Manchester City Council
Report for Information

Report to: Health Scrutiny Committee - 18 December 2014

Subject: 2014 Public Health Annual Report

Report of: Director of Public Health

Summary

Under the provisions of the Health Service Act 2006, the Director of Public Health (DPH) must produce an annual report on the health of the population for their area. The draft attached, is the report of the Manchester DPH under the responsibilities that transferred to the City Council on 1 April 2013. The final report will be properly formatted and published on the Council internet early in the New Year and will also include additional images relating to the case studies in the report. A small number of hard copies will be printed for libraries and national bodies.

Recommendation

The Committee is asked to note the report.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

The Annual Report of the Director of Public Health for Manchester 2014

Foreword

This is my third annual report on Public Health in Manchester, and my second since the move of Public Health back into its traditional home in the City Council.

Within Manchester, we have been fortunate to have had a strong Public Health presence within the Council for many years. The Joint Health Unit was established in 2002, and formed a core part of the Manchester Public Health system, working alongside our NHS colleagues. We have been working as a single Public Health team based in the Council since May 2012, and we are already able to show many positive outcomes from our closer links with other council teams and directorates.

In this Annual Report, I will outline our current health statistics and trends for Manchester. In many areas, we have considerable cause for optimism, but I will also describe the approach that we are taking to address some of the long standing and complex health problems that we see in parts of the city. Many of these issues are typical of those faced by other Northern cities, and it will take concerted efforts, from national as well as local government, to address them. For this reason, the final part of my report describes the ambitions that we in Public Health have for Manchester in its role as a major city of the North West region. In this section I describe the work undertaken with Public Health colleagues across the Region on our Call to Action to Government. This includes the priority actions that we believe would have the largest impact on reducing the unacceptable gap in life expectancy between the North West, and Manchester in particular, and the England average.

Finally it is important to acknowledge that the report will be published as the consultation on the City Council's budget savings options is underway. Clearly the outcomes of the consultation and the review and reform of public health services will form the basis of my 2015 Annual Report.

David Regan

Director of Public Health for Manchester **November 2014**

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Introduction

The poor health of Manchester's population has been well documented over many years. The city remains one of sharp contrasts, with a thriving business hub, vibrant nightlife, excellent cultural resources, and a huge knowledge based economy through its universities and hospitals. Manchester is a hugely popular destination for UK students, and is also highly attractive to students from overseas. It is surrounded by some of the most beautiful and easily accessible countryside in the world. Despite this, the city is the fourth most deprived in the country, and we have areas with high population churn, low educational attainment, and high unemployment. The recent economic downturn, and the ongoing impact of recessions in the 1970s and 80s have left us with a city with fewer older people than the national average, many of whom are at risk of social exclusion. Unsurprisingly, we see high levels of mental health problems in the city, especially anxiety and depression, and high levels of smoking, alcohol and other substance misuse, poor diets and a lack of physical activity. These lead to higher incidence, at a younger age, of many illnesses, in particular cancer and coronary vascular disease, and often late diagnosis of these diseases, leaving fewer treatment options. In a city where 36.4% of children live in poverty we do take deprivation and its inter-generational impact seriously and what we can always be sure of is the energy and enthusiasm of the people who live and work here to improve things for the better.

In this report, I outline the current health statistics and trends for Manchester. I then describe some of the actions that the Public Health team in the Council, alongside partners from the statutory, the voluntary and the independent sector, are taking to tackle some long-standing issues. In particular, I have focussed on our engagement with Public Service Reform, and on the key role that preventative services have in reducing ill health, worklessness and dependency in the city. Finally, I describe the work undertaken with public health colleagues across the North West region, including details of our collective Call to Action, describing the priority actions that we believe would have the largest impact on reducing the unacceptable gap in life expectancy between the North West, and Manchester in particular, and the England average.

Chapter 1

Manchester's Health Profile 2014

Population trends

1.1 Manchester's population has been growing steadily, and the Office of National Statistics' latest estimate (mid 2012) is that 511,000 people live in the city. Manchester is the largest city in the North West, and, with a 19% increase in population between 2001 and 2011, had the third largest population increase in England and Wales. This population growth bears out what many of us know: that Manchester is a great place to live; but rapid population growth can bring its own challenges to services and infrastructure, and we need to ensure that population health is protected and promoted at such times.

1.2 Manchester's population has a younger age profile than the national average, with its working age population boosted by the large number of students in the city. Manchester's older population is almost unique in England. Older people form a smaller than average proportion of the population and the number of people aged 65 and over is currently decreasing, set against an above average number of young adults. Having fewer older people in a population might be thought to lead to a reduced need for services: however, given that many older people are the bedrock of the voluntary sector, and provide huge amounts of care and support to family members and others, the impact of these lower numbers may be detrimental to Manchester's wellbeing. Additionally, whilst there are some settled communities of older people, many live in areas where they experience higher levels of social exclusion and many report very poor health and loneliness. The characteristics of Manchester's older residents also mean that they are more likely to place high demands on hospital emergency services, mental health services and that they suffer from long term limiting illnesses at an earlier stage in their old age than seen nationally. In response to this, the city has launched the *Living Longer, Living Better* initiative, with a goal of health and social care integration, and *Age-friendly Manchester*, a wide-ranging programme affiliated to the World Health Organisation.

1.3 Manchester is famed as a multinational and culturally diverse city, having long been a centre for inward migration. Researchers at Manchester University claim Manchester to be the UK's language capital, with over 200 languages spoken by its long term residents. After English, the most commonly spoken languages in Manchester are Urdu, Arabic, Chinese, Bengali, Polish, Panjabi and Somali, reflecting recent immigration patterns. Of our residents for whom English is a second language, 80% report that they speak it well or very well, with only 3% reporting that they cannot speak English. The largest ethnic group in Manchester is White, accounting for two thirds of the total population, with 17% of the population being Asian/Asian British, 8.6% Black or Black British and 5% from mixed or multiple ethnic groups. The proportion of non-White groups increases in younger age groups, with 52% of 0-4 year olds being from ethnic minority groups. Ensuring that services are culturally sensitive and that they meet the specific needs of particular groups is a focus of much work within public health.

1.4 Manchester's economy has continued to recover from the impacts of the recession, with businesses reporting increasing levels of confidence. However, although the number of residents in employment has increased, employment rates are still notably lower than the national average, and youth unemployment is still a cause for concern. Educational attainment levels in parts of the city are lower than the national average and this, coupled with a large amount of low paid or part time employment, means that many families are trapped in benefit dependency. One of the priorities for the city is to focus on improving employment and skills, in order that all residents can benefit from the many opportunities available, and that poverty, whether in or out of work, is reduced. And we are seeing results in this area, with our GCSE 5 A*-C rate improving, and many more opportunities emerging for young people to remain in education and training.

