS.

What are we doing now?

- A multi-agency partnership, the Tameside Tobacco Alliance, co-ordinates action on tobacco control in the Borough.
- A Stop Smoking Service provides free support to smokers who wish to quit smoking or using other types of tobacco such as sisha or paan.
- Stop smoking support is also available via GPs and pharmacies.
- All pregnant smokers are referred to the local Stop Smoking Service.
- Some pregnant women are referred to a specialist midwife.
- Trading Standards identify and stop trading in illicit and illegal tobacco. Work includes seizures of illicit and counterfeit tobacco, reviews of Premise Licences where illicit tobacco is found, and test purchasing for under age sales.
- A Workplace Health Improvement Officer supports employers who want to help their employees to stop smoking.
- The 'Take 7 Steps Out' campaign is promoted to encourage smoke free homes.
- Making Every Contact Count (MECC) http://www.makingeverycontactcount.co.uk/ training for frontline staff. Over 600 frontline staff have received training so far.
- The Local Government Declaration and NHS Statement of Support on Tobacco Control have been signed up to.
- Campaigns such at Stoptober, January Health Harms and No Smoking Day are promoted by TMBC and members of the Tobacco Alliance.

What needs to happen next, and by whom?

- Make smoking history for children
  - Equip young people to make positive decisions to avoid taking up smoking.
  - Work through the Children and Young People's Forum to identify resources and support for prevention work with young people.
  - A pilot peer education scheme will involve young people from TMBC youth groups and one secondary school in exploring the tobacco industry and teaching their peers about the issues they find.
- To increase the numbers of smoke free homes and spaces.
- To ensure groups who are at higher risk of being smokers have appropriate access to services e.g. people who are Lesbian, Gay, Bisexual or Transgender, have mental health illness or are routine and manual workers.
- To strengthen links with mental health providers to address smoking amongst their patients.
- To support more smokers to become smoke free so that the Tameside smoking rate matches the England rate.
- To follow the national decline of smoking towards being smoke free.
- During 2013/14 the Tameside Stop Smoking Service (SSS) helped 896 people quit.
- In order for Tameside to have the same percentage of adult smokers as England, we need an estimated 7100 smokers to quit.

Alcohol related illness

Outcomes framework:

Public Health Outcomes Framework 2.15/2.16/2.18/4.3/4.6i/ii,

NHS Outcomes framework 1.3

Indicator Name:

Alcohol related illness
Alcohol related & specific hospital admissions
Deaths attributable to alcohol
Deaths attributable to drug misuse
People entering prison with substance dependence not know to community treatment

Implications for the population's health and well-being:

Drug and Alcohol use is a key public health priority and is a considerable lifestyle cause of disease and death.

Their impact is felt across society and the total cost to the UK economy of alcohol alone is estimated to be £21 billion.

At risk or vulnerable groups:

- Children and Young people – especially those aged 18-25, and those experiencing parental substance misuse.

- Those in contact with the Criminal Justice System

- Women

- BME communities who are under-represented within treatment services.

- Adults with multiple and complex needs

Benchmarking:

Alcohol

Alcohol-related harm in Tameside is extensive and is significantly worse than the national average across a range of measures as evidenced within the Local Alcohol Profile for Tameside:
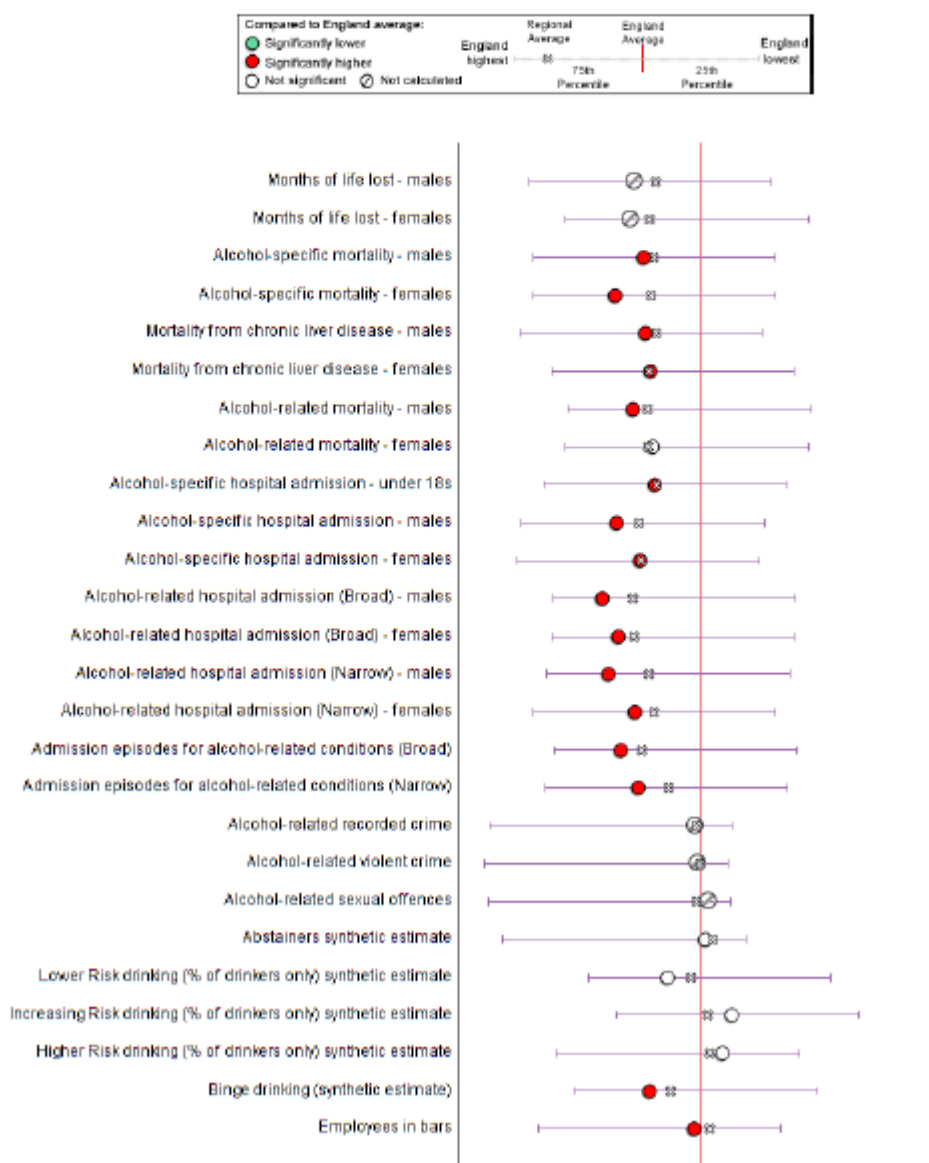
Source: PHE, 2015 [27]

It is estimated that 45,312 adults within Tameside are binge drinkers, 38,320 are increasing or higher risk drinkers, and 14,200 are dependent drinkers.

The numbers of adults in Alcohol Treatment as a % of estimated dependent drinkers is significantly below the national average and NICE guidance.

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[27] http://www.lape.org.uk/LAProfile.aspx?reg=X25003AD

A detailed analysis of Alcohol Use within Tameside can be found in the Tameside Alcohol Joint Needs Assessment which was completed in 2014. http://www.tameside.gov.uk/puplichealthreports/AlcoholNeedsAssessment2014-15.pdf

Drugs

Tameside has a substantial cohort of Opiate and Crack Cocaine Users with prevalence rates that are significantly higher than that of the national population.

Tameside is comparable to the national picture on a range of measures, but is an outlier on some significant indicators:

- 83% of adults in drug treatment successfully completed treatment and did not return compared to a national average of 89% and representing a significant deterioration over recent years.

- 49% of those in treatment had been there for 2 or more years, compared to a national average of 43%

- 71% of children and young people left treatment as part of a planned exit compared to a national average of 79%.

- 11% of children and young people who exited in a planned way represented compared to a national average of 7%

Source: JSNA Drugs Support Pack 2014 and JSNA Young People Support Pack 2014

http://www.nta.nhs.uk/uploads/jsna-support-pack-template-drug.pdf

http://www.nta.nhs.uk/uploads/jsna-support-pack-template-young-people.pdf

Policy Context:

- National Drug Strategy (2010) – Reducing demand, restricting supply, building recovery: Supporting People to live a drug free life.

- National Alcohol Strategy (2012)

- Putting Full Recovery First: The Recovery Road Map (2012)

- Drug Treatment in England: The Road to Recovery (2012)

- Greater Manchester Alcohol Strategy (2014)

What interventions work?

The evidence base pertaining to tackling Drugs and Alcohol use is complex and multi-layered.

Health First provides an evidence based strategy to tackling Alcohol related harm in the UK and is accessible via:

http://www.cph.org.uk/wp-content/uploads/2013/03/Health-First-An-evidence-based-alcohol-strategy-for-the-UK-1.pdf

NICE provide a range of guidance materials and quality assurance frameworks which can be accessed via the following links

http://pathways.nice.org.uk/pathways/alcohol-use-disorders

http://pathways.nice.org.uk/pathways/drug-misuse

http://pathways.nice.org.uk/pathways/reducing-substance-misuse-among-vulnerable-children-and-young-people

A wider review of 'what works' in terms of Treatment and Recovery has been undertaken as part of the review of services in Tameside and can be accessed within section 4 of *Transformation Paper # 1 - 'The Case for Change'*

Drugs and Alcohol
The Case for Change

What are we doing now?

We are currently in the midst of a transformation programme aimed at fundamentally shifting our approach to reducing the harm associated with Drug and Alcohol use.

This has 5 main elements:

1. Transformational redesign of Treatment and Recovery Services
2. Development of a new 10 year strategy
3. Commencement of a programme of activity to challenge prevailing social norms and cultural attitudes
4. Improvement to governance
5. Enhanced use of regulatory powers to restrict availability, price and marketing of alcohol

We are currently delivering against objectives 1 and 5.
We are currently part of a Health Scrutiny review into Alcohol-related harm.
We are a pilot site for a per-led led review of Alcohol-related harm being led by Public Health England.

What needs to happen next and by whom?

We need to commence objectives 2-4.

Recorded diabetes

Outcomes framework: Public Health 2.17

Indicator Name: including
Recorded diabetes
Preventable sight loss
Under 65s hospitalisation for Type II diabetes

Implications for the population's health and well-being:

The report into mortality from the National Diabetes Audit in December 2011 concluded that 24,000 people with diabetes are dying each year from causes that could be avoided through better management of their condition. The audit, which is managed by the NHS Information Centre and commissioned by the Healthcare Quality Improvement Partnership (HQIP), also showed how women with diabetes are nine times more likely to die young.

Diabetic retinopathy is the commonest cause of blindness in people of working age in the UK, and early detection and treatment can preserve sight.

At risk or vulnerable groups:

The risk of developing Type 2 diabetes increases with age and weight and is more common in South Asians and African-Caribbean's, and gestational diabetes can occur during pregnancy.

Retinopathy screening is offered to all newly identified patients with diabetes, and then annually.

Benchmarking:

Tameside & Glossop patients with diabetes have a higher than average mortality rate.

At March 2014 there were 12,049 patients on diabetes primary care disease registers in Tameside, which accounted for 7.6% of the GP registered population.

Chart 72: Percentage of GP registered patients with a diagnosis of diabetes
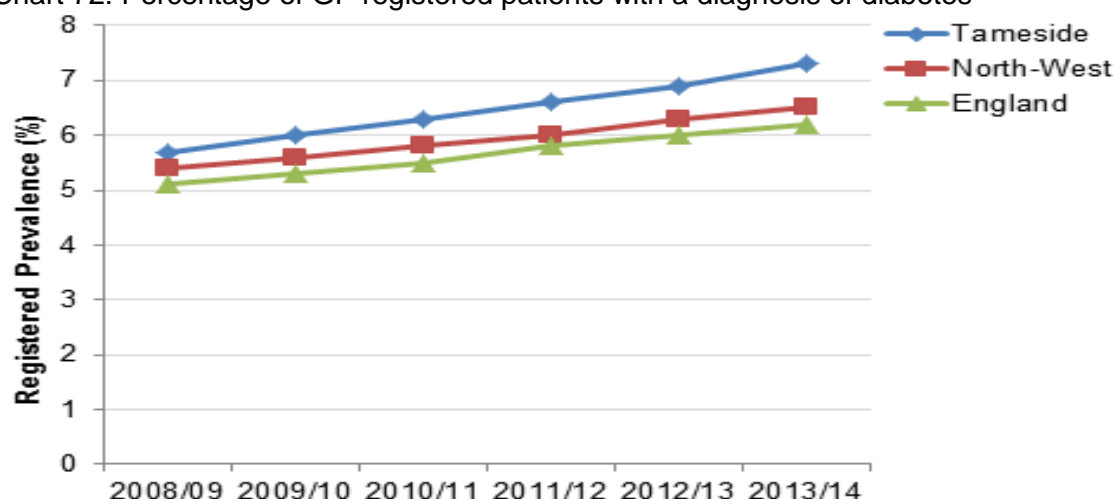
Source: Quality and Outcomes Framework (HSCIC)

Healthier Lives reports that 68.6% of people with diabetes in Tameside and Glossop have good blood sugar control, and the CCG ranks 5th in England.

People with diabetes may need admission to hospital for their diabetes, related complications and illnesses or for unrelated issues. In the three years 2011-14 there were 387 admissions of Tameside's under 65 years primarily for Type 2 diabetes, and 17,989 for under 65s with diabetes for a complication or unrelated reason. These were reductions from the previous year:

Chart 73: Directly standardised rate of hospital admissions with a primary or secondary diagnosis of Type 2 Diabetes
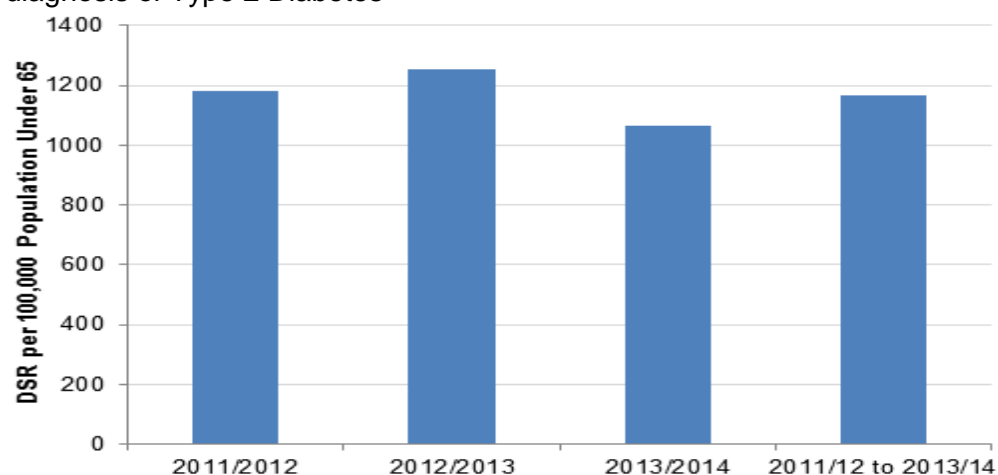
Source: Quality and Outcomes Framework (HSCIC)

Policy Context:

The NHS Five Year Forward View emphasises the continuing importance of prevention and effective treatment of diabetes.

What interventions work? (Including those from outside of Public Health & the Local Authority)

- NICE guidance PH35 - Preventing type 2 diabetes: population and community-level interventions
- NICE guidance CG15 - Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults
- NICE guidance TA60 - Diabetes (types 1 and 2) - patient education models

What are we doing now?

Diabetic retinopathy screening service, delivered from several community locations (see indicator Access to non-cancer screening programmes), which increases access and choice for patients.

Redesign of diabetes care was identified as an early priority for the CCG. The new service objectives are:

- Reduction in secondary care admissions/ readmission
- Seamless movement of patients/ flow of information between all providers of diabetic care
- A holistic view of a diabetes, maximising physical/psychological well being
- An educational role for patients, relatives and providers of diabetic care
- Using education and support to promote self-management
- Reduce diabetic complications
- The service has also been commissioned to support delivery of a number of NHS Outcomes Framework indicators, including:

C1.4 - Reducing premature mortality from the major causes of death: cardiovascular disease – myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes
C2.1 – Improved health related quality of life for people with long term conditions
C2.2 – Proportion of people feeling supported to manage their condition
C2.4 – People with diabetes who have received nine care processes
C2.5 – People with diabetes diagnosed less than a year who are referred to structured education
C2.8 – Reducing time spent in hospital for people with long term conditions: complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation

What needs to happen next and by whom?

- Continued promotion of healthy diet and weight by all local agencies including by the TMBC Wellness Offer

- The CCG has committed to reducing deaths in people under 75 from diabetes to at least the national average by 2017.

Quality of life for Carers

Outcomes Framework:
- Adult Social Care 1D: Carer reported quality of life
- NHS 2.4: Health related quality of life for carers

Implications for the population's health and well-being

There are nearly six million carers in the UK, with one in 10 people taking on the role of Carer. According to the 2011 census there are 24,059 Carers in Tameside out of a population of 219,324, meaning that 11% of the population of Tameside takes on the role of unpaid Carer. 6.4% of those Carers provide between 1 and 19 hours of care per week, 1.6% provide between 20 and 49 hours, and 2.9% provide over 50 hours of care per week. The average age of (unpaid) family carers is between 60 and 65 years, and many are much older[26].

Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner. Many Carers do not recognise themselves as such, and simply see themselves as a husband, wife, son, daughter, parent or friend. As such, they could be missing out on valuable advice and support, and become at risk of ill health or isolation. Research suggests that the responsibility and worry of caring for a friend or relative can result in Carers experiencing poorer self-reported health, engaging with fewer health promotion activities, as well as reporting lower life satisfaction .(Amrikhanyan and Wolf (2003) Caregiver stress and no caregiver stress: Exploring the pathways of psychiatric morbidity. Gerontologist, 43:817-827) (Danhauer et al (2004) Do behavioural disturbances in persons with Alzheimer's disease predict care giver depression over time? Psychology and Ageing, 19: 198-202)

Young Carers (children under the age of 18 years) take on the adult role of caring for a member of their family who may be suffering from a wider range of problems, such as long term illness, mental health problems, physical disability or problems related to drug or alcohol misuse. Such responsibilities may include domestic duties, personal care, emotional support or nursing care; often impacting on their own lives, including school attendance and educational attainment, opportunities to take up further education or job roles, as well as their ability to socialise with peers, and enjoy a life outside of their caring role.

Unpaid Carers provide care and support that is often the responsibility of health or social care services, and this support often helps in delaying the need for more costly and intensive home care, residential or health services. Carers play a key role in the effective functioning of families and communities as a whole. As more people live longer with long term conditions, more demand will be placed on unpaid Carers. Therefore they need the support and skills required for caring, considering the safety and well-being of the person they care for, to help them continue in that caring role.

Dementia Carers

Caring for someone with dementia can be different from caring for people affected by other types of illness or disability because of the complex, unpredictable and progressive nature of the illness[26]. Carers of people with dementia are likely to have higher than normal levels of

stress, and report higher levels of depression than carers of other older people.[28;29]Consequently, carers' needs for practical and emotional support, to relieve the emotional stress of caring are especially high, although carers will rarely have time to look after, or seek help in relation to, their own health[30]. Female carers in particular are less likely to see their GP than would be expected.[31]

The majority of people with dementia are cared for at home by a relative or friend. As such, the role of informal carers in maintaining the independence of a person with dementia and in preventing admission into institutional care is key. It is vital therefore those carers are well supported, both to adequately care and support the person with dementia; and to ensure their own health and wellbeing. Almost half the respondents to a recent survey of people with early onset dementia felt their carer was not, or was only sometimes, getting the support they needed in their caring role[32].

It is however impossible to define any 'common core' of advice and support, because the needs and preferences of carers (and people with dementia) will be different. Advice and support therefore needs to be bespoke and specific to each individual carer, which reflects a challenge in terms of ensuring relevant specialism and expertise of staff in advisory roles.

At risk or vulnerable groups:

- Young carers
- Black and Minority Ethnic (BME) Carers
- Hidden carers (these are Carers that are not known as Carers to any agencies, services or to local authorities)
- Carers not registered with GPs
- Carers in employment
- Carers who look after people with long term conditions (including dementia)
- Lesbian, Gay, Bisexual & Transgender Carers
- Lone Parents that are Carers
- Carers that are in poverty
- Carers with learning disabilities

Benchmarking:

The Carers survey carried out in 2012 on behalf of the Health and Social Care Information Centre is a biennial survey, sought out the thoughts and opinions of Carers aged 18+on a

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[28] Wills, W. and Soliman, A. (2001). "Understanding the Needs of the Family Carers of People with Dementia", *Mental Health Review Journal*, (6)2, pp. 25–28.

[29] Moise, P, Schwarzinger, M and Um, M-Y (2004). *Dementia Care in 9 OECD Countries: A Comparative Analysis* (Paris, OECD Health Working Paper No. 13, OECD).

[30] Arksey, H, Jackson K, Wallace A, Baldwin S, Golder S, Newbronner E and Hare P. (2002). *Access to Health Care for Carers: Barriers and Interventions.* London: Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)).

[31] Arksey, H and Hirst, M (2005), 'Unpaid carers' access to and use of primary care services', P*rimary Health Care Research and Development,* 6, 2, 101–116.

[32] Alzheimer's Society (2012), *Dementia 2012 Report* (London, Alzheimer's Society).

number of topics that are considered to be indicative of a balanced life alongside their caring role.

Analysis of the data indicates that Tameside is largely on a par with the rest of the country in terms of supporting Carers. Some of the key findings are set out below:

- Nationally 57,860 people out of a sample of 126,755 Carers of Social Care users responded to the survey, which is a response rate of 46%. The Tameside response rate was 444 returns out of a sample of 900, equating to 49.3%.
- Nationally 36% of respondents reported that they were either extremely or very satisfied with the support and services that they and the person they care for received from Social Services in the last 12 months. However, 4% stated they were either very or extremely dissatisfied. Locally, 53.3% were satisfied and 8.8% were dissatisfied.
- Nationally 29% reported they have as much control as they want over their daily lives. 59% reported they have some control with the remainder (12%) stating they had no control over their daily lives. Locally, 31.2% reported they have as much control as they want, with 57.7% reporting some control and 11.1% reporting they have no control over their daily lives.
- Nationally 85% of Carers reported that they had no worries about their personal safety. A further 13% stated they had some worries about their safety. 1% of Carers reported that they were extremely worried about their personal safety. 88.2% of Tameside Carers reported that they had no worries about their personal safety, 10.2% had some worries and 1.6% of carers were extremely worried.
- Nationally the average score for Carer related quality of life was 8.1 out of a maximum possible score of 12. This is a composite measure calculated using a number of questions which cover six different outcome domains relating to quality of life.   In Tameside, the average score was 8.2.

Chart 74: Results from the National Carers Survey 2012/13
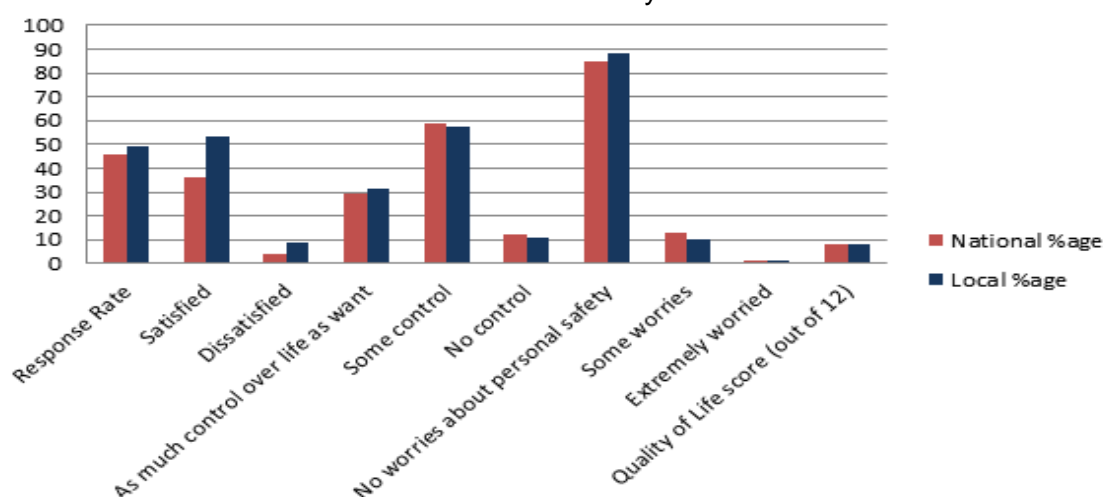
Source: HSCIC Personal Social Services Survey of Adult Carers in England - 2012-13

Policy context:

- [Recognised, valued and supported: Next steps for the Carers Strategy (2010](#)) show the government's commitment to support carers. The strategy builds on the vision and outcomes set out in the previous strategy.
- [National Strategy for Carers (2008)](#)
- [National Dementia Strategy (2009)](#)
- [National Stroke Strategy (2007)](#)

The local Joint Strategy for Carers 2011-14 adopted its vision in line with the national strategy. A key theme throughout the strategy is for carers to have access to a wide range of advice and information, to support them to carry out their caring role and having a greater choice and control over their own health needs. The Strategy will be refreshed during 2014.

What interventions work?
Carers have told us that the following are key to them being able to continue in their caring role:

- Provision of timely and accessible information, advice and support for Carers Adopting an 'early intervention and prevention' approach to help Carers stay healthy and independent
- Access to education, training, work and leisure for Carers
- Appropriate and improved support from a lead health professional to be offered to ensure early intervention when circumstances for Carers change
- Support from GPs, by providing appointments that are tailored around their caring responsibilities
- Health checks for Carers
- Improving emotional support offered by 3rd sector organisations, particularly access to bereavement counselling
- Considering Carers when developing and implementing pathways such as hospital discharge, falls, dementia, stroke and end of life.

What are we doing now?

[The Joint Strategy for Carers 2011-14](#) was launched in March 2012 and was developed by the NHS, Local Authorities, Carers and Service Users. It set out how services for Carers would be delivered over the next 4 years by Tameside MBC, Derbyshire CC and NHS Tameside and Glossop (now CCG). The main aim was to work together in partnership with Carers and local organisations to implement local actions set out in the annual action plan, which identified priorities for Carers locally and met the requirements of Department of Health.

The outcomes and actions against the priorities outlined in the action plan were regularly monitored and reported to the Carers Strategy Group during 2012/13. All identified outcomes have been met. The Strategy will be refreshed during 2013/14 and a revised action plan and performance monitoring framework produced.

Some of the actions currently delivered include:

- Appointment of GP link worker, funded by CCG, to increase GP awareness and identification of Carers registered at their Practice
- Training sessions for GP Practice staff on how to support Carers provided by the Carers Centre
- Increased support to Young Carers transitioning into adulthood
- Redesign of the Carers Breaks schemes, into the Carers Individual Grants scheme
- Holistic Carers assessments carried out by Adult Social Care and the Health and Wellbeing Service where education, training, work, leisure, home, community, health and wellbeing, daily living , managing money, contingency arrangements, emergency respite and young carers needs are taken into consideration
- Various activities offered to Young Carers by Tameside MBC, giving them time away from their caring responsibilities and safeguarding them from inappropriate caring
- Decaf in Tameside and Glossop – a social support group for carers and the people they care for (who have a dementia).
- Work with a local Carers representation group (Carers Action Group Tameside) to enable them to deliver trips and meals for Carers

What needs to happen next, and by whom?

CCG, through the GP Link Worker, to continue to ensure Carers' needs are highlighted within the responsibilities and plans of the NHS Clinical Commissioning Groups (CCGs)

CCGs to continue collaborative working with Derbyshire County Council (DCC) and Derbyshire Carers Association to commission Carers' support for Glossop residents

To continue to seek to identify new/more carers, and offer carers assessment and personalised support through more targeted outreach activity and partnership working

To refresh the Joint Strategy for Carers and the associated action plan, and to ensure that issues are prioritised for consideration at appropriate partnership meetings and Boards.

