Joint Strategic Needs Assessment for Tameside

2025/26

Summary of
Health & Wellbeing

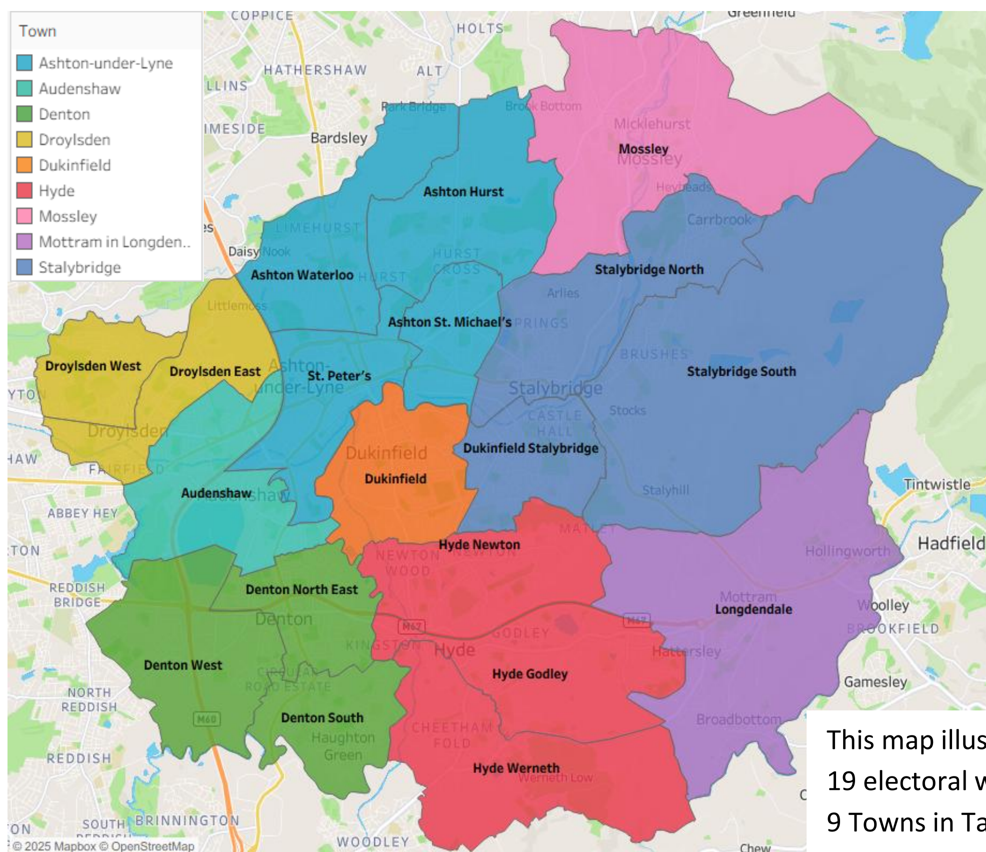
The following JSNA summary is based around Tameside's Corporate Plan 2024-2027 - 'A place where everyone can achieve their hopes and ambitions'. The plans aims and aspirations for the area and will enable commissioners and service providers to better understand the complexities and needs of the population served within the Tameside borough boundaries. A wider set of statistics and information is available on the council website at [Health and Wellbeing (tameside.gov.uk)](https://www.tameside.gov.uk).

The local view of Health and Wellbeing in Tameside

Tameside sits on the edge of both the Pennines and the Peak District. Tameside is named after the river Tame which flows through the borough and spans the areas of Ashton-under-Lyne, Audenshaw, Denton, Droylsden, Dukinfield, Hyde, Longdendale, Mossley and Stalybridge. The Tameside borough shares its border with Manchester, Stockport, Oldham and the borough of High Peak. In Tameside there are:

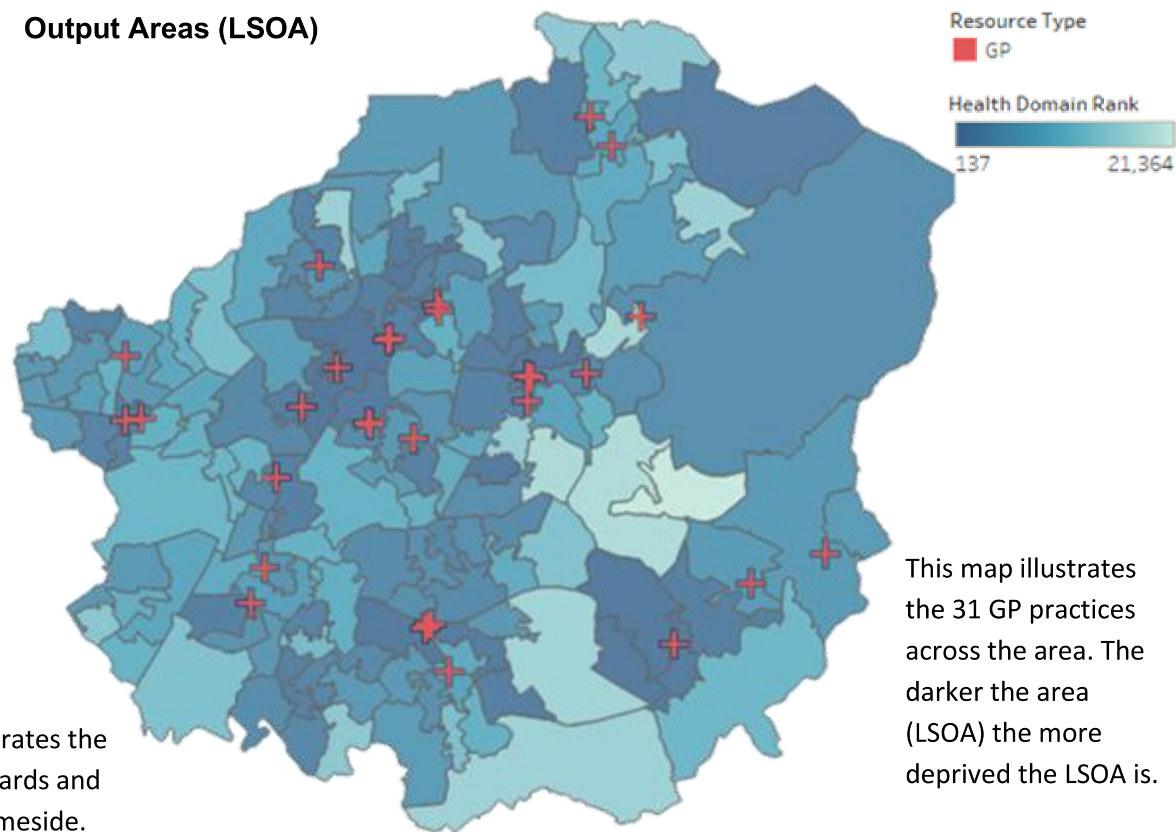
- 142 Lower Super Output Areas (LSOA) (census geography)
- 30 Mid-layer Super Output Areas (MSOA) (census geography)
- 19 electoral wards
- 9 Towns
- 4 neighbourhoods
- 4 Primary Care Networks (PCN)
- 3 parliamentary constituencies

Map of Wards and 9 Towns of Tameside



This map illustrates the 19 electoral wards and 9 Towns in Tameside.

Map of Tameside illustrating the position of GP practices across Lower Super Output Areas (LSOA)



This map illustrates the 31 GP practices across the area. The darker the area (LSOA) the more deprived the LSOA is.

Population

The Office of National Statistics (ONS) Mid-Year population estimates 2023 identifies there are 234,666 usual residents of Tameside, who usually live at an address within the authority. As of June 2025 the number of people registered at GP practices in the Tameside area was lower, at approximately 228,810, suggesting around 2.5% of the resident population are registered with GPs outside Tameside.

More people now live in Tameside than at any time in the past, with population projections estimating that this will continue to increase over the next 20 years.