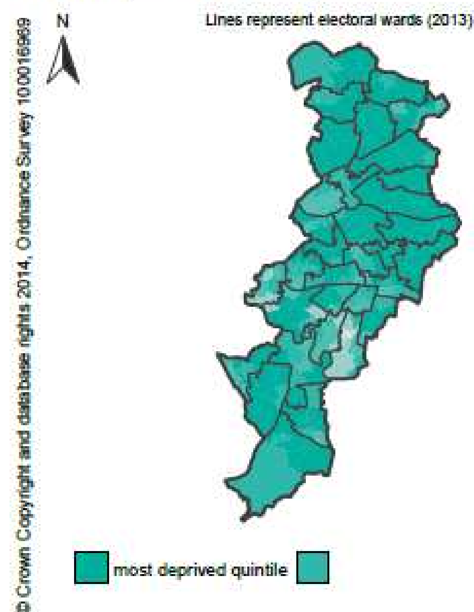
1.5 Despite recent improvements, the health of people living in Manchester remains among the worst in England, with life expectancy remaining stubbornly low and with the city showing a high number of preventable deaths, and with our under 75 mortality rates for both cancer and cardiovascular diseases being among the very worst in the country. All the modifiable lifestyle factors that lead to poor health outcomes are highly prevalent in Manchester: high numbers of overweight or obese children, high recorded levels of drug misuse; high levels of alcohol use and of poor diets. Although smoking rates at 24.6% are higher than the England average of 19.5%, they are some way from the national worst of 30.1%. Despite this we have the highest number of smoking related deaths in the country, possibly reflecting higher smoking rates in the past, and/or late access to diagnosis and treatment. One very encouraging sign is our progress in reducing the number of women who are smoking in pregnancy. This has dropped to 12.6%, matching the England average, and has been coupled with significant success in introducing 'Smoke Free Homes' across the city. Our success in early years' interventions can also be seen in our improving rates of breast feeding initiation. We can take some hope from our improving indicators in relation to children's health and attainment for the health of our future citizens.

1.6 In addition to the gap between Manchester and the England & Wales average, we see considerable variation in health and other statistics within Manchester, with some wards and areas, and some particular groups in the population, showing considerably higher levels of ill health and deprivation than others. This is true both for life expectancy1 and for healthy life expectancy2 and has led us to consider what steps we need to take to help the worse performing areas catch up with the better performing, and to consider how to target services effectively at those most in need. This has been a strong feature of our Ward Health Plans, a political priority of our Executive Member for Adults, Health and Wellbeing. The plans have been developed by ward councillors and local agencies looking at the data and gathering other sources of intelligence to identify the health priorities for their area. I will report on the first year of ward health plans (2014/5) in my next Annual Report.

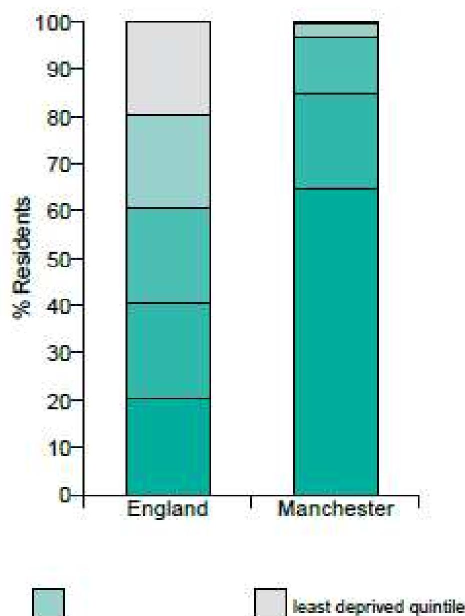
[1] Average number of years that a newborn is expected to live if current mortality rates continue to apply.

[2] Average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

The map shows differences in deprivation levels in this area based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by Lower Super Output Area. The darkest coloured areas are some of the most deprived areas in England.



This chart shows the percentage of the population in England and this area who live in each of these quintiles.



1.7 In order to reduce the burden of ill health in Manchester, and to reduce the life expectancy and healthy life expectancy gap that we see in the city, we must address the underlying causes of this ill health. To achieve this, we will need to support people to make healthier choices; work to make the healthier choice become the easier choice; and ensure that our population can access services in a timely manner, so that interventions are as effective as possible.

1.8 The low uptake of preventative services, whether screening, immunisations, or health checks, and the late presentation of symptoms to GPs or other healthcare professionals, are all more common in our populations living in more disadvantaged areas, and this low uptake and/or late presentation all add to the poor health outcomes in these groups. We know that, for example, diabetes rates are higher in some Black and Minority Ethnic groups and that therefore the health impact of obesity is likely to be greater in these groups. But at the moment we are not able to demonstrate that we are consistently targeting these higher risk groups for preventative activity or that such targeting is effective. Similarly, our HIV prevalence rate in Manchester is one of the highest in the country, with particularly high rates among sub-Saharan Africans and gay men. However, our HIV testing is not well embedded and routine, and so we continue to have a high proportion of people diagnosed at a point at which their disease is already starting to have clinical implications for them. This is dangerous both for the individual involved, because of the implications for their treatment and life expectancy, but also for the wider population, as a longer time pre-diagnosis may increase the risk of onward transmission and further spread of this very unpleasant disease.

1.9 Despite the fact that we know a lot about the different prevalence of disease among different groups, our delivery and targeting remains inconsistent, with much remaining dependent on the knowledge and skills of individual clinicians.

1.10 In order to achieve a more consistent approach to the delivery of preventative services, and better uptake among higher risk groups, we are focussing on two key policy drivers. The first is to deliver Public Service Reform, so that our services are modernised to tackle complex dependency, enable all children to get the best start, support the integration of health and social care, and target those most in need. The second is to deliver against the Public Health Outcomes Framework for England, 2013-2016, with its vision of improving and protecting the nation's health and wellbeing, and improving the health of the poorest fastest: clearly a particularly relevant goal for Manchester. Within this, we are particularly focussing on where we see the largest discrepancies between different areas and sub-populations, so that we can address both life expectancy gaps between Manchester and the UK, and also address the gaps between different areas of and groups within Manchester.

1.11 In Appendix 1, I have included the website links to the Public Health Outcomes Framework, as well as the most recent Health Profile data for Manchester from Public Health England. Please note that these data are in some cases from 2013, leading to the occasional discrepancy with data from 2014 used in the main body of this report.

Chapter 2

2.1 Delivering Public Health Services in Manchester – developing a healthy population

It is clear, from the preceding section, that improving both life expectancy and healthy life expectancy in Manchester bring with them some particular challenges, especially against a backdrop of significant financial restraint. For this reason the leadership and support for this task that is being shown by the Health and Wellbeing Board and its constituent members is vital. The Public Health team is pleased to be able to support and advise the Board, and to be able to play a key part in redesigning services in the light of the requirements and expectations of Public Service Reform, to make them more effective and appropriate for today's circumstances. Tackling the lifestyle factors of poor diet, physical inactivity, smoking, excess alcohol use and poor sexual health will inevitably form a major plank of any public health strategy for Manchester. Helping to design environments that are conducive to making healthy choices easier, and supporting families to live a healthy lifestyle, is far from simple and the negative impact of the stresses caused by poverty and deprivation should not be dismissed.