Some of the key actions will include continued activity on:

- Organisation of more Carer awareness sessions for health and social care staff, community groups, faith groups, voluntary organisations and local employers, and work with schools to identify, recognise and signpost Young Carers
- Identification of more Carers within primary care settings, acute trust and community settings including staffs that are Carers. This also includes Carers within military families
- Promotion of information, advice and support for Carers
- Involving Carers, including Young Carers, in service planning, development and changes
- Ensuring Carers are not financially disadvantaged through access to appropriate Benefit advice
- Reducing the waiting time for assessments both for Carers and the people they support
- Continued development of flexible support services and emergency short term situations

- Continued work with relevant professionals/organisations to identify Young Carers, protecting them from inappropriate caring and giving them the right to be children
- Ensuring that the link between the Carers' Strategy and Dementia Strategy is supported in practical terms
- Reviewing the Carers Individual Grant scheme
- Implementing the Support Bill.
- Specific support to carers of people with dementia, accounting for specific emotional needs.

Take up of the NHS Health Checks Programme

Outcomes framework: Public Health 2.22

Indicator Name: including
Take up of NHS health Checks Programme
Cumulative % of eligible population (40-74) *offered* an NHS health check
Cumulative % of eligible population (40-74) *received* an NHS health check
Cumulative % of eligible population (40-74) *offered* & received an NHS health check

Implications for the population's health and well-being:

Collectively, vascular disease (heart disease and stroke), diabetes and kidney disease, affect the lives of more than four million people and kill 170,000 every year. They also account for more than half the mortality gap between rich and poor.

- Heart and circulatory disease is the UK's biggest killer - in 2009, deaths of around one in five men and one in eight women died were from coronary heart disease.
- Stroke is the main cause of disability in the UK. It's the third most common cause of death. But many strokes can be prevented, through small and long-term changes to your lifestyle.
- Approximately 2.9 million in UK suffer from diabetes. It can also increase risk of vascular diseases, such as heart disease. Type 2 diabetes is linked to being overweight, and accounts for 90% of cases of diabetes.
- Chronic kidney disease is thought to affect between one and four people out of every 1,000 in the UK. But risks can be minimised making small, long-lasting changes to your lifestyle

Modelling work undertaken by the Department of Health found that offering NHS Health Checks to people between 40 and 74 years, and recalling them every five years would be clinically and cost effective.

At risk or vulnerable groups:

Patients aged 40 -74 years who are not currently on a disease register for heart disease, stroke, hypertension, and diabetes and kidney disease.

Benchmarking:

Table 12: NHS Health Checks – Local target and performance

Tameside and Glossop	Invites Sent	Health Checks Delivered	% Uptake
2010-11	3,294	2,150	65%
2011-12	18,242	7,614	41%
2012-13	13,871	7,328	53%
TOTAL	**35,407**	**17,092**	**48%**

Source: NHS Tameside and Glossop, 2014

Table 13: NHS Health checks 2013-2018 – Progress at January 2015

Total eligible population 2013-2018	66687	
Number (%) of people who were offered	23913	35.9%
Number (%) of people that received	8864	13.3%
Percentage of people that received an NHS Health Check of those offered	37.1%	

Source: Public Health England

Due to low numbers of NHS Health Checks in 2010/11, the GP service contract was redesigned, and provided by 41 GP Practices. An additional incentive to send invitations was piloted during 2013-14, and further revision made to the contract for 2014/15.

Chart 75: Number of NHS health checks, Tameside, 2013/14
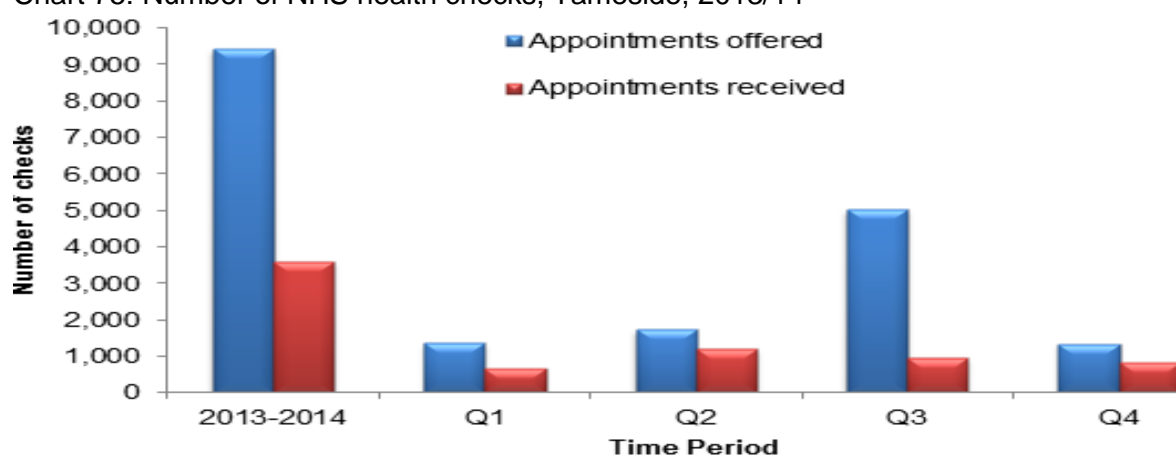
Source: NHS Tameside and Glossop, 2014

A Community Health Checks programme during 2012/13 contributed to better uptake, and a detailed Health Equity Audit confirmed the impact of this approach on broadening engagement. A revised Community NHS Health Checks service was commissioned in 2014.

The combination of the changes to the GP contract and addition of the community programme have increased the numbers of invitations and checks received.

Table 14: Number of Invitations for NHS health checks, Tameside MBC

Tameside	Invitations sent	Health Checks	% received
2013-14	9,420	3598	38.2%
2014-15 (April to December)	14,493	5266	36.3%

Source: Public Health England, 2014

Policy context:

In 2008, the Government announced its intention to shift the focus of the NHS towards empowering patients and preventing illness. As part of this, the health checks programme was outlined to dramatically extend the availability of 'predict and prevent' checks. The NHS Health Checks programme was designed to provide people with information about their health, support lifestyle changes and, in some cases, offer early interventions.

- NHS Health Checks
- Putting prevention first - vascular checks: risk assessment and management

The NHS Health Check implementation review and action plan in July 2013 confirmed the cost effectiveness and commitment to the programme.

What interventions work?

Local experience strongly suggests that a combined GP and community programme is best suited to the local population. During 2013/14 a review of NHS Health Checks was undertaken by the Tameside Personal and Health Scrutiny Panel. This included a stakeholder event involving providers, service users and commissioners. There was significant support for the programme, particularly the reintroduction of the Community Health Checks programme.

What needs to happen next and by whom?

- Continue with GP contract to ensure:
  - uptake of health checks is optimised
  - general practice capacity is sufficient to meet demand for health checks
- Community programme to:
  - target group with lower uptake
  - pilot in pharmacies
  - have sufficient capacity

Access to non-cancer screening

Outcomes framework: Public Health 2.21

Indicator Name: including
Non cancer screening programmes
Diabetic eye screening (see Diabetes section)

Implications for the population's health and well-being:

NHS Abdominal Aortic Aneurysm Screening Programme contributes to reducing premature mortality from cardiovascular disease. An abdominal aortic aneurysm is a weakening and expansion of the aorta, the main blood vessel in the body. Large aneurysms are rare but can be very serious, and approximately 3,000 men aged 65 and over in England and Wales die every year from ruptured abdominal aortic aneurysms.

At risk or vulnerable groups:

Men are invited for a "one-off" screen in the year they turn 65 years of age.

Benchmarking:

Tameside residents are included in the Greater Manchester screening programme for which attendance is in line with the North and England average.

Chart 76: Percentage attendance of men eligible for AAA screening 2013/14
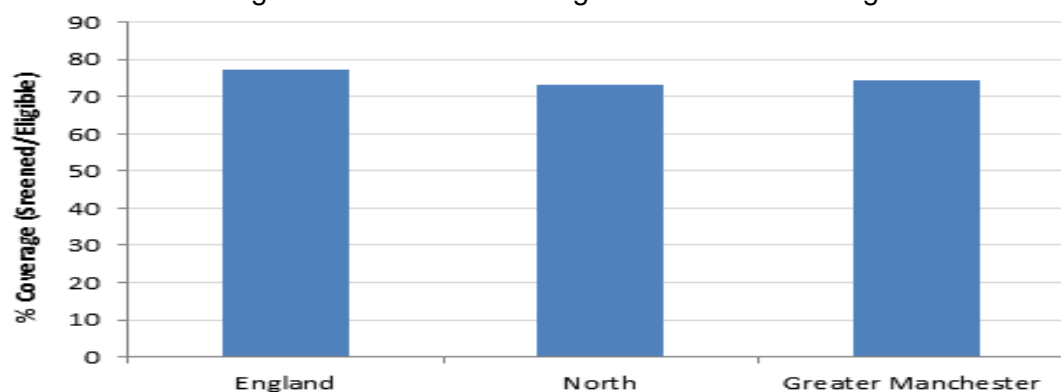
Source: www.screening.nhs.uk, 2015

The chart above illustrates that the percentage of men who are eligible for AAA Screening in 2013/14 and attended, is similar at a Greater Manchester level to the North and England averages.

Just over 1% of men invited for screening in GM are found to have AAA, a little lower than for the North and England. In contrast, over 4% who self-refer in GM have AAA, substantially more than for the North and England.

Chart 77: Percentage of invited men found to have AAA 2013/14
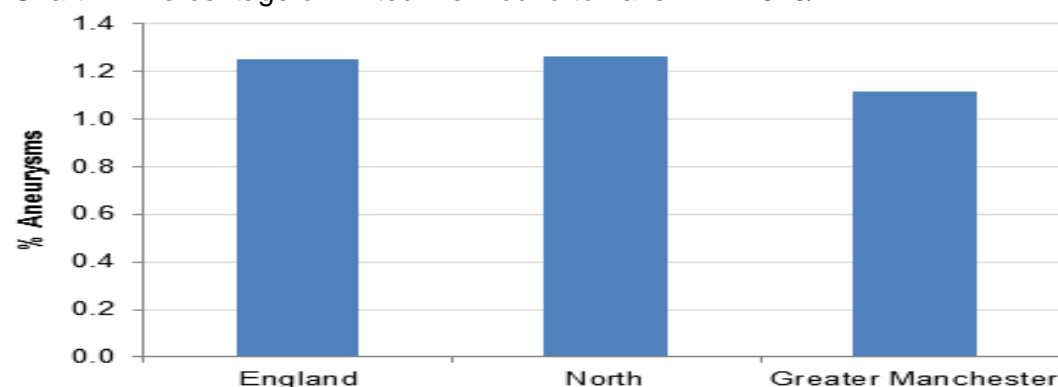
Source: www.screening.nhs.uk, 2015

The chart above illustrate that a lower percentage of men in Greater Manchester who were invited were found to have AAA than in the North and England

Chart 78: Percentage of men who self-refer for screening found to have AAA 2013/14
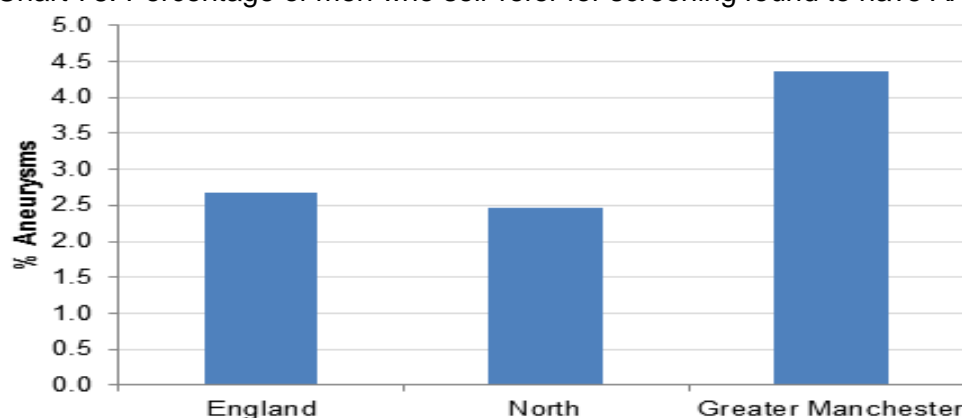
Source: www.screening.nhs.uk, 2015

The chart above illustrates that a higher percentage of men in Greater Manchester who self-refer were found to have AAA in 2013/14

Policy Context:

NHS screening programmes are developed, adopted and overseen by the National Screening Committee, and there are operating and quality assurance standards in place or under development for all programmes. A national set of KPIs are published that provide information on performance.

In 2013 responsibility for screening programmes transferred from PCTs to NHS England, with Public Health England providing advice on the specification of programmes and quality assurance. Directors of Public Health in Local Authorities are responsible for providing challenge and advice to NHS England on the performance of screening programmes.

What interventions work? (Including those from outside of Public Health & the Local Authority)

The National Screening Committee will not approve a screening programme for use in the NHS unless there are associated interventions that can improve outcomes for anyone found to have the condition screened for. There is detailed [guidance for all national screening programmes](#) .

What are we doing now?

Greater Manchester AAA Screening Programme is provided by University Hospital of South Manchester NHS Foundation Trust. The Programme covers the following CCGs: Manchester; Stockport; Trafford; Tameside & Glossop; Bolton; Bury; Oldham; Heywood, Middleton & Rochdale; Salford; Ashton, Leigh & Wigan; part of East Cheshire

What needs to happen next and by whom?

- Key challenge is to maintain coverage levels.
- Continuing challenge and advice from GM Directors of Public Health.

Cancer screening coverage

Indicator Name: including
Cancer diagnosis at early stage
Incidence of Cancer
Screening coverage for Breast, Bowel and Cervical Cancer

Implications for the population's health and well-being:

Cancer is the commonest cause of premature death in people under 75 in Tameside, and England as a whole. The chance of developing cancer increases with age, so as the number of older people continues to increase, so we can expect there to be more people with cancer. At the same time, death rates from cancer have reduced in the last twenty years, so the chance of dying from cancer is reducing. Stopping smoking, screening and better treatments have all helped to make this change. But if unchecked, current increases in obesity and alcohol consumption will result in increases in cancer in the future.

Breast cancer is the commonest cancer in women in Tameside, and a significant cause of long term illness and death, but early detection and effective treatment have improved the outlook over the past 20 years. Cervical screening enables the early detection and treatment to prevent the development of, and progression of, cervical cancer and the national programme is estimated to prevent about 4,000 cases of cancer and save about 4,500 lives each year.

The likelihood of developing breast or cervical cancer increases with age, which means that as the number of older people in Tameside increases there will be more cases of breast and cervical cancer. Obesity increases the risk of breast cancer, so the increasing obesity in Tameside will also result in an increase the number of women with breast cancer.

At risk or vulnerable groups:

Cancer is commoner and mortality generally higher in deprived communities, older people and men. There are significant differences between areas across England and within the North West.

According to the Reducing Cancer Inequality Report, it is also estimated that if survival from cancer in England was as good as the best in Europe about 66 lives would be saved in each PCT area per year.

Whilst breast cancer occurs in both men and women, the risk is much greater in women, so the breast screening programme is only offered to women. Women who have a family history of breast cancer are at greater risk, and those at highest risk are screened more often in line with NICE guidance. There is evidence that Lesbian, Gay, Bisexual and Transgender (LGBT) women do not access breast or cervical screening services as readily as most women (NHS Cervical Screening Programme, 2009).

Women with learning difficulties generally require additional support when accessing screening services, and this has been recognised in guidance developed by the breast and cervical screening programmes (NHS Cancer Screening Programme, 2006).

Invitations for breast and cervical screening are restricted to specific age groups at greatest risk (47 to 73 years for breast, and 25 to 64 years for cervical). Women over the target age groups may choose to be screened, but younger women may not.

Benchmarking:

Cancer is the most common cause of death in Tameside for males and females, and there are significantly more deaths than there should be, given the population age and gender profile.

The chart below illustrates that Cancers are the commonest cause of premature death in Tameside – responsible for 38.2% of all deaths in males under 75 years, and 49.7% of deaths in females under 75 years in 2014.

Death rates for all cancers as a whole are higher in Tameside than the average for the North West and England for under 75s and at all ages.

Chart 79: Mortality from All cancers, Under 75s (DSR), 2011-13
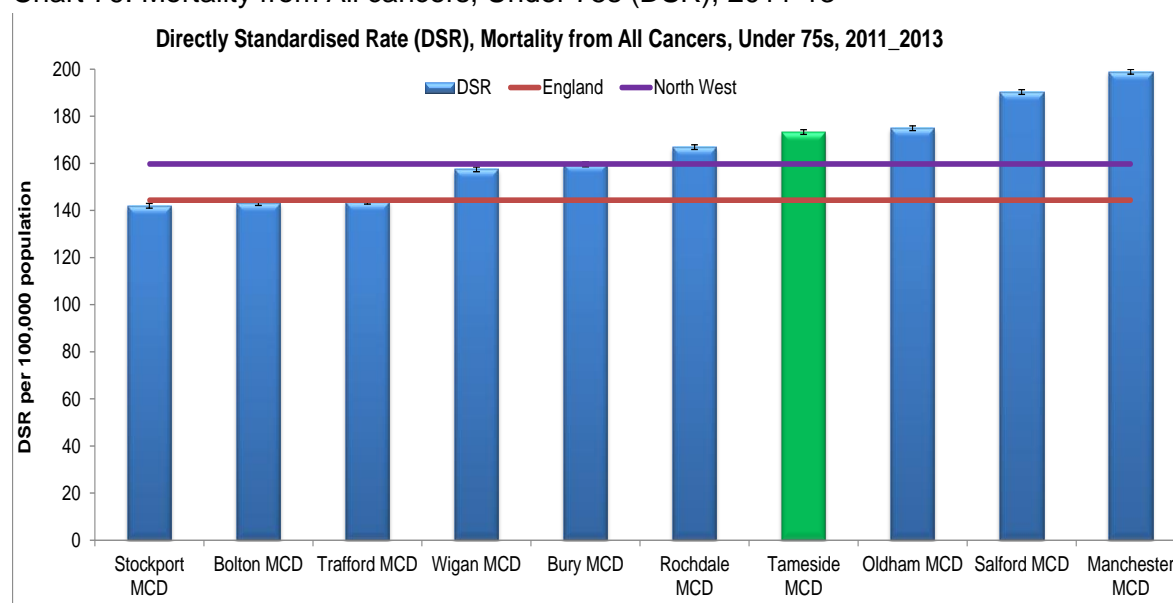
Source: HSCIC, 2015

Chart 80: Mortality from all cancers, under 75 years, (DSR), 2000 to 2013

Directly standardised rate (DSR) per 100,000 population, mortality from all cancers, Under 75 years 2000 to 2013
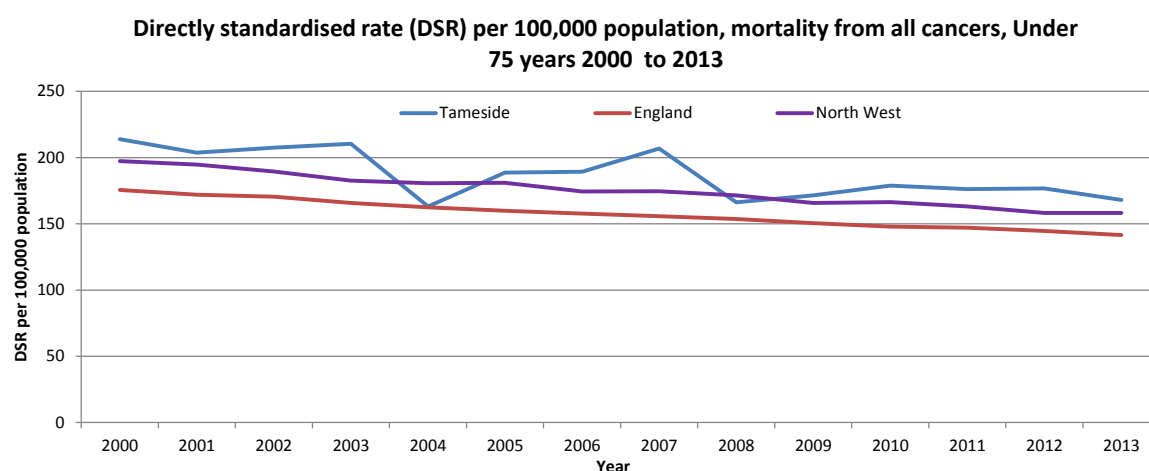
Source: HSCIC, 2015

The chart above illustrates that Tameside consistently has a higher rate of mortality from cancer in the under 75 years population, than either the North West or England.

Local uptake of breast screening is consistently above the national standard. Uptake of cervical screening has been reducing in recent years in line with a national trend of fewer young women being screened.

- **Breast Screening**: Women aged 50 to 70 are invited for breast screening every 3 years. Nationally there is a reduction in coverage across all age groups. This trend is reflected in Tameside and Glossop, where coverage is 74.7%; however this is above the minimum programme standard of 70%. There will be forward planning next year for the service to provide additional screening capacity.
- **Cervical Screening**: The eligible population is women aged 25 to 64 years. Women aged 50 to 64 are invited for cervical screening every 5 years. Nationally there is a reduction in coverage. This trend is reflected in Tameside and Glossop, where 25 to 64 years of age coverage is 79%, which is below the minimum programme standard of 80%.
- **Bowel Cancer Screening**: Men and women aged 60 to 74 years are invited for bowel screening every 2 years. Nationally coverage is lower than for breast and cervical screening. In Tameside and Glossop uptake is 50.30% (2013/14) which is below the minimum programme standard of 52% standard.

Table 15 and table 16 below show screening coverage rate and uptake for Tameside and Glossop, the North West and England. They illustrate that breast screening has decreased slightly in the last 3 years. Cervical screening in Tameside and Glossop has remained fairly consistent being higher than both the England and North West averages.

Table 15: Breast screening coverage (2007/08 to 2012/13)

Indicator definition	% of eligible women who have had a mammogram with a recorded result at least once in the previous 3 years			Performance threshold/acceptable standard	70%	
	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
NHS Tameside and Glossop	74.7	76.3	76.4	75.1	74.8	74.7
North West	72.3	73.2	73.0	72.0	71.5	74.1
England	73.2	73.6	73.2	73.4	73.1	76.4

Source: Breast Screening Programme, England 2012-13

Table 16: Cervical Cancer Screening Uptake (2007/08 to 2012/13)

Indicator definition	% of eligible women who have a recorded adequate test result within the last 5 years			Performance threshold/acceptable standard	80%	
	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
NHS Tameside and Glossop	79.3	79.6	79.2	78.8	78.8	79
North West	78.2	78.5	78.4	78.0	78.1	76.1
England	78.6	78.9	78.9	78.6	78.6	78.3

Source: Cervical Screening Programme, England 2012-13

Policy Context:

- Improving Outcomes: A Strategy for Cancer DH 2012. The NHS Cancer Plan and Cancer Reform Strategy
- Tameside Health and Wellbeing Strategy
- PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop. June 2010.

Breast and cervical screening are national programmes provided in line with national guidance from the National Screening Committee which is regularly reviewed and updated.

The age range of the breast screening programme is currently being extended beyond 50-70 years to 47 to 73 years.

In 2013 responsibility for screening programmes transferred from PCTs to NHS England, with Public Health England providing advice on the specification of programmes and quality

assurance. Directors of Public Health in Local Authorities are responsible for providing challenge and advice to NHS England on the performance of screening programmes.

What interventions work?

About 50% of cancer is preventable, and survival is improving for all cancers with early detection and better treatments. PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop, sets out how the challenge of reducing the impact of cancer on local communities will be met. Alcohol and obesity make significant contributions to cancer risk. Effective and timely treatment is also essential to reducing cancer mortality.

It is important to provide good information to women about the benefits of screening, and what examinations involve. The most effective approach to good uptake of breast and cervical screening programmes is the sending of invitation and reminder letters when screening is due. Further reminders of appointments once booked, and reminders for those who do not attend to re-book are also very effective. Social marketing programmes can have an impact on specific groups, but are less cost-effective than reminders (Greater Manchester Public Health Practice Unit, 2009).

The national programmes provide guidance on promotion of breast and cervical screening to minority ethnic groups (NHS Breast Screening Programme and NHS Cervical Screening Programme

What are we doing now?

The key issues for action in PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop are grouped into four work-streams:
- Reducing inequalities with a focus on:
  - Gender
  - Social deprivation
  - Age
  - Ethnicity
  - Disability
- Lifestyle
  - Reduce the prevalence of smoking
  - Improve the diet of the population
  - Reduce the prevalence of obesity and overweight
  - Increase the amount of physical activity
  - Reduce the excessive consumption of alcohol
- Targeted programmes
  - Reduce exposure to specific causes of cancer
  - Reduce the spread of infections that can cause cancer
- Early detection
  - Improve communication about cancer signs and symptoms
  - Make diagnostic pathways follow best practice and be available to all
  - Improve attendance at cancer screening especially in disadvantaged groups

What needs to happen next and by whom?

- Stopping smoking, as well as taking up healthy eating, physical activity and reducing alcohol intake all help to prevent cancer. There are partnership strategies in place to address each of these and these should be actively supported as part of cancer prevention.
- Deliver priorities for local action within PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop.
- Consistent achievement of good NHS Cancer Waiting Time performance.

People with mental illness and/ or learning disability in settled accommodation

Outcomes Framework:

- Public Health 1.6i: Percentage of adults with learning disabilities known to social services who were in settled accommodation at the time of their latest assessment.
- Adult Social Care 1G: Proportion of adults with learning disabilities who live in their own home or with their family
- Public Health 1.6ii: Percentage of adults receiving secondary mental health services known to be in settled accommodation.
- Adult Social Care 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support

Implications for the population's health and well-being:

Enhancing the quality of life for people with care and support needs, by ensuring people are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation. The aim is to improve outcomes for adults with mental illness/ learning disabilities by demonstrating the proportion in stable and appropriate accommodation. The nature of accommodation for people with mental illness/learning disabilities has a strong impact on their safety and overall quality of life and the risk of social exclusion.

Living on their own or with the family is intended to describe arrangements where the individual has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium to long-term, or is part of a household with tenure/residency. Situations included within this scope are:

- Owner occupier/shared ownership scheme (where tenant purchases percentage of home value from landlord).
- Tenant – Local Authority/Arm's Length Management Organisation/Registered Social Landlord/Housing Association.
- Tenant – private landlord.
- Settled mainstream housing with family/friends (including flat-sharing).
- Supported accommodation/Supported lodgings/Supported group home (accommodation supported by staff or resident caretaker).
- Approved premises for offenders released from prison or under probation supervision (e.g. Probation Hostel).
- Sheltered Housing/Extra care sheltered housing/other sheltered housing.
- Mobile accommodation for Gypsy/Roma and Traveller community.
- Shared Lives scheme.

Non-settled accommodation refers to accommodation arrangements that are precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice. The accommodation types that represent non-settled accommodation for the purpose of this indicator are:

- Rough sleeper/squatting.

- Night shelter/emergency hostel/direct access hostel (temporary accommodation accepting self-referrals).
- Refuge.
- Placed in temporary accommodation by Local Authority (including Homelessness resettlement) – e.g. Bed and Breakfast.
- Staying with family/friends as a short term guest.
- Acute/long stay healthcare residential facility or hospital (e.g. NHS or Independent general hospitals/clinics, Long stay hospitals, specialist rehabilitation/recovery hospitals).
- Registered Care Home.
- Registered Nursing Home.
- Prison/Young Offenders Institution/Detention Centre.
- Other temporary accommodation.

At risk or vulnerable groups:

Adults aged 18 – 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).

Adults who receive long term support during the year with a primary support reason of Learning Disability.

It is also important to recognise that there will be a proportion of adults with mental illness / learning disability who are not accessing mainstream support services.

Benchmarking:

In Tameside, the proportion of people with learning disabilities living in settled accommodation is higher than the North West and England average.

Amongst people with mental health problems, there has been a recent increase in those in settled accommodation. Local figures are now much higher than the average across the North West and England.

Table:17 The Proportion of adults with learning disabilities and mental health problems, in settled accommodation, (with or without support).

People with:	Learning Disabilities	Mental Health Problems
2009/10	74.9%	63.4%
2010/11	65.2%	91.8%
2011/12	93.8%	69.4%
2012/13	93.7%	77.2%
2013/14	93.7%	85.9%
2013/14 - Regional	87.9%	74.9%
2013/14 - National	55.4%	60.8%

Source: Pennine Mental Health Trust and Tameside MBC

Policy context:

[Supported Living – Making the Move](#) : Developing Supported Living options for people with learning disabilities

What interventions work?

- Re-ablement
- Routes to Work for pre-employment training
- Housing Strategy for appropriate housing
- Telecare systems to promote independent living.
- A mixed economy of housing options including Extra Care Housing
- Shared Lives scheme
- Aids, Adaptations and equipment.