The ethnic composition of the Tameside population is also changing, with the census 2021 highlighting that 18% of the local population are from an ethnic minority community (82% of the population identify as White British).

Health & Well-being

The issues for health & wellbeing in Tameside are complex and often lie outside the traditional health and care services. It is widely recognised that social and environmental determinants and their interdependencies influence the health and wellbeing outcomes of our population and communities.

As the population continues to grow, age and change, so too will the demand for health and care services across the area, thus a need to enable our population to live as long as possible in good health, free from illness and disability. This will ensure services can cope with increased demand and that health and care are affordable to the local economy.

Changes in the ageing population are currently contributing to the increased demand on health and care services. People in Tameside are now living longer than they have ever done. However, this longer life is not always in good health so the demands on services that support people with long term health and care will continue as people live longer and the dynamics of the ageing population changes. The number of carers will also increase as more people live longer and therefore it is important to have responsive flexible arrangements in place to support people caring for others and to support people who want to live independently; this will create an health and care culture where the need for secondary hospital services are a last resort.

Demand for early years and school age children's services is also on the increase, in the calendar year 2024 there were 480.5 children in need per 10,000 children, 3,797 referrals to children's social services, 392 children with child protection plans in place and 645 looked after children. Therefore children's services will need to adapt and respond to take into account the changing diversity of the population going forward.

Health and Well-being at a glance

- The health and well-being of people in Tameside is improving but slowly and is generally worse than the England average.
- Life expectancy at birth in Tameside for both males and females is lower than the England average (**76.5 years** for **males**, **80.6 years** for **females** 2021-2023) (England average=78.7 for males: 83.2 for females).
- Locally Life expectancy varies widely across geographic areas and in some areas was **9.8 years** lower for **men** and **9.3 years** lower for **women** in the most deprived areas of Tameside compared to the least deprived areas, as of 2021-23.

- Healthy life expectancy at birth in Tameside as of 2021-23 was **55.6 years** for **males** (ranked 9th in Greater Manchester) and **56.2 years** for **females** (ranked 9th in Greater Manchester). Both are significantly lower than the England averages.
- Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average.
- Deaths from cardiovascular disease in 2021-2023 shows that 613 people (rate of 100.3 per 100,000 population) in Tameside died prematurely, significantly higher than the England average rate (77.1 per 100,000 population).
- Deaths from Cancer in 2021-2023 shows that 853 people (140.2 per 100,000 population) in Tameside died prematurely, significantly higher than the England average (121.6 per 100,000 population).
- Deaths from Respiratory disease in 2021-2023 shows that 288 people (47.5 per 100,000 population) in Tameside died prematurely, higher than the England average (33.3 per 100,000 population).
- Deaths from liver disease in 2021-2023 shows that 163 people (26.5 per 100,000 population) in Tameside died prematurely, higher than the England average (21.5 per 100,000 population)

More Information at a glance Public Health Outcomes Framework -Tameside Health Profile - National General Practice Profiles - Data - OHID (phe.org.uk)-- Tameside Child Health profile Older people's health & wellbeing

Inequalities

Tameside's health and care system is split into four neighbourhoods or Primary Care Networks; North (Ashton), West (Denton), South (Hyde) and East (Stalybridge), with 31 general practices serving the four neighbourhoods in total. Of the 31 practices all were more deprived than the England averages, with 18 practices (58%) being more deprived than the Tameside average. There are five practices in Tameside that fell into the 10% most deprived practices in the country as of 2019 (Hattersley Group Parctice, Ashton GP services, West End medical centre, Gordon Street medical, Stamford House). These practices are in the neighbourhoods of North (Ashton) and South (Hyde).

Tameside is also broken into 19 wards. Health and Wellbeing outcomes across these wards varies considerably with poor health outcomes such as disaese prevalence and premature mortality being significantly higher in the ward of St Peters.

