Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board –8 May 2013

Subject: Manchester Public Health Annual Report 2012/13

Report of: David Regan, 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 report attached is the last joint report of the Manchester DPH under the arrangements covering the period 2012/13. From now on the requirement to produce an annual report will come under the wide range of responsibilities that transferred to the City Council on 1 April 2013.

The journey of public health in Manchester back into local government over the past decade, beginning with the formation of the Joint Health Unit in April 2002, has been accompanied by marked improvements in the health of the local population. Over this period, life expectancy at birth has increased by nearly 3 years in men and nearly 2 years in women and death rates from the biggest killers, circulatory diseases and cancers, have fallen by 21% and 16% respectively. The rates of teenage pregnancy in the city are now the lowest they have been for many years and we have recently seen some welcome news on alcohol related admissions

Despite these successes, many challenges remain. There is some evidence to suggest a recent increase in the suicide rate, our childhood obesity rates have not come down and the impact of the recession on worklessness and health cannot be underestimated. Also, perhaps our biggest challenge in the years ahead is to reduce health inequalities within Manchester and between Manchester and other parts of the country, as they remain stubbornly high. These are some of the issues we are seeking to tackle through our Joint Health and Wellbeing Strategy and our Joint Strategic Needs Assessment (JSNA), which is the focus of the 2012/13 Public Health Annual Report (PHAR).

The report provides the narrative on the six themes of the JSNA to complement the online version. In addition a progress report on the implementation of the recommendations from the 2011/12 public health annual report is also provided

Recommendations

The Board is asked to:

1) Note the report

2) Receive a brief presentation from the Director of Public Health on the current Health Profile for Manchester in relation to the JSNA themes.

Board Priority(s) Addressed:

All

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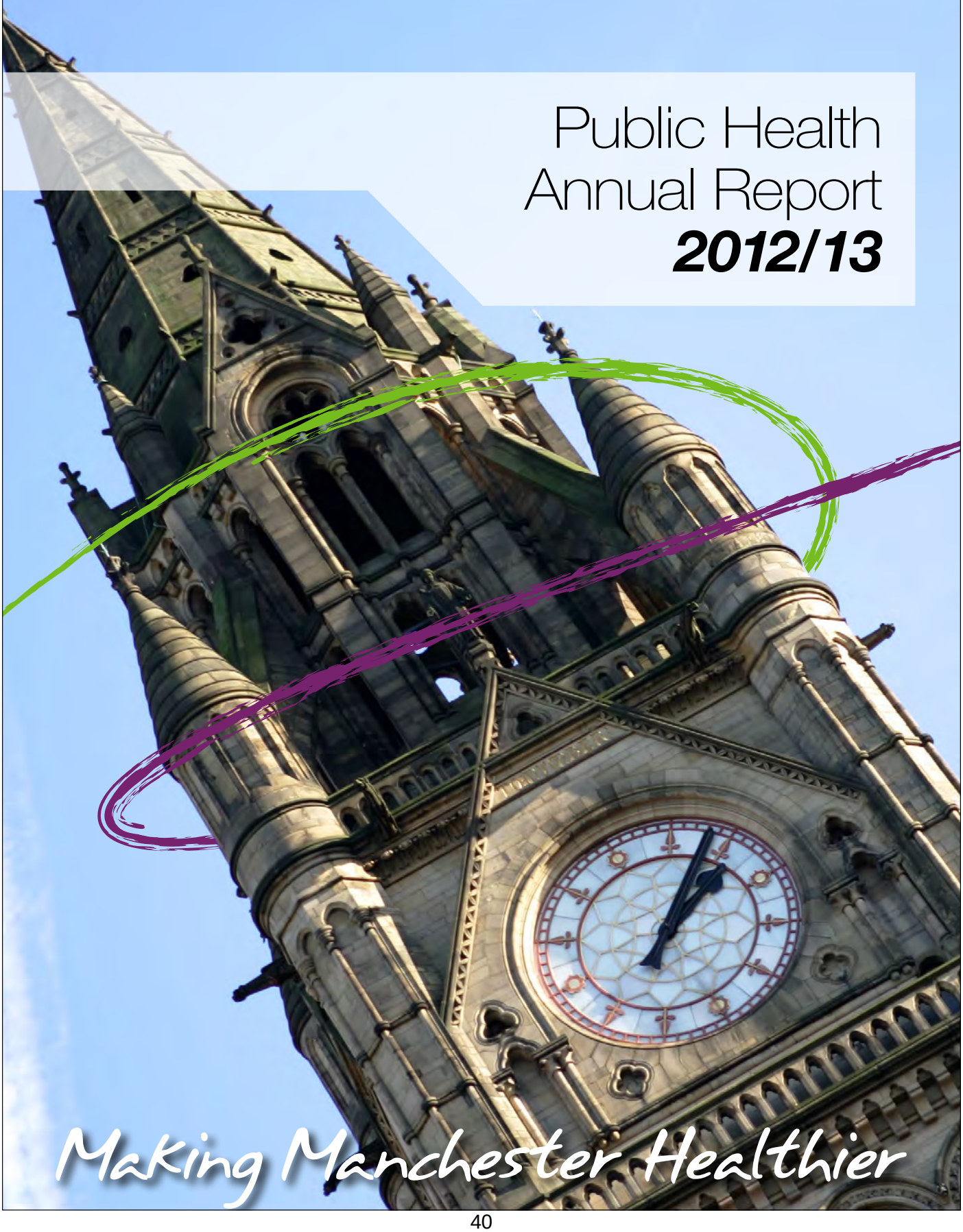
Background documents (available for public inspection):

None

MANCHESTER CITY COUNCIL

NHS Manchester

Public Health Annual Report 2012/13



Making Manchester Healthier

Dedication

This Manchester Public Health Annual Report is dedicated to the memory of Kieran Crump Raiswell (13th April 1994 - 16 January 2013)

Acknowledgements

"I would like to thank all of the contributors listed below for the production of this report. Special thanks go to Katrina Stephens, who has done an excellent job in project managing the process, and also Eleanor Roaf, not only for supervising Katrina, but also her outstanding contribution to public health in Manchester over the past decade. Eleanor has recently taken up a new role, as Regional Director at Sustrans, and will continue to work closely with us in our shared objectives."

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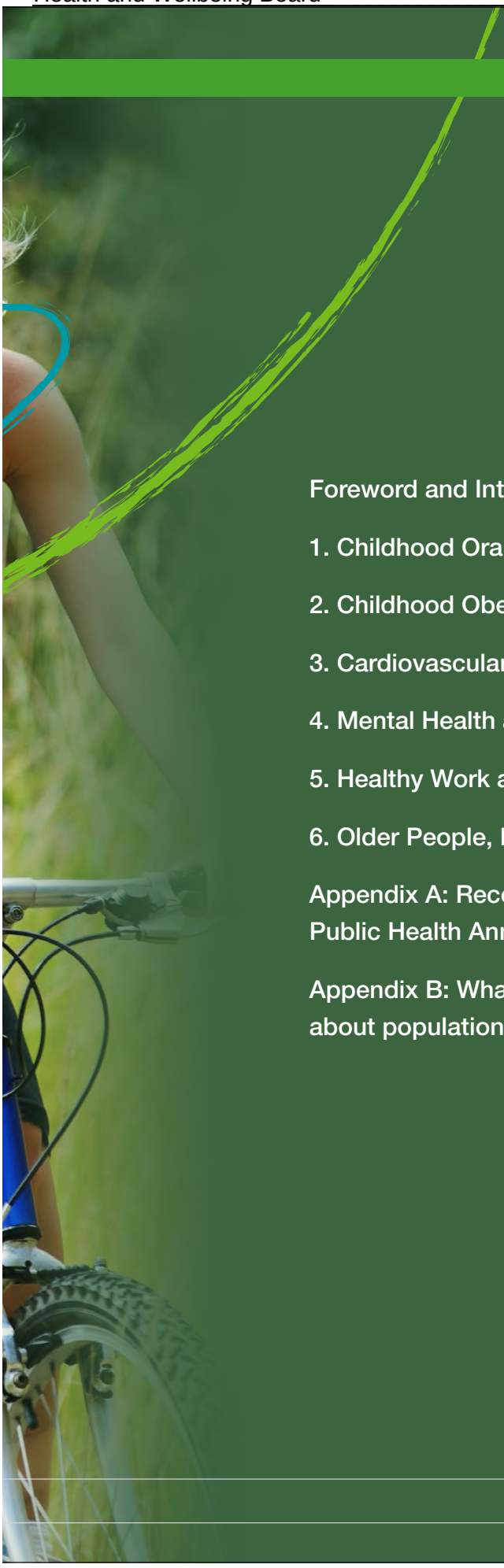


Foreword and Introduction

2012 has been a year of significant transition for public health. Under the government's reforms of the NHS, most of the public health functions in the city were transferred from the Primary Care Trust (NHS Manchester) to Manchester City Council on 1st April 2013. The last year has seen an enormous amount of work being done across the NHS and the Council, and by public health staff, to prepare for this change. We co-located the whole Public Health Manchester team in Council offices in March 2012, which was an important practical and symbolic change, and the work required to transfer staff and contracts from the NHS to the Council has been considerable and complex. I would therefore like to begin this report by recording my thanks to everyone who has put so much time and effort into ensuring that this transition went so smoothly and we go into 2013 with a safe and effective public health system integrated within the Council. There will be many challenges in the years ahead but I am really looking forward to the future in our new Council home.

Of course the mainstream work of public health has continued over the last year despite managing the transition. As usual this report contains a summary of the action that has been taken in response to the recommendations I made in last year's report, which was about various aspects of health protection. While more remains to be done, it is heartening to see how much progress has been made on this critical issue. The year has also seen a number of other notable achievements, including:

- A complete redesign of the adult drug treatment system, providing improved recovery focused services
- A reduction in alcohol related admissions
- A reduction in the under 18 conception rate (teenage pregnancies)
- Excellent performance in relation to the take up of NHS health checks
- Achievement of smoking cessation quit rate targets and a significant reduction in the number of pregnant women who smoke at the time of delivery.

2012 has also seen the establishment of the Health and Wellbeing Board for the city – a partnership that became statutory on 1st April 2013. This Board is required to produce a Joint Health and Wellbeing Strategy, informed by a Joint Strategic Needs Assessment (JSNA) – and it is the JSNA that is the subject of this annual report.

Local Authorities and Primary Care Trusts have been legally obliged to work together to produce a JSNA since 2007; from April 2013 this responsibility is being transferred to the Health and Wellbeing Board. The JSNA is our analysis of the health needs of the population. It informs and guides commissioning of health, wellbeing and social care services in Manchester, in order to improve the physical and mental health and wellbeing of the population.

The current JSNA has been developed as an online tool (www.manchester.gov.uk/jsna) to allow the material to be revised and expanded on an ongoing basis.

In addition, all of the data used in the JSNA, together with a range of other information, including 2011 Census data, can be accessed online via Manchester City Council's new Intelligence Hub Analysis Tool (IHAT) at http://www.manchester.gov.uk/intelligencehub.

The JSNA is in two sections. The first contains a broad profile of the health needs of the population living in the three areas of the city covered by the North, Central and South Manchester Clinical Commissioning Groups. This report includes a short summary of our local population, based on the emerging results of the 2011 census. The area profiles of the health needs of the population will be updated regularly and can be accessed via the JSNA web pages.