In this section, I shall give some examples of the work that we are undertaking, within the team and in partnership with others, to design services that promote independence and community asset building, while targeting those most in need of support for either the short, medium or longer term. These examples will illustrate how we are responding to the specific public health needs in the city; how we are modernising and reviewing our services; and how we reflect a life-course approach to our patterns of service delivery. These case studies can only give a flavour of a small part of the work that is underway, but I hope will give an indication of the breadth and depth of the work that we are involved with, and will demonstrate how we are responding to the challenges outlined in the preceding chapter.

2.2 Delivering Public Service Reform

2.2.1 Work and Health programme: why work is now a health outcome and how we commission for employment

People in work live longer, healthier lives. Being out of work, at any age, can lead to poor mental and physical health, with major implications for individuals and for their families. Getting into good quality work improves people's health, and in turn a healthy population in good employment benefits the local economy, setting up a virtuous circle. The Public Health team sees supporting people into employment as a critical part of our plans for improving the health of the population, as well as being a key component of public service reform and the promotion of independence. We are a key partner in the Work Programme Leavers (Working Well) and have established a number of employment programmes, such as that in North Manchester, working with GPs to support out of work patients with health conditions move back into training and employment. Additionally, a city wide primary care programme aims to prevent people who are off work sick from falling into unemployment. We have also been providing education and training for healthcare workers on the relationship between work and health, and to reinforce this, we are now including work as a

health outcome into routine assessment and care pathways. Thinking of work in this way has sometimes been challenging for our health colleagues, but we are seeing a real shift in attitudes, and we are finding that people are now being given much more active support and encouragement to return to meaningful employment.

2.2.2 Developing our understanding of our 'at risk' population: making targeting effective

Within Public Health, we are constantly balancing the need to provide universal interventions, which can be costly, with the need to use our limited funds to provide targeted interventions aimed at higher risk individuals or groups. Universal interventions can be powerful in that they are often more acceptable to individuals, can be simple to administer, and enable consistent messages or interventions to reach people who might otherwise miss out or avoid the intervention. Examples of universal interventions are immunisations, health visiting, midwifery, or the smoking ban. Even within universal interventions, however, we typically operate a system known as 'progressive universalism': we describe some actions or interventions that everyone can and should access (e.g. immunisations, 12 week pregnancy scan) and others that are only available once a need has been established (e.g. specific support with drug or alcohol use). Identifying the highest risk populations for early preventative or protective interventions is not always straightforward and within the Public Health team we have been focussing on how we ensure that the projects we deliver or commission are directed at the population groups most at risk of poor health and early death. Our **Public Health Intelligence** team provide data, information and evidence to help us target the work we do in the most effective way. An example is our work on **identifying people at high risk of emergency hospital admission.** Through analysing data on those people who have experienced higher numbers of emergency admissions, we have improved our understanding of the socio-economic and behavioural factors that influence this. We have fed these findings into the *Living Longer Living Better* programme, so that they can be used to identify higher risk people, and contribute to redesigning services so that people can be supported to stay at home and not rely on emergency care. These findings can also be used to assist in modelling the financial impact of the programme.

2.2.3 Living Well: Designing services to manage complex dependency

This element of the lifecourse section describes the working age population. Ideally this population should be able to support themselves, and have the wherewithal to live healthy lifestyles, in gainful employment and in stable households. Family structures should be established and people should be living in strong, supportive social networks, in areas of high social capital. Where people have specific needs for support (either because of health conditions, learning or physical disabilities or other issues), these should be understood and services should be established to provide the relevant support, based on clear need assessments.

2.2.4 Domestic Violence and Abuse

Domestic violence and abuse is a serious public health issue and an important cause of long-term problems for children, families and communities. It is responsible for two deaths of women a week in this country, and has intergenerational consequences in

that many victims of violence and abuse go on to become abusive themselves. In Britain there are approximately 15.4 million incidents of domestic abuse each year, mostly unreported, and many people suffer repeated episodes. The cost to the NHS alone, excluding mental health costs, is £1.7bn a year. Manchester is by no means exempt: domestic abuse was identified as a key factor in all of the seven most recent domestic homicide reviews or serious case reviews to be undertaken in the city. Furthermore, the Manchester Safeguarding Children Board reports that currently 73% of children on a child protection plan in Manchester are living in households where domestic abuse or violence is an identified factor.

The Manchester Public Health team has worked with partners to develop the Identification and Referral to Improve Safety (IRIS) programme, a domestic violence training, support and referral programme for general practice staff. It provides clear pathways to support for patients living with abuse, as well as information and signposting for victims and perpetrators. The training is co-delivered by a specialist in domestic abuse and a local female GP. In the first 18 months of the programme, 16 GP practices were trained. This included training for 116 clinical staff and 136 admin/reception staff, and 169 referrals were made to specialist support. A recent review of the service has found that it is being successful in encouraging disclosure and consequent appropriate action, leading to a positive impact for affected families.

2.2.5 Substance misuse in Manchester

Substance misuse (which includes alcohol, illegal drugs, and the misuse of legal drugs) has a significant impact on individuals, families and communities in Manchester. This can include physical health problems and premature mortality, poor mental health and wellbeing, crime and antisocial behaviour, worklessness and lost productivity, homelessness and family breakdown. It is estimated that problem drug use costs England and Wales £15.4bn annually, with a further £21bn from alcohol misuse.

Within Public Health, we commission evidence based prevention services aimed at young people, to provide them with the skills they need to minimise any harm from drug or alcohol use. We also commission treatment services to address drug and alcohol misuse, including approaches to improve housing, training and employment prospects, in order to make a sustainable difference to people’s lives. Following our service review and re-commissioning in 2012, we are seeing more of the clients successfully completing treatment and improving their housing and employment prospects. We have also seen a decrease in alcohol related hospital admissions over this last year.

Drug and alcohol misuse is a multi-faceted problem, requiring a multi-agency approach. The strategies and services that the public health team deliver are an important part of the city’s response, and can be shown to be of high quality and demonstrable impact.

2.2.6 Improving mental health

Maintaining good mental health and wellbeing is critical to maintain good health, but many people lack the confidence to talk about this important issue. One in four

people in the UK will experience a mental health problem each year, and low level mental health problems are a particular problem for people who are unemployed, have complex family lives (especially where financial problems or substance misuse are involved) or who have long term health conditions. Addressing physical health or practical issues without understanding the importance of improving mental health is unlikely to lead to sustainable improvements, but many health or social care staff are not confident in discussing matters relating to mental health.

In order to address this, we have commissioned training for frontline staff and local communities in public mental health. The Connect 5 programme targets staff from the statutory and voluntary sectors and aims to improve confidence in discussing and managing common mental health problems such as depression and low mood. They are also given information on how to signpost or refer to more specialist services as and when required. One thousand local workers attended this course in 2013/14, and the evaluation is proving extremely positive. Boost is a complementary course for the general public, teaching basic skills in maintaining emotional health. Nearly 300 people signed up for this course in 2013/14, and the evaluation is showing positive outcomes.

We are developing a network of support to workers, and commissioning further training, in order that as many people as possible have access to the mental health support they require, so that they can lead more fulfilled and independent lives.