In England, the cost of treating illness and disease arising from health inequalities has been estimated at £5.5 billion per year. In terms of the working-age population, it leads to productivity losses to industry of between £31–33 billion each year. Through lost taxes and higher welfare payments. Estimates equate that health inequalities cost in the region of £28–32 billion Estimating the cost of health inequalities.

Best Start in Life

The early years are a key determinant of health. The Marmot Review recognised this in its priority policy objective - *'Give every child the best start in life'* - which is crucial to reducing health inequalities across the life course, and other social and economic inequalities throughout life.

The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being - from obesity, heart disease and mental health, to educational achievement and economic status.

The following information is important for Tameside across the early years as they highlight the challenges and priorities. More statistics and information can be found here Child and Maternal Health - OHID

Population of children under 5 years

Of those aged 4 and under, across Tameside there are approximately 13,205 children resident in the borough according to the mid-year estimate 2023 and 11,599 registered with a GP practice in 2024.

Births per year in Tameside increased to a peak of 3,138 in 2010 and have fallen gradually since then. In 2024 there were 2,508 babies born in Tameside. 7.5% of babies were born with a low birth weight (<2,500 grams) in 2024 and the highest proportion of births were born to mothers aged 25-34 years (63%). In 2024, 2% of babies were born to mothers aged 19 and under and 20.3% to mothers over the age of 35 years. Additionally in 2024, following the trend for the last 10 years, birth rates were higher in Tameside amongst the most deprived deciles in England.

Children in low income families

Challenge

Deprivation is higher in Tameside with approximately 11,429 (24.9%) children under 16 years living in relative poverty, and 7,999 (17.4%) children living in absolute poverty which is based on whether households have less than 60% of the current median household income to live on after housing costs. (2021/22). Child poverty levels vary across Tameside. The Chart below illustrates ward level child poverty levels as of 2019.

Figure 1: Levels of child poverty across Tameside wards *Source: Office for Health Improvement and Disparities (OHID) Local Health, Fingertips*

Child Poverty, Income deprivation affecting children index (IDACI) New data 2019 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	1,777,642	17.1	17.1	17.1
Tameside	–	9,741	22.3	21.9	22.7
St Peter's	–	905	30.3	28.7	32.0
Longdendale	–	485	28.5	26.4	30.7
Hyde Godley	–	727	27.9	26.3	29.7
Ashton St Michael's	–	707	27.3	25.7	29.1
Ashton Hurst	–	661	27.3	25.5	29.1
Dukinfield	–	610	24.5	22.9	26.3
Stalybridge North	–	628	24.5	22.9	26.2
Droylsden West	–	557	24.2	22.5	26.0
Denton South	–	433	23.3	21.5	25.3
Ashton Waterloo	–	473	22.2	20.5	24.0
Hyde Newton	–	651	22.0	20.5	23.5
Droylsden East	–	446	21.3	19.6	23.1
Stalybridge South	–	404	18.6	17.0	20.3
Denton North East	–	338	17.7	16.0	19.4
Hyde Werneth	–	416	17.1	15.7	18.7
Mossley	–	359	16.1	14.6	17.7
Dukinfield Stalybridge	–	305	15.6	14.1	17.3
Audenshaw	–	324	15.5	14.0	17.1
Denton West	–	311	14.0	12.6	15.5

Implications

The [Marmot Review 10 years on (2020)] suggests that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. Children born in the poorest areas of the UK weigh, on average, 200 grams less at birth than those born in the richest areas. Children from low income families are more likely to die at birth or in infancy than children born into richer families. They are also more likely to suffer chronic illness during childhood or to have a disability.