What are we doing now?

- We are refreshing the Learning Disabilities (LD) and Mental Health (MH) housing strategy to ensure that future housing is accessible for the MH and LD population.
- All new builds are being designed with future planning in mind.
- Promotion of personal budgets to offer increased choice and control.
- Expansion of Re-ablement services, including the use of technology to promote independent living skills and ensure people are safe.
- Development of Extra Care Housing schemes for people with LD and MH problems.
- Received accreditation by National Autistic Society to enable us to provide better support for people with Autism within their own homes.
- Programme of resettlement for people living out of borough.

What needs to happen next, and by whom?

- Continue to prioritise and expand the programmes above to meet the increasing demographics within these client groups.
- Continue to engage and involve clients groups in the commissioning and delivery of services.
- The Health and Well-being Board drive and govern programmes of joint commissioning and integrated service delivery for Health and Social care Services.

Proportion of adults with learning disabilities, mental ill health or long term conditions in employment

Outcomes Framework:

- Adult Social Care 1F: Proportion of adults in contact with secondary mental health services in paid employment.
- NHS 2.5: Employment of people with mental illness
- Adult Social Care 1E: Proportion of adults with learning disabilities in paid employment
- Public Health 1.8: Employment for those with a long term condition (LTC) including those with a learning difficulty/disability or mental illness
- NHS 2.2 Employment of people with LTC

Implications for the population's health and well-being:

Enhancing the quality of life for people with care and support needs, by ensuring people are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness, isolation, and risk of social exclusion and discrimination. Employment outcomes demonstrate quality of life and are indicative that social care support is personalised. Employment is a wider determinant of health and social inequalities.

There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits.

The measure is focussed on "paid" employment, voluntary work is excluded.

At risk or vulnerable groups:

- Adults aged 18 – 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).
- Adults aged 18-64 who received Long term Support during the year with a Primary Support Reason of Learning Disability.
- Those with long term conditions (LTC) (see more information about LTC in LTC indicator reviews).

Benchmarking:

In Tameside, the proportion of local people in employment for those with mental ill-health, performance is slightly higher than the regional average but lower than the national averages. This is a similar picture for those with learning disabilities.

Chart 81: Proportion of adults in contact with secondary mental health services in paid employment.

Adults with Mental Health in Contact with Secondary Mental Health Services in Paid Employment
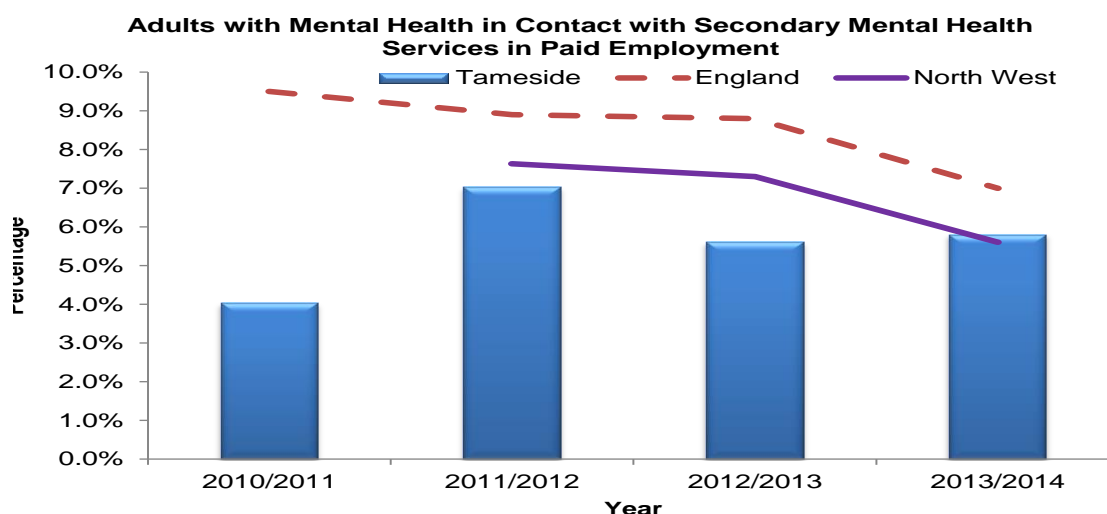
Source: Pennine Mental Health Trust

The chart above illustrates that the percentage of adults with Mental Health issues who are in contact with the Secondary mental health services and who are in paid employment is lower in Tameside than in the North West and England. The percentage for England and the North West has fallen since 2011/12, however it has stayed fairly static in Tameside.

Chart 82: Proportion of adults with learning disabilities in paid employment

Adults with Learning Disabilities in Paid Employment
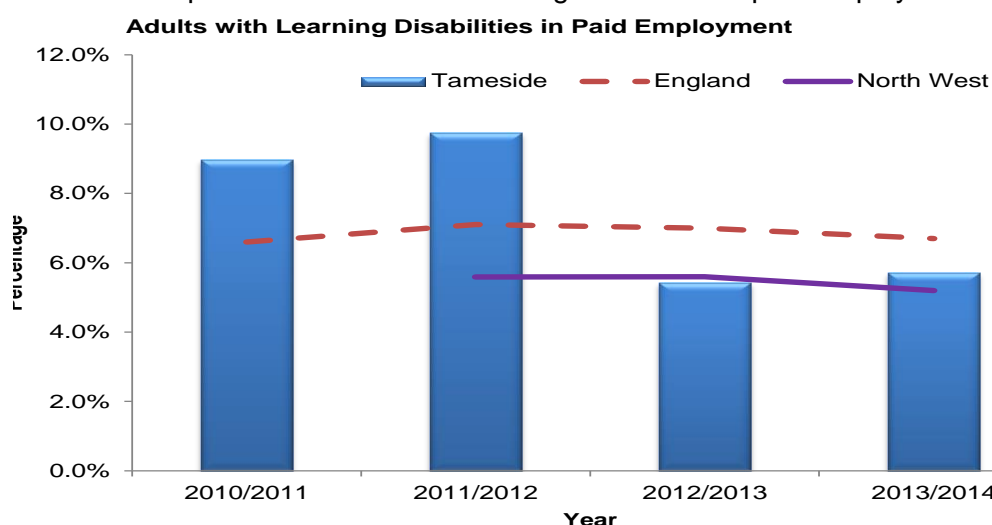
Source: *TMBC, 2015*

The chart above illustrates that in Tameside the proportion of adults with learning disabilities who are in paid employment has fallen compared to the North West and England where the proportion is fairly level.

Policy context:

- [Work, Recovery & Inclusion: Employment support for people in contact with secondary mental health services](#)

- [Improving the Employment Rates of People Using Secondary Mental Health Services: A Regional Strategy for the North West](#)
- The mental health outcomes strategy, [No Health without Mental Health](#), sets out that mental health should have parity of esteem with physical health and lists six objectives for improvement.
- [Valuing Employment Now: real jobs for people with learning disabilities](#)

What interventions work?

- Routes to Work pre-employment training
- Strong links with local employers and job centres
- Considerable investment in supporting individuals into employment

What are we doing now?

The Mental Health Local Implementation group have met and produced an action plan in relation to "No Health without Mental Health" to inform future commissioning decisions. Progress to date includes:

- Joint pilot with probation services to increase the access to psychological therapies for offenders and promote joint working.
- Increasing Access to Psychological Therapy (IAPT) - for the last 3 quarters the recovery rate has been over 50%. Targets include getting people back into work.
- Plans in place to increase the uptake of primary care mental health services for older people and people from Black and Minority Ethnic (BME) groups. The range of referrers has been increased from GP's to a wider number of professionals, e.g. health visitors/district nurses, and the range of therapies has increased to include Interpersonal Psychotherapy (IPT), Eye Movement Desensitization and Reprocessing (EMDR) and mindfulness.
- Everyone on the Care Programme Approach (CPA) has an annual health check.
- Access to psychological services: The NHS Clinical Commissioning Group (CCG) supported Pennine Care MH Trust to submit a successful bid to join the Children and Young People's IAPT. A number of local staff are being trained and service redesign will follow.
- Development of an employment pathway for all client groups which includes a qualification framework for students to assist in securing paid/unpaid employment.
- Working towards the key objectives in "Valuing Employment Now" for people with learning disabilities.
- Link with the Work Programme to support long term unemployment into work.

What needs to happen next, and by whom?

- Development of an older people's pathway
- Development of an offender health pathway
- A single point of entry will be developed from April 2012 which encompasses primary and secondary care and will streamline access to services
- Develop further links with the Health Improvement team in relation to the BME networks to increase the uptake of psychological services for this minority group.

- Increase the range of therapies on offer to include Cognitive Analytical Therapy (CAT) therapy.
- A general psychological therapy pathway will be developed.
- The Local Enhanced Service (LES) component of the Primary care Mental Health service will be refreshed and re-launched.
- Continue with the pilot to increase access to psychological therapies for offenders.
- Evaluate effectiveness of pathways into early intervention for Looked After Children
- Implementation of the employment project plan which includes good practice interventions that work and is led by Adults Service Management Team.
- The Local Authority will redesign the employment pathway for people with mental health, learning disabilities, autism and physical disabilities to ensure that they have access to pre-employment training/support/qualifications to help access employment. This will be overseen by Routes to Work support in employment scheme.

Social care related quality of life

Outcomes Framework: Adult Social Care 1A

Implications for the population's health and well-being:

Enhancing the quality of life for people with care and support needs. This indicator gives an overarching view of the quality of life of users of social care. The overall quality of life measure brings together peoples experiences of eight outcomes related to social care, into a single measure: control, personal care, food and nutrition, accommodation, safety, social participation, occupation and dignity.

At risk or vulnerable groups:

All adult, social care users.

Benchmarking:

Chart 83: Social care related quality of life for Tameside, England and North West Averages
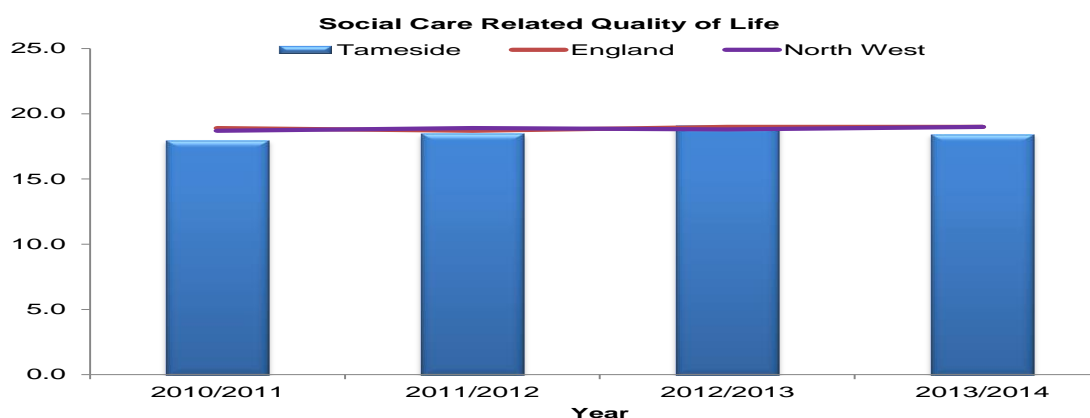
Source: TMBC, 2015

The chart above illustrates that Tameside performance in 2013/2014 is slightly below both regional and national average.

Policy context:

Social Care related quality of life is an overarching measure within the "Enhancing quality of life for people with care and support needs" outcome domain in the [2014 - 2015 Adult Social Care Outcomes Framework](#).
[Our health, our care, our say: a new direction for community services](#)

What interventions work?

- Contract Monitoring to improve quality and outcomes within commissioned services
- Regulated Services that meet national minimum standards

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- Inspections by regulators to ensure compliance and quality standards
- Assessments / Reassessments and Support Planning
- Care Management
- Personal Budgets to promote choice, control and independence
- Person Centred Planning
- Re-ablement – support to optimise capabilities and independence
- Assistive Technology
- Tele Health
- Safeguarding
- Well-being, Early Intervention and Prevention Services to improve quality of life
- Service User engagement and consultation.

What are we doing now?

- Drive and monitor improvements via the Tameside Adults Transformation Programme Board.
- Continue to restructure and transform services to ensure alignment with policy drivers.
- Produce an annual Local Account for citizens to demonstrate accountability and transparency.
- Engage in the national Sector Led Improvement Programme.
- Continue to engage and involve service users and carers in the commissioning and development of local services.
- Continue to engage with and promote shared learning with partners with regards to Dignity in Care.
- Regular reviews of Care Packages
- Maintain regular contact / communications with Independent Providers
- Learning from Complaints

Self-reported well-being

Outcomes framework: Public Health 2.23

Implications for the population's well-being[33]:

People with higher well-being have lower rates of illness, recover more quickly and for longer, live longer and generally have better health, and the Government and ONS are leading on work to develop a new measures for national wellbeing.34

Well-being can be defined simply as, "feeling good and functioning well". The term 'well-being' moves individuals into a more 'personal' space of positive feelings of happiness, comfort and lack of stress. This includes having sufficient material resources, feeling in control and having the capability to manage problems, and experiencing a sense of belonging and meaning with people and place.

Improving well-being can lead to better outcomes in employment and productivity, educational attainment, healthy lifestyle behaviours and life expectancy, and better quality of life for the individual, their family and the wider communities by broadening and strengthening networks. In addition, health is the top thing people say matters to their wellbeing.

However, it should be understood that the terms 'well-being' and 'mental illness' are different conditions. The Chief Medical Officer (CMO) explains in her most recent Annual Report35 , there is, as yet, no good evidence that achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have sub-clinical disorder (those 'languishing').' Therefore policy-makers, practitioners of and researchers in Public Mental Health (PMH) should avoid using measures of psychiatric disorder in individuals and other proxy measures to describe well-being in populations. Indeed, wellbeing and mental illness are not opposites or ends of the same continuum: it is possible to have high levels of subjective well-being despite having a mental illness and vice versa.

Nevertheless, there is utility for improving well-being and it has a more established and robust place within 'quality of life' research with strong correlation between quality of life and life satisfaction (part of well-being) measures. Therefore, the CMO recommends that wellbeing should be associated with 'quality of life' rather than attempts to link mental well-being to mental health outcomes.

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[33] Department of Health (2014) Health and wellbeing policy documents
https://www.gov.uk/government/publications/wellbeing-and-health-policy
[34] Department of Health (2014) Improving outcomes and supporting transparency Part 2: summary technical specifications of public health indicators
[35] Annual Report of the Chief Medical Officer (2013). Public Mental Health Priorities: Investing in the Evidence. Public mental health: evidence based priorities. Chapter 2 – summary.

At risk or vulnerable groups:

Particular groups at risk of poorer well-being include people with:
- long-term physical illness,
- low incomes and unemployed,
- low or no qualifications
- living in socio-economic deprivation

Benchmarking:

ONS are currently measuring individual/subjective well-being for adults (aged 16 and over) based on four questions included on the Annual Population Survey:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?
4. Overall, to what extent do you feel the things you do in your life are worthwhile?

Chart 84: Responses are given on a scale of 0-10 (where 0 is "not at all satisfied /happy/ anxious/ worthwhile" and 10 is "completely satisfied /happy/ anxious/ worthwhile)
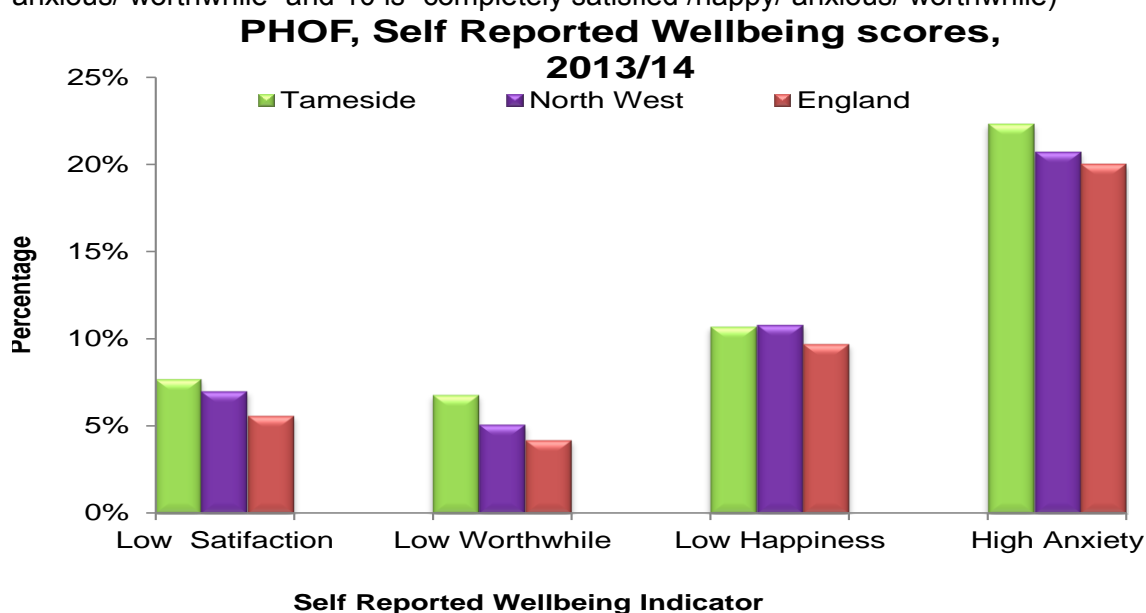
Source: Public Health Outcomes Framework, 2015

The above Chart 84: Responses are given on a scale of 0-10 (where 0 is "not at all satisfied /happy/ anxious/ worthwhile" and 10 is "completely satisfied /happy/ anxious/ worthwhile) illustrates that Tameside has a higher percentage of people with self-reported well-being scores for High Anxiety than the North West and England. Tameside also has higher percentages of people reporting low satisfaction, and feelings of low worth than the North West and England.

As part of the Tameside MBC Citizens Panel (Winter 2015), respondents were asked to answer seven questions about their feelings and thoughts during the last two weeks. These

standardised questions are used as a mental wellbeing measurement tool called WEMWBS (Short Warwick Edinburgh Mental Well-being Scale), which is used by organisations such as the NHS and local authorities to help develop strategies to improve and sustain mental wellbeing

Results have been analysed by an external company (MUQ) to Mean Scores, where the scores assigned to each response are 'none of the time' = 1; 'rarely' = 2; 'some of the time' = 3; 'often' = 4; and 'all of the time' = 5 (the higher the score the more positive the response). A total WEMWBS Score for each respondent has also been calculated by adding together the scores from the responses to each of the seven questions (Q22a-g). (This means that the maximum score possible is '35' and the minimum is '7').

Table 18: Q22a-g: Mean Scores

	Un-weighted Base Number	Weighted Mean
Q22g) I've been able to make up my own mind about things	1336	4.15
Q22e) I've been thinking clearly	1320	3.80
Q22d) I've been dealing with problems well	1333	3.65
Q22f) I've been feeling close to other people	1328	3.64
Q22b) I've been feeling useful	1323	3.57
Q22a) I've been feeling optimistic about the future	1335	3.34
Q22c) I've been feeling relaxed	1324	3.27

Source: TMBC Citizens Panel Questionnaire, winter 2014/15

As shown in the table above, for each part of the question the Mean Score was higher than the neutral score of '3': respondents were most positive in respect of the statements 'I've been able to make up my own mind about things' (Weighted Mean Score 4.15); 'I've been thinking clearly' (3.80); 'I've been dealing with problems well' (3.65); and 'I've been feeling close to other people' (3.64). This was followed by 'I've been feeling useful' (3.57), 'I've been optimistic about the future' (3.34), and 'I've been feeling relaxed' (3.27).

The total weighted mean score was 25.49, a positive result given that the 'neutral' score is '21' (when a respondent answers 'some of the time (3)' to each part of Q22).

The top line results to the Citizens Panel Questionnaire provided by MUQ from Question 22 can be seen in the chart below.

Chart 85: Citizens panel questionnaire – question 22 results.

WEMWBS results from winter Citizens Panel, March 2015
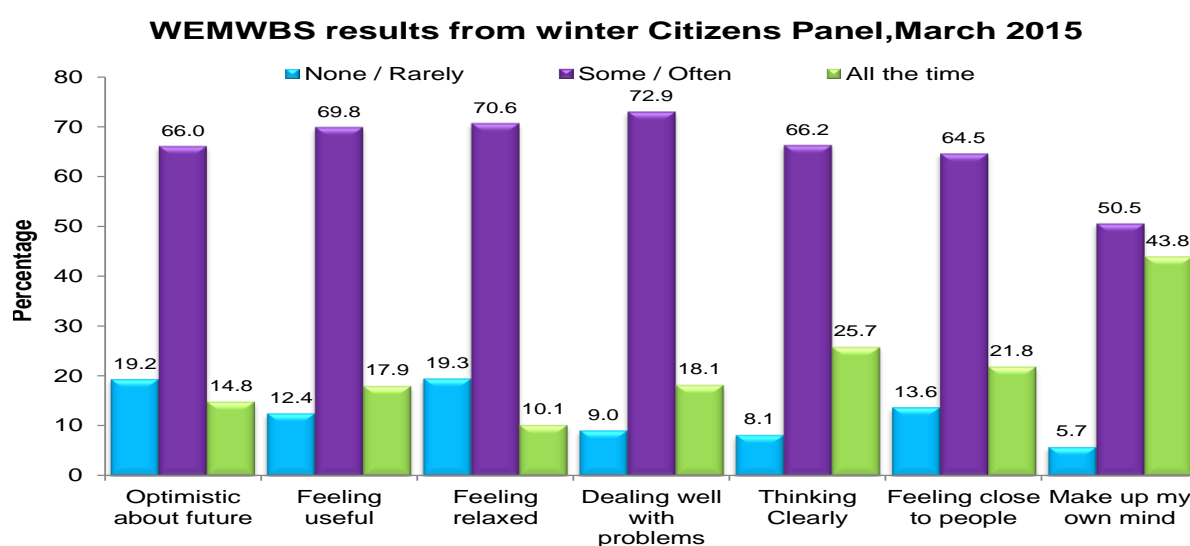
Source: TMBC Citizens Panel, winter 2014/15

Policy context:

The Tameside Health and Wellbeing Strategy has wellbeing as a central theme and has a range of activities covering the determinants of wellbeing. However, there is a need to refresh the more specific approach to wellbeing locally, using initiatives such as the wellness offer and the neighbourhood offer, whilst reflecting the changing climate of local services within Care Together, Healthier Together and Public Sector Reform.

- Wellbeing: Why it matters to health policy. Evidence on why wellbeing matters to health throughout someone's life, and what policy makers can do about it. Department of Health, February 2014.

- Five Ways to Wellbeing. New Economics Foundation.

- The Role of Local Government in promoting Wellbeing

- North West Mental Health and Wellbeing Survey. Public Health England, Centre for Public Health. Liverpool John Moore's University.

The following guidance and policy documents can help explain the differences and relationship between wellbeing and mental health, and the direction of travel for PMH going forward:

- Closing the Gap: Priorities for essential change in mental health. Department of Health (2014)

- Better Mental Health for All, Faculty of Public Health. (2014)

- Chief Medical Officer's (CMO) Annual Report (2014): Public Mental Health

- The government mental health strategy. Department of Health (2011) *"No health without mental health – a cross-government mental health outcomes strategy for people of all age".*

- NICE Guidance includes:
  - Mental health and wellbeing at work (PH22) 2009
  - Social and emotional wellbeing in early years (PH40) 2012
  - Mental wellbeing of older people in care homes (QS50) 2013
  - Occupational health and Public Health to promote mental health and wellbeing of older people in primary and residential care (PH16) 2008
  - Social and emotional wellbeing in secondary education (PH20) 2009 (update for primary and secondary education is in development)
  - Older people and independence and Mental Health and Wellbeing is in development.

What interventions work?[1]

Policy interventions which can improve wellbeing include health, learning, work, environment, social inclusion, activity and relationships, and parenting and early year's interventions. Examples include:

Social interventions
- Effective interventions to improve relationships and reduce social isolation include:
  - Time-banking
  - Social prescribing
- For older people effective policies include:
  - Befriending
  - Community navigators
  - Self-help groups

Learning interventions: Early education programmes are associated with:
- increased cognitive skills
- school preparedness
- better academic achievement
- positive effect on family outcomes

Health interventions
- Increasing physical activity has been found to improve the wellbeing of older people.
- This can be delivered through community based exercise programmes.

Parenting and early year's interventions: Pre-school interventions have been found to be the most cost effective, followed by school age interventions. Effective policies include:
- Skin to skin contact; kangaroo care
- Parental programmes
- Intensive family support and family recovery programmes

The New Economics Foundation developed the 'Five ways to wellbeing' (5WTWB), which are an evidence based list of actions that can improve the well-being for the whole population.

- Take Notice
- Give
- Connect
- Be active
- Keep learning

With regard to PMH, the CMO recommends that PMH should be framed according to the WHO model: mental health promotion, mental illness prevention and treatment and rehabilitation. 'Well-being' should not be funded in PMH but considered as one poorly-evidenced strand within the WHO model and 'Well-being' social marketing campaigns for PMH should not be rolled out unless and until there is robust evidence for their effectiveness. As further national work is required to clarify the psychometric relationships between measures of mental wellbeing and measures of mental disorder/illness, the CMO recommended that local governments should not be held to account for 'improving well-being'.

What are we doing now?

Key Achievements 2014-15

- 5WTWB was used as the central theme for the [Director of Public Health Annual](#) Report and regular articles in the Citizen publication that is distributed to all Tameside residents.
- The Public Health Team within Tameside MBC have funded a number of programmes and interventions that support and promote wellbeing and quality of life:
  - Support for community groups that promote and take up the 5WTBW via large community grants, and smaller grants via the Tameside 4 Good programme.
  - The 5WTWB have continued to be promoted across Tameside
  - Wellbeing, 5WTWB and mental health promotion are embedded within the transformed local health improvement services.
  - Activities through Age UK Tameside and New Charter Housing Trust to provide opportunities for social networking, to reduce loneliness in Tameside.
  - Pilots programmes that support development of community connections and cohesion, e.g. Health and Housing; Asset Based Community Development
  - PH has funded local third sector organisations, such as Mind Tameside and Glossop, to deliver wellbeing and mental health awareness activities in schools.
  - Older people's exercise sessions (e.g. walking football, dance) that promote opportunities for the development of social ties, to both reduce loneliness and support the adherence to programmes.

What needs to happen next, and by whom?

The action plan for the Tameside Health & Wellbeing Strategy needs to be updated with current intelligence, progress and new challenges. The issue needs to be further embedded across the life course and refocused beyond, to the wider determinants of health that all impact on personal and population wellbeing.

Access to GP services

Outcomes framework: NHS Outcome Framework 4.4i

Indicator Name: including
Access to GP Services

Implications for the population's health and well-being:

General practice undertakes approximately a million consultations each working day and is the main point of entry to other NHS services. There is over £7.7 billion invested in General Practice every year.

Easy, timely and convenient access to GP services and appropriate onward referral to specialist services, with good patient experience are essential to ensure that all patients are offered high quality patient care and value for money.

At risk or vulnerable groups:

- People with learning disabilities
- Older people
- Children and families living in deprivation
- People with disabilities
- People not registered with GP practices

Policy Context:

High Quality Care for All – Primary Care and Community Care Services: Improving GP access and responsiveness, highlights what NHS commissioning organisations and GP practices can do to improve access to GP services.

What interventions work? (Including those from outside of Public Health & the Local Authority)

- providing transparent information
- ensuring minimum standards
- providing regular insights into practice performance
- undertaking research focused on understanding the needs of the local population to address their needs
- supporting quality improvement
- engaging key stakeholders

- sharing views of the general public
- understanding the demand for services and how it can be met
- putting systems in place to manage this demand
- ensuring that practice environment supports access to information in the waiting area
- providing a patient-friendly service
- setting up patient participation groups and methods of obtaining reliable feedback

What are we doing now?

Responsibility for General Medical Services passed over to NHSE however the CCG has continued to develop plans with practices to support patients.

There are two key initiatives which focus on those patients aged 75 and over and those with complex needs. Each person has an accountable GP and for those who need it a comprehensive and co-ordinated package of care. There are a range of models that will operate as they are focused on practice populations. Key to all is a proactive approach to identifying patients and dedicated support, both clinical and social, to provide individualised plans to improve health and wellbeing.