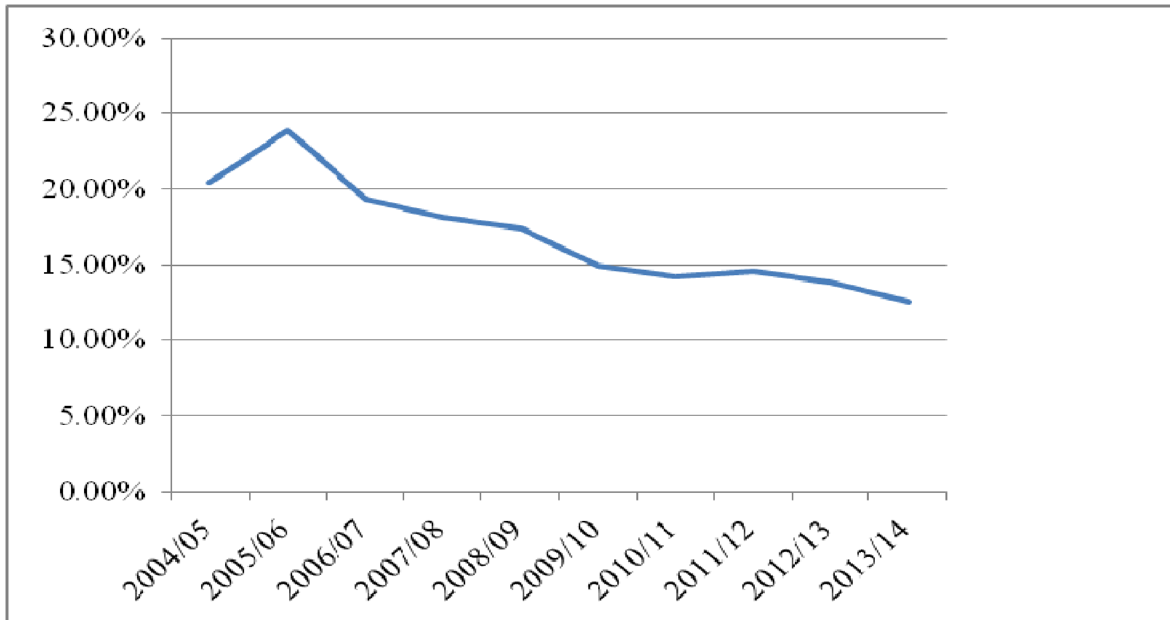
2.3 Starting Well/ Developing Well

Getting children off to a good start is crucial if we are going to address the health inequalities that many children in Manchester face. A child's life chances (e.g. their mental and physical health, life expectancy and life prospects) are all strongly influenced by experiences in their early years. Across Manchester, the City Council, health and voluntary sector partners have been working together to offer effective support to families through the development of a new, integrated model of early years' service delivery. This is aimed at ensuring that every child is offered the support he or she needs, provided through the framework of 'progressive universalism'. The goal of the early years' service is to enable children to meet their developmental goals, supported by a loving family and secure attachments, so that they enter school ready and able to learn, to make friends, and to flourish. The Public Health team has had a key role to play in the development of the new service model, ensuring that the new service is developed on evidence based practice, promotes key health messages and actively supports positive health behaviours including breast feeding, immunisation and healthy diet.

2.3.1 Smoke free homes and a smoke free start

Smoking in pregnancy can increase the risk of illness such as low birth weight, asthma, learning difficulties, miscarriage and stillbirth. With support from health professionals, pregnant women can give up smoking and continue to be smoke free following birth. Over the last 10 years, the numbers of women smoking at the time of delivery have declined dramatically in Manchester. (See figures below)

Women smoking at time of delivery



This a considerable achievement and with the success of smoke free homes, more babies and children are growing up protected from smoke in their daily lives. A special mention must go to Manchester Stop Smoking Service and Wythenshawe Community Housing Association for a community arts project in which local pregnant women used their scan photos to contribute to the design of a sculpture to celebrate and promote smoke free pregnancy. It is permanently sited outside Wythenshawe Hospital's maternity unit and the 'Air to Breathe' project, as this was called, won a prestigious Royal Society for Public Health Award for 2014.

2.3.2 Universal Supplementation of Vitamin D in pregnancy: responding to a renewed threat

To many people, vitamin deficiency is associated with other parts of the world or other times in history. But the reality is that Vitamin D deficiency is a serious and growing problem in this country, leading to cases of rickets and hypocalceamic seizures. These are significant health problems, but are entirely preventable by giving dietary supplements of vitamin D. As a Public Health measure in Manchester, we will offer free vitamin D supplements to all pregnant women and to babies for one year after birth, thus ensuring that all children born in Manchester have an adequate supply of vitamin D. The vitamins will be available from local health centres and from Children's centres, and will also be used to promote discussion between parents and midwives, health visitors and Children's Centre staff, about the benefits of ensuring that babies and children get the nutrients they need in their diets. A healthy diet is a key component of getting every child off to the best possible start.

2.3.3 Helping children maintain a healthy weight

Being overweight in childhood is a good predictor of being overweight or obese as an adult, and supporting children to maintain a healthy weight is an important component of any programme to tackle obesity. The Public Health team, together with local partners, have developed a programme to identify children who are not a healthy weight (whether over or under weight), provide them and their families with appropriate advice and support, and refer them into specialist services as required. By working in nursery settings, it provides input to very young children, before habits have become too ingrained. Many of the children in the programme have complex needs, and this intervention means that children are more physically ready to start school.

2.4 Delivering Public Health Outcomes: Increasing Life Expectancy

2.4.1 Increasing life expectancy by reducing population risk factors

In Manchester, most of the burden of disease in our population is contributed to by a small number of modifiable risk factors, such as smoking, high blood pressure, obesity, physical inactivity, alcohol and diet. These risk factors, and the consequent poor health outcomes, are most prevalent in the more deprived areas of Manchester, and go a long way to explain the different life expectancies by ward in Manchester.

2.4.2 The NHS Health Check is a national programme aimed at people aged between 40 -74 who are at risk of heart disease, kidney disease, strokes or diabetes. The programme delivers a simple series of checks and questions in primary care and community settings, and can refer people for clinical interventions or help people access support for lifestyle change. In Manchester, we have found that many of the people at higher risk are less likely to come forward for the Health Check, and so we have been working to identify settings that make it easier for people to attend. Because of the high correlation between diabetes and gum disease, and the high attendance rates at dentists in Manchester, we have piloted a programme offering health checks in a dental practice serving a population with high rates of

cardiovascular disease. This is in line with our objective of increasing uptake of prevention services in our highest risk populations.

2.4.3 Accessing services when they are needed: increasing life expectancy by tackling late diagnosis; and building community skills on the way.

In the UK, late diagnosis of cancer contributes to between 5000 and 10000 deaths a year. Traditionally, we have relied on people recognising symptoms and going to the GP. However, we know that people from disadvantaged communities, who already suffer poor health, often present late and have worse cancer survival rates than the national average. We have set up a project in partnership with Macmillan Cancer Support, the Chrisite NHS Foundation Trust and others, to recruit and train a network of volunteers to promote cancer awareness messages in their communities, targeting those at high risk or who may not usually access health or social care services. Because the volunteers live and work locally, they have good networks in their communities and can help engage people with services, with nearly 3000 people reached to date. We have found that this project has led to positive outcomes for our volunteers too, with volunteers finding that they have gained skills and confidence, and many have now gained employment in the health and social care field. This project is an excellent example of how using a community asset building model to address an identified need delivers effectively against a wide range of outcomes, including health, employment, and community cohesion.