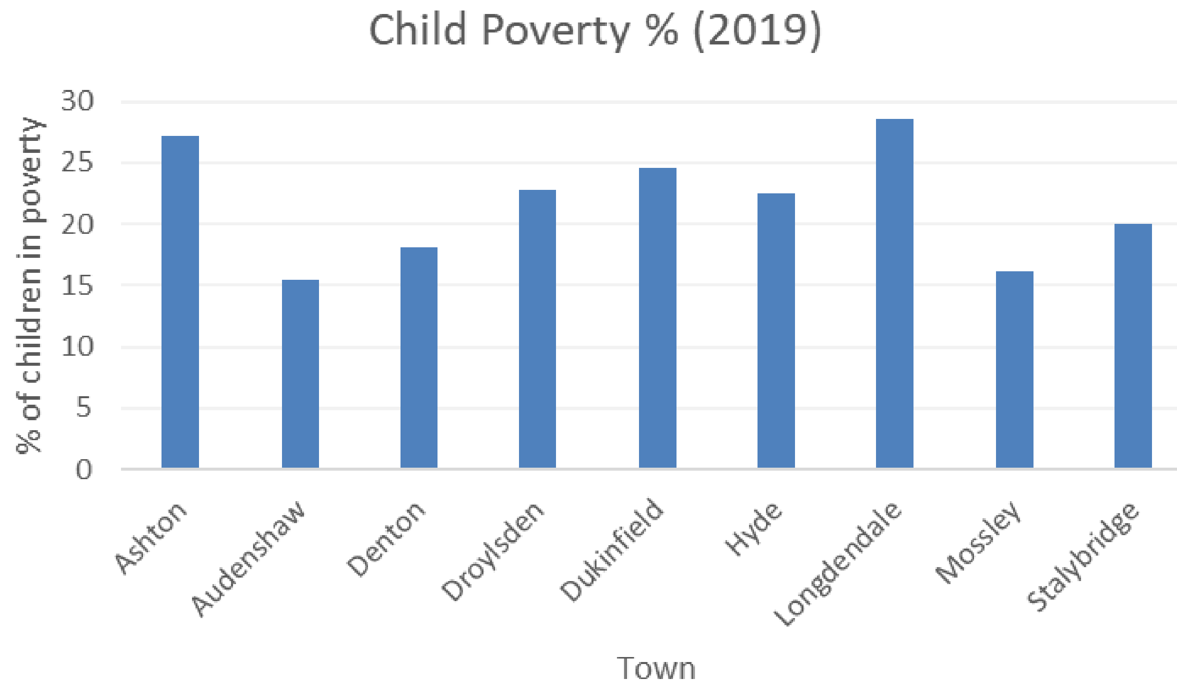


Figure 2: Levels of child poverty within the 9 Tameside Towns *Source: Office for Health Improvement and Disparities (OHID) Local Health, Fingertips*

Tameside 9 Towns Summary

Ashton and Longdendale exhibit the highest child poverty rates within Tameside, at approximately 27% and 29% respectively. In contrast, Audenshaw and Mossley report the lowest rates, both around 15%. The remaining towns—Denton, Droylsden, Dukinfield, Hyde, and Stalybridge—fall within a mid-range, with poverty levels between 20% and 23%. This distribution highlights notable disparities in child poverty across the region, with some towns experiencing nearly double the rates of others.

Recommendations

Increase opportunities for parents to work and to work in well paid employment. Support parents from more deprived backgrounds at the pre-birth stage more. Reduce smoking in pregnancy, increase pre-birth health visiting visits to parents to be, from the most deprived backgrounds to ensure they are fully prepared for birth.