Such support includes
Proactive contact to assess needs and identify services that may support the patient
- Practice based link workers who would identify peoples' needs (health and social care) build on relationships with community service organisations, signpost or provide information and support older people to engage
- Primary Care Navigator service/Champions
- Medication reviews to increase effective use and reduce waste
- Dedicated GP appointments
- Dedicated nurse practitioner for patients, families and carers to provide assessment, advice, Education, individual patient care
- Weekly 'ward round' of care home and house bound patients
- Integrative CBT counselling service

Our models use the relationship between patients and their practice to enable people to access additional help and develop opportunities for people to become more engaged with other services and voluntary groups such as Tameside Carers, Age UK and New Charter Housing Trust Group.

What needs to happen next and by whom?

In 2015-16 we are moving to a co-commissioning arrangement with NHSE which will enable us to develop General Practice services further.

Loneliness, Social Connectedness and Social Isolation

Outcomes framework: Public Health 1.18

Implications for the population's health and well-being:

Loneliness is:

> *"an individual's subjective evaluation of his or her social participation or social isolation and is the outcome of…having a mismatch between the quantity and quality of existing relationships on the one hand and relationship standards on the other."* [36]

Loneliness is associated with an increased risk of depression, high blood pressure, cognitive decline, dementia and heart disease. Lonely people rate their own health as poor.

People who are lonely are more likely to engage in risky life style behaviours (e.g. smoking, alcohol use, drug use, poor diet, low physical activity), placing it amongst the key public health issues facing our current population.

The majority of suicides of men aged 40-59/early 60's is due to loneliness, thus affecting mental as well as physical health.

Understanding 'loneliness' in these terms also challenges to the very core how we currently understand health as being in relation to 'illness': addressing loneliness requires a shift from the discourse about numbers of acute beds, to social determinants is needed, as well as greater investment in prevention, early intervention and wellbeing.

Loneliness should be understood as being distinct to that of social isolation – a term used often incorrectly used to describe loneliness.

Loneliness can be social, or emotional. It can also be transient, situational or chronic. Social isolation on the other hand is objective, as a measure of the number of contacts or interactions a person has. This is often used as a proxy measure when thinking about loneliness, but this cannot accurately be applied to this subjective phenomenon.

Loneliness must also be distinguished from solitude:

> *"Language...has created the word "loneliness" to express the pain of being alone. And it has created the word "solitude" to express the glory of being alone."*
> (Paul Johannes Tillich).

Social connectedness refers to the relationships people have with others and the benefits these relationships can bring to the individual as well as to society. Social connectedness is vital for health and well-being.

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[36] Perlman, D. and Peplau, L.A. (1981). "Towards a Social Psychology of Loneliness", in Duck, R. and Gilhour, R. (eds), *Personal Relationships in Disorder.* London: Academic Press.

Recently, several studies have demonstrated links between social connectedness and positive outcomes for individual health and well-being. People with a wider circle of friends are generally happier, healthier and better off than those that have limited interaction with others. Evidence has also proven that a strong sense of well-being and happiness spreads through social networks. However, as well as having a positive influence on health and well-being, social networks can also have a negative influence on health behaviours depending on the 'culture' of the group; for example, starting and stopping smoking.

Membership in groups is essential to our mental and physical health and well-being. As individuals, a large part of our sense of self is driven by group membership and social identity. Membership of groups gives us a sense of social identity whether it is sporting clubs, volunteering groups or local common-interest community groups. Our ability to access and be part of local groups is part of who we are as individuals and communities.

Linked to social connectedness is a strong sense of community cohesion and good community relations. Feelings of difference can influence individual choices around which services people feel comfortable accessing. For example, perceptions that a service is specifically targeted at one group over another can leave people feeling isolated and unwilling to seek support.

At risk or vulnerable groups:

Loneliness can affect people of any age, although there are more trigger points as we age, meaning that older people are more at risk of experiencing chronic loneliness.

A lack of social connectedness is most prevalent amongst groups that are at risk of social exclusion e.g. Black and minority Ethnic (BME) communities; ex-offenders; Lesbian, Gay, Bisexual and Transgender (LGBT) communities; migrant communities; refugees and asylum seekers, people with learning disabilities and mental health needs.

Benchmarking:

There is currently no population-based loneliness indicator, against which to understand local prevalence and to prioritise action.

A recent local consultation however of over 100 people across the borough indicated the following:
- 51% of people surveyed felt lonely either all of the time or some of the time
- There had been a trigger for feeling lonely for 59% of people
- For 47% of people, their strategies to avoid feeling lonely are to watch TV or listen to the radio
- The majority of people surveyed did not have a partner
- A majority of people (60%) had health issues that limited daily activities.

Policy context:

- [Creating the conditions for Integration](#) – UK National Integration Strategy (February 2012)
- [Tameside Community Cohesion Strategy](#)
- [Tameside Volunteering Strategy](#)
- Combatting Loneliness: A Guide for Local Authorities – Local Government Association & Campaign to End Loneliness, March 2012
- Promising Approaches to Reducing Loneliness and Isolation in Later Life – Campaign to End Loneliness & Age UK.
- Dementia 2013: The Hidden Voice of Loneliness – Alzheimer's Society

What interventions work?

Proactively identifying the points in people's lives where, 'triggers' of chronic loneliness occur, and refer into support services.

Social connectedness is fostered when family relationships are positive, and when people have the skills and opportunities to make friends and to interact constructively with others. Good health, employment, and feeling safe and secure all increase people's chances of developing positive social networks that help improve their lives.

What are we doing now?
- Delivering a range of group-based activities to prevent loneliness, in a range of different settings.
- Developing a bereavement support service to offer befriending and/or therapeutic bereavement counselling
- Promoting *The Silverline* 0800 4 70 80 90 - a 24-hour older people's helpline, offering telephone befriending, support and advice.
- Co-ordinating activity to reduce loneliness.
- Delivering cultural activity to bring people together and increase their sense of belonging.
- Providing access to networks and groups that create social connectedness (through the faith, community and voluntary sectors)
- Implementing Tameside Race Equality Framework.
- Awareness raising campaign to 'Spread the Warmth', challenging the stigma of loneliness and encouraging 'pledges' from individuals of how they can contribute to reducing loneliness.
- 5 ways to well-being promotion and community grants

What needs to happen next, and by whom?

- Public Health England (PHE) recognises loneliness as a determinant of health, and as such prioritises it as a public health issue. PHE has five key messages in relation to loneliness, calling all stakeholder organisations to action:

1. ***Government needs to be seen as an enabler to address loneliness***, to convene partnerships around the issue. Localities need to be asking central/local government what it is doing to build networks and facilitate local action.
2. **PHE calls for data and measures of loneliness** – a briefing paper will be published soon, with a population-based measure being developed.
3. ***Loneliness is a key factor in all other public health issues.***
4. ***Local action is virtue***: Local Government must make it easier for locally embedded community groups and organisations to do what they need to do to address loneliness.
5. ***Men and loneliness needs to be prioritised***: there is a link between loneliness-related suicide in men and the uptake of unhealthy ways of coping with difficulties in their relationships and emotions, rather than finding ways to talk about them.

- Develop understanding locally of the link between social connectedness and health and well-being
- Development of a population-based loneliness indicator by Public Health England, against which to understand local prevalence and to prioritise action.

Statutory homelessness

Outcomes framework: Public Health 1.15

Implications for the population's health and well-being:

Homelessness is the most extreme form of social exclusion and is a strong indicator of social injustice in any society.

The prevention of homeless in Tameside continues to be a key priority for the Council and its partners. Households experiencing homelessness or who are threatened with homelessness are trapped in cycles of deprivation that impact on their health, emotional wellbeing and life chances. The effects on children within households experiencing or threatening homelessness can be lifelong.

At risk or vulnerable groups:

The links between homelessness and health inequality are now well established by research and include a range of both physical and mental health conditions including respiratory issues, poor dental health, skin diseases, depression, and schizophrenia and substance dependency. Research collated by Homeless Link illustrated that:

- 80% of homeless people have more than one health condition
- 70% of homeless people have at least one mental health condition
- People who sleep rough are 200 times more likely to contract tuberculosis than the general population.
- A third of rough sleepers have attempted to commit suicide

Benchmarking:

The level of households found to be unintentionally homeless and in priority need over the past 12 months has remained relatively stable despite there being a drop in the number of people making homelessness applications in the first place.

The tables below illustrate the main reasons behind statutory homeless in Tameside compared to the north-west as a region. Both record the violent breakdown of a relationship with a partner as the largest single cause of homelessness contributing just over 23% in Tameside and just over 20% in the north-west. Tameside's figure for this indicator is much closer to the regional figure in 2013/14 compared to the previous year when there was an 8% difference.

In Tameside the percentage of homelessness caused by parents no longer willing to accommodate is recorded as 3.6% compared to 12.2% across the region as a whole. Some of this difference can be explained by the effective joint protocol that is place between Customer Services and Advocacy and Children's Social Care clearly outlining the approach to take when 16 & 17 year olds present to the Council as homeless. This approach ensures

that the young person is properly assessed and contact made with their family to fully explore the options for returning home.

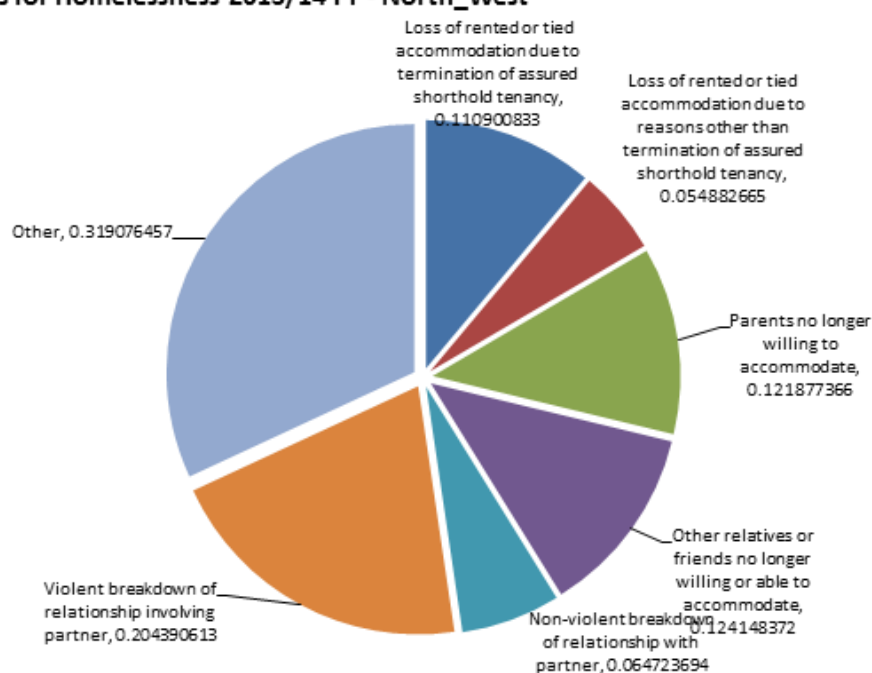Chart 86: Homelessness statistics provided by the Department for Communities and Local Government (DCLG) 1. This includes comparative data for the North West.

Reasons for Homelessness 2013/14 FY - Tameside

Loss of rented or tied accommodation due to termination of assured shorthold tenancy, 0.017857143

Parents no longer willing to accommodate, 0.035714286

Other relatives or friends no longer willing or able to accommodate, 0.125

Non-violent breakdown of relationship with partner, 0.107142857

Other, 0.482142857

Violent breakdown of relationship involving partner, 0.232142857
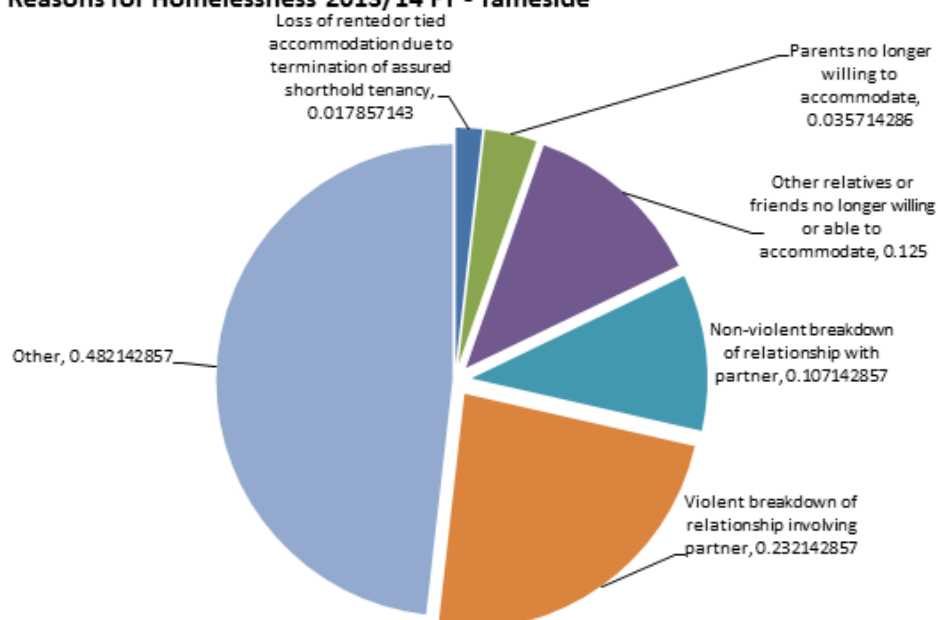
Reasons for Homelessness 2013/14 FY - North_West

Loss of rented or tied accommodation due to termination of assured shorthold tenancy, 0.110900833

Loss of rented or tied accommodation due to reasons other than termination of assured shorthold tenancy, 0.054882665

Parents no longer willing to accommodate, 0.121877366

Other, 0.319076457

Other relatives or friends no longer willing or able to accommodate, 0.124148372

Violent breakdown of relationship involving partner, 0.204390613

Non-violent breakdown of relationship with partner, 0.064723694

Source: Dept. for Communities and Local Government, 2015

Policy Context
- Health and Wellbeing Strategy 2013-16

- Troubled Families
- Sustainable Communities Strategy
- [Tameside Housing Strategy 2010-16](#)
- [Tameside Homelessness Prevention Strategy 2013-18](#)

What interventions work?

The Homelessness Prevention Strategy has identified the following 4 key strategic themes.

- Early Intervention and Prevention
- Accommodation and Access
- Positive Move-On and Sustainability
- Improving Health and Wellbeing

What are we doing now?

Early Intervention and prevention

We have continued to focus on the prevention of homelessness as the most effective method of assisting people overcome difficulties with their housing. Our reporting on prevention now includes cases recorded by the Citizen Advice Bureau where their customers considered themselves at risk of becoming homeless prior to their intervention. This has complemented the strong partnership approach we have taken and adds to the prevention work already recorded by Tameside Housing Advice, the Welfare Rights team and the Sanctuary service.

The numbers of recorded prevention cases over the past 12 months has remained relatively stable with a 4% increase on the numbers achieved over the previous period. There are now more cases where prevention has been achieved by helping people access alternative accommodation as opposed to helping them retain their existing living situation.

Mitigating the impact of Welfare Reform

Through the action plan accompanying the Homelessness Prevention Strategy we have identified specific objectives connected with enabling households to meet the challenges presented by welfare reform and other forms of austerity. We have set targets to increase the number of referrals our Registered Providers make to specialist advice services when they have identified households who may be facing financial hardship. This could be in the form of referring to money advice at the start of a tenancy or a referral to Tameside Housing Advice where legal repossession proceedings are being considered. A multi-agency pre-eviction protocol has been written to help with the latter process.

Positive Move-on

Tameside's Preventing Homelessness Forum chose to promote the role employment can have in helping people develop a greater range of independent living skills and increased resilience against the risk of homelessness in the future. With this in mind a networking event was held in December 2014 between homelessness agencies and Jobcentre Plus with

the stated aim of improving mutual understanding between the respective sectors. The key learning points from a Jobcentre Plus perspective was the increased understanding of the support planning process undertaken by supported housing workers. Staff from the homelessness sector gained a better understanding of the claimant commitment required from people when they claim benefits and an insight into how they could help this process.

Gold Standard

In the summer of 2014 Tameside Council along with its partners took part in a peer review of their homelessness service alongside Stockport and Manchester Council's respectively. This process was part of the Gold Standard challenge developed by the National Practitioner Support Service with the support of the government. Tameside achieved a positive score of 67% overall and was commended on a number of aspects and in particular its partnership arrangements, public information on the website, the level of customer service at Housing Advice and the quality of its temporary accommodation facilities.

Improving Health and Wellbeing

The Hospital Discharge (Homelessness Prevention) Protocol was approved by the Health and Wellbeing Implementation Group in May 2014 and Tameside Public Health have agreed to fund the specialist advice worker attached to the protocol for a further 2 years commencing in April 2015. Plans are in place to promote the importance of homelessness prevention at the General Practitioner network meetings and will include the contact details of all the key services engaged in frontline work.

What needs to happen next, and by whom?

Homelessness Prevention

Over the next 12 months we will continue to make the prevention of homelessness a priority and seek to promote that message across a wider range of agencies. We particularly want to refocus on promoting initiatives that assist households that remain in their own home. We will be improving our joint approach towards tackling illegal evictions by landlords and looking at other initiatives that can contribute towards improving the quality of private sector accommodation and increasing customer confidence in finding suitable properties from this source.

Housing Options

Tameside Housing Advice will continue to take the lead on accessing and improving upon the housing options available to homeless households. More resources have been made available to the Councils Housing Register and together with improving access to the private rented sector we expect to see more households accommodated over a shorter time frame.

Strengthening Partnerships

We intend to build upon the positive outcome of the networking event held with Jobcentre Plus and set some joint working initiatives that strengthens our partnership and further emphasises the role employment has in moving people away from dependency and towards greater resilience.

In the next action plan attached to the Homelessness Prevention Strategy, we intend to set ourselves some specific targets related to improving the liaison and communication with key health partners with the aim of achieving effective referrals into housing, advice and other specialist support services.

Reducing Reoffending

We have considered the indicators in relation to both the National Offender Management Targets of reducing reoffending, GMPT 3 year Plan and the transforming rehabilitation Agenda and also within the Tameside 'Joint Health and Well-Being Strategy 2013 - 2016' , the aims of which complement each other inextricably. We have assessed the crimogenic needs of our cohort against the aims of the wellbeing strategy and will highlight areas of current successful delivery within these key areas. We will then further draw on where we might increase, expand or create services aimed at reducing reoffending and encouraging wellbeing and health among the cohort and larger community within Tameside.

Implications for Population's health and well being

We know that 90% of prisoners have a diagnosable mental health or substance misuse problem or both and more than 80% of offenders smoke –and these patterns are reflected amongst those on Probation Community caseloads. There are many advantages to Health Service and Criminal Justice organisations working in partnership, particularly when financial resources are limited and the need for value for money to intervene before these situations become even more acute. Supporting offenders to choose and maintain healthier lifestyles can have a significant impact on the Health Service. These include reducing alcohol related crime which directly impacts upon medical services such as A&E departments. Likewise obesity, poor nutrition, smoking, sedentary lifestyles, feelings of wellbeing and excessive drinking are all life style issues that are resulting in high health care costs through emergency admissions, hospitalisation, community services, prescribing costs, disease and infirmity as well as related costs of incapacity benefits.

At Risk or Vulnerable Groups

In order to holistically manage our offenders we carry out an assessment utilising the Oasys management system. This tool allows practice staff to plot key indicators regarding an individual's needs and any vulnerability that will impact on the likelihood of them reoffending. The indicators that are most relevant to Tameside's JSNA data capture are: Sex, Age, Disability, Ethnic Origin, Parental Responsibility, Education, Finances, Housing, Employment, Mental Health, Drug Use, Alcohol Use, and Violence Relating to Domestic Abuse, Emotional Issues, and Well Being. The below demonstrates the averages for the above through the most recent 3 month period which we believe to be within the norm for our cohort.

- 87% of offenders are White Caucasian
- 10% of offenders are female
- 22% of offenders have a disability
- 14% of offenders are of no fixed abode
- 46% of offenders are unemployed
- 38% of offenders have learning difficulties
- 26% are in financial hardship
- 23% have a problem with using drugs
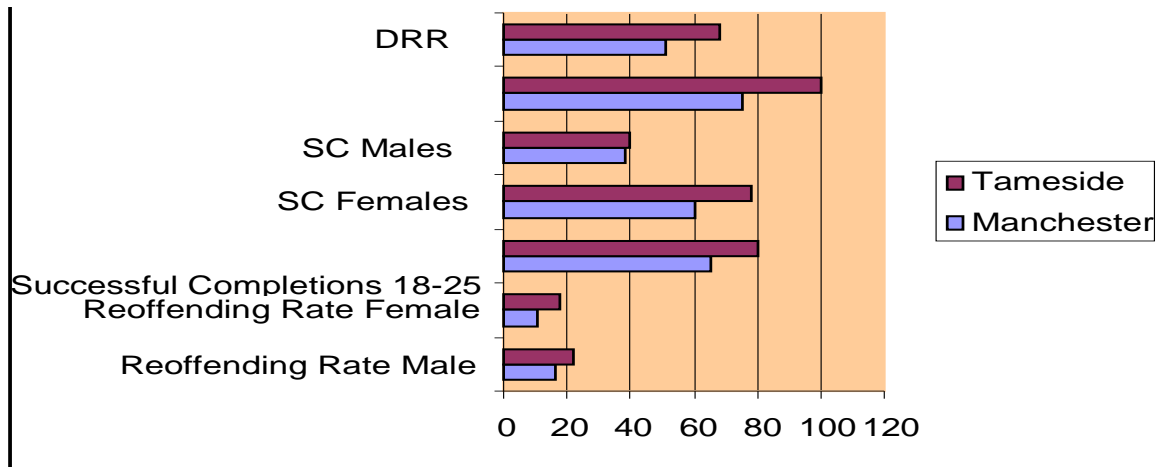- 57% have problems with alcohol

- 75% have mental health and coping issues
- 25% are in poor health
- 24% are DV offenders

Chart 87: Relevant JSNA Indicator Average for most recent 3 month
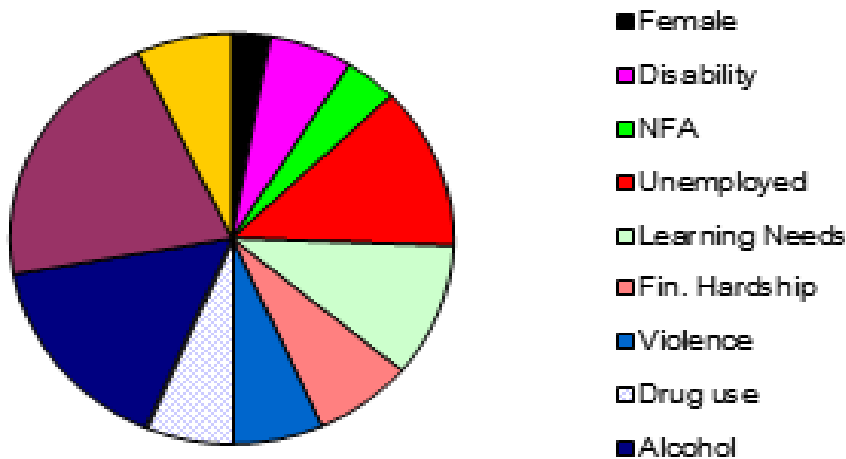
Source: TMBC, 2015

Chart 88: Reducing reoffending figures and completion rates for priority groups, Tameside, 2013
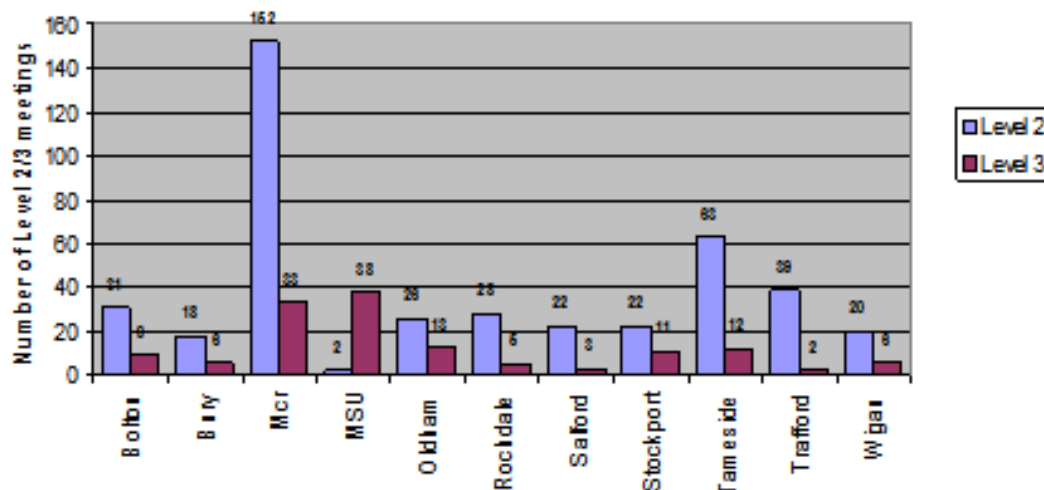

Source: TMBC, 2015

The headlines are whilst our male reoffending rates are still higher than GM , they are considerably reduced compared to 2 years ago .This needs to considered too within our rates of serious harm offenders as outlined above. Despite a considerable rise in numbers of women offenders up by 42% on 2 years ago, the reoffending rates are lower than the GM level. Anecdotally we attribute the former to the economic downturn and changes in welfare reform. We would hope that the latter is as a result of improved women offender services. We would also draw attention to our very high rates of successful alcohol treatment requirements and completions of young male supervision orders. Our Drug Treatment Order completions too are an improving picture.

The graph below illustrates that Tameside has a much higher rate of serious harm offences that reach the threshold for MAPPA interventions than would be expected for size of the Borough. This is contributed to by serious Domestic Abuse and serious Organised Crime Offenders.

Chart 89: Number of MAPP level 2/3 meeting, 1st April 2013 to 31st March 2014

Source: TMBC, 2015

What Interventions Work?

The Women and Their Families Support Centre: This provides supervision to all our women offenders who are being managed in the community and those being supervised on licence post a custodial sentence. In addition the Centre provides holistic wrap around support for victims of domestic abuse, substance misuse service users and other hard to reach vulnerable groups such as BME women and LGBT groups. The Centre has been developed on a one stop shop model to enable easy access to services which seek to provide Recovery pathways including education and training, parenting programmes, healthy eating and budget management. The centre has contributed to a 6% drop in expected re-offending.

IOM: Integrated Offender Management in Tameside has contributed year on year since 2009 to contribute in reductions in reoffending of between 35 %and 37%per annum for our most serious and prolific offender rates. This Partnership led intervention provides a rapid information and response approach combined with prison in reach and full package of rehabilitative support to offenders who wish to turn their lives around. The Programme relies extensively in the use of peer mentoring and ex offender interventions who are able to champion the Recovery approach. The Tameside model was highly acclaimed in a Joint Thematic Inspection by HMIC and HMIP in June 2013. .

Troubled Families; this is being supervised within the CJS but families are deemed to be at risk of further criminality. The project aims to do this by addressing   issues surrounding unemployment, anti-social and criminal behaviour and poor school attendance. These families frequently display problems with substance misuse and domestic violence. The Criminal Justice results for the initiative are currently attracting 65% success rate using PBR indicators.

Forensics Psychology: Complex case discussion service offered on a monthly basis through Probation led initiative with Calderstones Hospital. This is facilitated by a forensic psychologist who supports Offenders Managers with working with difficult cases where personality disorder, Autism and Asperger's and learning disability are a feature.

Young Adults Specialism : Establishment of a co-located Probation and YOT to bridge the gaps between youth and adult criminal justice services for the most vulnerable and immature young adults.   Research by the T2A alliance demonstrates that a change to adult CJ services around age 18 can hinder a young person's pathway out of offending and their transition to adulthood (given that probation services are most often geared up to manage adults). Successful completion rates for YAs in Tameside are among the highest in GMPT; usually around 80%, indicating positive engagement and therefore a greater likelihood of successful outcomes.

Service User Questionnaire: A recent mixed male and female consultation of service users in Tameside carried out by CLI our peer led Recovery group, highlighted an alarming concern around a wide variety of health issues including having no GP, no access to a dentist, concerns around inter-generational cardio vascular disease, poor diet and sleeping patterns and fuel and food poverty. The overwhelming view that their situation was five times worse than five years ago .This largely concurred with what we know are the disadvantages that offenders and indeed their families often experience within our society generally when compared to the general population.