The second section looks at six topic areas in more depth: childhood oral health, childhood obesity,

cardiovascular disease, mental health and wellbeing, healthy work and skills, and falls prevention (focusing on older people). These topics were chosen using a systematic selection process that sought to cover a range of different issues across health and social care and the wider determinants of health; striking a balance between issues that are confined to a particular stage in the life course and those that run between and cross-over different life stages.

The choice of specific topic areas within the JSNA does not imply that these are the most important issues affecting people's health in Manchester or that commissioners should focus their efforts purely on these areas. However, they are all topics that are worthy of more in-depth investigation as part of the JSNA because they are of relevance to more than one agency and require joint working and collaborative effort to deliver the necessary improvements. Further topic areas will be considered in depth over the coming year and will be added to the website.

The Public Health Annual Report therefore complements the online JSNA by providing a written summary of the JSNA. Many of the recommendations from the JSNA will be taken forward by the Public Health Manchester team in partnership with others and I will report on progress in next year's report. Finally, we have included information about the 2011 Census as an appendix, which I hope will be of value.

David Regan - Director of Public Health

Introduction

The JSNA topics were selected using the following criteria:

- Is the issue one of concern to multiple partners?
- Is data relating to the topic available at locality level and below?
- Has any needs assessment work or data analysis relating to the topic already been carried out?
- Does the issue demonstrate any potential for short term interventions or 'early wins'?
- Will addressing the issue deliver any financial benefits or cost savings in the short to medium term?
- Does the issue represent a current gap in policy (i.e. there is no existing strategy or work programme currently in place)?

The six topics for 2012 are presented in the same format in each section of the report. The topics are:

- Childhood oral health
- Childhood obesity
- Cardiovascular disease
- Mental health and wellbeing
- Healthy work and skills
- Older people, falls and falls prevention

1. Childhood Oral Health

Why is this topic important?

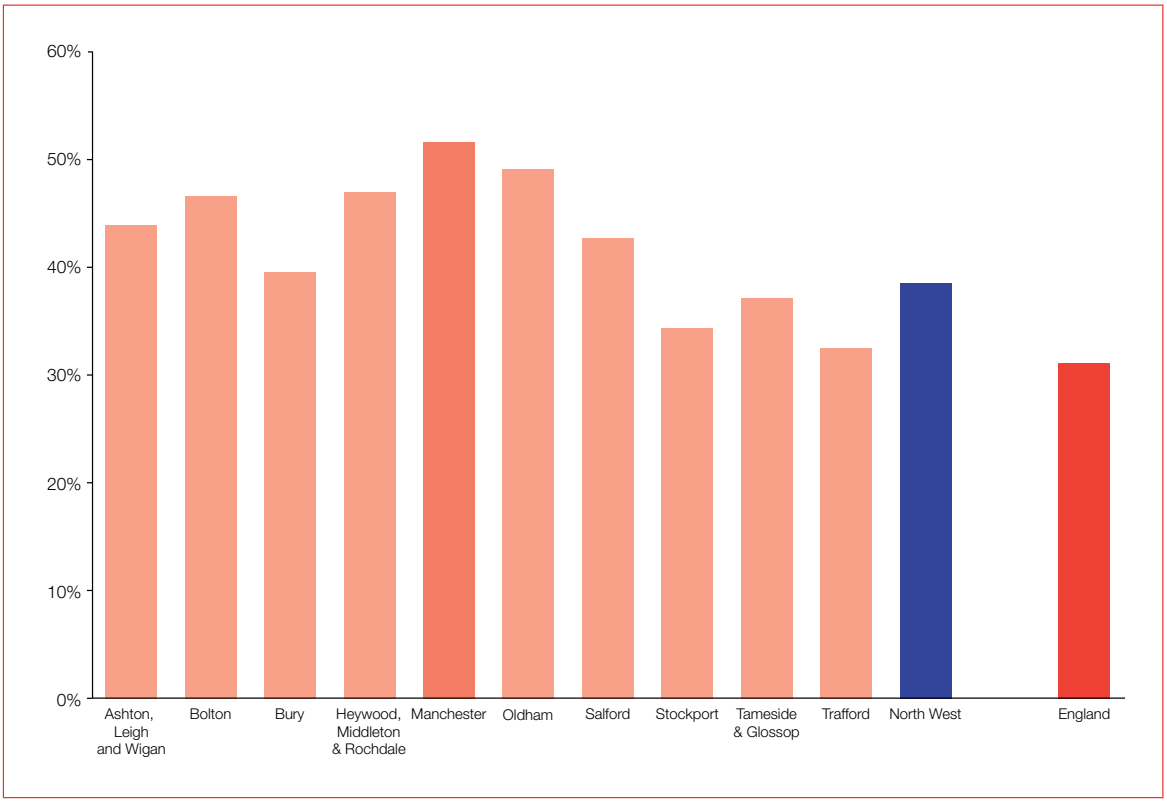
Measures of the oral health of young children are a valuable source of information about their general health and upbringing. Poor baby feeding practices, weaning habits and diets can lead not only to dental decay but also to higher risks of obesity, diabetes, cardiovascular disease and some cancers in later life.

Dental decay in itself causes problems for children and their families, children's services and unscheduled care services. Dental pain and infection leads to lost sleep, poor concentration and a narrow choice of foods, as well as days off school and days off work for carers.

Dental decay is caused by a diet which is high in sugar, and a lack of brushing with fluoride toothpaste. In Manchester, like most areas of England, the drinking water has very low levels of fluoride. Therefore young children should have their teeth brushed twice daily with a family fluoride toothpaste to offer protection.

In Manchester, at least 26% of 3 year-olds have one or more teeth affected by decay and, on average, those affected have four primary teeth with decay. More than 50% of 5 year-olds have experience of decay, compared with 31% in England as a whole, and 8% have experienced extractions because of decay, many of them in hospital (Figure 1). Rates of decay are higher among children attending special support schools in Manchester.

***Figure 1:** Proportion of 5 year-olds with decay in one or more teeth, 2007/8*



1. Childhood Oral Health

The costs of providing treatment for routine and urgent care are high. Dental decay (caries) and poor gum health (periodontitis) are widespread but much could be done to control them[1,2]. Extraction of decayed teeth is the main reason for admission of children to hospital in Greater Manchester[3] (Figure 2).

***Figure 2:** Extractions in hospital by child's Primary Care Trust (PCT) of residence 2008/09*

PCT of Residence	Total number of extraction episodes	Extractions per 100 children in population
ASHTON, LEIGH AND WIGAN PCT	735	0.59
BOLTON PCT	408	0.99
BURY PCT	769	1.64
HEYWOOD, MIDDLETON AND ROCHDALE PCT	581	1.06
MANCHESTER PCT	**1,289**	**1.11**
OLDHAM PCT	212	0.35
SALFORD PCT	557	1.05
STOCKPORT PCT	780	1.17
TAMESIDE AND GLOSSOP PCT	457	0.74
TRAFFORD PCT	564	1.06
TOTAL for Greater Manchester	**6,352**	**0.97**

Source: The Dental Observatory

The Public Health Outcomes Framework specifies oral health among five year-olds as a key indicator. This reflects the importance the Coalition Government has laid on improving oral health among children and reducing inequalities[4].

Much has been done in Manchester to reduce levels of dental disease but we still want to develop this work further.

1 Davies, G.M., Jones, C.M., Monaghan, N., Morgan, M.Z., Pine, C.M., Pitts, N.B., Neville, J.S. and Rooney, E. The caries experience of 5 year-old children in Scotland, Wales and England in 2007-2008 and the impact of consent arrangements. Reports of coordinated surveys using BASCD criteria. *Community Dental Health 2011*; 28: 5-11. www.nwph.net/dentalhealth/reports

2 NHS Information Centre *Adult Dental Health Survey 2009 – England Key Findings;* 2011. www.ic.nhs.uk/default.asp?sID=1300888592035

3 The Dental Observatory. *Production of data about admission of children to hospital for dental extractions in the North West region in 2008/09 - A statement paper;* 2010

4 Department of Health *Public Health Outcomes Framework*; 2012. http://www.dh.gov.uk/health/2012/01/public-health-outcomes/

What are we doing?

A city-wide, experienced, Oral Health Improvement (OHI) Team has been commissioned to run several population and community level activities to increase fluoride exposure, including:

- Purchase and widespread distribution of toothbrushes and family fluoride toothpaste
- Supervised brushing at children's centres and primary school nurseries
- Provision of fluoridated milk in primary schools.

The OHI Team is providing training to all education, health, and social care partners focusing on the key oral health messages from 'Delivering Better Oral Health: an evidence based toolkit for prevention'.

The OHI Team also undertakes activities to improve home care and increase attendance with a primary care dentist.

Access to NHS general dental practices is being maintained across the city.

Provision of preventive activity by primary dental care providers is being increased through contracting and commissioning, with key performance indicators backed up by education, training and increased skill mix. The OHI Team actively supports this activity by means of a 'Preventive Practice Award' scheme.

What do we want to achieve?

We want all health, education and social care workers to know and apply the key messages for better self care to obtain stable oral health.

We want all health education and social care workers to understand that dental health, just like all other aspects of health, is everyone's business. Dental treatment providers should emphasise the importance of self care, and GP teams and others should consider dental health alongside general health.

We want to increase the proportion of pre-school children who attend a dentist by expanding the 'Manchester Smiles' scheme. This scheme, which involves the OHI Team, general dental practices and the Community Dental Service, links general dental practices and clinics with nearby schools and runs 'Meet the Dentist' sessions at school for parents of Foundation Years children who have not attended a dental practice recently.

Action continues to be needed to stimulate a more proactive preventive focus in general dental practices, and improve the management of pre-school children in line with the 'Baby Teeth DO Matter' campaign being run by Greater Manchester Dental Professional Network. This project aims to improve the oral health, and clinical management, of under 5 year-old patients, by incentivising attendance at dental practices and provision of training and support to improve treatment and prevention.

We also want to reduce the numbers of 0-19 year-olds who are referred to hospital for dental extractions and this requires action on multiple levels.

1. Childhood Oral Health

How will we measure progress?

We will measure progress though:

- Increased attendance by under 5 year-olds will be monitored using data arising from treatment claims submitted by General Dental Practitioners (GDPs).
- Reduced referrals of children will be measured from Hospital Episode Statistics and from collated data from the centralised referral system.
- Increased engagement in a pro-active prevention approach by primary care dental teams will be monitored by numbers involved with the Preventive Practice Award scheme and progression through the stages within this.
- The longer term monitoring of improved oral health. Epidemiological survey findings will demonstrate reduced numbers of children affected by decay and its severity.