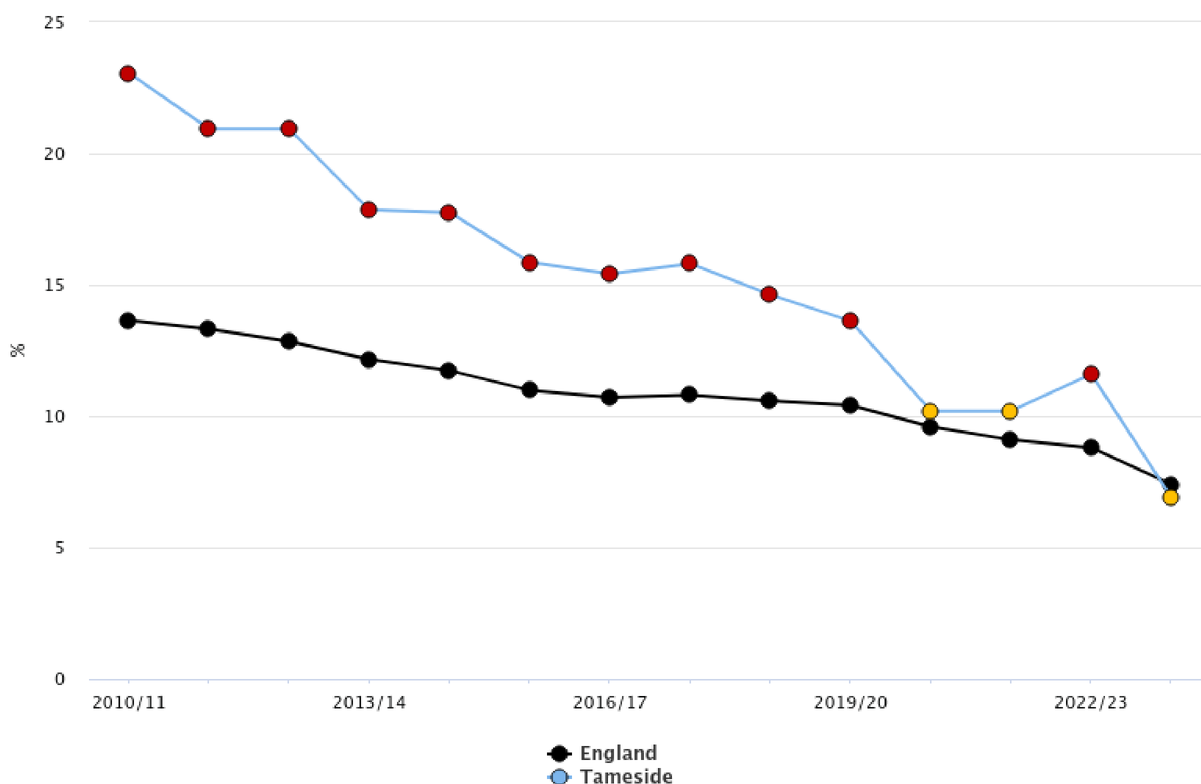
In 2019 the UCL Institute of Health Equity was asked to support Greater Manchester to become the first Marmot City Region. The motivation for this was to assess what more Greater Manchester could do to address health inequalities in the city-region and to further develop system-wide approaches. Marmot principles had been used to inform Greater Manchester's new unified public services model, but the ambition in 2019 was to develop these further and incorporate new approaches outlined in the 2020 update of the Marmot Review – Health Equity in England: The Marmot Review 10 years on. Read the Marmot Greater Manchester Evaluation 2020 Here.

Smoking at Time of Delivery (SATOD)

Challenge

Smoking in pregnancy in 2023/24 has declined again sharply after a sudden rise the previous year, and is now below the England average with only 6.9% of women still smoking at time of delivery (7.4% for England and 7.7% Greater Manchester average).

Figure 3: Trends in smoking in pregnancy *Source:OHID, Fingertips*



Implications

Smoking during pregnancy is related to many effects on health and reproduction, in addition to the general health effects of tobacco. A number of studies have shown that tobacco use is a significant factor in miscarriages among pregnant smokers, and that it contributes to a number of other threats to the health of the foetus, such as premature birth, complications in birth, still birth, low birth weight, asthma and other respiratory conditions and sudden infant death.