The Social Exclusion Unit Report 'Reducing Re-offending by Ex-prisoners' identified Physical and Mental Health, and Drugs and Alcohol as two of the 7 Pathways to reducing re-offending. The recently published Bradley Report concerning people with mental health problems or learning disabilities in the CJS further highlights the need for criminal justice and health care systems to work in partnership.

Next steps:

Health Trainers – Tameside council are looking to work with us to develop a health volunteering service for offenders- Public Health and Offender Management Services

It is evident that we have significant issues with both serious organised crime and domestic abuse which are disproportionate to the size of the Borough and numbers of offenders that are supervised. This requires intensive intervention and improved integration of Services if further intergenerational harm is to be avoided – Public Service Reform Team

Offender Management Services to be represented on Health and Well Being Board to ensure that offender health is ensured within CCG and Public Health commissioning – Health and Wellbeing Board

PCC funding to be made available to ensure that IOM and Peer Mentoring activity continues to ensure a safe and secure Borough and provision of wrap around Recovery Services for offenders who chose rehabilitation – Public Health

Expansion of Women and Their Families Centre to hard to reach groups in Ridge Hill and Hattersley –Offender Management Services and New Charter commissioned services

Further development of Offender Mental Health and Diversionary Systems to reduce numbers of offenders with mental health issues being sentenced inappropriately to custody- Health and Wellbeing Board, Public Health and CCG

Given the very high levels of alcohol misuse in the offender population in Tameside high priority should be given to Alcohol Treatment Requirement provision – Public Health and Offender Management Services

Greater Manchester Probation Trust has been a strong partner within the Tameside Partnership arrangements and consideration needs to be given to development of new working arrangements with the newly formed NPS and Community Rehabilitation Companies post May 2014 to ensure offender health needs are met – Tameside Neighbourhood Board

Violent Crime, including domestic violence and sexual violence

Outcomes Framework: Public Health 1.11 and 1.12

Implications for the population's health and well-being:

Domestic Abuse is linked to:
- Alcohol and increased risk due to alcohol use
- A&E attendances
- Maternity Services due to increased risk of domestic violence during pregnancy
- Increased risk due to substance misuse (e.g. steroid rage)

Violence is linked to:
- Night Time Economy and alcohol related crime
- Forced Marriage
- Honour Based Violence
- Female Genital Mutilation –a clear health risk for women and girls and also a crime

At risk or vulnerable groups:

Women, young males and females, same sex relationships

Benchmarking:

There are no local statistics around Domestic Abuse (DA) on iQuanta (Home office database for police performance) other than the number of incidents for the Force as a whole. Comparison to other areas is not possible.

Violent Crime: To fall in line with HMIC rationale there are two indicators 'Violence with Injury' and 'Violence without Injury'.

Table 19: Violent Crime for Tameside, January 2014- December 2014

Type of Crime	GM Rank	MSG Rank	Tameside Rate	GM Average	MSG Average
Violence Against the Person	8/10	11/15	16.342 / 1,000 residents	13.977 / 1,000 residents	14.753 / 1,000 residents
Violent Crime with Injury	8/10	11/15	7.443 / 1,000 residents	6.468 / 1,000 residents	7.345 / 1,000 residents
Violent Crime without Injury	8/10	12/15	8.890 / 1,000 residents	7.496 / 1,000 residents	7.397 / 1,000 residents

Source: iQuanta, 2015

Table 20: Sexual Crime for Tameside, January 2014- December 2014

Type of Crime	GM Rank	MSG Rank	Tameside Rate	GM Average	MSG Average
Sexual Offences	5/10	5/15	1.392 / 1,000 residents	1.632 / 1,000 residents	1.612 / 1,000 residents
Rape	6/10	9/15	0.490 / 1,000 residents	0.580 / 1,000 residents	0.542 / 1,000 residents
Other Sexual Offences	*3/10*	*5/15*	*0.902 / 1,000 residents*	*1.052 / 1,000 residents*	*1.070 / 1,000 residents*

Source: iQuanta, 2015

*Ranking system with 1 being the best ranked position and 10 being the worst ranked position

Policy context:

- Government launch of 'Ending gangs/violence report'- key themes are support, prevention, punishment, complex families
- Development of a local violent crime strategy- delivery plan with 4 themes; domestic abuse, sexual violence, night time economy and young people
- Police and Crime Plan 2013-2015 includes 'protecting vulnerable people: We will work with local people and our partners to: identify and protect individuals and groups at most risk and pursue the most persistent offenders and reduce the harm they cause.'

What are we doing now?

New partnership hubs to coordinate resources and tackle chronic problems, building on the lessons of Operation Challenger and Troubled Families in tackling complex families, crime families and organised crime

- Prioritise investigation of missing persons according to Absent/Missing protocols and work with children's homes to improve care management, risk-sharing and more effective management of Absent/Missing young people
- Support and intervention for all domestic abuse victims; standard, medium and high risk.
- Current interventions- IDVA (Independent Domestic Violence Advisors) service, Sanctuary housing
- Statutory duty of domestic homicide reviews
- GMP centralised rape unit
- Weekly Licencing Operations to tackle night time economy
- Non-criminal justice perpetrator programme - 'New Paths'
- CPD for all front line officers relating to Domestic Abuse

What needs to happen next, and by whom?

- Further develop the prevention, investigation and prosecution of child sexual exploitation, by further developing Operation Phoenix
- Develop and implement new Multi-Agency Safeguarding Hub (MASH) involving the police and partners
- Holistic approach to identify and manage victims across all organisations with access to support services
- Develop and implement new process for offenders of standard risk DA to be offered referrals to services whilst in Custody.
- Embed workforce development

Utilisation of green space for exercise/health reasons

Outcome Framework: Public Health 1.16

Implications for the population's health and well-being:

For the purposes of this paper, green space is defined as the green open spaces in and around towns, including parks and the wider countryside. Access to good-quality and well maintained green spaces promote physical activity, positive mental well-being and healthy childhood development. Ninety one per cent of people report using parks and countryside to some extent. In England, 42 per cent of people use these spaces at least once a week.

The value of green space for exercise is unquestionable. Good quality spaces will encourage people to make short journeys on foot or by bike. Regular physical activity contributes to the prevention and management of over 20 conditions including coronary heart disease, diabetes, certain types of cancer and obesity. For example, strokes cost the NHS £2.8 billion a year and physical activity reduces the risk of having a stroke by a third.

Access to green space positively impacts on mental health. Responses to nature have a calming and restorative effect helping to improve mental well-being. Moderate activity in a green environment can be as successful at treating depression as medication.

Children with access to safe green space are more likely to be physically active and less likely to be overweight. Outdoor play encourages healthy brain development and promotion of healthy well-being through adulthood.

At risk or vulnerable groups:

People from the most deprived areas are much more likely to visit urban destinations and places closer to home with 46% of visits (DE social grades) being within one mile of their starting point. This is a significantly larger proportion than recorded amongst the more affluent AB social grades (38 %).

Respondents from Black and Minority Ethnic (BME) communities were twice as likely to visit green space within two miles of their starting point compared to respondents from white communities.

Benchmarking:

It is estimated that between March 2010 and February 2011, the 41.7 million adult residents in England took a total of 2.49 billion visits to the natural environment. Just over half of these visits (53 per cent or 1.31 billion) were to places in the countryside and just over a third (37 per cent or 0.92 billion) were taken to green spaces within a town or city.

Across England, the use of green spaces for exercise or health reasons was given as the main reason for the visit by 36% of people surveyed, while in Greater Manchester the figure was 31%.

Unfortunately declining budgets and reductions in resources mean that there may be a reduction in quality in green space, not just in Tameside but nationally. This decrease in standards could have a significant impact on the numbers of people visiting parks and countryside; people are less likely to visit and will feel less safe in green space which appears unloved and uncared for. It is therefore important that everyone, the Council and the community, work together to protect green space and get involved in its management and maintenance.

Chart 90: Percentage of people using green space for exercise/health reasons (England and Greater Manchester)
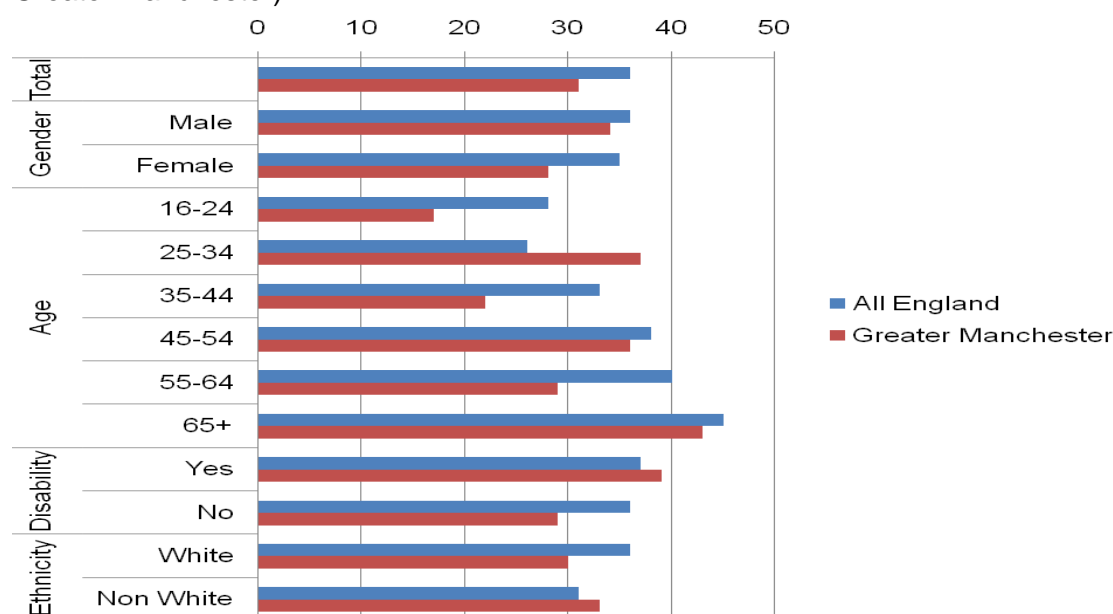
Source: Tameside MBC, 2012

Chart 90 illustrates that there are more non-white people in Greater Manchester using green spaces for exercise and health reasons than the England average. It also illustrates, there are more people with disability using the spaces than the England average. The age group with the highest percentage of users in Greater Manchester is the 65 plus which is the same for England, however, Greater Manchester has a lower percentage. The age group with the fewest users of green space for health and exercise reasons is the 16 to 24 years, which again, is the same age group for England as a whole. Both in Greater Manchester and England more males use the green spaces than females, but Greater Manchester has a lower percentage use across both sexes.

Chart 91: Percentage of people's reasons for not using green space (England and Greater Manchester)
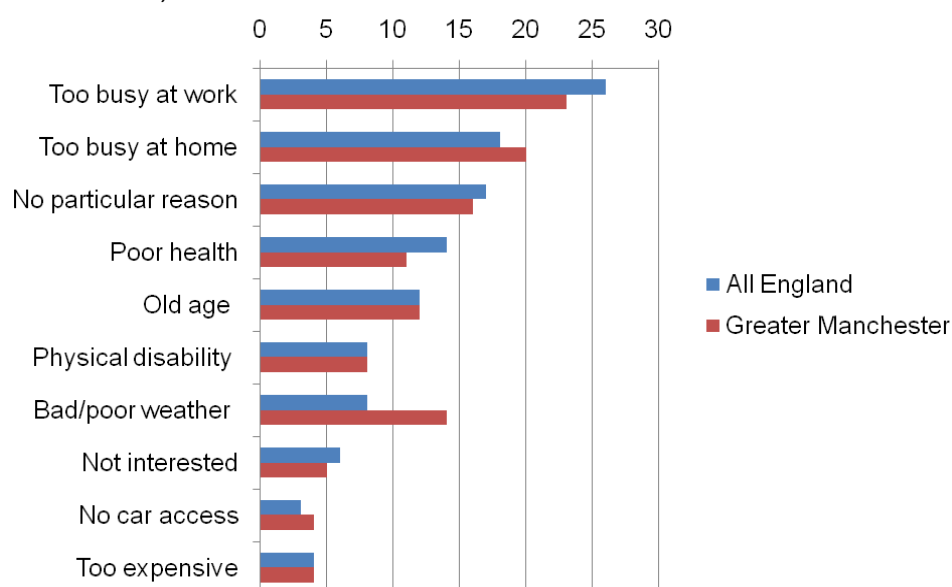
Source: Tameside MBC, 2012

Policy context:

- [Our Natural Health Service](#) published by Natural England
- [Community green: using local spaces to tackle inequality and improve health](#) published by Cabe space
- [Tameside Council PPG17 Open Space Study](#) final assessment report August 2010
- [Tameside Countryside Strategy 2009 – 2019](#)
- http://www.green-space.org.uk/resources/aboutparks/health.php

What interventions work?

- Accessibility to good, well managed green space close to where people live.
- British Trust for Conservation Volunteers (BTCV) Green Gym
- Activities led by volunteers/local community as part of locally led initiatives.
- Walking for Health initiative
- Initiatives and activities that involve whole intergenerational family groups.

What are we doing now?

- Provision of network of freely accessible parks, countryside and green spaces for informal grass root sports/fitness/well-being activities.
- Annual green space events and activities programme.
- Opportunities for active volunteering within green space.
- Supporting groups/volunteers wishing to use parks and countryside sites.
- Promotion of parks and countryside to targeted underrepresented groups.
- Provision of opportunities for exercise such as allotments, play areas, football pitches, bowling greens, outdoor adult gyms.

- Working with hard to reach groups such as the Routes to Work Scheme providing people who have been long term unemployed due to physical or mental health issues with work experience and placements as gardeners in our parks.
- Working with corporate partners such as British Gas and Brother to provide opportunities for their staff to volunteer in green space. This enables the staff to get involved, get active and give something back whilst enhancing green space for the community.

What do we need to do now?

- Work with Active Tameside to development of an effective mechanism to link GP referrals to existing Greenspace health improvement opportunities such as Wild Work Outs, events and activities programme, volunteering opportunities and park activities.
- Identify and secure further investment in the Parks, Countryside and Green spaces close to where people live.
- Development of the 'Green pathways' project, linking Parks and Countryside sites through investment in footpaths, bridleways and cycle paths.
- Work more closely with planning to deliver health and well-being benefits from every development.
- Ensure that the value of green space is represented on health and well-being boards.
- Further promotion of parks and countryside to targeted groups such as those with heart conditions, older people and Black and Minority Ethnic (BME) groups.

Air Pollution

Outcome Framework: Public Health 3.1

Implications for the population's health and well-being:

Air pollution is currently estimated to reduce the life expectancy of every person in the UK by an average of 7-8 months with estimated equivalent health costs of up to £20 billion each year. Very high concentrations of some pollutants are associated with the development of cancer, in particular leukaemia.

At risk or vulnerable groups:

Older and younger people may be more susceptible to poor air quality episodes. Individuals with pre-existing medical conditions such as heart disease, bronchitis, asthma and other types of lung disease are most at risk of suffering adverse health effects from poor air quality.

Policy context:

Under the requirements of Part IV of the Environment Act 1995, all local authorities are required to periodically review and assess air quality in their areas against health based objectives prescribed by the Government.

Where it is found that the objective levels are unlikely to be met, local authorities must declare Air Quality Management Areas (AQMAs) and draw up an Air Quality Action Plans (AQAPs) for improving air quality in those areas.

Benchmarking:

In GM, a regional approach to dealing with air pollution has been adopted, recognising that the sources of pollution do not respect political boundaries. A GM Air Quality Strategy, 'Clearing the Air', was produced in 1997 setting out the framework for improving air quality in the region. It links air quality to planning, transport, sustainability and environmental health functions.

Tameside MBC and the other Greater Manchester Combined Authority (GMCA) authorities contribute to a GM wide air quality monitoring and modelling programme. The authorities have also worked with Transport for Greater Manchester (TfGM) and update the Emissions Inventory for Greater Manchester (EMIGMA). This database records all emissions from stationary point sources (industry), mobile line sources (road and rail links) and area sources (domestic emissions), across $1272km^2$ of GM.

This database allows the magnitude and spatial distribution of emissions across the City region to be investigated.

What interventions work?

Currently the health based objectives are being met for all pollutants of concern with the exception of nitrogen dioxide and particulates. There are still significant areas across GM, predominantly associated with the road network where these two pollutants may exceed the objectives.

What are we doing now?

Tameside MBC and the other authorities in the Greater Manchester (GM) city region identified these areas of poor air quality, designated them as AQMA and introduced a joint AQAP. Given that the predominant source of this pollution is from road traffic, the air quality action plan was absorbed into the Greater Manchester Local Transport Plan.

Work is due to commence in the spring of 2015 to investigate how the boundaries of the declared AQMA have changed and to designate a new AQMA if necessary. Work will also begin on designing and implementing a new AQAP to help improve air quality across the GM city region.

The links between improving air quality and reducing our carbon footprint continue to be strengthened and developed.

What needs to happen next and who needs to do it?

Continue to proceed with the implementation of the GM AQAP. It is imperative that a joint approach to improving air quality across GM is maintained and strengthened. A closer working relationship with public health experts needs to be developed to encourage an exchange of information and expertise.

The Percentage of the population affected by noise

Outcomes framework: Public Health 1.14

Indicator Name: The Percentage of the population affected by noise

Implications for the population's health and well-being:

The significance of noise pollution has been recognised for some time. Noise can disrupt human activities and make the environment unpleasant for large numbers of people. The effect of noise on human health both physically and psychologically is undoubted. Noise damages hearing and is the greatest single cause of preventable sensor neural loss in the world. Noise, unlike other forms of pollution, has prompted members of the public to commit acts of violence against each other, against enforcement officers and has, unfortunately, also led to the suicide of those unwillingly exposed to it.

At risk or vulnerable groups:

No data is available to correlate environmental noise with socio-economic status as we do not have an overlay of socio-economic and noise maps. However, inspection of the noise map for Tameside would suggests that areas of higher noise levels coincide with areas of socio-economic need.

Benchmarking:

The Environmental Noise Directive (END) requires Member States to develop and adopt action plans 'designed to manage noise issues and effects, including noise reduction if necessary'.

The END requires, on a five year cycle:

- The determination, through noise mapping, of exposure to environmental noise from major sources of road, rail and aircraft noise and to environmental noise in the larger urban areas (known as agglomerations), including noise from industry;

- Provision of information to the public on environmental noise and its effects;

- Adoption of Noise Action Plans, based upon the noise mapping results, which are designed to manage environmental noise and its effects, including noise reduction if necessary; and

- Preservation of environmental noise quality where it is good, particularly in urban areas.

Policy Context:

The World Health Organisation reports that in the European Union countries about 40 % of the population are exposed to road traffic noise with an equivalent sound pressure level

exceeding 55 dB(A) daytime and 20 % are exposed to levels exceeding 65 dB(A). Taking all exposure to transportation noise together about half of the European Union citizens are estimated to live in zones which do not ensure acoustical comfort to residents. More than 30 % are exposed at night to equivalent sound pressure levels exceeding 55 dB (A) which is disturbing to sleep.

Population exposure figures are calculated by firstly statistically assigning census output area data to buildings in the mapped area (rather than precisely determining the number of people living in each building). A count is then made of number of people falling in each noise band calculated. All population exposure figures are rounded to the nearest 100 people, in accordance with the requirements of the END.

What interventions work?

The Association of Greater Manchester Authorities (AGMA) local authorities have agreed joint policies with respect to dealing with neighbourhood noise including response times and standardised responses. Analysis of the response time data and the number of repeat complaints shows that neighbourhood noise complaints are being resolved more quickly with fewer repeat requests for service.

What are we doing now?

Tameside has adopted the AGMA standardised approach to dealing with neighbourhood noise.

What needs to happen next and by whom?

The implementation of the END in England has delivered a number of key benefits. The first round of strategic noise mapping provided a high level assessment showing exposure to environmental noise within agglomerations and from major transport sources. The data have been used both in support of the action planning process, but also more widely in policy appraisal and in raising the profile of noise as a wider determinant of health.

The first round Action Plans have provided a framework to support relevant transport authorities in the investigation and, where appropriate, treatment of Important Areas, so that efforts and resources can be targeted where they are most needed.

Defra has now published the second round of Noise Action Plans, which revise Round 1 plans. Local Authorities are to continue to liaise with Defra in respect of local data and in particular quiet area.

Comprehensive, agreed inter-agency plans for responding to public health incidents

Outcomes framework: Public Health 3.6

Indicator Name: including
Public sector organisation with a broad approved sustainable development management plan

Implications for the population's health and well-being:

The change in climate will alter the physical geography of the world, leading to major changes in the human geography– where people live and how they live their lives.
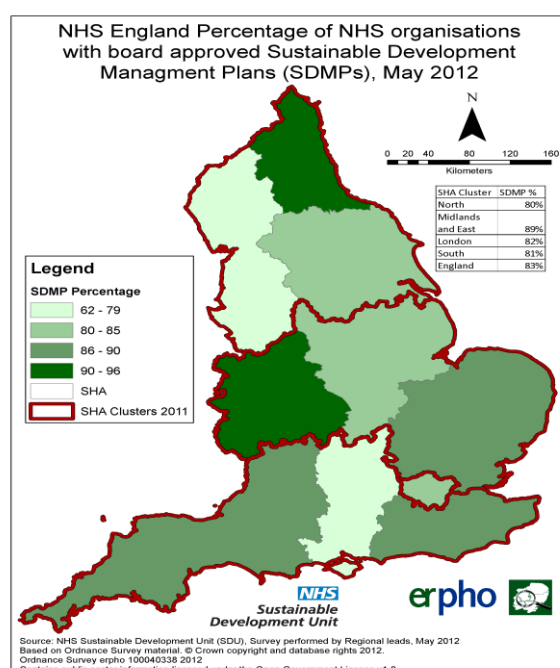Even at more moderate levels of warming, studies show that climate change will have serious impacts on world output, on human life and on the environment.

The changes threaten the basic elements of life for people around the world – access to water, food, health, and use of land and the environment. Hundreds of millions of people could suffer hunger, water shortages and coastal flooding as the world warms, and millions of people will potentially be at risk of climate-driven heat stress, flooding, malnutrition, water related disease and vector borne diseases.

Sustainable development plans provide the framework for balancing economic, social and environmental considerations, including climate change, and looks to communities' resilience and adaptation in the years ahead. The first step to monitoring sustainability is a process measure for board approved Sustainable Development Management Plans (SDMP).

Benchmarking:

Map 4: NHS organisations with Board approved SDMP, 2012.

Source: East of England Public Health Observatory (ERPHO), 2012

Policy Context:

- [Climate Change Act 2008](#) – which identifies an 80% reduction in carbon emissions by 2050 to reduce the UK impact on climate change?
- [National Sustainability Strategy " Taking the long term view"](#)
- [National NHS Strategy " Saving Carbon, Improving Health](#)"
- [The Stern Review](#)

What interventions work? (Including those from outside of Public Health & the Local Authority)

The local [Tameside strategy](#) highlights the need to:
- Make more efficient use of energy and natural resources, and tackle fuel poverty
- Reduce carbon emissions and develop a strategy for adapting climate change
- Reduce the impact of transport on our highways, reduce reliance on the car and encourage people to make more use of sustainable ways to travel, e.g. cycling and walking
- Raise awareness of our impact on the environment amongst local people and businesses, and encourage a more sustainable approach to everyday life
- Support Tameside's businesses, organisations, community groups and residents in the transition to a low carbon economy
- Adopt a sustainable approach to procurement and economic growth

What are we doing now?

The CCG no longer has responsibility for the buildings used for services but is ensuring that the where possible those building that meet sustainable standards are utilised to reduce the carbon footprint of services.

What needs to happen next and by whom?

Opportunities for ensuring effective use of buildings to reduce carbon emissions have continued with Tameside Metropolitan Borough Council (TMBC) and Derbyshire County Council (DCC and as we integrate services through Care Together we are working to promote sustainable buildings and transport.

Public sector organisations with broad-approved sustainable development management plan (SDMP)

Outcomes framework: Public Health 3.6

Indicator Name: including
Public sector organisation with a broad approved sustainable development management plan

Implications for the population's health and well-being:

The change in climate will alter the physical geography of the world, leading to major changes in the human geography– where people live and how they live their lives.
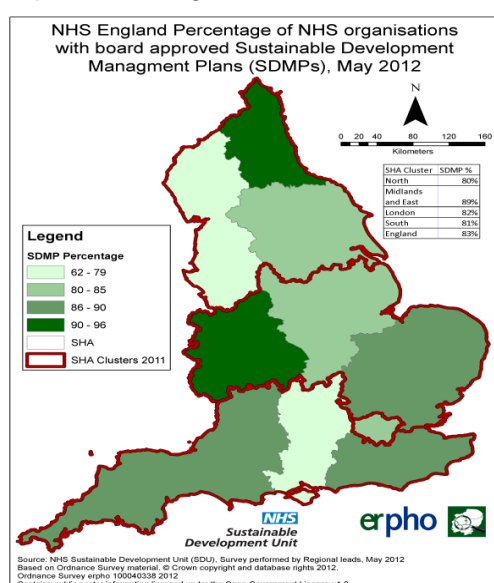Even at more moderate levels of warming, studies show that climate change will have serious impacts on world output, on human life and on the environment.

The changes threaten the basic elements of life for people around the world – access to water, food, health, and use of land and the environment. Hundreds of millions of people could suffer hunger, water shortages and coastal flooding as the world warms, and millions of people will potentially be at risk of climate-driven heat stress, flooding, malnutrition, water related disease and vector borne diseases.

Sustainable development plans provide the framework for balancing economic, social and environmental considerations, including climate change, and looks to communities' resilience and adaptation in the years ahead. The first step to monitoring sustainability is a process measure for board approved Sustainable Development Management Plans (SDMP).

Benchmarking:

Map 5: NHS organisations with Board approved SDMP, 2012.

Source: East of England Public Health Observatory (ERPHO), 2012

Policy Context:

- [Climate Change Act 2008](#) – which identifies an 80% reduction in carbon emissions by 2050 to reduce the UK impact on climate change?
- [National Sustainability Strategy " Taking the long term view"](#)
- [National NHS Strategy " Saving Carbon, Improving Health](#)"
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What interventions work? (Including those from outside of Public Health & the Local Authority)

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- Make more efficient use of energy and natural resources, and tackle fuel poverty
- Reduce carbon emissions and develop a strategy for adapting climate change
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Ageing and Dying Well

Older People's perception of community safety

Outcomes Framework: Public Health 1.19

This indicator is currently not defined in the framework and there is no existing indicator which specifically considers Older People's perception.

Implications for the population's health and well-being:

Feeling and being unsafe or 'at risk' has a significant negative impact on older people's health and can leave them isolated and unable to participate socially and economically in their community.

Home Office Research Study 269 (June 2003) considered the impact of distraction burglary amongst older adults and minority ethnic communities:
- An increased level of trauma above the cut off for PTSD
- Poor mobility is a significant vulnerability factor in older people being targeted
- In some cases a worsening of health status over three months post incident of crime
- Significant impact on quality of life
- Increased concern about crime in general

At risk or vulnerable groups:

Focus on...Fear of Crime, (CARDI, 2010) highlighted that:
- Fear of crime has been shown to be significantly higher amongst older people
- The fear of crime can reduce the level of participation of older people in physical activity and social interaction. This can lead to further isolation and social exclusion.

Benchmarking:

Limited benchmarking data is available, but age categories in the Tameside ROS and Citizen's Panel questionnaires have been considered to develop a proxy indicator for this:
- ROS 2010-11: Question related to level of satisfaction with community safety measures (e.g. CCTV, Patrollers). Baseline – 30% (age 60+) fairly or very satisfied compared to 32% all ages.

- Citizens' Panel: Question – how safe do you feel when you are out in your local area during the day?

Table 21: Citizens Panel results, Tameside, 2011 to 2014

	Very/Fairly safe (All ages)	Very/Fairly safe (60+)
a) In your local area during the day	**97.4%** 97.3% 97.7% **97.8%**	**97.5%** 98.7% 96.9%(60-69) 98.2%(70-79) 93.5%(80+) **97.4%**

Comparative results from the **Summer 2014, Summer 2013, Summer 2012, Summer 2011**
Source: TMBC, 2015

The table above (21) shows that from the baseline in 2011 - 97.4% (of the 60 plus age group) felt very or fairly safe compared to 97.8% all ages. In 2014 this had risen to 97.5% (for 60 plus age group) compared with 97.4% for all ages.