Key messages to improve oral health by better self care:

- Start to brush with a family fluoride toothpaste from when the first baby tooth shows in the mouth
- Brush twice daily, last thing before bed and in the morning
- Supervise children when brushing to ensure correct amount of toothpaste is used
- Brush all surfaces of all teeth
- Limit how often sugar-containing food or drinks are consumed
- Do not smoke
- Drink alcohol in moderation only

Recommendations

On 1st April 2013 Manchester City Council became responsible for achieving improvements in oral and general health, and should now engage, through Public Health Manchester, with the National Commissioning Board Local Area Team to commission programmes to improve oral health. In Manchester we need to maintain current activities with support from Public Health England for strategic and scientific functions. This includes:

- Support for specific OHI Team activity to increase fluoride exposure by:
  - widespread distribution of free toothbrushes and family fluoride toothpaste
  - running of a supervised brushing scheme at children's centres and primary school nurseries
  - taking steps to continue provision of fluoridated milk in primary schools with increased subsidy to allow more parents to purchase milk at school
- Improve the proportion of pre-school children receiving applications of fluoride varnish, having healthy home care habits and regular attendance with a primary care dentist, by expanding the 'Manchester Smiles' scheme.
- Support training of all education, health and social care partners so they know and can apply the key health messages for better oral health.
- Support OHI Team activity to increase pro-active prevention in dental practices.
- Support adoption of healthy food and drink policies in child care sites, including those for pre-school children, schools and homes for Looked After Children by linking with directors of all relevant departments and ensuring healthy food policies involve consideration of dental health.

In addition to our work to improve children's oral health, activities we would like to develop to improve oral health among adults include:

- Services to assist people to seek and access suitable treatment services, focusing on: older dependent adults, adults with mental health problems, families affected by dependency on drugs or alcohol.
- A health promotion initiative to assist particular Black and Minority Ethnic (BME) groups that are known to have higher levels of dental disease and improve access to services.
- Activities to improve daily hygiene and care of the dependent elderly population, more of whom will be retaining some natural teeth for life. Oral care is currently given low priority by many carers, which leads to poor daily hygiene, loss of dentures, poor awareness of the importance of oral health and limited food choices.
- Support and expertise for the adoption of healthy food and drink policies in homes and day care centres for adults with learning and other disabilities, by linking with directors of all relevant departments and ensuring healthy food policies involve consideration of dental health.


2. Childhood Obesity
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Why is this topic important?

In the past 25 years obesity rates have more than doubled[1]. Increasing levels of obesity in the United Kingdom (UK) are a result of a wide range of factors including individual lifestyle factors (diet and physical activity) and broader environmental determinants. For example, environmental determinants such as the cost of, and access to, healthy foods, development of cooking skills, sedentary workplaces, and transport systems, all have a major influence on individual lifestyle factors, particularly among people in lower socio-economic groups.

Obesity is measured using Body Mass Index (BMI). This is calculated as a person's weight (in kilograms) divided by their height (in meters) squared. The World Health Organization's classification of BMI in adults denotes a BMI of between 25 and 29.99 as overweight, and of 30 or over as obese. BMI is also used to measure obesity in children, but the thresholds for children are more complicated as they vary with age and sex.

Consequences of obesity in children include poor dental health, mechanical problems e.g. back pain and foot strain, worsening of asthma, type 2 diabetes and psychological problems such as poor self esteem and depression[2]. Obese children are more likely to become obese adults, increasing the likelihood of developing further health problems, such as heart disease, stroke and some cancers, later in life[3].

Among children, national statistics show that 17% of boys and 16% of girls aged 2-15 are obese, and 31% of boys and 28% of girls are either overweight or obese[4].

The importance of reducing childhood obesity has been recognised nationally, and in 2006 the Government introduced the National Child Measurement Programme (NCMP); weighing and measuring children at school, in Reception Year and Year 6.

We now have six years of NCMP data[5], which enable us to monitor how rates of childhood overweight and obesity are changing. In Manchester, rates of overweight and obesity have been relatively stable, however our local rates have been consistently higher than North West and national rates (Figures 1 & 2).

1 NHS Information Centre *Health Survey for England 2010*; 2011
2 Department of Health *Healthy Weight, Healthy Lives: A toolkit for developing local strategies;* 2008
3 *Ibid*
4 NHS Information Centre *Health Survey for England 2011*; 2012
5 NHS Information Centre *National Child Measurement Programme: England, 2011/12 school year;* 2013 (Available from http://www.ic.nhs.uk/ncmp)

2. Childhood Obesity

Figure 1: Overweight and obesity - Reception 2006/7 - 2011/12

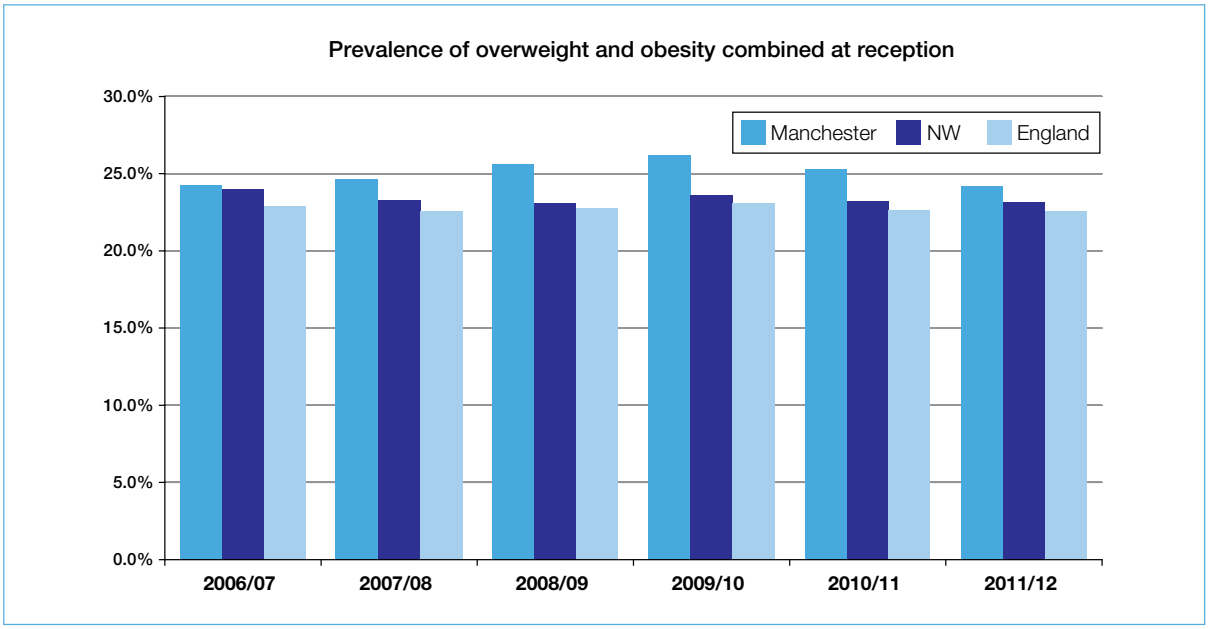
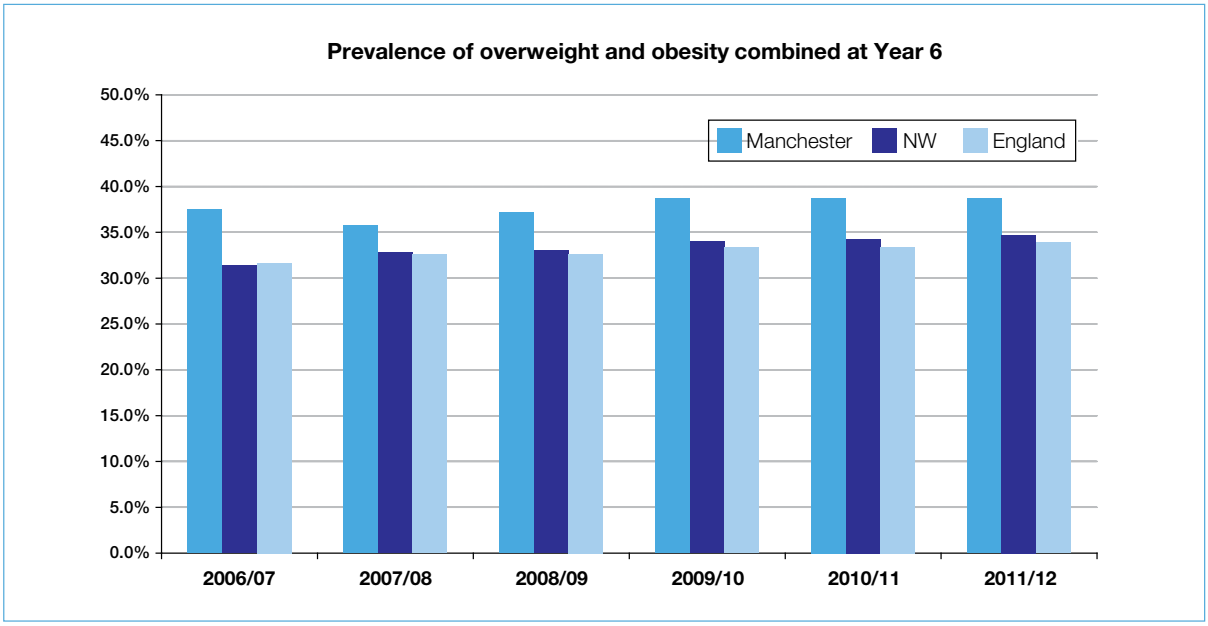


Figure 2: Overweight and obesity - Year 6 2006/7 - 2011/12



In Manchester, in 2011/12, 11.2% of reception-age children were classified as obese. The proportion of children in Year 6 classified as obese was over twice as high, at 23.6%. This suggests many children become obese between Reception and Year 6.

Prevalence of obesity in the most deprived areas of the country is almost double that of the least deprived areas[6]. Local NCMP data show that in the majority of wards in the north of the city, where there are high levels of deprivation, the percentage of children who are obese is greater than the Manchester average. These data also show us that the prevalence of obesity in Reception and Year 6 is higher among boys than among girls.

There is substantial variation in levels of childhood obesity between ethnic groups, with the highest rates among Black/Black British children[7]. Children who live in households where both parents (or one lone parent, where applicable) are classed as either overweight or obese, are also more likely to be obese.

Within Manchester the level of deprivation, ethnic profile and high levels of adult obesity, help to explain why the prevalence of childhood obesity is high, and higher than the national average.

What are we doing?

The 'Manchester Healthy Weight Strategy: Tackling overweight and obesity (2010-2013)' uses a life-course approach to prevent and treat obesity within the whole population. To address rising levels of overweight and obesity we are targeting weight management services at those children defined as overweight and obese, and implementing interventions to prevent obesity in Early Years settings.

The strategy focuses on specific groups within the population who are more at risk of developing obesity, including the most deprived socio-economic groups, people from particular ethnic groups, disabled people (including people with learning disabilities), Looked After Children, young parents and single parents, and people with mental health needs.

Since the launch of the Manchester Healthy Weight Strategy in 2010, the following services/interventions have been commissioned and implemented to help prevent and treat childhood obesity:

Health, Exercise and Nutrition for the Really Young (HENRY):
A training programme for Early Years community and health practitioners to support more effective healthy lifestyle work with parents and young families.

Manchester's Early Years Health Award (MEYHA):
An award for Early Years settings that focuses on:

- Personal, social and emotional development
- Healthy eating and drinking
- Physical activity
- Emotional health and wellbeing

25 Early Years settings in Manchester have either achieved this award or are working towards it.

Manchester's Early Years weighing and measuring protocol:
Manchester's Early Years weighing and measuring protocol was implemented in January 2013 in Sure Start children's centres and some private nursery settings. Each service is weighing and measuring children over the age of 6 months, at quarterly intervals, and children classified as overweight will be referred to the appropriate service. As well as tackling childhood obesity, this process will also provide data on obesity levels in Early Years for the first time.