2.5 Ageing well

Across the world we are seeing people living longer, which on the one hand creates new opportunities for people in later life, but can also present new challenges related to age-specific health and social issues: we are seeing increasing numbers of people suffering from conditions such as dementia, meaning that people often have considerable care needs as they age. But the increasing number of older people does not need to be seen in negative terms, and there are a number of steps that can be taken to ensure that people have a healthy older age, and are able to continue to contribute to society in the ways they wish. But for this to be a reality we are going to have to rethink how we prepare ourselves for older age; how we maximise our fitness levels when we are younger, how we build in preventative health care, and how we plan society and the environment.

Approximately 10% of the population of Manchester is aged 65 or older, and it is predicted that this will double by 2050. Supporting older people to take more control of their local environment can improves the quality of the local environment for other age groups, especially if ‘intergenerational’ approaches are involved. We are also able to mobilise the wealth of local experience in engaging older people in planning services, and in reflecting the value of older people’s contributions, for example as volunteers, role models and care givers.

2.5.1 Living Longer Living Better – a programme to integrate health and social care

Across Manchester, through the Living Longer Living Better programme we have already been putting together proposals for integrated health and social care for older

people, to reduce gaps or duplication and to ensure that there are streamlined services, responsive to needs and focussed on maintaining older people's independence.

2.5.2 Increasing life expectancy and improving the quality of life: reducing the risk of falls

Falls among older people are a significant public health challenge. Approximately one in three people aged over 65 fall each year, and not only does this cost the NHS more than 2.3 billion a year, but the human cost, in terms of pain, injury, distress, and loss of independence is immense. For many people, the fear of falling can also have a severe impact on their lives, curtailing activities and leading to loss of skills. Family members can also be severely affected by a fall of a loved one, and a fall is often the trigger for a move to supported accommodation or residential care.

Research shows that one of the most effective ways an individual can reduce their risk of a fall is to engage in Strength and Balance Training (sometimes known as falls prevention classes).

In 2013 Public Health launched a review of our falls services, not only to improve the existing service but to reduce the number of people who fall in the first place. By shifting our focus from *treatment* to *prevention,* we are hoping to improve the quality of life of our older residents, helping them stay independent for longer. Not only will this bring personal benefits to individuals, but over time it will also reduce demand on services.

As an initial step in the expansion of our exercise programme, we have set up a pilot class (together with the University of Manchester) at a sheltered housing scheme in Clayton. This is the first time a class has been accessible to people who could not travel far from home, and residents in the housing scheme were encouraged to attend the class and to adhere to the programme of exercises, supported by an instructor with specific skills in delivering this type of training to older and more infirm people. We are already seeing positive results, with participants able to engage in wider types of exercise, regaining movement and gaining in confidence.

2.5.3 Designing an Age-friendly City

The Age-friendly Manchester (AFM) team within Public Health is affiliated to the World Health Organisation's global age-friendly partnership, and aims to move the ageing debate away from the 'deficit' model of ageing, towards a 'citizenship' approach (see illustration below) where older people are seen as an asset with rights to participate in city life. In practice AFM works on four themes: age-friendly neighbourhoods; age-friendly services; knowledge and innovation; and, involvement and communication.

Illustration 1: AFM Citizenship-based policy approach to ageing compared to medical and care approaches

Medical	**Care**	**Citizenship**
Patient	Customer	Citizen
Focus on individual	Focus on individual, family and informal networks	Focus on neighbourhood and city
Clinical interventions	Care interventions	Promoting social capital and participation
Commission for 'frail elderly'	Commission for vulnerable people	Age-proofing universal services
Prevention of entry to hospital	Prevention to delay entry to care system	Reducing social exclusion
Health (and care system)	Whole system	Changing social structure and attitudes

The AFM team has been working with Southway Housing Trust in the Old Moat area to develop an age friendly environment initiative. Older people worked with architects, urban planners and gerontologists to address the social and environmental barriers to participation in the local community. Suggestions made included changes to seating, improved access to toilets, reviewing signage, and the development of an Age Friendly Charter for local businesses. These changes were not expensive to introduce, but have led to an increase in older people's confidence in using their local area. Older people report that they have a real sense of empowerment, and that they feel encouraged to take a more active role in their local area, thus keeping themselves independent for longer.

The project also led to the development of Housing Design Guidance, and it is anticipated that the learning from the project will be able to be used in other areas of the city.

2.5.4 Improving Standards and Protecting the Vulnerable – the work of the Community Infection Control Team

Many of our most vulnerable people live in care homes, and paying scrupulous attention to infection control is essential if we are to keep some of our frailer citizens well. The Council's Community Infection Control Team (CICT) works proactively with care home providers, carrying out infection control audit visits, providing telephone advice and regular training for staff, as well as responding complaints or advice calls.

The aim is to prevent the adverse impact of poor infection control practice on the health and wellbeing of residents in Manchester care homes. Many of the residents will be vulnerable or prone to infection, but through maintaining high standards of

infection prevention and control, if there are cases of infection, they can be swiftly contained and the risk of other residents being infected is reduced. This helps prevent hospitalisation of already frail residents and reduces care costs across the health and social care economy, as well as improving the quality of life for residents.

The CICT has developed strong links with care home providers and seen a measurable increase in infection control standards due to the audit programme carried out over the past five years, helping to ensure that those Manchester residents in care homes will receive 'harm-free' care.

2.6 Conclusions: Reducing the life expectancy gap, both between Manchester and the UK, and within Manchester: the steps we must take as a City

It is clear that we continue to have a major challenge in the city, both in reducing the gap in life expectancy (and healthy life expectancy) between Manchester and the England & Wales average, and within Manchester.

There are some specific issues that we need to tackle. Firstly, we need to ensure that our **universal and preventative services are taken up consistently** and across all sections of our community. These services include for example, screening, immunisation, antenatal care and early years interventions. If all groups accessed these at the rates of the best, we would see big improvements in population health. In order for us to monitor and improve take up, we need to ensure that all partners keep accurate demographic data on service uptake. We need to be producing regular Health Equity Audits, showing how different groups (for example, grouped by sex, gender, ethnicity, age, disability or sexuality) are accessing services and what the outcomes for these groups are. Unless we work with local populations to encourage them to use the services, and to recognise the benefits of these, we will not make the required difference.

And this is not, of course, all or even mostly about services being 'delivered' to passive recipients. We need to work with local communities, groups and individuals to get them to design the services and that they will help take responsibility for running and for participating in. The work on Age Friendly Environments is exactly to this model, where by working with older people we have made an environment that supports older people to maintain social networks, build physical activity and contribute to the local community. It has also led to guidance being produced on housing for use across the city, enabling other areas to benefit from the learning, while at the same time building up the evidence base.