Policy context:

Older people are a national priority across a range of agendas, however within crime and disorder there is nothing specifically relating to older people. Vulnerability seems to be the overarching category.

What interventions work?

Home Office Research Study 269 suggests that work to raise awareness within communities and amongst older people can impact on reducing the risk of becoming a victim of crime. The Home Office Research Study also suggests that when a crime does occur, appropriate referral and support to health provision should be a protective factor in reducing the risk of the crime being repeated:

> "The findings from the study with older adults highlighted the importance of assessing and treating victims of distraction burglary as individuals, rather than developing a standard response to distraction burglary victims. For victims, the assessment and prolonged intervention for physical and mental health problems should concentrate on the relatively small proportion of victims and repellers experiencing serious trauma as a result of the distraction burglary incident."

What are we doing now?

There is extensive awareness amongst front line staff groups of the importance of reducing the risk of crimes occurring. There is a need to ensure that this is part of on-going training and induction with appropriate front-line services. We undertake awareness raising work within communities that are at risk and try to build up social awareness and support where possible.

What needs to happen next, and by whom?

- There needs to be a whole system approach to prevention of vulnerability that should be part of an integrated programme rather than only considering crime and fear of crime.

- Programme focussing on prevention needs to be developed which includes health professionals and frontline services.
- Health professionals and frontline services need to be more aware of the impact of crime and fear of crime on Physical and Mental health.
- Joint referral
- Homes for life

On-going Consultation

Tameside Citizens' Panel was set up in 1998 as a corporate resource to investigate resident perception of service delivery and Council priorities. The Panel is made up of around 2,000 residents, with membership being routinely refreshed. There are three questionnaires sent out each year that are developed in partnership with service areas and external organisations.

Questions relating to community safety and crime are entered in the Panel annually, with results being tracked to highlight changes in perception.

Health related quality of life for older people

Outcomes Framework: Public Health 4.13

Implications for the population's health and well-being:

The conception of age and older age can be subjective, although "older people" are typically considered within public service delivery to be those of 65 years and over. More recently however, there has been a move to include people over the age of 50 within older people's preventative and responsive services, recognising that many of the health and wellbeing issues associated with older age can be prevented earlier in life, whilst also recognising that the health of people younger than 65 years can often be poor in areas of high health inequalities, such as Tameside.

The population is growing older. In England, the number of people aged over 65 is due to rise by a third by 2025. In the same period the number of people over 80 will double and the number over 100 will increase fourfold. This welcome increase in life expectancy is however associated with an increase in years spent with some disabling illness, and a dramatic increase in the demands that will be places on health and care systems.

It is suggested however that nationally, the health and care system has struggled to keep up with the demographic shift[37], leading to unmet need. Evidence shows us that common conditions of older age receive less investment, fewer incentives and lower quality care than general medical conditions prevalent in mid-life.[38;39.] This will have a negative impact on health inequalities for older people.

More specifically, it is recognised that, in Tameside, there continues to be pressures placed on the social care system, where very frail people are discharged from acute care back into the community. Whilst it is the right response to offer this group of people the opportunity to regain their confidence and strength to remain at home, a major challenge for 'system transformation' is to ensure that the right infrastructure is in place to offer a community based approach, and that people are discharged at the appropriate time in their recovery. Inappropriate discharges risk people re-entering the system, thus increasing the risk of them being able to maintain their independence.

So, our ageing society offers great challenges to health and social care providers. Investing in prevention services at a local level can help to meet these challenges. Prevention services for older people are services that offer advice, support or interventions to help:

- Older people who are healthy to continue to live independently for longer
- Older people who are unwell to regain their independence or to prevent or delay the onset of further health problems

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[37] The Kings Fund (2014). *Making our Health and Care Systems Fit for an Ageing Population.* London: The King's Fund.
[38] Steel N, Bachmann M, Maisey S, Shekelle P, Breeze E, Marmot M, Melzer D (2008). 'Self reported receipt of care consistent with 32 quality indicators: national population survey of adults aged 50 or more in England'. *British Medical Journal*, vol 337, a957.
[39] Melzer D, Tavakoly B, Winder R, Richards S, Gericke C, Lang I (2012). *Health care quality for an active later life: improving quality of prevention and treatment through information: England 2005 to 2012*. A report from the Peninsula College of Medicine and Dentistry Ageing Research Group for Age UK. Exeter: PCMD, University of Exeter.

These issues have led to a dominant 'dependency' narrative of older people informing the mind-set of public service – viewing older people as a 'burden' on an ever fragile health and social care system. This fails to account for older people as citizens, where notions of respect and social inclusion carry as much meaning as questions of functional mobility, health and understandings of ageing as a condition of mounting dependency and need. Neither does it allow for the proactive development of programmes and strategies that actively address the disproportionate impact that social exclusion, deprivation and socio-economic disadvantage has had on people's experience of growing old.

Evidence also shows that when older people become ill or dependent, health and care services are only part of the picture in terms of what they value as enabling a good quality of life. Many other things matter: the ability to remain at home in clean, warm, affordable accommodation; to remain socially engaged; to continue with activities that give their life meaning; to contribute to their family or community; to feel safe and to maintain independence, choice, control, personal appearance and dignity; to be free from discrimination; and to feel they are not a 'burden' to their own families and that they can continue their own role as caregivers.[40;41;42.]

Economic well-being also has a direct correlation with the quality of life that older people can experience. Achieving economic wellbeing is not just about ensuring that older people who are retired receive the benefits they are entitled to, but ensuring that as they approach retirement, at whatever age they choose, they are able to be as economically active as possible.

Helping older people achieve such goals should be an integral part of every service offer and not something that sits in isolation. It is also recognised that transforming services for older people requires a fundamental shift away from single diseases and towards care that is co-ordinated around the full range of an individual's needs[7].

These issues, along with the projected demographic changes in future years, reflects a key challenge in terms of managing demand across the system; and integrating services, both now and longer term.

At risk or vulnerable groups:

- Frail older people
- Economically inactive
- Older people with long term limiting illnesses
- Older people living in poverty
- Older people living in isolation or on their own

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[40] Nazroo J, Matthews K (2012). *The impact of volunteering on well-being in later life: a report to WRVS*. Cardiff: WRVS. Available at:
www.royalvoluntaryservice.org.uk/Uploads/Documents/Reports%20and%20Reviews/the_impact_of_volunteering_on_wellbeing_in_later_life.pdf
[41] Tadd W, Vanlaere L, Gastmans C (2010). 'Clarifying the concept of human dignity in the care of the elderly: a dialogue between empirical and philosophical approaches'. *Ethical Perspectives*, vol 17, no 1, pp 253–81.
[42] Personal Social Services Research Unit (2010). *The National Evaluation of Partnerships for Older People Projects*. Canterbury: Personal Social Services Research Unit. Available at:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240

Benchmarking

Over the next 20 years the age profile of Tameside and Glossop will change quite significantly. Currently there are 34,525 people aged 65 and older in Tameside, making up 15.7% of the population. The proportion over the age of 35 is expected to increase to 21.9% by 2035. Similarly, the projections show a doubling in the number of people over the age of 85: from 4,213 to 10,800 by 2035 (Older People Health and Wellbeing Atlas).

Tameside has a significantly higher proportion of older adults affected by income deprivation compared with England as a whole. In Tameside almost a quarter of adults over the age of 60 (23.4%) live in households receiving pension credit (guarantee), compared with 18.1% of over 60s year olds in England (Older People Health and Wellbeing Atlas). High levels of income deprivation are likely to have a negative impact on health and wellbeing.

Self-reported wellbeing in Tameside is shown as being significantly lower than it is both regionally and nationally[43]. This is based on responses to the GP Patient Survey, which asks respondents to describe their health status in relation to: mobility, self-care, usual activities, pain/discomfort, anxiety and depression.

Policy context:

- Department of Health - Building the National Care Service, March 2010
- Department of Health – Integrated Care: Our Shared Commitment, May 2013
- Audit Commission - Improving value for money in adult social care, June 2011
- The King's Fund – Making our Care System Fit for an Ageing Population, 2014.
- World Health Organisation - Global Age Friendly Cities: A Guide. 2007
- UK Urban Ageing Consortium - A Research and Evaluation Framework for Age Friendly Cities, 2014.

What interventions work?

- Investing in prevention services at a local level can offer a more efficient use of resource and help deliver better outcomes for older people enabling them to live healthy, happy and independent lives.
- Delivering services that are co-ordinated around the full range of an individual's needs, rather than care based around single diseases.
- Proactive development of strategies that challenge dependency narratives of ageing and provide opportunities for older people to be active citizens within their community.

What are we doing now?
- Beginning work against the Age Friendly Cities framework:
    - Reviewing the role that housing and transport has in promoting wellbeing
    - Promoting social participation, through an older people arts engagement project and an Asset Based Community Development (ABCD) programme,

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[43] Public Health Outcomes Framework http://www.phoutcomes.info/

which aims to increase connectedness within communities and build on their strengths and assets when. This in turn will help communities to gain confidence and ability to make changes and take on responsibility for their health and wellbeing. ABCD is an underpinning programme of the Tameside Health & wellbeing Board.

- Investing in a range of preventative services that provide opportunities to develop social networks and reduce loneliness, through a range of options.
- Over 75's 'wrap around' support service for very vulnerable older people and those at risk of hospital admission
- The Pennine Care Health Improvement Service offers a range of interventions and programmes for all adults in Tameside. These include Stop Smoking Services, Weight Management and Physical Activity classes and Health Trainer services. The NHS Health Check Programme is available to all Tameside residents between the ages of 40 and 74 years who do not have a long term condition for example Diabetes and Hypertension
- Commitment at Greater Manchester level to prioritise understanding the long term housing need of older people.

What needs to happen next?
- Tameside Council to undertake a housing market needs assessment, to determine what housing options need to be available to older people both now and in the future.
- Tameside Council to ensure that findings from a housing market needs assessment inform housing market developments.
- Tameside Council lead by Public Health is currently redesigning and transforming local Health Improvement Services. From October 2015 there will be a new Tameside Wellbeing Service available to everyone over the age of 16 year. The vision for the new Wellbeing Service is to provide person-centred, holistic and accessible wellbeing services which are flexible and creative, easy to access and navigate and responsive to the needs of local people. The services will be focussed upon prevention and early intervention, and achieve exceptional, meaningful and sustained outcomes.
- A partnership approach to the mapping of assets relevant to older people that contributes to the Health & Wellbeing Board's asset based approach.

Falls and injuries in the over 65s

Outcomes Frameworks:
- Public Health 2.24:Falls and injuries in the over 65s
- Public Health 4.14: Hip fractures in over 65s
- NHS 3.5: Improving recovery from fragility fractures

Implications for the population's health and well-being:

Hip fractures account for 25% of fractures from all falls in the community. 10% of people who sustain an osteoporotic hip fractures die within one month and 33% die within 12 months. Fewer than half of older people return home after hip fracture and half of all fallers who fracture their hips are never functional walkers again. Frequent falls are a contributing factor in 40% of admissions to nursing homes.

Falls in the over 65s is a significant cause of admissions, morbidity and mortality, accounting for over 4 million bed days per year in England and costing the NHS over £2 billion. In Tameside and Glossop the cost of inpatient spells alone for fractures, falls and osteoporosis for people over 55 was over £5 million in 2010/11. Falls are the leading cause of accident-related mortality in older people; 35% of people over 65 fall and 45% of people over 80 living in the community fall each year. 10% result in a serious injury requiring admission and 5% result in a fracture. One third of falls resulting in hospital admission occurs in residential care settings.

- Each year, 35% (estimate) of people aged 65 and over falls at least once. In Tameside & Glossop this equates to 13,440 falls per year currently, due to the expanding population we can expect this to increase to 21,000 falls per year in over 65s by 2030

- 10% of all ambulance service calls are to people over 65 who have fallen, about 60% are taken to hospital. In 2010/11 there were 3,900 ambulance call outs for falls in T&G. Based on population projections there could be almost 6000 by 2033

- One in ten falls in over 65s results in injury requiring hospital admission; from 2007 to 2011 there were an average of 1,400 admissions to Tameside Foundation Trust each year for falls.

- One in twenty falls in over 65s results in a fracture; from 2007-2011 Tameside Foundation Trust treated an average of 600 fractures each year in over 55s

At risk or vulnerable groups:

Older people are most at risk from falls, in particular those aged over 85, females, and those from the least advantaged social groups. The ageing population in Tameside and Glossop means that the rate of falls and hip fractures will increase unless preventative measures are put into place.

Policy context:

- The British Orthopaedic Association, The Care of Patients with Fragility Fractures ("Blue Book")
  http://www.bgs.org.uk/pdf_cms/pubs/Blue%20Book%20on%20fragility%20fracture%20care.pdf
- RCP 2010 National Audit of Falls and Bone Health for Older People (RCP)
- Department of Health 2009 Prevention Package: Falls and fractures
- NICE Guidance CG21 Falls: The assessment and prevention of falls in older people
- NICE Guidance CG124 Hip fracture: The management of hip fracture in adults
- NICE TA160 Primary prevention of osteoporotic fragility fractures in postmenopausal women
- NICE TA161 Secondary prevention of osteoporotic fragility fractures in postmenopausal women

Benchmarking:

Although numbers are small in Tameside currently with an average of around 40 deaths per year, the rate of deaths from accidental falls has increased dramatically since 2001 and is now around double that for the North West and Industrial Hinterlands.

By 2033 there will be around 59 deaths per year due to falls (based on population projections).

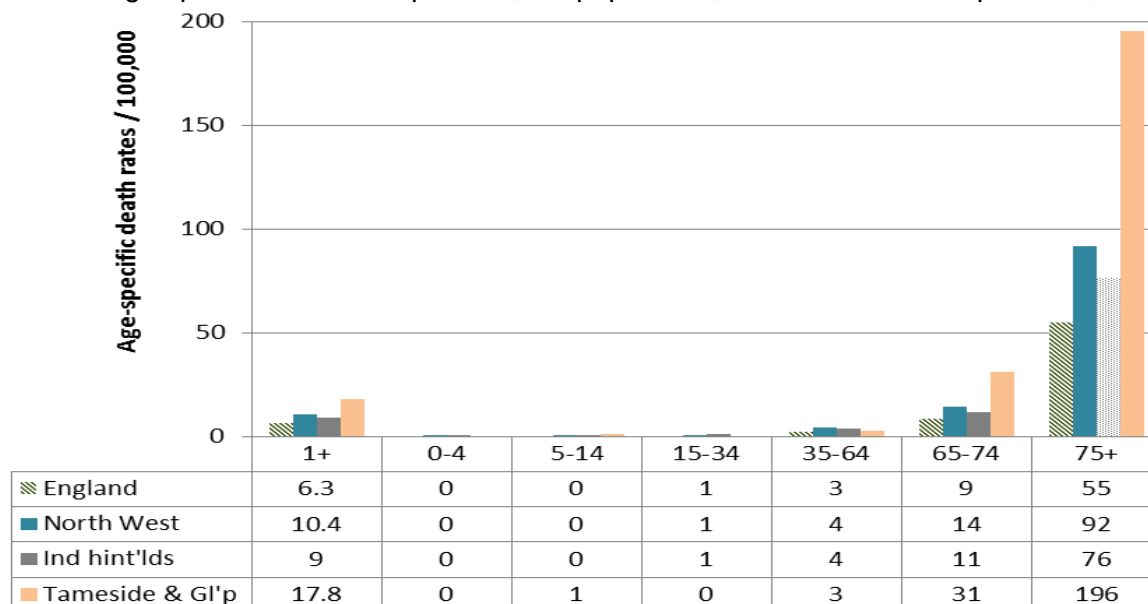Chart 92: Deaths from accidental falls, Tameside, 1993 to 2009
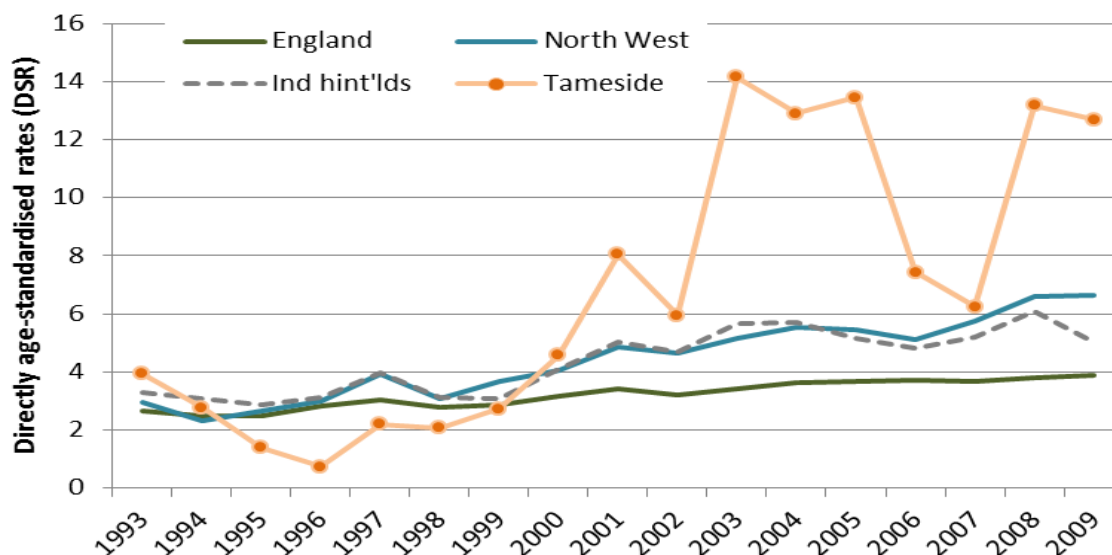
Source: Pubic Health, Tameside MBC 2014

Chart 92 above illustrates the rate of deaths from accidental falls across Tameside, compared to the North West, England, and the Industrial Hinterlands group. Tameside has a higher rate than any of the other comparators consistently since 2000

Mortality from falls

It can be seen from the chart below that the vast majority of these deaths are in people aged over 65.

Chart 93: Age specific death rate per 100,000 population, Tameside and comparators,

	1+	0-4	5-14	15-34	35-64	65-74	75+
England	6.3	0	0	1	3	9	55
North West	10.4	0	0	1	4	14	92
Ind hint'lds	9	0	0	1	4	11	76
Tameside & Gl'p	17.8	0	1	0	3	31	196

Source: Tameside MBC 2014

What interventions works?

Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.
- Rapid admission (within 4 hours) and early surgery (within 48 hours) of hip fracture patients.
- A care bundle approach to the initial management of hip fracture patients (to include, as a minimum, pain relief, pressure sore prevention and intravenous fluids).
- Mobilisation on the day after surgery, and daily thereafter, improves recovery from hip fracture.
- Fracture liaison services following the best-evidenced models either for acute-based services (e.g. Glasgow) or primary care-based services (West Sussex).
- Routine screening for falls of older people presenting to Emergency Departments or minor injury units (MIUs).
- Therapeutic exercise programmes and falls prevention programmes, particularly for those older people who have fallen and fractured or who are at risk of fracture.
- Individualised multi-factorial interventions, for older people with recurrent falls or at risk of falling, including strength and balance training, home hazard assessment, vision assessment and medication review.
- Multidisciplinary assessment following a fall to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function.

- Treatment with bisphosphonates for primary and secondary prevention of fragility fractures in postmenopausal women who have osteoporosis.

What are we doing now?

- All existing falls prevention/post fracture clinical services and social care provision is being reviewed to ensure a stronger and more consistent offer for people at risk of falls and to prevent future falls.
- Public Health is working with academic partners and colleagues across Greater Manchester to develop a comprehensive and evidence-based model of falls prevention, for local implementation.
- Public Health and Age UK Tameside have collaboratively developed a community-based primary falls prevention exercise programme for older people, accounting for the motivations of older people to exercise and evidence of what leads to the greatest level of adherence to exercise[44]. Dance and walking football are two such examples that deliver strength and balance training along with opportunities for social connection.
- Age UK Tameside provides home environment assessments to prevent falls risk.
- Tameside Council commissions a Handy Person service via Age UK Tameside to provide balance and stability aids.
- Tameside Foundation Trust participates in the National Hip Fracture Database and the Best Practice Tariff.
- Greater Manchester Fire and Rescue Service (GMFRS) undertake a falls risk assessment via their Home Safety Checks.
- A new GMFRS service is in place to support the ambulance service and local falls services to respond to people who have fallen and offer initial support and referral.
- Out-patient Falls Clinic operates from Tameside General Hospital, to provide multi-disciplinary assessment, treatment and referral.

What needs to happen next, and by whom?

- Local service integration programme (Care Together) to redesign local health and social care services to accommodate falls prevention functions and ensure adequate capacity, including pro-active case finding of those at risk of falls and fragility fractures. This should include:
  - Primary care and community services to screen older people for falls and refer those at risk for intervention
  - Primary care to identify, and treat according to NICE guidance, people with osteoporosis
- Tameside Hospital Foundation Trust to comply with the Department of Health falls and fractures standards and NICE guidance
- Public Health to produce standards and guidance for community-based falls prevention exercise.
- Age UK Tameside and Public Health to collaboratively devise a falls-prevention intervention programme for residential care homes.

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[44] Hartley, S.E. and Yeowell, G. (2014). "Older adults' perceptions of adherence to community physical activity groups." *Ageing and Society*, pp.1-22. Available on CJO 2014 doi:10.1017/S0144686X14000464 http://journals.cambridge.org

Fuel poverty and Excess winter deaths

Outcomes framework: Public Health 1.17 and 4.15

Indicator Name: including
Fuel poverty

Implications for the population's health and well-being:

From 2013 the way the Government defined fuel poverty changed. Fuel poverty in England is now measured by the Low Income High Costs definition, which considers a household to be fuel poor if:
- They have higher than typical energy costs
- Their income would be below the poverty line, were they to spend that amount on energy.

Millions of people in the UK are currently living in fuel poverty. Living in a cold home can be very damaging to physical and mental health and is associated with increased morbidity and mortality. Older people are at particular risk of health problems as a result of living in fuel poverty, but children and those living with disabilities are also vulnerable.

Respiratory illnesses such as asthma are made worse by living in a cold home and people are more likely to suffer strokes and heart attacks as the blood pressure can increase when household temperatures decline. These illnesses are amongst the main causes of excess winter deaths.

The number of excess winter deaths in England and Wales in 2013/14 is estimated at 18,200 – this is the lowest number since records began in 1950/51. The winter of 2013/14 was characterised by slightly colder than average temperatures in November followed by a sustained period of milder than average weather, which is the likely reason for the decrease in figures since the previous year.

At risk or vulnerable groups:

Typical vulnerable groups are disproportionately affected by fuel poverty; over 60s, people with long term disabilities, long term unemployed and low income families (particularly those with young children); as are people with existing conditions such as circulatory or respiratory diseases. Many of these groups spend more time in their homes therefore requiring more heating, have a lower financial capacity to pay for energy and are also more likely to live in homes with poor energy efficiency ratings. It should be noted that due to the wide roll out of the decent homes programme among the social housing sector, we have seen the rate of fuel poverty in the private housing sector increase above that of the social rented sector for the first time. This is also attributable to particularly poor quality housing in the private rented sector.

Benchmarking:

Chart 94: Trend in the Excess Winter Mortality Index in England, North-West and Tameside
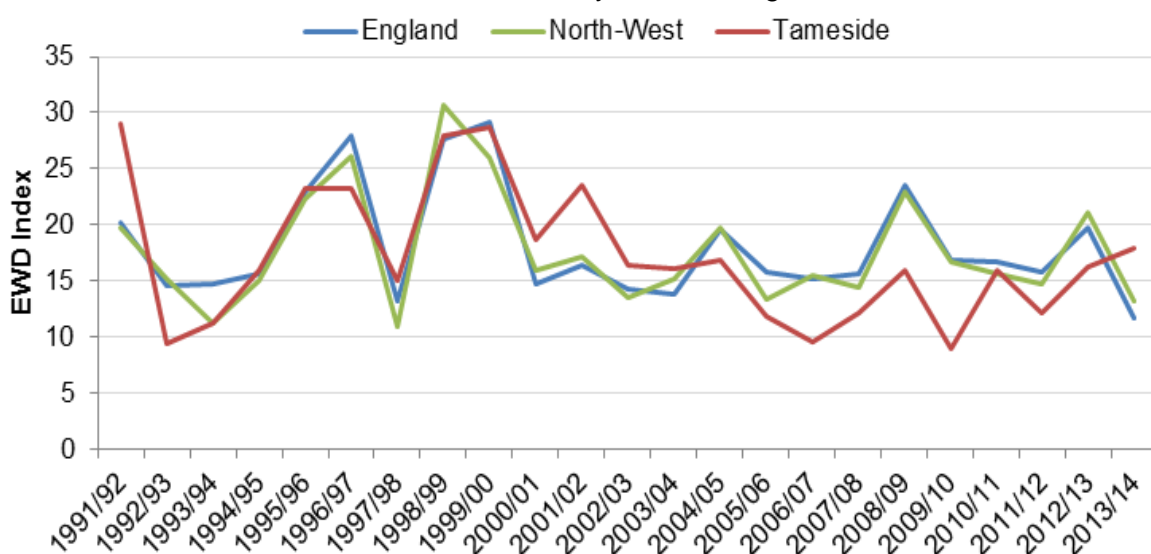
Source: TMBC 2015

The chart above illustrates the trend in Excess winter mortality for Tameside compared with the North West and England averages. Tameside has had lower Excess Winter Mortality than both the North West and England figures consistently over the last 10 years.

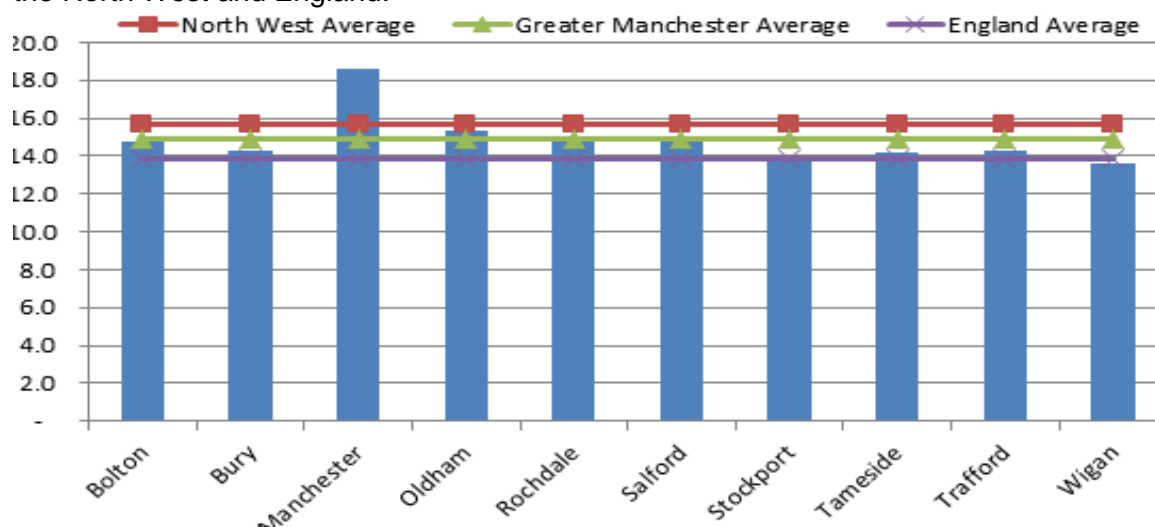Chart 95: Excess Winter Mortality Index by Tameside Ward (2013/14)
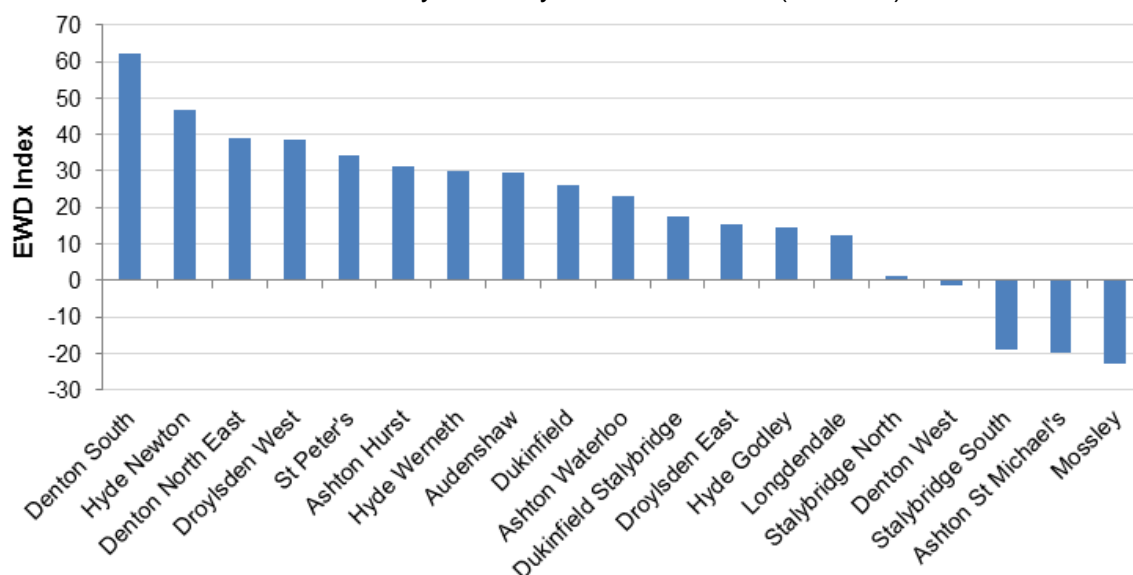
Source: TMBC 2015

The chart above illustrates the levels of Excess Winter Mortality by ward across Tameside. It shows that the ward of Denton South has the highest level compared to Mossley at the other end of the scale.