Two-year health visitor-led health and development review:
All children who attend this review are being weighed

6 NHS Information Centre *National Child Measurement Programme: England, 2011/12 school year;* 2013 (Available from http://www.ic.nhs.uk/ncmp)

7 *Ibid*

2. Childhood Obesity

and measured and those classified as overweight are referred to the Children and Family Weight Management Service and encouraged to participate in Active Lifestyles activities.

Children and Family Weight Management Service (ages 2-17):
This community service provides support to help overweight children and their families to achieve and maintain a healthy weight.

School Health Service:
A new School Health Specification has been developed by Public Health Manchester for April 2013. Through this specification we are developing the role of school nurses and Healthy Schools staff to help prevent, identify and treat obesity early in children and adolescents.

What do we want to achieve?

In Manchester we want to encourage and support all potential partners – statutory, voluntary and commercial sectors and local communities – to work together to tackle obesity and achieve improvements in the population's health, through a family-based approach.

The Healthy Weight Strategy (2010-2013) is currently being reviewed with a view to re-launch in 2013. We are working with partners to link a future Healthy Weight Strategy to other relevant work and strategies in the city, for example, mental health, cancer, alcohol. Linking the Healthy Weight Strategy to other strategies and interventions will help to provide a joined up approach to reducing health inequalities and the prevalence of obesity.

How will we measure/monitor our achievements?

The Government's public health strategy 'Healthy Lives, Healthy People' (2011) set a national ambition for reducing childhood obesity: "a sustained downward trend in the level of excess weight in children by 2020". This ambition will be measured using the NCMP Year 6 data. In line with this ambition we want to see a reduction in Year 6 obesity in Manchester. This will be monitored by Manchester's Healthy Weight Strategy Executive Group.

In Manchester, we are expecting that interventions with the Early Years age group will result in a reduction in the percentage of children classified as obese in Reception, in 3-5 years time. In the longer term this will also contribute to reducing the Year 6 obesity rate in line with the national ambition.

Recommendations

- Public Health Manchester and NHS partners should commission further preventative and weight management services (following local research) that meet the needs of:
  - Women of pre-conception age
  - Women who are pregnant
  - Women who have recently had a baby
- Public Health Manchester, Central Manchester Foundation Trust (CMFT), Children's Services and Early Years age group need to implement further family-based interventions focusing on the Early Years age group.
- Public Health Manchester and CMFT should develop preventative services for children with learning disabilities and their families.
- Public Health Manchester need to commission additional capacity in the local Children and Family Weight Management Service, in order to meet increasing referrals.
- Public Health Manchester should commission a holistic model of community services to address all aspects of the child's/family's health e.g. mental health services, dental services, alcohol services, weight management services.
- Public Health Manchester, NHS partners and other Local Authority departments should increase the focus on the links between safeguarding and childhood obesity, using the newly developed healthy weight care pathways.
- All agencies should work in partnership to develop an environment that promotes physical activity and healthy eating, as part of daily life.

3. Cardiovascular Disease

What is CVD?

Cardiovascular disease (CVD) refers to any disease that affects the heart or blood vessels, for example stroke, heart attack or angina.

Why is this topic important?

Premature mortality rates from CVD have declined in England and Manchester in the past 10 years. This fall in deaths is believed to be due to a combination of increased public understanding of risk factors, government policies aimed at helping people to lead healthier lifestyles and improved treatment and management of established disease[1].

However, CVD remains the greatest cause of ill health and premature death in Manchester (premature death is defined as death below the age of 75 years).

In Manchester, in 2011, CVD led to 495 deaths amongst males (accounting for 27% of all deaths). In the same year there were 415 deaths from CVD in females (25% of all deaths)[2].

Most of the premature deaths from CVD are preventable. In Manchester, in 2011, there were 373 deaths from CVD in persons aged under 75; accounting for 23% of premature deaths in that year[3].

CVD is the major reason why people living in Manchester have a lower life expectancy compared with those living elsewhere in England. For men, CVD accounts for 27% of this gap in life expectancy. Among women, it accounts for 25% of the gap[4].

Many of the risk factors for the development of CVD are also associated with other health-related conditions including some common cancers, chronic respiratory disease, obesity, diabetes, kidney disease and mental wellbeing. An effective, local response to the prevention of CVD is therefore highly likely to help prevent some of these other conditions.

What are we doing?

Locally, there are numerous services and programmes that contribute to reducing the risk of CVD within Manchester's population. These include:

Healthy Living Networks

ZEST in North Manchester and the Healthy Living Network in South Manchester provide a local infrastructure for community and voluntary sector groups. The networks work with local people, community organisations and the health service to encourage healthier lifestyles and reduce CVD risk.

Food Futures

Food Futures is a programme of work led by Public Health Manchester. It supports the public sector, private sector, voluntary sector and communities to work in partnership to improve diet and nutrition in the city.

Active Lifestyles

Active Lifestyles is a city-wide physical activity and wellness programme. The programme brings together a number of services that contribute to a reduction in CVD.

1 British Heart Foundation *Coronary Heart Disease Statistics*; 2010
2 ONS *Deaths Registered in England and Wales in 2011*; 2012. Crown Copyright.
3 *Ibid*
4 ONS *Life expectancy at birth and at age 65 by local areas in the UK*; 2011. Crown Copyright.

3. Cardiovascular Disease

Manchester Public Health Development Service

The Manchester Public Health Development Service (MPHDS) promotes the health and wellbeing of all people who live or work in the city. The MPHDS Stop Smoking and Health Trainer programmes are both particularly relevant to the prevention of CVD. In addition, MPHDS hosts the "Getting Manchester Moving" website that provides individuals with all the information they need to get more physically active, eat more healthily and thereby reduce their CVD risk.

NHS Health Checks

All adults aged 40-74 years, who have no pre-existing CVD, are offered a CVD risk assessment as part of the NHS Health Checks programme. In April 2013, the responsibility for commissioning an effective and equitable NHS Health Check service transferred from NHS Manchester to Manchester City Council.

The Greater Manchester "First Stop Health Bus"

Public Health Manchester commissions the "First Stop Health Bus". This offers general health advice, Stop Smoking services and NHS Health Checks in locations across Manchester where CVD outcomes are worst

Initiatives within local Clinical Commissioning Group (CCG) localities

Public Health Manchester is working in partnership with each of the Manchester CCGs to improve the prevention of CVD.

In North Manchester, a preventative CVD programme is delivered via General Practice (GP); focusing on improving the identification and management of atrial fibrillation, heart failure and chronic kidney disease.

Central Manchester CCG is developing local capacity to deliver NHS Health Checks in GP and community settings, in order to reach all communities. Training, support and development in CVD prevention is being offered to all staff in GP practices. As high blood pressure has an impact on CVD mortality, Public Health Manchester has invested in new technology to improve the early detection and effective management of high blood pressure.

In South Manchester, Public Health Manchester is working with University Hospital of South Manchester NHS Foundation Trust (UHSM) to deliver health checks via outreach teams. A GP-led team to support local practices in the delivery of the NHS Health Checks programme is also currently being piloted.

What do we want to achieve?

In order to improve the prevention, identification and management of CVD we are aiming to:

- Promote and strengthen CVD prevention at policy, environment and service delivery levels.
- Improve social environments and ensure that the healthy choice is the easy choice.
- Take a partnership approach to the implementation of recommendations from relevant guidance across the life-course.

The key objective for the coming year is to produce a long-term CVD prevention plan for Manchester and ensure political commitment to its implementation. The plan will make CVD prevention everyone's business. It will build on previous successes in identifying and managing CVD risk, promoting healthier eating, tobacco control and increasing physical activity and will include:

Health Impact Assessment of all policies:

Policies in a wide variety of areas can have a positive or negative impact on CVD risk factors and frequently the consequences are unintended. We will promote and encourage systematic health impact assessment to embed a structured approach to identifying the potential impact of policies on health inequalities.

Action to improve our diet, including reducing consumption of salt and saturated fat:

Priority will be given to helping food outlets improve the nutritional quality of the food they provide. We aim to use local planning to control the availability of take-away outlets, where the food supplied is often high in salt, sugar and saturated fats.

We will work to ensure that food procured by, and provided for, people who use or work in public services in Manchester meets Food Standards Agency approved dietary guidelines.

Eating and drinking patterns get established at an early age so measures to protect children from the dangers of a poor diet will be built into local plans, to help children and young people to develop positive, life-long habits in relation to food and healthy lifestyle.

Action to promote physical activity:

CVD prevention is most effective when the physical environment encourages people to be physically active.

The key levers of spatial planning, transport and leisure policies will be used to best effect to promote physical activity. Active travel offers an important opportunity to help people become more physically active.

Partner organisations will be supported to create an environment which promotes physical activity, including physically active travel to and at work.

Opportunities to conduct research into locally effective interventions will be maximised. This will include evaluating the impact of involvement in mass participation sporting events in the long-term adoption of healthier lifestyles.

Collaborative commissioning of effective preventative services:

Public Health Manchester will use the coming year to improve the local NHS Health Checks programme; securing an equitable and accessible service model.

A comprehensive Healthy Living Service will provide the infrastructure for CVD risk reduction. This will continue to be developed over the coming year.

The role of primary care, particularly General Practice, is crucial in the prevention of CVD. Consistent action in terms of identification of early disease, effective medicines management, maintenance of practice-level CVD risk registers, appropriate referral to lifestyle services and support for weight management, will all have an impact. Actions to address variation in quality of primary care outcomes will continue in partnership with local CCGs.

How will we measure progress?

The ultimate aim is to increase healthy life expectancy. However, using the available data, it is difficult to identify a stable underlying trend in the short term and this has to be considered when setting targets for increasing life expectancy and narrowing the inequalities gap. A practical approach is to use proxy measures. These will include take up of preventative services and outcomes for service users.

Recommendations

The development, delivery and monitoring of an effective, preventative CVD programme will only happen if there is a strong partnership approach, with senior leadership in stakeholder organisations.

It is recommended that the Manchester Health and Wellbeing Board actively promotes involvement of partners in the adoption of a co-ordinated approach to CVD prevention and maintains oversight of this work programme.

4. Mental Health and Wellbeing

Why is this topic important?

For too long, mental health and wellbeing has not received the attention that physical health has been given. High levels of mental ill health and low levels of wellbeing in the city have a significant impact on our health and on our social and economic aspirations.

People with mental ill health experience discrimination and suffer from the stigma associated with their condition. They also experience high levels of health inequality. It is estimated that people with serious mental illness live between 15 and 25 years less than average.

There is no single measurement that we can use to identify mental health status across the population but there are several indicators of the level of need that we must address.

Nationally, mental ill health represents up to 23% of the total burden of ill health in the UK – it is the largest single cause of disability[1].

In Manchester, approximately 50% of people claiming Incapacity Benefit or Employment Support Allowance have a mental health condition[2].

The 2009 North West Mental Wellbeing Survey shows that mental wellbeing (feeling good and functioning well) is low for 23.7% of the Manchester population, compared with 16.8% of the North West population.

Depression registers held by Manchester GPs show a wide variation in the percentage of patients listed on the register, averaging at 11%, with some practices registering nearly 25%.