We need to think about health in very broad terms and in the social context. For example, if we are encouraging people to be more physically active, we need to think about the environment in which this takes place. How do we help make active travel a reality? How do we encourage employers to support this goal? How do we make better use of our parks and excellent leisure facilities? We know for examples that cities with high numbers of walkers and cyclists are ones that are able to deliver both economic and health benefits. Are we capturing all the health impacts of our policies, and could we do more to maximise health gain from services, policies and interventions?

Chapter 3

Manchester and the North West of England: a coordinated approach from Public Health

When we are considering the population's health, it is obvious that a city or borough boundary may not always carry much meaning. People may live in one area and work in another; their children may attend school in a third and nights out might be spent in a fourth. In the same way, poor air quality in one area will affect its neighbours, and contagious diseases are no respecters of boundaries.

In Manchester, we are very well aware of the importance of working across the ten Greater Manchester authorities, and we are also proud of our historical and cultural identity within the North West of England. Cheshire, Merseyside, Greater Manchester, Lancashire and Cumbria form a definitive, distinctive grouping and with 7 million people we are the third largest region in England. As a region, however, we still suffer from substantial health inequalities and the North West Directors of Public Health have worked together to produce a Call for Action, with three stated goals:

- To raise awareness of important public health issues and evidence based high impact interventions
- To develop a consensus of shared priorities for action that will improve the public's health across the North West
- To influence and inform the development of national public health policies.

The priorities chosen represent a consensus, developed through by the Directors of Public Health in consultation with others, of the areas where the impact will be great and the evidence for the proposed intervention is strong.

The priorities, together with the key evidence and rationale for each, are as follows:

i. Commit to the eradication of childhood poverty, to meet the targets set by the Child Poverty Act 2010 and to improve the health and wellbeing of all children.

An estimated 3.5 million children in the UK, 27% of the total, live in poverty. Children in poverty are at increased risk of a range of poor health and social outcomes, including diabetes, asthma, mental health problems and lower school achievement. The children of persistently poor parents are at increased risk of becoming poor in adulthood themselves, and the cycle continuing.
The Child Poverty Act (2010) includes two targets to be met by 2010 (for less than 10% of children to be in relative poverty, and for less than 5% of children to be in absolute poverty). Neither of these targets are currently on target to be met, and concerted action is required by National Government in partnership with others.

ii. Work with employers to increase payment of the living wage and to introduce a higher minimum wage to improve quality of life, happiness and productivity in work.

The Living Wage is the hourly rate that has been agreed to provide an acceptable standard of living for employees and their families. The rate (outside London) is

currently £7.65, compared to the Minimum Wage of £6.31 for workers aged 21 and over. The UK has a high proportion of low paid workers compared to other Organisation for Economic Cooperation and Development (OELD) countries, with one in five employees earning less than the Living Wage. Low wages lead to difficulties in buying essential goods such as food, clothing and heating; reduced participation in social activities; and vulnerability to debt. Families on low wages often become dependent on in work benefits and can experience housing problems. Evidence shows that paying the Living Wage improves mental wellbeing and increases productivity, giving benefits to employer and employee.

iii. Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing.

The British population is increasingly sedentary, and we are seeing the negative results of this across a wide range of physical and mental health outcomes, including type 2 diabetes, cancers, cardiovascular diseases, dementia and depression. Walking, cycling and using public transport are all highly effective ways of building the required level of physical activity into our daily lives. These modes of transport also have a positive impact on the environment, especially air quality and carbon emissions.

i.v. Implement tougher regulation of pay day loan companies to improve the health and wellbeing of people with debts.

Pay day loans are short term, unsecured loans that attract a high rate of interest and are expected to be repaid in full on a fixed date. Up to 8.2 million such loans were arranged in the UK in 20111/12, at a value of c£2.3 billion. The average cost of borrowing has been put at about £25 per £100, but additional costs accrue with late payments, which occur in approximately 20% of cases. Use of payday loans is associated with financial difficulties and debt, and concomitant problems such as anxiety, stress and depression.

The Government has recognised the problems caused by easily accessible payday loans, and new regulations are being imposed by the Financial Conduct Authority. The impact of these must be carefully monitored, and consideration should be given to how access to credit and savings can be improved, as well as to increasing debt management advice.

v. Implement the recommendations contained within the '1001 critical days' cross party report to ensure all babies have the best possible start in life.

The first few years of a child's life are critical for their development, and exposure to adverse experiences in childhood is associated with a wide range of health harming behaviours in later life, and to poor physical and mental health outcomes. The National Society for the Prevention of Cruelty to Children estimate that a quarter of all babies born in the UK have a parent affected by domestic abuse, mental health issues, or drug and alcohol problems. Interventions that help develop secure attachments between infants and their carers can support maternal mental health, promote positive parenting and can generate long term cost savings. Health visiting,

home visiting and parenting programmes have been shown to have positive outcomes on parent and child behaviour, reduce mental health problems, and reduce childhood injuries.

vi. Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health and social outcomes.

The cost to the NHS of alcohol related harm is estimated at £3.5bn a year. Shockingly, in 2010 five percent of the deaths in England (over 21,000 deaths) were caused by alcohol consumption. Evidence suggests that implementing a minimum price of 50p per unit of alcohol would reduce population levels of alcohol consumption and related harm among heavier drinkers without penalising moderate drinkers. Modelling the impact of a 50p unit price suggests a reduction in consumption of 7% in England, with a reduction over time in alcohol related deaths by 3,060; hospital admissions by 97,000 and crimes by 42,500.

vii. Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption.

Over consumption of pre-packaged food and alcohol is contributing to the rising health burden in the UK from diseases such as diabetes, cardiovascular disease and cancer. Clear, consistent, front of pack labelling is seen as an effective method of providing consumers with information to assist them in making informed choices about their diet. Currently, food labelling is inconsistent and it can be hard for consumers to get the information they need. By simplifying and standardising labelling, consumers will be better placed to make comparisons between products and therefore to be able to make decisions based on accurate nutritional information.

viii. Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds.

Physical inactivity is a risk factor for a range of conditions including obesity, cardiovascular diseases, cancers, mental health problems and type two diabetes. It is therefore recommended that children participate in at least 60 minutes of moderate activity a day, with vigorous activity on at least 3 days/week. Currently only 21% of boys and 16% of girls in England achieve this, and policy action is required to increase levels of physical activity and reduce the future burden of ill health. It is estimated that for every inactive child that reaches the recommended activity level, there are lifetime savings of £40,000 to accrue from reduced health care costs. Furthermore, increasing of physical activity in school children not only improves physical health but also has positive implications for behaviour, attitudes and academic achievement.

Other priorities include plain packaging on all cigarette packets, national measures to tackle childhood obesity and the importance of Age Friendly programmes.

History tells us that all these measures and proposals are unlikely to be adopted. However if we continue to make the case with public support, in the medium term we will see real progress in a number of areas.

Manchester City Council led the way when it came to the sanitation reforms of the 19th Century, the Clean air Act in the 20th Century and will undoubtedly play a key national role in the public health reforms needed in the 21st Century.