The following graphs show the % of Fuel Poverty across the 10 Greater Manchester authorities using data for the old definition (10% of Income) and the new definition (Low
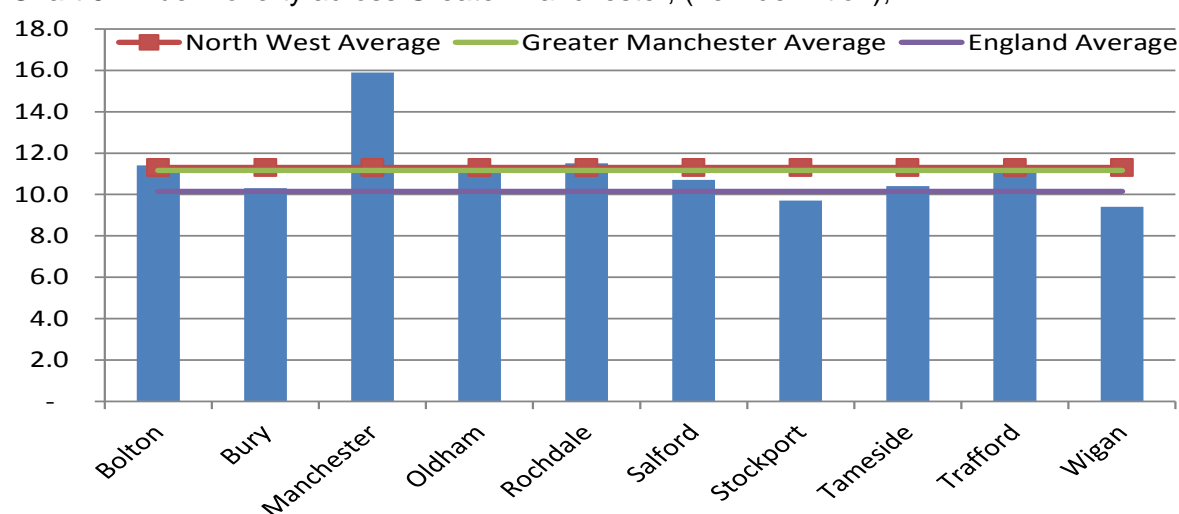
Income High Costs). Both graphs show Tameside to be below the Northwest average and Greater Manchester average, but above the national average.

Chart 96: Fuel Poverty across the Greater Manchester Local Authorities Compared Against the North West and England.

Source: https://www.gov.uk/government/statistics/fuel-poverty-subregional-data-under-10-indicator, 2015

Chart 97: Fuel Poverty across Greater Manchester, (new definition),

Source: https://www.gov.uk/government/statistics/2012-sub-regional-fuel-poverty-data-low-income-high-costs-indicator, 2015

Policy Context:

In July 2014 the Government launched its consultation 'Cutting the Cost of Keeping Warm' - the new approach to tackling fuel poverty in England. This consultation was launched to help Government to prepare a new fuel poverty strategy for England and to gather views on how Government can improve the design and delivery of policy in order to try and meet the new fuel poverty target. The closing date for feedback on the consultation was October 2014, as of yet no date has been released for the publication of the new strategy. There has previously been an active Affordable Warmth Strategy within Tameside, co-ordinated by

Tameside Council. This strategy is now out of date, due to the uncertainty and delay in the government publishing their national fuel poverty strategy, Tameside Council is also delaying publishing a new strategy to ensure that an appropriate and long term policy and action plan can be set out in the near future.

The Government also published a consultation on the Warm Home Discount Scheme in autumn 2014. This scheme initially launched in April 2011 and was set to run until March 2015. The Warm Home Discount has been extended into 2015/16 (further continuation to be reviewed at the 2015/16 spending review).This consultation document realised in 2014 set out what the Warm Home Discount had achieved since its introduction in 2011 and government proposals for changes to the scheme for 2015/16. The Government do not propose to make significant changes to the scheme for the one-year extension. The intention is to keep the structure of the scheme as it is currently, divided into the Core Group, Broader Group and Industry Initiatives. They intend to maintain the same delivery methods, with the Department for Work and Pensions (DWP) continuing to work with suppliers in helping deliver the Core Group and Ofgem continuing as the scheme administrator. The Core Group, eligibility criteria will remain as they are currently: people on Pension Credit Guarantee Credit. This should result in over 1.4m Core Group customers continuing to receive rebates. Under the Broader Group, views were sought on whether the current scheme introduces barriers to switching and how this can be overcome and on whether more low income working families should receive help through the Broader Group and how this could be achieved.

The Local Authority is promoting Green Deal and ECO through the Greater Manchester Little Bill Scheme. This is a joint initiative between Greater Manchester Energy Advice and the 10 authorities across Greater Manchester and is designed to increase update of retrofit measures across the area.

What interventions work? (Including those from outside of Public Health & the Local Authority)

- Maximising uptake to national funding such as Energy Company Obligation (ECO) funding for improving energy efficiency levels and thermal comfort of homes.
- Targeted outreach schemes involving doorstep interventions, advice and support in community areas.
- Partnership working with local partners as well as internal Council Departments and Public Health.

What are we doing now?

- Currently the amount of funding provided via the ECO grant is no longer enough (in many cases) to fund the installation of a new boiler. Also, further works are often required such as replacement of pipes or relocation of flues etc. which can increase the cost above the amount of the grant. In cases where there is a funding shortfall, the installers will approach the resident for a financial contribution towards the cost of these extra works but as they are a low income household, they can rarely afford this and therefore the work could not go ahead. Tameside Council are currently offering 'top up funding' to some of the most vulnerable, low income households in the

borough in order to ensure they are able to remain warm in their homes and who, without this assistance would otherwise miss out on this funding.

- Working in Partnership with the Association of Greater Manchester Authorities (AGMA) we have set up the Little Bill Initiative. This scheme has been established to offer our residents (homeowners and private tenants) energy saving improvements for their home. One of the key factors in ensuring that residents keep warm and healthy in their homes is to ensure that their homes are as energy efficient as possible. Programmes such as Little Bill aim to maximise this.

- Currently working in 3 GP surgeries in Tameside offering welfare rights advice / support which includes help and support around fuel poverty and debt.

- An e-learning training package has been purchased with funding provided by Public Health. The online training package from National Energy Action (NEA) focuses on the causes and effects of fuel poverty and is designed to be rolled out to front line staff. It aims to highlight key issues and raise awareness so that staff are better able to assist residents and others who are likely to be in fuel poverty.

- The Greater Manchester Fuel Poverty Strategy Group provides a strategic overview of work on fuel poverty across GM. Through this group we have accessed some help through the NEA and British Gas via the Community Action Partnership – the aim of this is to work with local authorities and their partners to bring affordable warmth to residents through practical activities and evaluate the impact on improving lives and the prosperity of the community.

What needs to happen next and by whom?

Tameside Council intend to rewrite the Tameside Affordable Warmth strategy once the Government release the national fuel poverty strategy. Key actions for the LA will be the continuation of housing retrofit schemes, increase outreach work in most vulnerable communities and build on collaborative work with Public Health team. There is also a responsibility on other partners to work to tackle fuel poverty such as Registered Housing Providers, community agencies (CAB), charities, third sector and private landlords. A collaborative and partnership approach will be encouraged and much of this will be led by the Local Authority and the local Health & Wellbeing Board.

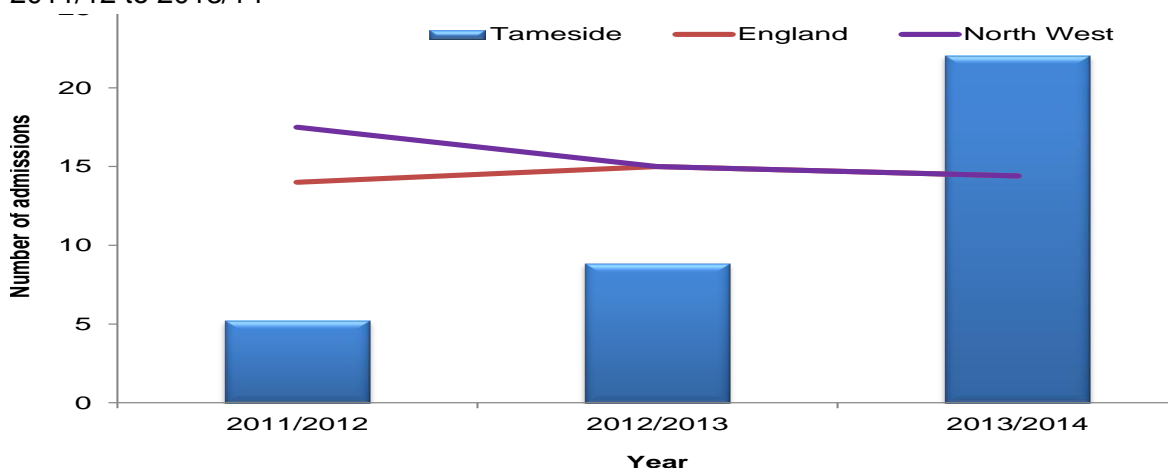**Permanent admissions to residential and nursing care homes per 100,000 population**

Outcomes Framework: Adult Social Care 2A

Implications for the population's health and well-being: Delaying and reducing the need for care and support. Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency, and local health and social care services will work together to reduce avoidable admissions. Research suggests where possible people prefer to stay in their own home rather than move into residential care. This is a high level indication of the success of social care services in delaying dependency, in particular for older people, and reducing inappropriate permanent admissions to residential and nursing care.

At risk or vulnerable groups: This is a two part measure reflecting the number of admissions of younger adults and older people to residential and nursing care homes relative to the population size of each group. The measure compares council records with ONS population estimates.

Benchmarking: Admissions for people aged 18-64 has increased in comparison to regional / national averages. For people aged 65+ performance is well below the regional and national average – this is excellent performance and aligns with our reducing placement policy over the years.
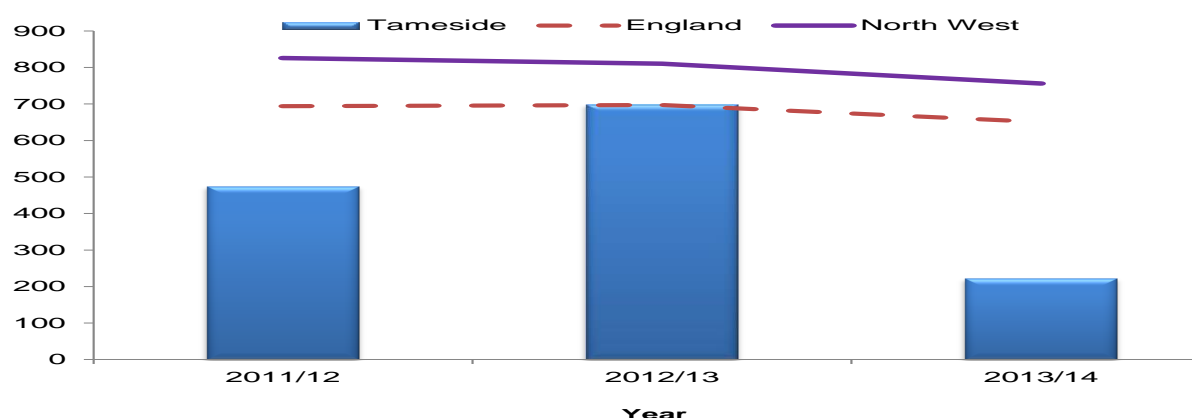
Chart 98: Permanent admission to Nursing/ Residential Care, (18 – 64 years), Tameside, 2011/12 to 2013/14

Source: TMBC, 2015

The chart above shows significantly higher number of admissions to Nursing or Residential homes for the 18 to 64 years age group than either the North West or England.

Chart 99: Permanent Admissions to Nursing / Residential care, Aged 65+, Tameside, 2011/12 -2013/14

Source: TMBC, 2015

Chart shows Tameside has higher permanent admission to Nursing or Residential homes for the 65 year plus age group than both the North West and England, although the figure fell between 2012/13 and 2013/14

Policy context:
Permanent admissions to residential and nursing care homes per 100,000 population is an overarching measure within the "Delaying and reducing the need for care and support" outcome domain in the 2013 2014 Adult Social Care Outcomes Framework.
Half Way Homes Policy

What interventions work?

- Re-ablement
- Integrated Response and Intervention Service (IRIS)
- Assistive Technology
- Personal Budgets
- Aids, Equipment and Adaptations
- Investment in Wellbeing and Prevention
- Carers services
- Intermediate Care

What are we doing now?

- Expansion of the Re-ablement service, with increased promotion of Assistive Technology.
- Redesign of Intermediate Care services resulting from the Intermediate Care Strategy action plan.
- Increased delivery of Personal Budgets offering greater choice and control.
- Implementation of the Halfway Homes policy.
- Redesign of the Well-being and Prevention Service
- Redesign of the Assessment and Care Management Service

What needs to happen next, and by whom?
All of the above lead by the Adults Management Team

Reducing premature death in people with learning disabilities

Outcomes framework: NHS 1.7

Implications for the population's health and well-being:

People with learning disabilities (LD) have poorer health than their non-disabled peers and these differences in health status are, to an extent avoidable.

The health inequalities faced by people with LD start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The inequalities evident in access to health care are likely to place many NHS Trusts in England in contravention of their legal responsibilities defined in the Equality Act 2010, the Mental Capacity Act 1006 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People with LD have a shorter life expectancy and increased risk of early death when compared to the general population. Life expectancy is increasing, in particular for people with Down's syndrome, with some evidence to suggest that for people with mild learning disabilities it may be approaching that of the general population. Nonetheless, all-cause mortality rates among people with moderate to severe LD are three time higher than in the general population, with mortality being particular high for young adults, women and people with Down's Syndrome.

Health Inequalities and People with Learning Disabilities in the UK 2011

At risk or vulnerable groups:

- Those with learning difficulties and disabilities
- Those not known to services
- Those not accessing services
- Young Adults
- Women
- People with Down's Syndrome

Benchmarking:

There is no definitive record of the number of people with LD in England. However it is estimated that in England in 2011 1,191,000 people have learning disabilities.
This includes:
- 286,600 children (180,000 boys,106,000 girls) age 0-17;
- 905,000 adults aged 18+ (530,000 men and 375,000 women), of whom 189,000 (212%) are known to learning disabilities services.

In Tameside there are 929 people with a LD who access learning disability services. The median age at death in Tameside is 5 years higher (60 years) than the England and the North West average (55 years). For more information see Tameside Learning Disabilities Profile 2012

Policy context:

- Valuing people
- Valuing People Now
- People with Learning Disabilities in England 2011 (DH)

What interventions work?

- Specialist teams providing support
- Delivery and access to NHS Health Checks
- Maximising opportunities for Health Screening and Health Promotion
- Maximising work opportunities for people with LD

What did we do in 2012-13?

- Increase the number of NHS Health Checks and Screening opportunities delivered to adults with LD
- Implementation of the LES for NHS Health Checks and follow up any issues highlighted
- Further increase in awareness of the health issues experienced by people with learning disabilities
- Further develop strategies to meet the needs of people with LD with profound and complex needs, carers, BME and older people.
- Improved health promotion training and skill development for residential care staff
- Improved access to familial information for staff and carers

What were our plans in 2013-14?

With other CCGs across GM to develop better systems to identify when people with a learning disability have had any screening for cancers.

We have a hospital liaison nurse within the learning disability service who has oversight of all hospital admissions, planned or unplanned and will provide support to hospital staff as necessary. The hospital passport has been refreshed. We plan to increase the number of reasonable adjustments made by the hospital for people with a learning disability accessing their services and have a CQUIN to support this. We will also increase the use of formal end of life tools across health and social care.

We are making the patient experience questionnaire more user-friendly so that improvements can be made to services in light of feedback from people with a learning disability.

What were our plans in 2014-15?

We currently have an uptake of less than 50% of GP practices who carry out the Learning Disability annual health check as part of the Directed Enhanced Service. We have a primary care liaison nurse within the learning disability service who is working with GP practices and the plan is to increase the number of people with a learning disability who have their annual health check.

We do not currently have a data system which is sophisticated enough to determine how many people with a learning disability have been screened for cancer. So we are working with other CCGs across GM to develop better systems to identify when people with a learning disability have had any screening for cancers.

We have a hospital liaison nurse within the learning disability service who has oversight of all hospital admissions, planned or unplanned and will provide support to hospital staff as necessary. The hospital passport has been refreshed. We plan to increase the number of reasonable adjustments made by the hospital for people with a learning disability accessing their services and have a CQUIN to support this. We will also increase the use of formal end of life tools across health and social care.

We are making the patient experience questionnaire more user-friendly so that improvements can be made to services in light of feedback from people with a learning disability.

Mortality and hospital admissions due to serious mental illness, self-harm and suicide

Outcomes Framework:
- Public Health 4.9: Excess under 75s mortality in adults with a serious mental illness
- NHS 1.5: Excess under 75 mortality in adults with serious mental illness
- Public Health 4.10: Suicide
- Public Health 2.10: Hospital admissions as a result of self harm.

Implications for the population's health and well-being:

Poor mental health has both personal and societal costs. People with severe mental illness are estimated to die on average 20 years earlier than the general population largely due to co-existing physical health conditions (RCPSYCH). Poor mental health is associated with an increased risk of physical illness, due in part to a less healthy lifestyle and more frequent health-risk behaviour while physical illness increases the risk of poor mental health. In addition people who harm themselves can be subject to stigma and hostility (NICE).

In 2013 the rate of Suicides was 10.7 per 100,000 population. The rate of suicide was higher than in 2012, and was the highest rate since 2004. However, this apparent increase could be due to changes in the way narrative verdicts by coroners are recorded (ONS).

A significant number of admissions to medical wards in England are as a result of deliberate self-harm. Indeed, there are over 110,000 inpatient admissions in England every year as a result of intentional self-harm, and the incidence of self-harm appears to be increasing (HSCIC).

At risk or vulnerable groups:

People of all ages and from all social and cultural backgrounds may harm themselves but some groups are especially vulnerable because of life experiences, personal or social circumstances, physical factors or a combination of these elements. There is a higher incidence of self-harm among prisoners, asylum seekers, veterans from the armed forces, people bereaved by suicide, some cultural minority groups, people with learning disabilities and lesbian, gay, bisexual and transgender people.

There are approximately 3 in 5 admissions (59%) for self-harm for women; however, the highest rates of admission are among 15 to 19 year olds (HSCIC). Although this age group has seen the largest decrease (6.7%) compared to previous 12 months to August 2012.

In 2013 the highest suicide rate was for men aged 45-59. Female suicide rates were highest in 45-59 year olds (ONS).

Benchmarking:

The mortality rate for suicide in Tameside is significantly higher than the England average, and is among the highest in Greater Manchester

Chart 100: Mortality rate from suicide and injury of undetermined intent per 100,000 population 2011-2013 (Direct Standardised Rate)
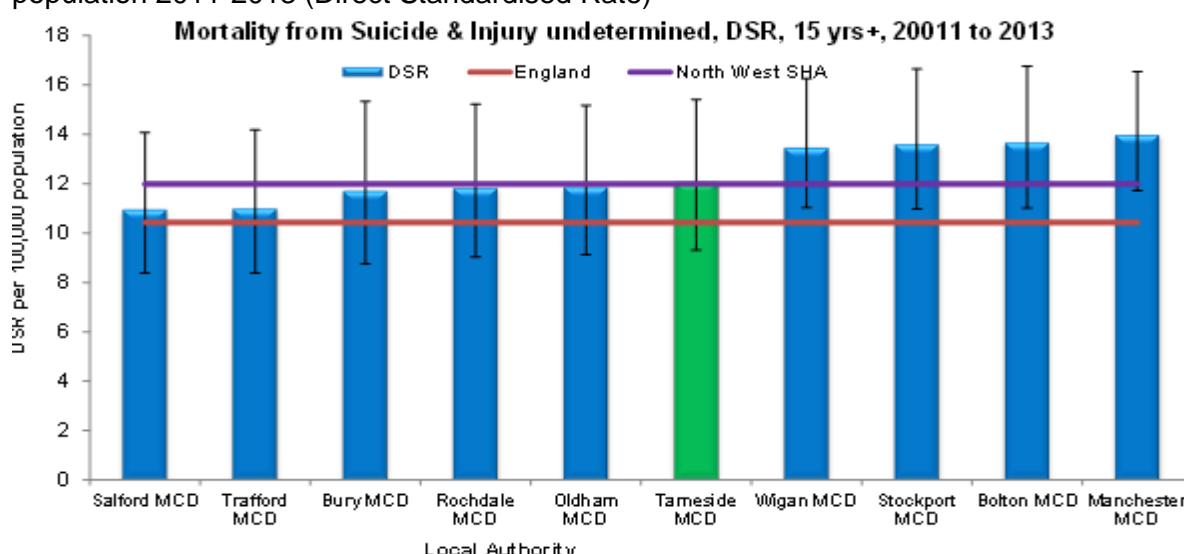

Source: HSCIC, 2015

The above chart illustrates Tameside has the sixth highest rate of mortality from Suicide and Undetermined injury in the 15 years and over age group across Greater Manchester. It has a rate which is higher than the England average and is on par with the rate for the North West.

The Public Health Outcomes Framework indicator for Suicide rate is still in development, however data from 2011-13 suggests the rate was higher in Tameside than then England.

Chart 101: Hospital Stays for Self Harm, per 100,000 population, 2012/13 (Direct Standardised Rate)
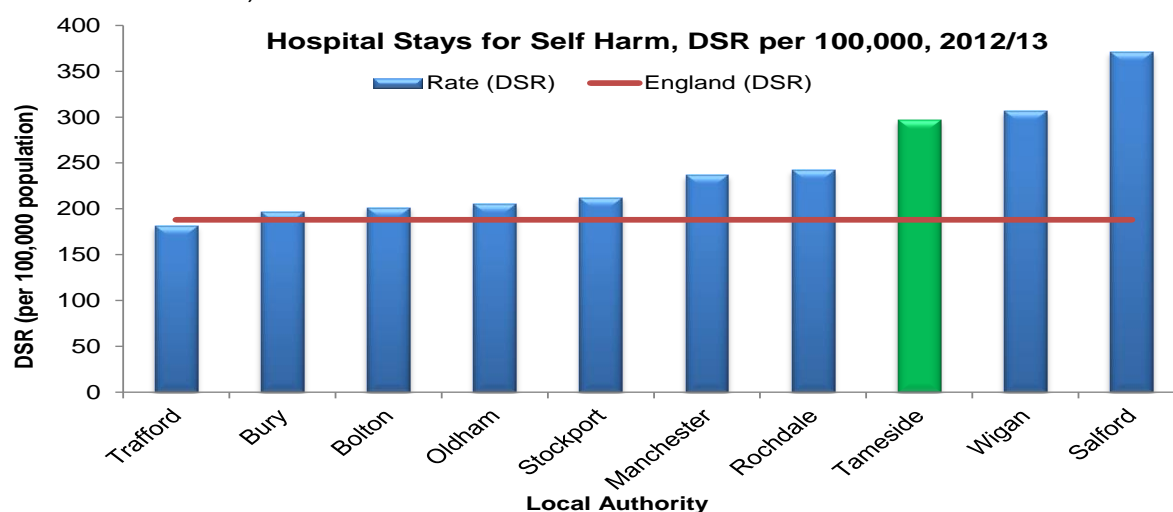
Source: PHE Health Profiles, 2014

The above chart illustrates the rate of hospital stays for Self Harm, with Tameside having the 3rd highest rate in Greater Manchester, and above the England average.

Policy context:

The national mental health strategy 'No health without mental health' was published in 2011. This strategy aims to involve a wide range of partners at national and local level, and the public, in improving mental health of the population and making high quality services available to all.

Other key national policy and guidance documents include:

- Department of Health (2014) Closing the Gap: Priorities for essential change in mental health.
- Faculty of Public Health. (2014)Better Mental Health for All,
- Chief Medical Officer's (CMO) Annual Report (2014): Public Mental Health
- DH (2014) Preventing suicide in England: One year on. First annual report on the cross-government outcomes strategy to save lives
- HM Government (2012) Preventing suicide in England: A cross-government outcomes strategy to save lives
- DH (2012) Prompts for local leaders on suicide prevention
- PHE (2014) Guidance for developing a local suicide prevention action plan. Information for public health staff in local authorities

Improving mental health and wellbeing is a key theme in the Tameside Health and Wellbeing Strategy, and is the focus for the Director of Public Health Annual Report 2013/14.

What interventions work?

Below is a list of the key NICE guidance and quality standard documents:
- **NICE pathways self-harm overview**
- **NICE guidance on Self-harm CG16**
- **NICE quality standard on Self harm QS34**
- **NICE Guidance on Long-term Self-Harm Management CG133**
- **NICE quality standard for self-harm QS34**
- **NICE Evidence Briefing on Youth Suicide Prevention**
- **NICE Guidelines Psychosis and schizophrenia in adults: treatment and management CG178**
- **NICE quality standard Psychosis and schizophrenia in adults QS80**

What are we doing now?

- Greater Manchester Public Health Network co-ordinated a 'Sector Led Improvement' process for suicide prevention to help local areas share good practice and identify gaps and potential for improvement.
- A Greater Manchester approach has been developed by GM Suicide Prevention Group to address serious mental health issues
- The substance misuse provision has been redesigned, and includes issues relating to mental health.
- TMBC has invested in a range of mental health promotion activities and interventions.
- The CCG has invested in increasing the access, range and availability of psychological therapies.

What needs to happen next, and by whom?

- A specific suicide prevention action plan is being developed.
- A strategic partnership approach to mental health, that includes suicide prevention, needs to be developed

Mortality from Communicable Disease

Outcomes Framework: Public Health 4.8

Implications for the population's health and well-being:

Communicable diseases include a range of conditions, including the seasonal influenza virus, healthcare associated infections (HCAI), sexually transmitted infections (STIs) such as Human immunodeficiency virus (HIV) and gonorrhoea, among many others. They have diverse routes of infection, various associated risk factors, and extreme ranges of related mortality and morbidity. Indeed, while mortality is high in some communicable diseases, time from contraction to death can be relatively long with early detection and high quality care.

At risk or vulnerable groups:

Some populations are more susceptible than others to different communicable diseases.

HCAI: HCAI cover a range of diseases including meticillin-resistant Staphylococcus aureus (MRSA), meticillin-sensitive Staphylococcus aureus (MSSA), Clostridium Difficile (C..difficile) and Escherichia coli (E. coli). HCAIs while often having low levels of infection in the general population, can be dangerous in environments (such as hospitals) where the infection can be spread quickly across a large number of people who are often already in poor health, e.g. the elderly, those with underlying illnesses, and anyone who is immune-compromised.

Seasonal Influenza: The most at risk from serious complications and mortality are those who already have underlying conditions, such as those with cardiac, respiratory, or immune system problems, as well as the elderly (who often have other conditions), and the young (who have not yet developed immunity).