Data for antidepressant prescribing in Manchester suggest that about one in ten adults in Manchester is being prescribed antidepressant medication.

Levels of mental ill health are higher amongst some population groups, including people who face social discrimination such as racism and homophobia, homeless people and those with drug and alcohol problems.

There are specific issues affecting the mental health of older adults in Manchester. In particular, loneliness and social isolation have been identified as priority areas in the Manchester Ageing Strategy. Dementia is a growing national and local problem, often leading to social isolation and is one of the main causes of disability in later life.

Children and young people in the city have high levels of mental health need. In 2005, a Manchester needs assessment involving a small sample of the school age population showed that 25% of 5 – 11 year-olds and 32% of 11 – 16 year-olds had mental health problems. This is compared with a national rate of 10% identified in the National Morbidity Survey.

Whilst the provision of mental health services is important, this is not sufficient by itself to manage this high level of mental ill health[3]. Economic, social and environmental factors are significant in the prevention of mental ill health. In addition, it is often harder for people with mental health problems to address physical health problems or to make lifestyle changes, such as stopping smoking, and they are more likely to face poverty as a result of difficulties in obtaining and sustaining employment.

If we are to improve the health of people in Manchester then it is time to acknowledge the importance of addressing mental health and wellbeing in achieving this. We must identify opportunities for prevention of mental ill health and improving wellbeing across the life course, from conception and early childhood through to older age.

1 WHO *The Global Burden of Disease (update on 2004)*; 2008

2 NOMIS/ONS *DWP Benefits dataset*, February 2012. Crown Copyright.

3 Friedli, L. and Parsonage, M. *Promoting mental health and preventing mental illness: the economic case for investment in Wales*. All Wales Mental Health Promotion Network; 2009

4. Mental Health and Wellbeing

What are we doing?

Manchester provides a 'stepped care' model of services based on a partnership commissioning approach[4]; ranging from universal preventative interventions, such as public health information and campaigns, through to highly specialised services:

- Public information and education focusing on mental health and wellbeing
- Voluntary and community sector organisations provide significant support to people with mental ill health as well as social networks to support mental wellbeing
- General practices (GPs) provide the greater part of support and treatment for people with mental ill health
- Primary care mental health services
- Specialist mental health services in the NHS (mainly Manchester Mental Health and Social Care Trust) and services in the voluntary/community sector commissioned by NHS Manchester and Manchester City Council
- Services, funded by Manchester City Council, meeting the social care needs of people with mental health issues in Manchester, including accommodation-based services, such as specialist registered care homes and supported housing and floating support services delivered to people in their own homes.

Front line services such as education, employment, housing, criminal justice and social care have a vital role in supporting people with poor mental health and fostering mental wellbeing. However, there is a varying level of understanding of mental health issues in these services.

Children and Young People

In line with the high level of need in the city, Manchester has a wide range of mental health services for children and young people.

The Manchester Healthy Schools scheme has developed a programme to support mental health and develop emotional resilience in the school setting, including work on anti-bullying.

We have developed services to target specific populations most vulnerable to poor mental health, for example Looked After Children, children and young people with physical and learning disabilities, parenting training for parents with children aged under 8 and targeted support for young people in transition.

When children, young people and their parents engage with mental health services the uptake and feedback is very good, however, there are some families who do not want to engage with services and are a cause for concern for a number of agencies.

Older People

A range of voluntary sector and community organisations provide support and opportunities for older people.

Valuing Older Peoples'[5] community engagement programme has focused on engaging older people, bringing them into communities more and reducing isolation and loneliness. This includes intergenerational working, consultation with older people, empowering older people through the Valuing Older People Board and networks, developing a cultural offer for older people, positive images campaigns and now research into loneliness and action to reduce it.

The Manchester Supporting Health Programme works to support people with dementia, and their carers, to improve their health by engaging with communities and primary care services in North Manchester. Services for people with dementia are also provided by Manchester Mental Health and Social Care Trust, and The Alzheimer's Society.

4 NHS Manchester & Manchester City Council *Manchester Mental Health and Wellbeing Commissioning Strategy 2009-14*

5 Valuing Older people is a Manchester City Council/Public Health led initiative to improve the wellbeing and engagement of older residents

What do we want to achieve?

In line with the recent national mental health strategy 'No Health without Mental Health'[6], we want to:

- Improve the mental health and wellbeing of the whole population.
- Improve outcomes for people with mental health problems with high quality services equally accessible to all.

Currently, most of our local investment is in secondary care for those with moderate to severe mental health problems; much less is spent on prevention and low level interventions that can improve emotional resilience and reduce the risk of the development of more severe problems.

If we are to manage the high level of mental health need in Manchester and foster better mental health then we need to place greater emphasis on promoting wellbeing in our communities, providing early intervention and support for those with lower level problems and re-focussing specialist services to foster recovery and self care.

An important aspect of this will be improving access to information on self care and community-based support, and providing training so that staff in a wide range of agencies can support people with mental health problems.

Children warrant special attention if we are to promote good mental health in the city. Many adult mental health problems have their origins in poor childhood experiences and a high percentage of those with long term problems show signs of illness before the age of 14. The most significant gap is how to engage families who do not want to access services. This will be a key area of work for the Community Budgets Troubled Families programme.

How will we measure progress?

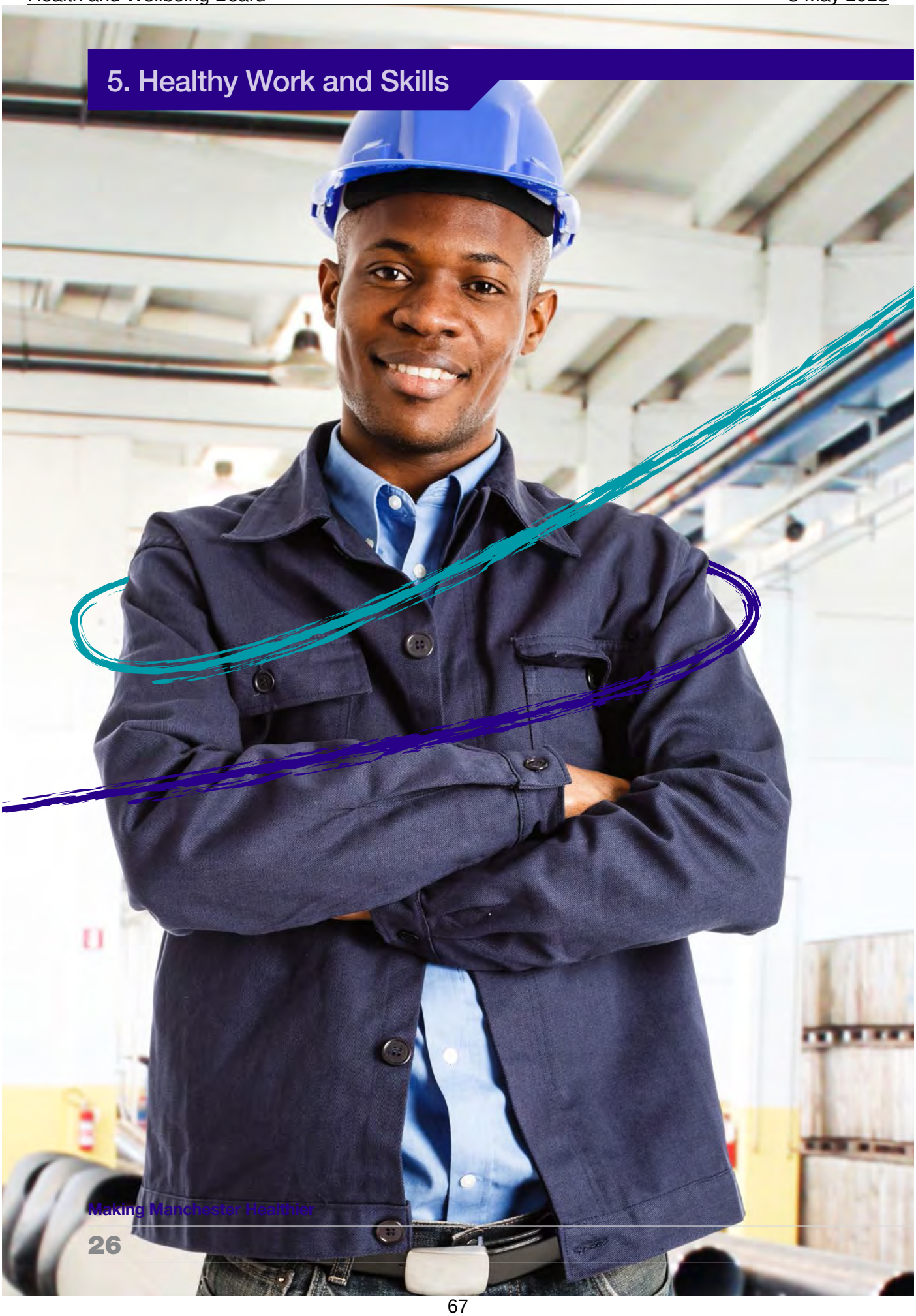
The Manchester Health and Wellbeing Board has agreed that mental health and wellbeing should be one of eight core priorities for the city and that priorities focussed on children and older people should also address mental health and wellbeing.

6 HM Government *No health without mental health. A cross-government mental health outcomes strategy for people of all ages*; 2011

Recommendations

- Commissioners and providers of mental health services should work together to change the focus of mental health specialist service delivery to support recovery.
- Public Health Manchester and partner agencies should invest in more mental health training for generic frontline staff.
- Public Health Manchester should improve access to information on self care and develop further training courses on emotional resilience for the public.
- GPs and Manchester Mental Health and Social Care Trust (MMHSCT) should ensure that the physical health needs of people with mental health problems are addressed as part of their care.
- Commissioners should promote improved responses to mental health problems in people with long term health conditions.
- Manchester should demonstrate effective programmes for greater social inclusion of older people, including those with dementia, across health and social care.
- Child and Adolescent Mental Health Services (CAMHS), MMHSCT and the Troubled Families programme should build on access to early intervention and support for children at risk of mental ill health.
- Public Health Manchester, in conjunction with the Health and Wellbeing Board, should develop a

5. Healthy Work and Skills



Why is this topic important?

The interrelationship between health and work (or lack of work) is vital to the economic and social wellbeing of a local economy, particularly in major cities such as Manchester. Being out of work, or never having been in work, puts individuals at increased risk of ill health and premature death, with all of the associated costs to society that this involves[1].