Appendix 1 Further information

1. Manchester Health Profile 2014 (see profile opposite)
http://www.apho.org.uk/resource/item.aspx?RID=142107

2. State of the City
http://www.manchester.gov.uk/info/100004/the_council_and_democracy/6469/state_of_the_city_report

3. Compendia of Indicators

A range of information relating to **health in Manchester** and different areas within it is available within the Compendia of Indicators for Manchester.

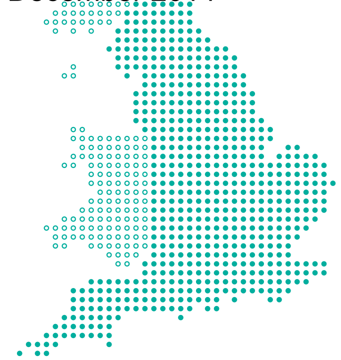
Compendia for the three Clinical Commissioning Groups (CCGs) in Manchester and the city as a whole are available on the Manchester City Council website at http://www.manchester.gov.uk/downloads/download/5724/compendium_of_statistics-manchester

Anyone wishing to find out more about the health of people living in Manchester is encouraged to consult these compendia as a starting point.

4. Public Health England

A range of data and tools relating to **key public health areas** are available at the Public Health England profiles site.
http://fingertips.phe.org.uk/

Public Health
England



Manchester

Unitary Authority

This profile was produced on 12 August 2014

Health Profile 2014

Health in summary
The health of people in Manchester is generally worse than the England average. Deprivation is higher than average and about 36.4% (34,600) children live in poverty. Life expectancy for both men and women is lower than the England average.

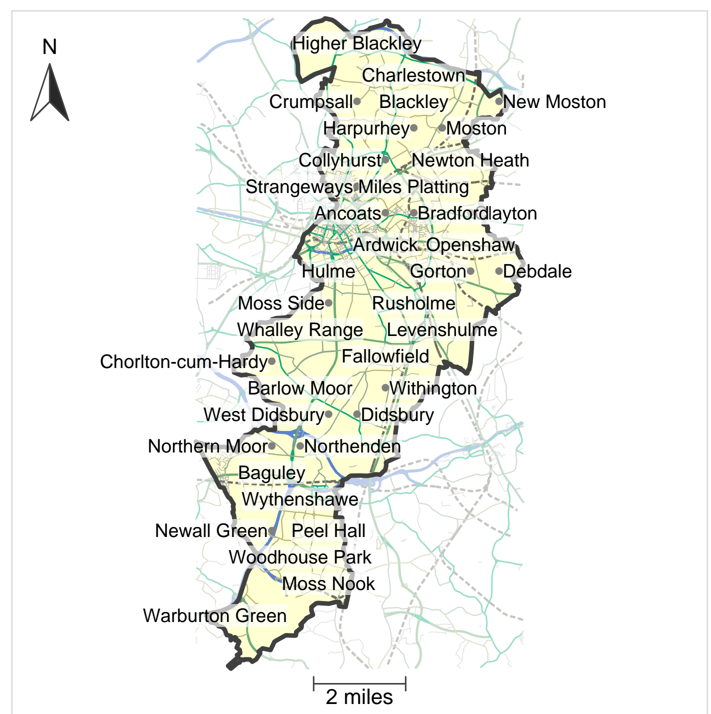
Living longer
Life expectancy is 9.6 years lower for men and 8.2 years lower for women in the most deprived areas of Manchester than in the least deprived areas.

Child health
In Year 6, 24.7% (1,106) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 68.5*, worse than the average for England. This represents 74 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 26.0% of adults are classified as obese. The rate of alcohol related harm hospital stays was 852*, worse than the average for England. This represents 3,421 stays per year. The rate of self-harm hospital stays was 236.5*, worse than the average for England. This represents 1,273 stays per year. The rate of smoking related deaths was 480*, worse than the average for England. This represents 761 deaths per year. Estimated levels of adult smoking are worse than the England average. Rates of hip fractures, sexually transmitted infections and TB are worse than average. The rate of people killed and seriously injured on roads is better than average.

Local priorities
Priorities include early years, community involvement, complex dependency, mental health and wellbeing, bringing people into employment and older people. For details see www.manchesterpartnership.org.uk

* rate per 100,000 population



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OpenStreetMap contributors ODbL

Population: 511,000

Mid-2012 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Manchester. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info
or scan this Quick Response code: for more profiles, more information and interactive maps and tools.

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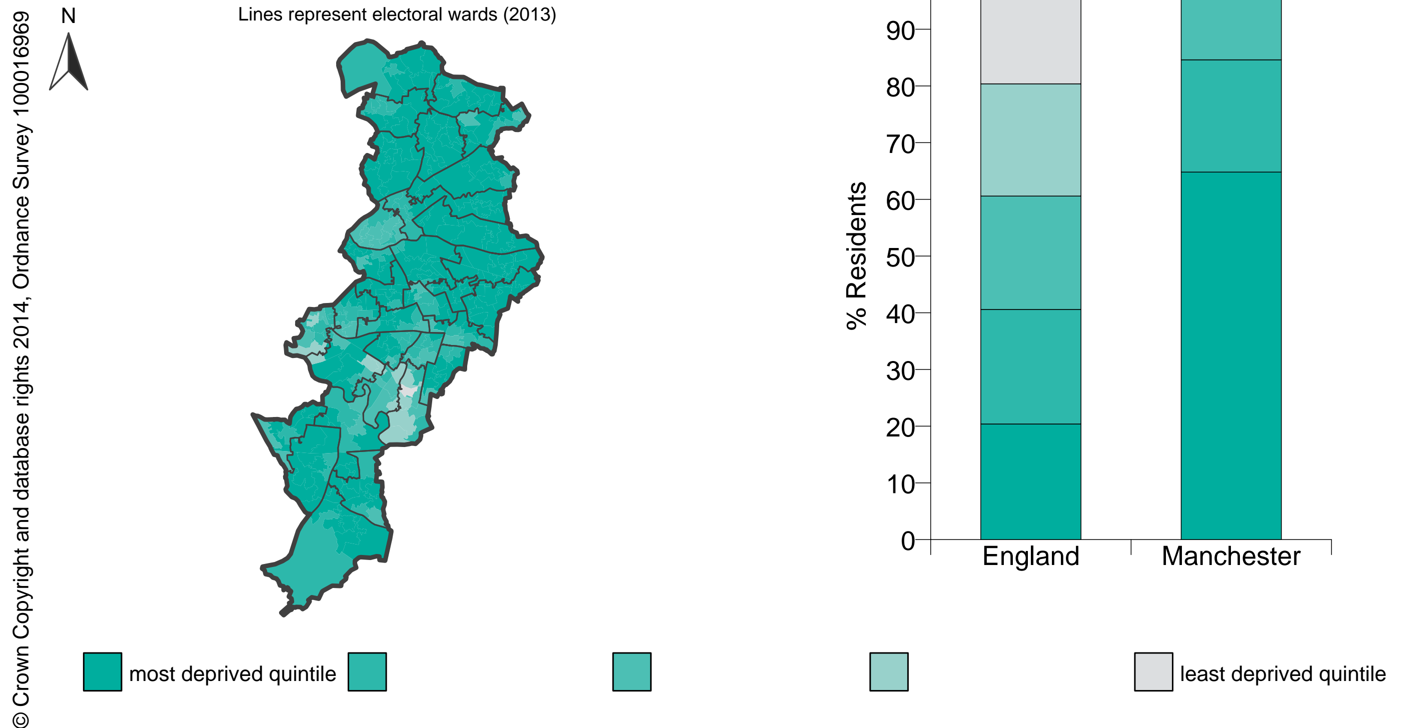
Deprivation: a national view

The map shows differences in deprivation levels in this area based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by Lower Super Output Area. The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England and this area who live in each of these quintiles.