Vaccine Protected Diseases: Vaccination up-take rates, particularly among children, vary according to a number of factors. There are significant reductions in vaccination rates among children in more deprived areas, those from large families, among travelling communities, and children by parents with chaotic lifestyles.

Policy context:

The Annual Report of the Chief Medical Officer 2011: Volume 2 highlights that while a new infectious disease has been discovered nearly every year over the past 30 years, there has been very few new antibiotics developed leaving our armoury nearly empty as diseases evolve and become resistant to existing drugs. In addition, to the development of new drugs the report highlights that looking after the current supply of antibiotics is equally important. This means using better hygiene measures to prevent infections, prescribing fewer antibiotics and making sure they are only prescribed when needed. The report covers a life course approach. There are 17 recommendations in this report (page 139 – 141) of which 2 relate to HWBB responsibilities. Other recommendations are relevant though the responsibility resides with PHE or NHSE.

www.gov.uk\government\uploads\systems

In support of this there is also the DH and DEFRA "UK 5 year Antimicrobial Resistance Strategy 2013 to 2018" (Sept 2013).

The PHE report, "Our Priorities for 2013\14" has 5 high level priorities, one of which is;

"Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics."

The key actions identified are:

- Reverse the current trends so that we can reduce the rates of TB infections. We will work with LAs and the NHS in those areas with high levels of TB infections to put into place effective strategies.
- Lead on the gold standards for current vaccinations and screening programmes, reverse the current increase in cases of measles, and support the delivery of the new programmes for Rota Virus, childhood flu, pertussis, pertussis in pregnancy and shingles.
- Tackle antimicrobial resistance (AMR) through surveillance of patterns of resistance to antibiotics, supporting microbial stewardship and other national strategies to address the rise of antimicrobial resistant organisms.
- Develop and implement a national surveillance strategy to ensure the PH system responds rapidly to new and unexpected threats to health of all kinds, bringing together the full range of PHE surveillance and intelligence capabilities.

Healthcare associated infections remain an issue of national importance. The reduction of clostridium difficile and MRSA bacteraemia are nationally set targets for CCGs and Acute Trusts.

Chart 102: Three Year Pooled Mortality Rate from Infectious and Parasitic Disease (2011 to 2013)
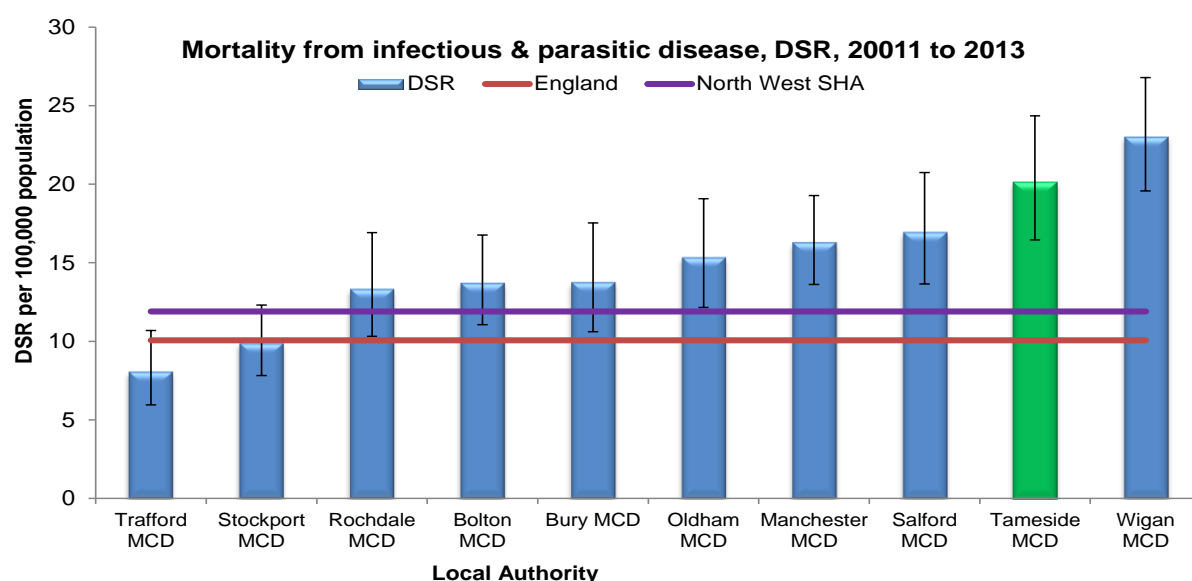

Source: HSCIC, 2015

The above chart shows the directly age- standardised rate (per 100,000 of European standard population) of mortality due to infectious and parasitic disease. The local rate is

higher than comparable local authorities, the North West and England, showing that there is opportunity to reduce the impact of infectious and parasitic disease locally.

Chart 103: Three Year Pooled Years of Life Lost due to Infectious and Parasitic Disease (2011 to 2013)

Years of Life Lost due to mortality from infectious & parasitic disease, DSR, (1 o 74 yrs) 20011 to 2013
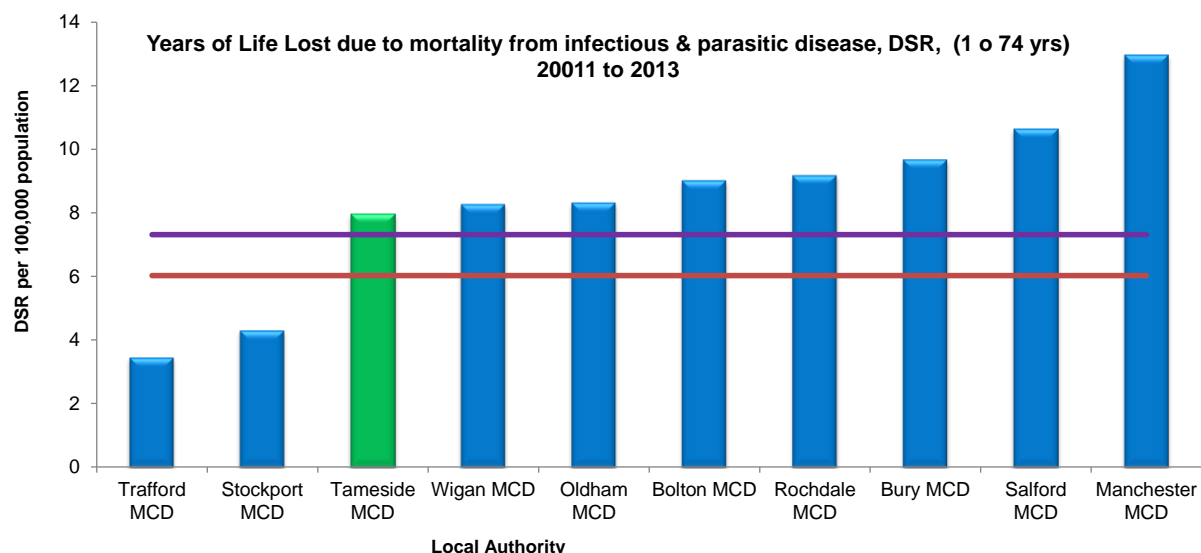
Source: NHS Information Centre, 2011

The figure above (Chart) highlights the years of life lost due to infectious and parasitic disease. The pattern here is not so stark; however, we are still above the England and North West average.

What works?

Vaccination is key to reducing the spread of communicable disease. When a population has sufficient rates of immunity to prevent spread of a communicable disease, this is known as herd-immunity. The level of vaccination required to achieve herd immunity changes depending on the disease: measles, for example, requires a vaccination rate of between 92 and 95% to effectively block transmission, whereas Diphtheria only requires a rate of 80 to 85%.

Seasonal Influenza: to protect against the dangerous effects of seasonal influenza, vulnerable groups need to be targeted: those with respiratory conditions; the elderly, and the immune-suppressed. Having comprehensive plans in place to reduce the spread in healthcare settings are very important.

Vaccination programmes should be combined with opportunistic interventions e.g. general appointment and clinic visits; ensure that all front line staff in clinics and practices are actively checking for immunisation status; work directly with communities who are under-vaccinated to increase vaccination rates; offer 'domiciliary' vaccination service for non-attendees; and use reminders to help promote attendance.

HCAI: to key is to continue with implementing clinical high quality clinical care standards in infection control; promotion of the use of alcohol hand gel; regular audits to ensure high

standards of hand hygiene in healthcare environments; availability of isolation facilities; as well as a culture of continuous quality improvement.

Sexually Transmitted Infections and HIV: Interventions include condom provision for high risk groups; condom subsidy schemes; Outreach health promotion and safe sex programmes for high risk groups and hard to reach groups; high quality integrated Sex and Relationships Education; short access times for GUM services.

What are we doing now?

- work with local healthcare providers to reduce their HCAI rate which encompasses education and audit around antibiotics prescribing and hand hygiene;
- providing specialist sexual health clinics; young person friendly community based sexual health and contraception services;
- dedicated specialist Tuberculosis service;
- primary care targeting of high-risk groups for vaccination;
- Targeting vulnerable groups for administration of vaccine

What needs to happen next, and who needs to do it?

To achieve population improvement in this domain involves the following key partners: PHE including Greater Manchester Screening and immunisation team, NHS Tameside and Glossop CCG, Tameside Foundation Trust, and TMBC (Public Health and Environmental health).

- Sexual health services are being redesigned to improve access and outcomes.
- Season flu plans are being developed to ensure that the most vulnerable to the effects of seasonal flu are targeted for vaccination.
- Clear joined up plans need to be in place to ensure that progress in reducing HCAI is sustained and improved further.
- Vaccine uptake rates are high in Tameside and Glossop for vaccine-protected conditions. Long and medium term strategies must be developed to ensure the maintenance of this performance and to target specific groups with low uptake rates.
- Further analysis on infectious disease mortality to be completed by PH Intelligence.

Under 75 mortality rate from all cardiovascular disease (CVD) and Improving recovery from stroke

Outcomes framework: Public Health 4.04

Indicator Name: including
Under 75 mortality rate from CVD & improving recovery from stroke
Under 75 mortality from all CVD & considered preventable

Implications for the population's health and well-being:

Cardiovascular disease (CVD) is the second largest cause of death in England causing around 130,190 deaths in 2011 (29% of all deaths). Around 46% of all deaths from CVD are from coronary heart disease (CHD) and almost a fifth from stroke (18%). CHD is the most common single cause of death in England (13% of all deaths in 2011).

At risk or vulnerable groups:

- There is a strong social gradient in the incidence of Cardiovascular Disease
- More people could live longer and with a better quality of life if they were supported to adopt healthy lifestyles – particularly quitting smoking, eating more healthily and being more physically active. Evidence shows that these risks factors are clustered in the more disadvantaged groups of the population.
- Some individuals and families are at very high risk of CVD, in particular those with inherited cardiac conditions such as Familial Hypercholesterolemia (FH) and some causes of sudden cardiac death.

Benchmarking:

The 'Cardiovascular disease health profile', released in 2013, includes the following as key messages for Tameside and Glossop in relation to CVD:
- Early mortality (under 75 years) rates from cardiovascular disease are significantly higher than the national rate, and have decreased by 58.3% since 1995.
- Emergency admission rates for CHD are significantly higher than the national rates, but for stroke the local rate is similar to the national rate.
- The mortality rate within 30 days of a STEMI is significantly higher than the national rate.
- For people having myocardial infarction reperfusion in 2011/12, the median time to primary angioplasty treatment from a call for help was 133 minutes in Tameside; this is higher than in Greater Manchester, Lancashire & South Cumbria and England (122 and 111 respectively).
- Stroke patients under 75 years are less likely to be discharged back to their usual place of residence compared to the national picture.

Chart 104: Under 75 mortality from cardiovascular disease by PCT, England and North West averages 2013

Under 75 mortality from cardiovascular disease, DSR per 100,000 population, 2013
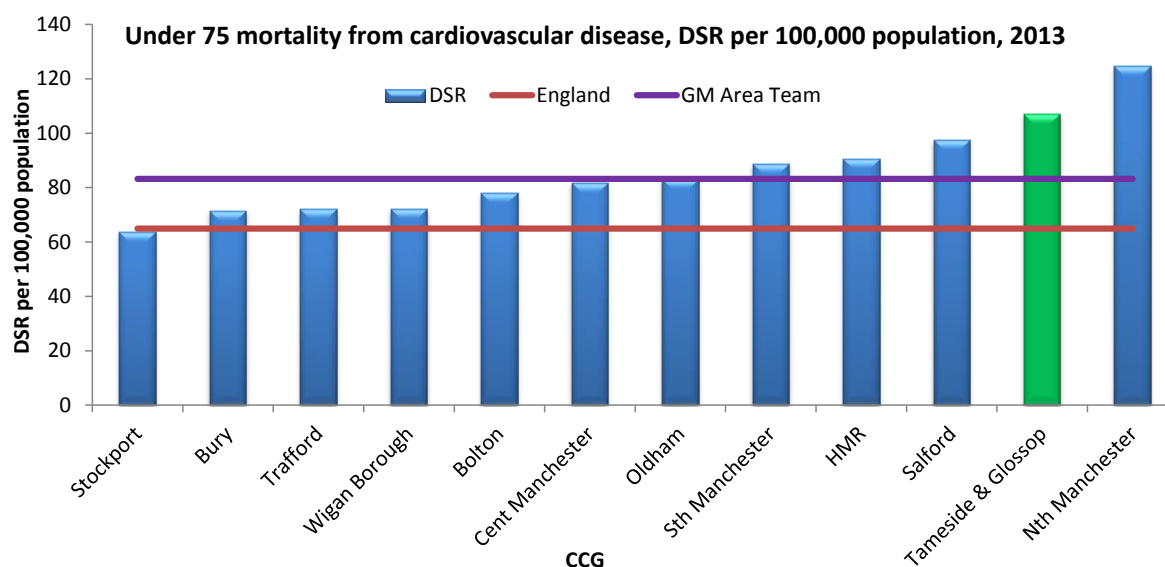
Source: HSCIS, 2015

The chart above illustrates that Tameside and Glossop had the 2nd highest rate of Under 75 year's cardiovascular disease in 2013 compared to the other PCTs in Greater Manchester. It was also significantly higher than the Greater Manchester area team and the England average.

Policy Context:

The 2013 DH 'Cardiovascular Disease Outcomes Strategy: Improving outcomes for people with or at risk of cardiovascular disease', sets out outcomes for people with or at risk of cardiovascular disease (CVD) in line with the NHS and Public Health Outcomes Frameworks. The strategy recommends:

- reducing premature mortality rates for CVD by improving prevention, diagnosis and treatment, bringing all services up to the standards of the best
- managing CVD as a single family of diseases and develop a standardised template for community and hospital care
- supporting better identification of families or individuals at high risk of CVD and improve its management in primary care
- improving intelligence, monitoring and research into CVD and publish comparative data on the quality of care provided for patients with CVD.

What interventions work?

- Healthy lifestyles and prevention interventions
- Health Checks- Invite 20% of eligible population and deliver health checks to 75% of those invited
- Quality Outcomes Framework (QOF) - Identify missing people from chronic disease registers
- Design and implement a pathway for universal care of all CVD patients:

- Embed referrals to health trainers into treatment pathway for people with CVD risk factors
- To include referrals for: physical activity, obesity, affordable warmth
- Quality of care in hospital/secondary care -Use Sentinel audit to monitor improvement the quality of local stroke services in secondary care, including stroke and cardiac rehabilitation.

What are we doing now?

- A clinical lead for cardiovascular disease is in place, working with the CCG and its stakeholders to design and implement improved cardiology pathways and services. This includes the development of primary care and community based diagnostic services, ensuring prompt access to diagnostics to ensure patients receive the optimum treatment in a timely fashion.
- Training has been delivered to CCG member practices (medical and nursing staff) on the identification and management of heart failure; and on the identification and management of atrial fibrillation, ensuring delivery of care in primary care is in line with the revised NICE guidance.
- Through Tameside's integration programme, a Stroke and Neuro Rehab model has been designed.

Establishment of a community base integrated diabetes service will improve diabetes care and reduce the incidence of cardiovascular disease in people with diabetes.

- A number of in year service improvements, aimed to reduce the incidence of stroke, and provide rehabilitation support to patients who do suffer a stroke have been carried out by the CCG. These include:
    - Redesign of TIA pathways – ensure prompt identification and management of TIAs, in line with national guidance, to support the stroke prevention agenda
    - Additional investment in community based stroke rehabilitation services, ensuring Optimum support to patients post-stroke
    - Continued work with the Stroke Association, providing support and advice to patients
    - On-going involvement in the Greater Manchester acute stroke model implementation, ensuring patients receive timely diagnosis and treatment

What needs to happen next and by whom?

- Development and implementation of the Care Together business cases to reflect early intervention and prevention across the health and social care system.
- More extensive training on atrial fibrillation is planned for 2015-16, along with the redesign the anti-coagulation pathways and services in primary and secondary care.
- Promotion of physical activity by all local partners
- Increased prescribing of drugs to control blood pressure and reduce cholesterol
- Improved blood sugar control in diabetes

Under 75 mortality rate from respiratory disease

Outcomes framework: Public Health 4.7; NHS 1.2

Indicator Name: Under 75 mortality rate from respiratory disease

Implications for the population's health and well-being:

15% of local deaths are caused by respiratory disease, which is the third largest cause of death after circulatory disease and cancer. Chronic Obstructive Pulmonary Disease (COPD) is one of the largest contributors to the life expectancy gap that exists between Tameside and England, and is the most common form of respiratory disease is COPD.

Respiratory disease, in particular COPD is a disabling illness. Although it affects people in different ways, those with COPD often have attacks of breathlessness, a bad cough and repeated chest infections, and can be affected both in the winter in a cold snap, and in the summer when air pollution can be high. Quality of life for people with advanced COPD is also affected. There are problems with restricted mobility and these are compounded by social isolation and self-esteem. The majority of COPD cases are caused by smoking, and stopping smoking, even after COPD is diagnosed can slow down the progression of the disease.

Asthma is a long-term condition that affects the airways in the lungs. Classic symptoms include breathlessness, tightness in the chest, coughing and wheezing. The goal of treatment is for patients to be free of symptoms, and able to lead a normal, active life. As it is not a condition involving gradual deterioration over time the aim is to achieve this goal in as many patients as possible.

At risk or vulnerable groups:

The National Outcomes Strategy for COPD and Asthma identifies those most at risk as:
- Current and ex-smokers are most at risk of contracting COPD
- People who have been exposed to inhaled dusts and gases in the workplace
- Those who have an inherited genetic problem that leads to the early onset of emphysema
- Who may have had a previous diagnosis of asthma
- Routine/manual workers
- Bangladeshi men and women

Benchmarking:

Premature deaths from respiratory diseases are more common in Tameside than in England as a whole, but in line with the average for Greater Manchester and the North West. This is also the case for premature deaths from pneumonia. In contrast deaths from bronchitis and emphysema for all age groups are much less common in Tameside than England, NW or Greater Manchester.
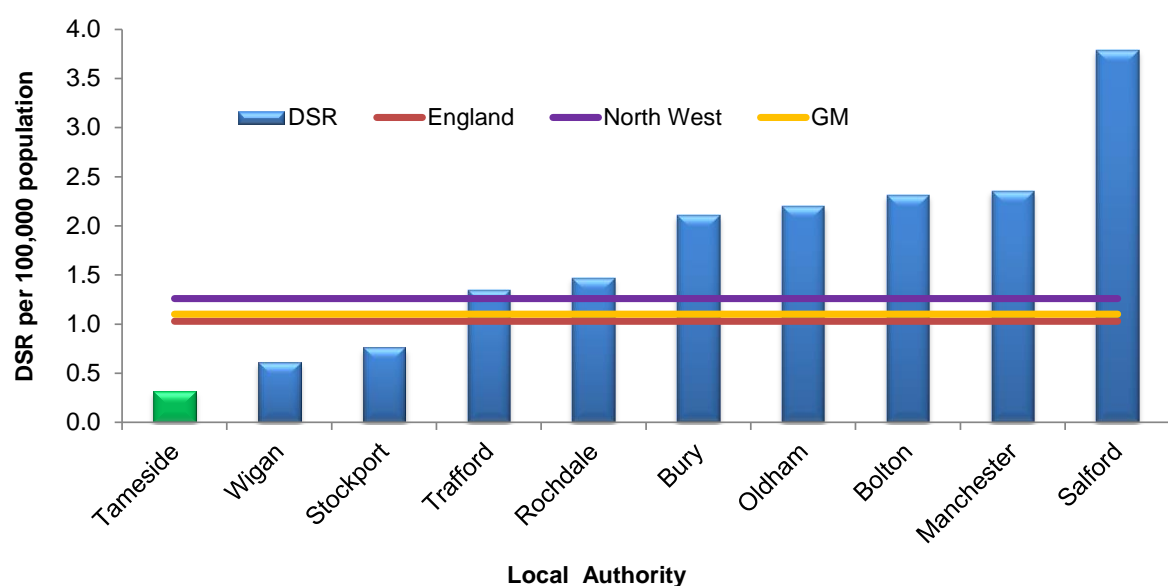
Chart 105: Directly Standardised under 75 mortality from respiratory disease (2011-2013)
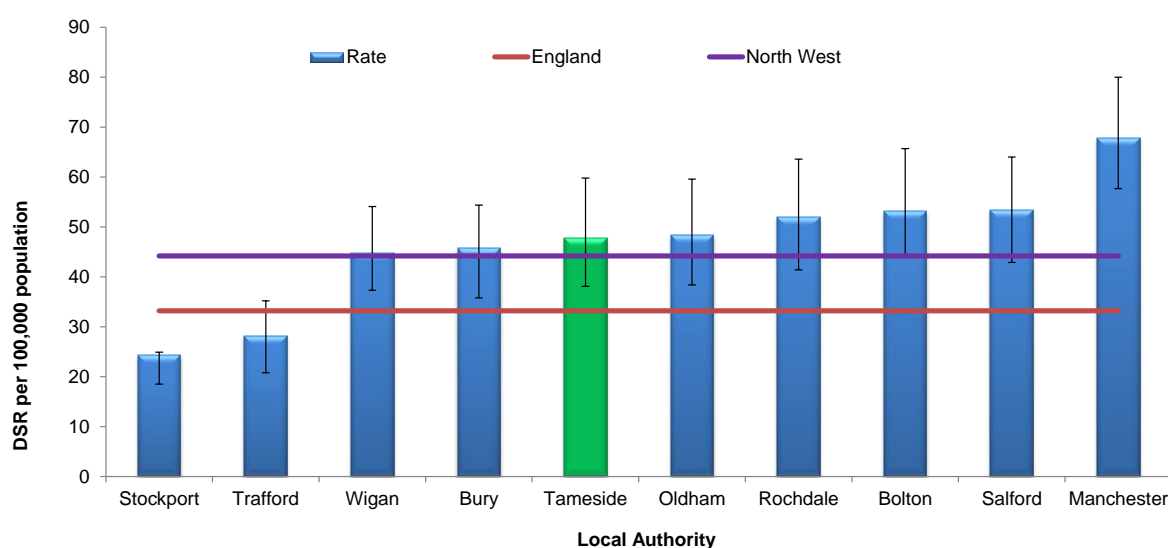
Source: HSCIC, 2015

Chart illustrates that Tameside has the 6th highest rate of Under 75 years mortality from respiratory disease, and is higher than both the North West and England averages.

Chart 106: Directly Standardised under 75 mortality from bronchitis and emphysema (2011-2013)

Source: HSCIC, 2015

The above chart (Chart) illustrates that Tameside has the lowest rate of Under 75 year mortality from bronchitis and emphysema across the Greater Manchester footprint of local authorities, and also fall below the averages for Greater Manchester as a whole, the North West, and England.

Chart 107: Directly Standardised under 75 mortality from pneumonia (2011-2013)
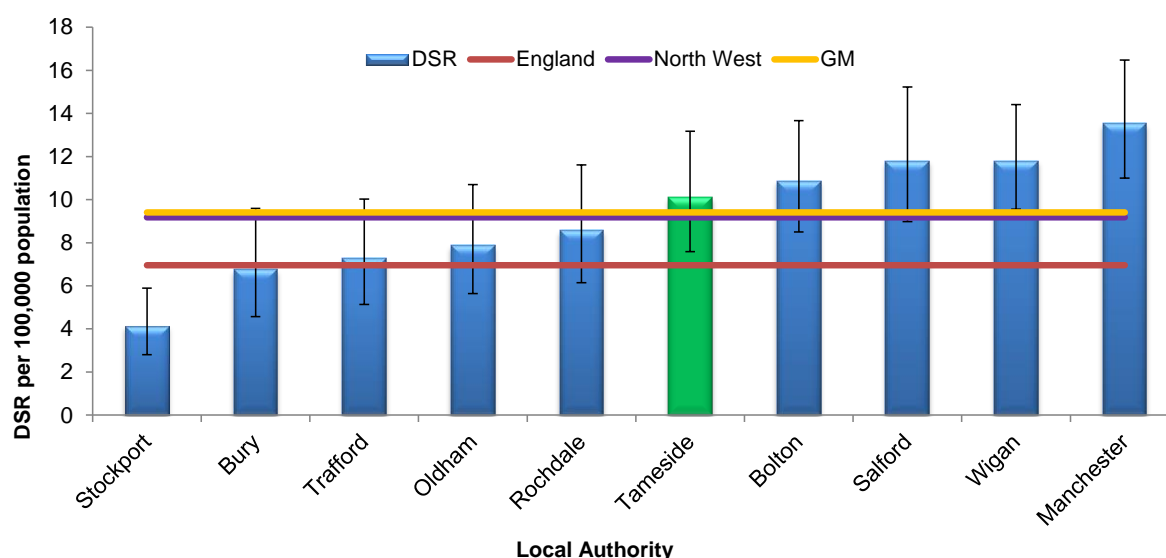
Source: HSCIC, 2015

The above chart illustrates Tameside has the 5th highest rate of Under 75 mortality from pneumonia in Greater Manchester. It is above the average for Greater Manchester as a whole, the North West and England

Policy Context:

NHS organisations should continue to support the other clinical strategies aimed at reducing early mortality from respiratory disease. There is strong evidence that early treatment supports better clinical outcomes. There are a number of key areas where commissioners and providers can work together to ensure earlier diagnosis and treatment.

An outcomes strategy for people with chronic obstructive pulmonary disease (COPD) and asthma in England.

An Outcomes Strategy for COPD and Asthma: NHS Companion Document

Service improvement guide for developing COPD services

NICE Guidance for Respiratory Disease

What interventions work?

National Guidance from NICE recommends the following interventions in order to manage respiratory disease, reducing mortality:
  ➢ Accurate diagnosis;
  ➢ Stop smoking;
  ➢ Promote effective inhaled therapy;
  ➢ Provision of pulmonary rehabilitation;
  ➢ Use non-invasive ventilation;
  ➢ Manage exacerbations;

What are we doing now?

Tameside and Glossop CCG have delivered a number of projects in year to support patients with respiratory disease, including:

- Improved delivery and uptake of community based pulmonary rehabilitation courses to patients with COPD
- Continued improvement in the delivery of home oxygen services, including regular clinical assessment of patients requiring this service
- Identification of primary care based "respiratory champions" and delivery of training to primary care professionals in the identification and management of COPD
- Promotion of 3rd sector support available for patients with respiratory disease – e.g. Breathe Easy
- Continued development of telehealth services to support patients with COPD and Heart Failure
- Additional funding secured and a project established to deliver supported self-care programmes for patients, working with Respiratory Education UK

What needs to happen next and by whom?

- Development and implementation of the Care Together business cases to reflect early intervention and prevention across the health and social care system.

- A model for an integrated respiratory disease service has been developed. The high-level objectives of the new service model are:
  - to ensure prompt, optimal management and integrated care for all patients in line with evidence-based guidance, providing:
  - expert care in the community when appropriate
  - admission to hospital when required
  - early, structured and assisted discharge of COPD patients when appropriate
  - To ensure effective management of co-morbidities, optimisation of therapy and smoking cessation as appropriate.
  - to minimise the impact of the disease (through faster and more effective treatment of exacerbations and fewer hospital admissions and re-admissions)
  - to improve symptom control, function and quality of life for all patients with the disease
  - to ensure that users of the integrated respiratory service have a positive experience
  - to ensure effective communication with the patient and support for self-management
  - To co-ordinate with all disciplines across the care pathway to ensure integration and effective communication with GP services, community and social services as appropriate.

- Reduce the local prevalence of smoking