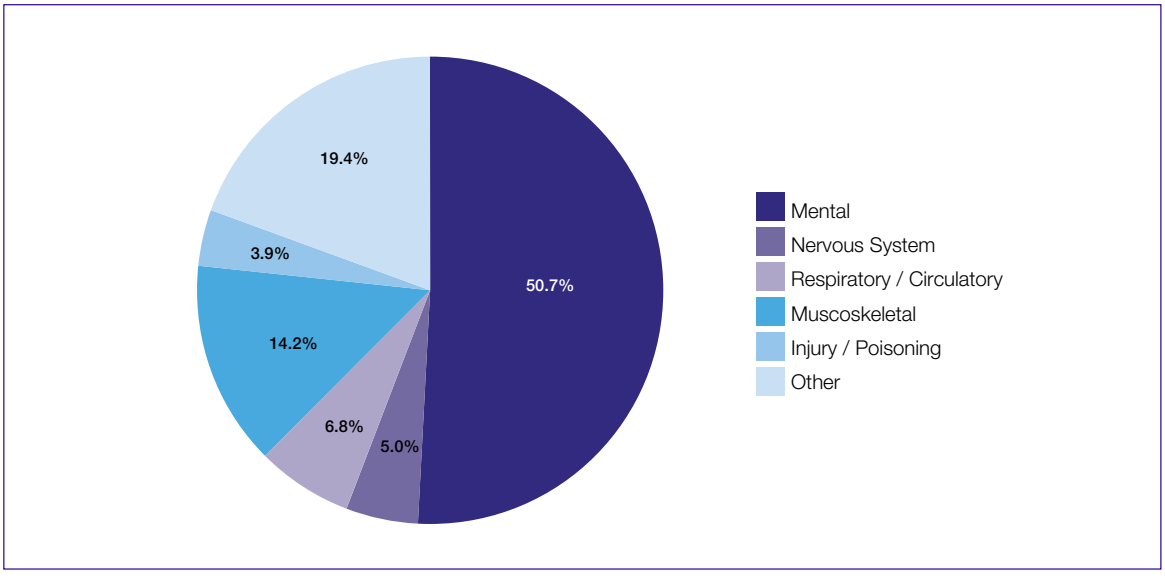
In Manchester, rates of worklessness are higher than the national average, with 5.6% of the working age population unemployed compared with 3.9% in the UK as a whole[2], and 9.2% claiming Employment Support Allowance (ESA) or Incapacity Benefit (IB) compared with 6.0% in England as a whole[3].

In Manchester, rates of worklessness are highest among those with no or few qualifications and skills, people with disabilities and mental ill health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and increasingly, young people.

There has been some progress in recent years to reduce number of residents claiming benefit. However, in February 2012 there were 64,210 residents claiming one of the three main out of work benefits, which accounts for 17.8% of the working age population (16-64). A little over half of those claiming out of work benefits – around 9% of the working age population – are in receipt of IB or ESA due to a health condition[4].

As 50% of IB and ESA claims are due to a mental health condition, support for people with mental health conditions is a priority for the Manchester Work and Skills Board (Figure 1).

***Figure 1:** Health related conditions of Incapacity Benefit and Employment Support Allowance claimants*



1 Waddell, G. and Burton, A.K. *Is work good for your health and wellbeing?*, London: TSO; 2006
2 NOMIS/ONS, October 2011 Crown Copyright.
3 DWP Information Directorate and Office for National Statistics, May 2012
4 NOMIS/ONS *DWP Benefits dataset*, February 2012 Crown Copyright.
5 Waddell, G. and Burton, A.K. *Is work good for your health and wellbeing?*, London: TSO; 2006

5. Healthy work and skills

The highest concentrations of IB and ESA claimants are in areas of the city where deprivation is high and where we have the highest concentrations of low income households, low skills and educational levels, poor nutrition and poor physical and mental health – in particular North Manchester and East Manchester and some parts of Wythenshawe.

Supporting individuals back into work and assisting them to sustain work not only boosts the local economy but improves life chances and health outcomes for individuals and their families[5].

Alongside this is the need to ensure that work supports good health. A healthy workplace is characterised by a safe and healthy working environment, clarity of expectation on staff, feedback on performance, and employees having some control and influence over their work. Wage levels need to meet a 'healthy living wage' level to enable individuals to achieve adequate warmth and shelter, a healthy diet, social interaction and avoid chronic stress.

These are policy areas that are not directly led on by Public Health Manchester, but there is no doubt that the health and social care system can do its part to support people to get into and sustain good employment, and that it should do so in order to improve the health, wellbeing and independence.

What are we doing?

Manchester has many good services that support healthy work and skills but they are often small scale, fragmented and not fully embedded in mainstream services. We need to strengthen the commissioning role of all strategic partners to tackle worklessness and support healthy work and skills.

Examples of current services to support individuals to acquire healthy work and skills include:

- Fit for Work, led by primary care, although there is limited adoption of this in Manchester.
- Specialist disability employment support.
- Sports-led services such as 'Successes Through Sport'.
- Adult education services.
- Mental health and social care services supporting people to become work ready.

In addition, within Manchester we also have several examples of good practice in supporting healthy work and skills including:

- Ardwick City Region Pilot: a multi-agency approach with front line worker training to provide an integrated approach to mental health service provision and employment services.
- Work Solutions: intensive support to help IB/ESA claimants back to sustainable work, with a focus on issues such as drug and alcohol dependency.
- Community Budgets Phase 1 and 2: working with complex families utilising case workers and sequencing of interventions.
- Developing wrap around services in conjunction with Prime Contractors to support those individuals being supported by the Work Programme.
- Development of employee health and wellbeing strategies. The Greater Manchester 'Good Work Good Health' Charter supports all employers to ensure that work does not have a negative impact upon health and that poor health does not impact upon work. In line with the Charter, Manchester City Council have adopted a strategy that fosters a proactive approach to enhancing the health and wellbeing of employees.

What do we want to achieve?

Target groups for 2013 - 2015

A large number of Manchester residents claim IB, ESA and other sickness related out of work benefits primarily because of a mental health condition, and this group is growing. Consequently, we are focusing on adults with diagnosed and undiagnosed mental health problems who are not in employment as a priority group.

In addition, there is currently an opportunity to support wider health and wellbeing through a focus on the role of employers in promoting health at work. Therefore, we will also be focusing on people employed by the public sector, large private sector organisations and public sector contractors.

How will we measure progress?

We want to achieve the following outcomes by 2015:

Supporting people into work

- More primary care practices will be working in a way that systematically supports people back into work or training.
- More adults with diagnosed mental health problems will have been supported into employment or training through primary care interventions or self help interventions.
- More adults with mental health problems will be appropriately referred to mental health services from employment services.

Healthy Workplaces

- An increased number of employers in Manchester will have signed up to the 'Good Work Good Health' Charter or equivalent workplace health standards.
- An increased number of Manchester City Council and NHS suppliers will have signed up to the 'Good Work Good Health' Charter or equivalent workplace health standards.

The Health and Wellbeing Board and the Work and Skills Board will provide the strategic drive for this work; however much of the action to support people into work sits with primary care.

Recommendations

- The Fit for Work Programme should be adopted by GP-led primary care services in targeted areas of the city with high levels of worklessness, with full roll-out by 2015.
- Public Health Manchester will develop and commission self help programmes with wrap around employment support, to help claimants of out of work sickness related benefits to manage their health conditions better and increase their chances of getting back into the labour market. We will support the integration of employment and skills support as part of any future commissioning of Improving Access to Psychological Therapies or similar services.
- A single referral process should be created between employment service providers and specialist mental health providers.
- The Health and Wellbeing Board and its strategic partners should work with a wide range of employers to encourage investment in workplace initiatives to promote the health and wellbeing of employees.
- Public Health Manchester will influence public sector commissioning to ensure that good, healthy work is promoted through procurement and contracting processes, encouraging all supply chain partners to sign up to the Greater Manchester 'Good Work Good Health' Charter or equivalent workplace health standards.

6. Older People, Falls and Falls Prevention

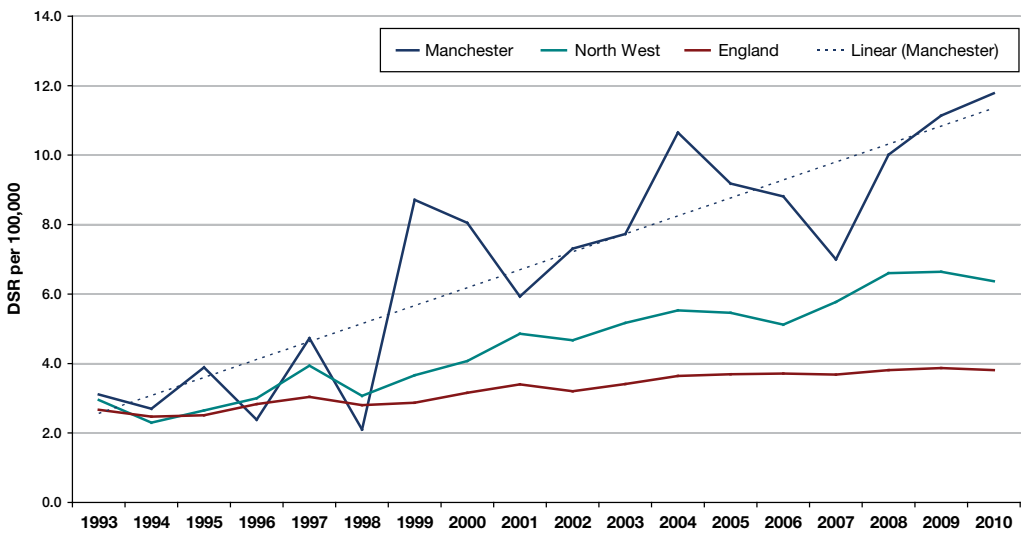
Why this topic is important?

In Manchester, we are very concerned about the number of falls suffered by our residents and the impact that these have. We know that falls occur mainly, but not exclusively, in older people and that they can cause injury, disability and even death.

The consequences of having one or more falls can be far reaching in terms of the physical and mental health of older people. For some, their quality of life will be severely and permanently affected after falling. Falls often represent a turning point in an individual's life, reducing their independence and mobility and leading them to rely on others for support. A significant number of older people need long term care at home, or in a residential facility, after a fall.

Obtaining accurate data on falls is problematic, as many falls do not result in a hospital attendance and there is no precise coding of falls in hospital data. However, the data that we do have show that, compared with England as a whole, Manchester has significantly higher rates of hospital admissions and deaths due to falls (Figure 1)[1].

Figure 1: ***Deaths from accidental falls in 1993-2010 (All Ages)***
Directly Standardised Rate (DSR) per 100,000, Manchester, North West and England



1 South West Public Health Observatory *Injury profiles*; 2012. (Available from http://www.apho.org.uk/resource/view.aspx?RID=115672)

6. Older People, Falls and Falls Prevention

Because our bones become less strong as we age, if an older person falls they are at increased risk of hip fracture (also called fractured neck of femur). In 2010/11, there were 333 admissions due to hip fracture among people aged 65 and over in Manchester. This is an important issue because around 80% of fallers who have a hip fracture do not regain pre-fracture mobility, and 70% of those will have another fracture after three years[2].

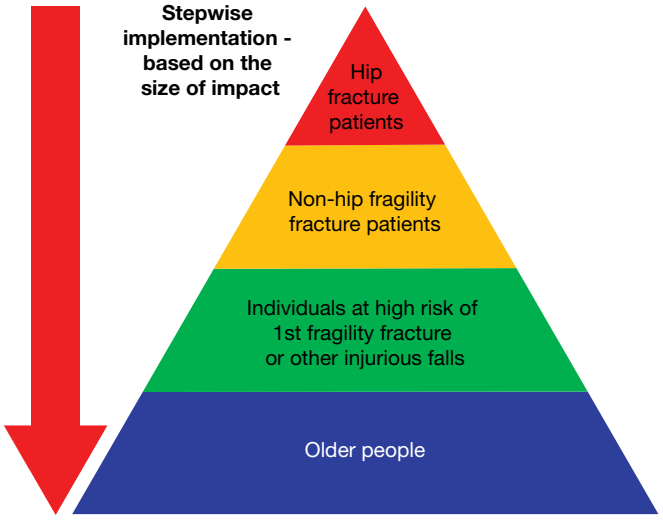
Falls generate huge costs for health and social care services, as well as a high personal cost to the older person and their carers. Nationally, it is estimated that a reduction in the number of hip fractures by 4500 per year would result in a net saving of £34 million[3]. Consequently, reducing the number of hip fractures in Manchester among over 65 year-olds, from their current level of 333 per year (2010/11), could result in significant improvements to the quality of life of older people in the city, as well as considerable savings in health and social care costs.