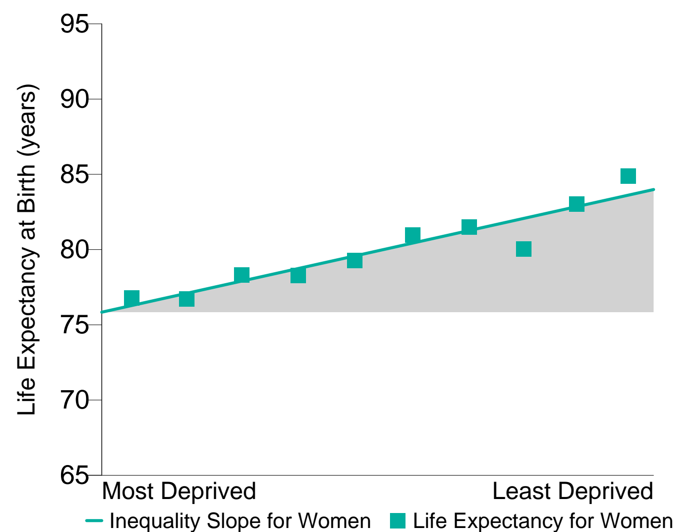


Life Expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2010-2012. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life Expectancy Gap for Men: 9.6 years

Life Expectancy Gap for Women: 8.2 years



Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

Early deaths from all causes: MEN

Early deaths from all causes: WOMEN

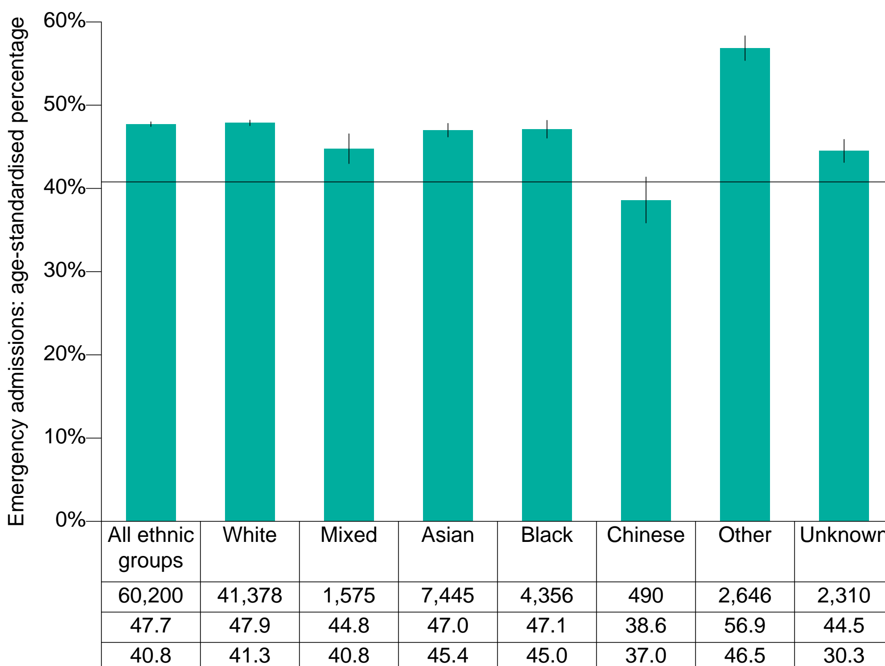
Early deaths from heart disease and stroke

Early deaths from cancer

England average — Local average — Local least deprived — Local most deprived — Local inequality

Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group



All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
60,200	41,378	1,575	7,445	4,356	490	2,646	2,310	Local number of emergency admissions
47.7	47.9	44.8	47.0	47.1	38.6	56.9	44.5	Local value
40.8	41.3	40.8	45.4	45.0	37.0	46.5	30.3	England value

This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Manchester

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

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Health Summary for Manchester

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

Regional average^ · England Average · England Worst · 25th Percentile · 75th Percentile · England Best

Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1 Deprivation	331,017	64.8	20.4	83.8		0.0
	2 Children in poverty (under 16s)	34,630	36.4	20.6	43.6		6.4
	3 Statutory homelessness	533	2.5	2.4	11.4		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	2,397	53.2	60.8	38.1		81.9
	5 Violent crime (violence offences)	7,322	14.6	10.6	27.1		3.3
	6 Long term unemployment	5,440	15.0	9.9	32.6		1.3
Children's and young people's health	7 Smoking status at time of delivery	1,133	13.8	12.7	30.8		2.3
	8 Breastfeeding initiation	5,356	65.1	73.9	40.8		94.7
	9 Obese children (Year 6)	1,106	24.7	18.9	27.3		10.1
	10 Alcohol-specific hospital stays (under 18)	74	68.5	44.9	126.7		11.9
	11 Under 18 conceptions	353	45.0	27.7	52.0		8.8
Adults' health and lifestyle	12 Smoking prevalence	n/a	24.6	19.5	30.1		8.4
	13 Percentage of physically active adults	n/a	51.6	56.0	43.8		68.5
	14 Obese adults	n/a	26.0	23.0	35.2		11.2
	15 Excess weight in adults	778	62.7	63.8	75.9		45.9
Disease and poor health	16 Incidence of malignant melanoma	33	8.2	14.8	31.8		3.6
	17 Hospital stays for self-harm	1,273	236.5	188.0	596.0		50.4
	18 Hospital stays for alcohol related harm	3,421	852	637	1,121		365
	19 Drug misuse	4,848	13.7	8.6	26.3		0.8
	20 Recorded diabetes	26,137	5.8	6.0	8.7		3.5
	21 Incidence of TB	200	39.8	15.1	112.3		0.0
	22 Acute sexually transmitted infections	7,321	1,456	804	3,210		162
	23 Hip fractures in people aged 65 and over	354	683	568	828		403
Life expectancy and causes of death	24 Excess winter deaths (three year)	182	16.2	16.5	32.1		-3.0
	25 Life expectancy at birth (Male)	n/a	74.8	79.2	74.0		82.9
	26 Life expectancy at birth (Female)	n/a	79.5	83.0	79.5		86.6
	27 Infant mortality	40	5.0	4.1	7.5		0.7
	28 Smoking related deaths	761	480	292	480		172
	29 Suicide rate	62	14.5	8.5			
	30 Under 75 mortality rate: cardiovascular	369	144.7	81.1	144.7		37.4
	31 Under 75 mortality rate: cancer	524	207	146	213		106
	32 Killed and seriously injured on roads	178	35.5	40.5	116.3		11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

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