Inequalities

It is very likely that the impact of falls is felt more by some groups of older people than others. People in more deprived wards of the city are more affected by some of the factors that can contribute to falls, such as poorer housing conditions and other medical conditions. To improve falls prevention, we will need to collect better information about whether some parts of our communities are disproportionally affected by falls and the consequences of falls.

DH Prevention Package for older people

A systematic approach to falls and fracture prevention
Four key objectives



Objective 1: Improve outcomes and efficiency of care after hip fractures - by following the 6 'Blue book' standards

Objective 2: Respond to the first fracture, prevent the second - through **Fracture Liaison Services** in acute and primary care

Objective 3: Early intervention to restore independence - through **falls care pathway** linking to acute and urgent care services to secondary prevention

Objective 4: Prevent frailty, preserve bone health, reduce accidents - through preserving physical activity, healthly lifestyles and reducing environmental hazards

2 Institute of Public Care *Manchester City Council: Use of social care resources for older people*; 2012

3 *Ibid*

4 Oliver, D. *Developing effective services for falls and fracture patients*; 2010. (Available from http://www.northwest.nhs.uk/document_uploads/Public%20Health/2.%20Developing%20Effective%20Services%20for%20Fall%20and%20Fracture%20Patients.pdf)

What are we doing?

Reducing falls is an objective within the Manchester Ageing Strategy (2010-2020) and the Age Friendly Manchester programme, which was launched in October 2012. This includes developing a more inclusive urban environment where older people can move around and access the city.

We now intend to develop a comprehensive falls strategy for older people in Manchester and this will involve a strategic review of services.

The Department of Health has suggested a model of good practice for the prevention of falls[4] (see opposite).

Preventing falls requires action from a wide range of agencies. We need to prevent falls in those who have not yet had a fall (primary prevention). This includes supporting people to remain physically active, as well as reducing environmental hazards, such as damaged pavements. We also need to reduce the risk of future falls in those who have already fallen (secondary prevention). For example, providing medication reviews, vision assessments and falls risk assessments.

There are several examples of good practice in the delivery of falls services in Manchester. However, historical differences in the way services have developed over time have resulted in variation in provision of falls services across the city. Improvements that we can make in our local service provision include ensuring that services are well joined up and have consistent criteria. We also need to address gaps in provision, such as the availability of fracture liaison services.

There are examples of services and improvement work underway in Manchester at all four of the levels of the Department of Health falls prevention model, for example:

Objective 1: Acute trusts are trying to improve the care of patients who have had a hip fracture, including reducing the time to surgery. In each acute hospital in Manchester there are specialist, consultant-led falls services. Each hospital also has an Orthogeriatrician who provides support to orthopaedic surgeons in the care of older people admitted following a fracture.

Objective 2: In the community there are falls services that see people who have fallen and arrange for them to have a full risk assessment. There are also services which provide care for older people who have fallen or are at high risk of falling, for example district nurses.

Objective 3: Services are in place to restore independence, for example community alarm services provide alarms and a response for older people who are at risk of falling. A formal integrated falls care pathway is now needed to coordinate work across different services.

Objective 4: There are a number of exercise programmes in the city which promote strength and balance.

What do we want to achieve?

The Joint Health and Wellbeing Strategy states that we are aiming to reduce falls among older people in Manchester. We are in the process of agreeing a target for the size of reduction we want to achieve.

We would also like to reduce the numbers of emergency and non-emergency admissions to hospital as a result of falls. If we reduced non-emergency admissions in Manchester to the national average, we could potentially save some 492 admissions per year[5]. We need to analyse these data so we have a better understanding of why our non-emergency admission rates are so high. We may then be able to make policy or service changes which can reduce the number of falls. This would not only give health benefits to older residents, but might release money from treatment services for falls prevention.

5 South West Public Health Observatory *Injury profiles*; 2012. (Available from http://www.apho.org.uk/resource/view.aspx?RID=115672)

6. Older People, Falls and Falls Prevention

There is significant scope for agencies to work more closely together to minimise the risk of falls and to ensure the right treatment, at the right time, should an older person fall. Stakeholders and agencies who could be involved in falls prevention, or falls treatment, for older people include housing providers, landlords, care home providers, GPs, community health services, primary care, the North West Ambulance Service, secondary care, acute trusts, tertiary care providers, mental health service providers, the Public Health Development Service, Adult Social Care, third sector and voluntary organisations, individuals and their families.

Older people who have fallen may require care from more than one organisation or service. We need to work towards a single risk assessment tool in Manchester to ensure consistency of standards, improve transfer of care and avoid duplication of assessment when someone is referred to another service.

How will we measure progress?

To fully develop and implement a local falls strategy we need a better understanding of falls in Manchester. We need to know the size of the problem, patterns, existing resources, gaps and good practice. This information will allow us to plan services and monitor our progress in reducing falls.

Recommendations

Public Health Manchester, health and social care services, community organisations and other relevant agencies should work together to achieve the following:

- Establish appropriate governance arrangements to develop and implement Manchester's falls strategy.
- Conduct detailed mapping and review of all falls related services delivered in community, primary, secondary, tertiary and social care settings, including voluntary and third sector organisations, across Manchester.
- Carry out a detailed epidemiological study of falls in older people in Manchester.
- Develop a comprehensive falls prevention (in older people) strategy.
- Coordinate the work of clinicians, agencies and academics to develop a systematic, integrated, multi-agency and multi-functional approach to falls interventions, based upon evidence and best practice.
- Prioritise falls in older people as a programme of work for the NHS (Clinical Commissioning Groups, Acute Trusts, North West Ambulance Service and Manchester Mental Health and Social Care Trust) and Manchester City Council.

Appendix A: Recommendations from 2011 Public Health Annual Report: update on progress

1. Preventing the infections associated with healthcare

Recommendation	Progress update
1. That we recognise the considerable reduction in healthcare associated infections (HCAI) across Manchester that has already been achieved.	Although we continue to focus on improved performance, our monitoring system also acknowledges the reductions in the incidence of HCAIs that continues to be achieved year-on-year.
2. That we also accept that we can do even better and that our driving principle must be 'zero tolerance', whereby there are no avoidable infections associated with the healthcare we provide locally.	Our performance on HCAIs has continued to improve, substantially so, underpinned by a zero tolerance approach. We are currently planning for the introduction of the formal assessment of avoidability in all MRSA cases in 2013.
3. Therefore the targets we set ourselves, for 2011/12 and beyond, must continue to be increasingly challenging.	For both 2011/12 and 2012/13, we set increasingly tough targets for HCAIs with, for example, a reduction in C.diff in 2012/13 of around 30%.
4. We must continue to monitor closely the number of healthcare associated infections locally and hold health providers to account when targets are not met.	We continue to robustly monitor the levels of HCAIs locally, both in hospital and in the community. A monthly 'stocktake' is key to this process.
5. We must also continue to strengthen our work on infection prevention and control, working collaboratively with health and social care providers and ensuring oversight of the HCAI problem.	We now have strong and established processes in place in Manchester to work across the whole health economy, and with social care partners, to reduce HCAIs.
6. The new citywide Strategic Infection Prevention and Control Committee should agree an annual action plan to focus collaborative working, including an emphasis in 2011 on further reducing C.diff infection rates to meet our much tougher 2011/12 targets.	This plan was completed, and a new action plan agreed by the Strategic Infection Prevention Control Committee for 2012/13. An emphasis on the reduction of C.diff infections continues.

Recommendations from 2011 Public Health Report: update on progress

2. Our vaccination coverage is too low

Recommendation	Progress update
1. That we all first accept that our performance on vaccination is under-par and that other areas, and some of our own GPs, have shown that we can reach, despite the undoubted challenges, national target levels for vaccination coverage.	This principle is now widely accepted and underpins our successful drive to improve immunisation coverage in Manchester.
2. Public Health Manchester should continue to lead the major strategic planning process that is needed to reach our goal of meeting the national target levels for vaccination coverage.	Our strategy has been accepted and is being taken forward. The implementation phase is well underway and has already produced significant improvements in our immunisation coverage in Manchester.
3. Our progress towards that goal should be clearly and robustly measured – using the national COVER data system – so that it is abundantly clear if we succeed or if we fail. Meeting all the national vaccination targets can not be achieved quickly, so we should use our 'Vital Signs' targets as the interim measures towards the ultimate goal of meeting all the national vaccination targets.	Our progress towards our vaccination coverage goals is being closely monitored. Our vaccination coverage is monitored and reviewed regularly in a targeted fashion, focusing on the under 5s, and more comprehensively.
4. Public Health Manchester should also ensure that the specific Immunisation Promotion Project is fully implemented and that the future of that project is reviewed during 2011.	This project is now fully in place and producing excellent progress in increasing vaccination coverage in the under 5s. For example, Manchester, for the first time, has now met the 'gold standard' target of 95% of all 1 year-olds having received their routine baby vaccinations. Coverage of the MMR vaccine is now well over 90%.
5. General Practices should work with Public Health Manchester, through the 'Manchester Standard' process, to ensure that all practices achieve a high level of vaccination uptake.	Instead of using the Manchester Standard process, Public Health Manchester is now working collaboratively with North Clinical Commissioning Group to develop an effective approach to improving GP vaccination delivery systems. This process will be rolled out citywide.

3. Halting the rising incidence of tuberculosis (TB)	
Recommendation	**Progress update**
1. Our challenging goal should be 'to halt, and begin to reverse', the increasing incidence of TB in Manchester.	This goal has been agreed, and the difficulty of reducing the incidence of TB in Manchester widely accepted.
2. Building on the key issues identified in this report, Public Health Manchester should lead the development of a strategy and accompanying comprehensive and practical action plan to address the control and prevention of TB in Manchester.	A TB prevention and control strategy has been agreed and a detailed action plan developed. Implementation of that action plan continues.
3. That action plan should focus on: a. improving BCG vaccination coverage in Manchester	Central Manchester Foundation Trust, who provide neonatal BCG through its health visiting service across Manchester, is taking several important actions that should significantly improve the coverage of neonatal BCG vaccination in Manchester over the coming year.
b. ensuring that there are sufficient specialist staff to treat the increasing number of TB cases, and to ensure that contact tracing and patient follow-up continue to be delivered to a high standard	Some increases in staffing capacity have been put in place but more still needs to be done. Central Clinical Commissioning Group are working with Central Manchester Foundation Trust – with advice from Public Health Manchester – on this problem.
c. reviewing our arrangements for screening new entrants from high prevalence countries	This complex problem has been reviewed on a Greater Manchester basis. The Port Health Unit team are being moved to the new agency, Public Health England, and national changes to port of entry identification of new entrants are in development. New entrant screening in some general practices in Manchester is under discussion.
d. working with third sector partners, particularly TB Alert, in engaging with the BME communities that are most affected by TB, and with healthcare professionals, to raise the awareness and understanding of TB	Engagement with community groups and collaborative work with TB Alert - to enhance awareness of TB and to better understand the community perspective on the TB problem - is taking place and will continue to develop.

Recommendations from 2011 Public Health Report: update on progress

4. Blood borne viruses in injecting drug users

Recommendation	Progress update
1. Early testing and treatment are important in preventing blood borne virus (BBV) infections, and improving the health of those who are already infected. We need to raise awareness in at risk groups and train frontline workers and volunteers to address the problem of BBVs at an earlier stage.	We have continued to commission training on BBVs, including testing, prevention and treatment. This training has included skills development in the delivery of harm reduction services such as needle exchange. 'Pass it on - the knowledge not the virus' is a bespoke model of training on blood-borne viruses that is being delivered in Manchester. To date over 95 frontline workers have received training.
2. GPs have a crucial role to play. They are often the first point of contact for patients. It is important to provide them with general information, access to training, and ensure they have advice on testing, including dried blood spot testing.	The GP Local Enhanced Service contract for substance misuse has been refreshed with a strong emphasis on BBV prevention, testing and treatment. An audit of activity was completed in 2012.
3. Raised awareness and more testing of BBVs will increase demand for treatment services. We need to explore the options for providing as much of this support and treatment in primary care as possible, rather than in hospital, both to improve access for patients and also to manage better the high costs of treatment.	The provision of BBV treatment in primary care is being explored with one city centre practice providing Hepatitis C testing under specialist supervision. The routine offer of an HIV test is now made in a number of settings, including to all general medical admissions at CMFT. HIV testing has been introduced for patients accessing abortion services and work to introduce the routine offer of an HIV test to all new patients registering at GP practices has commenced.
4. The re-design of substance misuse services in Manchester should include a strong focus on harm reduction throughout those services and ensure that BBV testing, treatment, prevention advice, and the provision of clean equipment are key issues.	The new contracts for the delivery of drug services in Manchester were issued in July 2012. In this new service 'RISE Manchester' there is a strong emphasis on harm reduction and prevention advice across the three elements of service: intake, clinical treatment and recovery.

4. Blood borne viruses in injecting drug users (continued)	
Recommendation	**Progress update**
5. Methadone prescribing as a substitute for heroin should continue to be available as a means of stabilising drug use and reducing the need for injecting.	Methadone continues to be prescribed as a core method of stabilising drug use and reducing the need for injecting in re-commissioned drug services. In addition, there is a stronger emphasis on recovery and the establishment of a drug free lifestyle. All longer term methadone users are being reviewed and offered additional options to support recovery.
6. Harm reduction services should work to encourage those who are not yet willing to give up drug use to stop injecting.	Harm reduction services, including needle exchange, have been reviewed and re-provided in the city via the new RISE contract. There is a clearer care pathway to encourage users into drug treatment and advice is available on alternatives to injecting.
7. Commissioners for drug and alcohol services, and for sexual health services, should work more closely together to improve the consistency of prevention advice, access to testing, and treatment.	The links between sexual risk-taking and the use of alcohol and drugs are well understood. Commissioners have, for instance, asked providers of sexual health services to undertake alcohol brief interventions in order to identify and support patients who require further support.
8. Much progress has been made to address BBV issues for prisoners. It is important that we build on this and ensure seamless care when prisoners are released in order to maintain support for a healthier lifestyle and their continued treatment, when that is needed.	Screening and immunisation, where appropriate, is provided for prisoners and coverage for hepatitis B vaccination is excellent. Prisoners at risk of hepatitis C are offered dried blood spot testing. Substance misusers engaged in prison treatment who are released to Manchester have robust continuity of care arrangements in place with community based services - including in respect of BBV testing and support.

Recommendations from 2011 Public Health Report: update on progress

5. Planning for emergencies

Recommendation	Progress update
1. The Greater Manchester NHS Commissioning Board Area Team should work with local partners to understand what reform and reorganisation of the NHS, and of other public sector bodies means for emergency planning.	An inaugural meeting of the Greater Manchester Local Health Resilience Partnership (LHRP) was held on 26 September 2012. The LHRP will be the strategic forum that sets the direction for health Emergency Preparedness, Resilience and Response (EPPR). Membership of the LHRP includes executive level representatives from the range of health partners across Greater Manchester, including acute, community and mental health trusts, Clinical Commissioning Groups (CCGs), Public Health England, local authorities and the NHS Commissioning Board Area Team. While the role of the LHRP has been defined nationally, further work is required to understand and agree local structures and responsibilities for EPPR. It is anticipated that the LHRP will play a key role in shaping the revised arrangements for emergency planning in Manchester. In addition, Greater Manchester Commissioning Support Unit has developed a 'resilience service' that will be offered to Greater Manchester CCGs and Directors of Public Health in order to support them with their preparedness for emergencies. The service will be provided by a teamof emergency planning practitioners that have extensive experience in NHS resilience.
2. With this knowledge we should make appropriate amendments to our plans for emergencies or, if necessary, develop new plans.	As local structures and responsibilities for EPRR are still emerging, the amendment of existing emergency plans and the development of new ones will be undertaken when revised arrangements are agreed.
3. The Greater Manchester NHS Commissioning Board Area Team should ensure that they are adequately prepared for another influenza pandemic.	Existing arrangements for responding to an influenza pandemic will remain in place until the new arrangements and structures for EPRR are operational. Influenza pandemic plans will be amended to reflect revised responsibilities once these are confirmed.
4. Public Health Manchester should ensure that an effective programme of awareness-raising, training and exercising for emergencies is delivered to all relevant individuals at a local level.	Public Health Manchester continues to access the training and exercising activities delivered by Greater Manchester NHS Resilience Team. Most recently, these activities have included exercising for potential emergencies associated with the Olympic events held in Manchester.

Appendix B: What does the 2011 Census tell us about population change in Manchester?

About the Census

Data from the 2011 Census give us important information about changes in the population of Manchester over the ten years since the last Census (2001). Looking at how the age structure and distribution of the population has changed over time helps us to understand better the patterns of need described in the JSNA and to anticipate the future demand for health and social care services in the city.

The response rate to the Census matters because people who don't return the Census may be different in a number of ways from those who do. This can then lead to a misunderstanding of population characteristics and needs. Manchester achieved a response rate of 89% for the 2011 Census. This is an improvement on the response rate achieved by the 2001 Census (86%) but still reflects the challenges of counting the population in a large, diverse, urban area such as Manchester.

Population size and structure

It is important to consider the size and structure of the population when looking at the health needs of the population. Increases or decreases in the total number of people living in an area can have an impact on the overall demand for health and social care services. Changes in certain age-groups can also affect the demand for particular types of services or interventions, such as those aimed at babies, young children, new or expectant mothers or older people. Particular population sub-groups have a higher prevalence of certain diseases and a growth in these groups may lead to increased demand on related services. Increases in the size of short term migrants or other transient populations (e.g. students, travellers) may lead to surges in demand for health and social care services at peak times.

The 2011 Census shows that Manchester is growing at a faster rate than the country as a whole, and continues to display a 'young' age profile, with growing numbers of very young children and young adults. The key figures to bear in mind are as follows:

- The population of Manchester is estimated to be in the region 502,900. This was an increase of 4,100, or 0.8%, over the estimated population for 2010.
- Manchester has a relatively young population. The proportion of the population aged less than 5 and between 15 and 39 years of age is higher than that seen in other parts of Greater Manchester and across England as whole. Among other things, this reflects the large number of students living in the city.
- Over the last of the decade, the population of Manchester has grown steadily, from 422,900 in 2001 to the current figure of 502,900. This represents an increase of 18.9%, or 80,000, making Manchester the fourth fastest growing local authority in England, behind the London Boroughs of Tower Hamlets (27.3%), Newham (24.5%) and Hackney (19.3%).
- The proportion of the population aged 0-4, 15-34 and 40-49 years has increased over the last decade, with particularly large increases in the proportion aged between 20-24 and 25-29. However, the number (and proportion) of children aged 10-14 has decreased since 2001. In contrast to the national picture, the number of residents aged 65 and over has fallen, by around 8,000 people (14.4%), since 2001.

Short term migrants

There has been a long standing debate about the extent to which short term migrants may be contributing to the rising demand for health and social care services. The 2011 Census included new questions designed to provide more information on this topic. By combining information on usual residents (people living in Manchester for one year or more) with that on short term migrants (people living in the city for a period of 3 to 12 months), it is possible to generate a clearer estimate of the actual number people living in the city.

The 2011 Census showed that there were around 5,500 short term migrants living in Manchester, adding

What does the 2011 Census tell us about population change in Manchester?

an additional 1.1% to the size of the usually resident population. Although this is much lower than some London boroughs, the figure is nevertheless higher than other 'core cities' in England, such as Liverpool, Sheffield, Leeds and Birmingham, where the number of short term migrants only make up around 0.5% of the usually resident population.

Future projections of the population

Subnational Population Projections use past trends in births, deaths and migration to project the population 25 years into the future. Data from the 2011 Census have been used to revise previously issued projections of the future population up to the year 2021.

Overall, the resident population of Manchester is projected to increase by around 29,300 people, from a figure of 502,900 in 2011 to 532,200 in 2021. The male population is projected to increase at a slightly greater rate than the female. The majority of the projected growth in the population of Manchester is due to an excess of births over deaths (natural change) and the rest to net migration.

The latest set of sub-national population projections implies a projected growth rate that is substantially lower than that suggested by historic (i.e. pre-2011) mid-year estimates. The rate of growth is also very low compared with previous projections and trends for this period. Manchester City Council is actively engaged currently in discussions with the Office for National Statistics on this issue and, until this is resolved, these figures should be used with caution.

Health and provision of unpaid care

The 2011 Census asked every individual within a household to answer three questions about their heath and about any unpaid care they provide. These questions cover the topics of self assessed general health, limiting long term illness and the provision of unpaid help or support to family members, friends, neighbours or others.

The Census shows that, although the vast majority of people in Manchester reported that their health was, in general, 'good' or 'very good', nearly 36,000 people in the city (around 7% of the population) reported that their health was 'bad' or 'very bad'. Furthermore, nearly 1 in 5 people (around 18% of the population) reported that they had a health problem or disability that in some way limited their day-to-day activities. Nearly 1 in 10 people (around 9% of the population) said that this health problem or disability limited their day-to-day activities 'a lot'. Overall, just over 8% of population of Manchester (around 42,600 people) reported that they provided at least 1 hour of unpaid care per week, with around 2% of the population (nearly 12,000 people) reporting that they provided 50 or more hours of unpaid care per week.

Although it is difficult to make precise comparisons between the 2001 and 2011 Census, the published figures suggest that Manchester is experiencing one of the biggest increases in the proportion of people describing their health as good over the past decade.

What's next?

More information from the 2011 Census will be released over the forthcoming months and years, including information for specific age and ethnic groups and also for smaller geographies, such as Super Output Areas (SOAs) and wards. This information will be incorporated into the JSNA and also made available through the new Manchester Intelligence Hub (see http://www.manchester.gov.uk/intelligencehub).

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