Recommendations

Identify pregnant women who smoke at the earliest opportunity. Ensure clear advice to smoking pregnant women is clear in respect of the implications of continuing smoking. Use Nicotine Replacement Therapy (NRT) or other pharmacological support. Work with the whole family re stop smoking through relevant interventions locally

Obesity in Pregnancy

Challenge

The national increase in obesity is reflected in increasing numbers of women with raised BMI becoming pregnant.. As of 2018/19 26.3% of pregnant women in Tameside were obese (BMI>=30kg/m2) at the time of booking appointment with their midwife. The 2nd highest level in Greater Manchester

Figure 4: Levels of obesity in pregnancy across Greater Manchester (2018/19) *Source: OHID Fingertips*

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	22.1	21.9	22.3
CA-Greater Manchester	-	-	-	-
Wigan	-	27.0	25.0	29.0
Tameside	-	26.3	24.5	28.2
Bolton	-	26.1	24.7	27.5
Oldham	-	24.8	23.3	26.3
Rochdale	-	24.0	22.3	25.6
Salford	-	23.5	22.1	24.9
Bury	-	22.6	20.8	24.4
Manchester	-	22.0	20.8	23.2
Stockport	-	20.1	18.8	21.5
Trafford	-	19.0	17.5	20.6

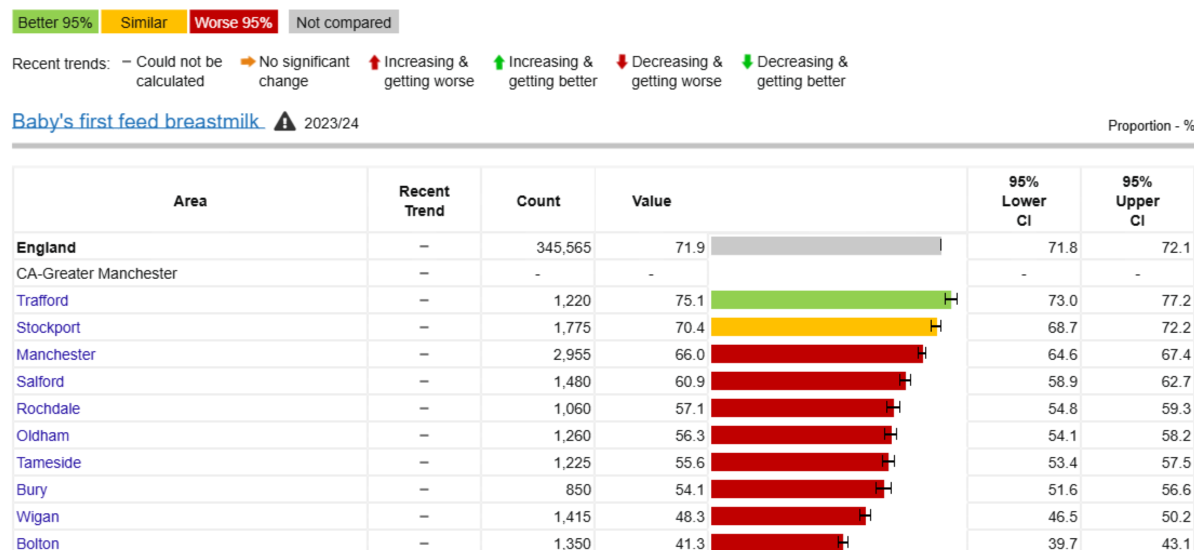
Implications

Mothers who are overweight or obese have increased risk of complications during pregnancy and birth including diabetes, thromboembolism, miscarriage and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity.

Recommendations

It is important that women are aware of the increased risk of maternal and foetal complications associated with obesity, and they should be advised about the possible strategies to minimise them prior to conception. All commissioners and providers should aim to implement NICE Guidance on weight management before, during and after pregnancy PH27. A particular emphasis of this guidance is on weight optimisation BEFORE pregnancy and if that was missed or was unsuccessful, the other opportunity would be in after delivery.

Babies first feed (Breast milk)



Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Baby's first feed breastmilk 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	345,565	71.9	71.8	72.1
CA-Greater Manchester	–	-	-	-	-
Trafford	–	1,220	75.1	73.0	77.2
Stockport	–	1,775	70.4	68.7	72.2
Manchester	–	2,955	66.0	64.6	67.4
Salford	–	1,480	60.9	58.9	62.7
Rochdale	–	1,060	57.1	54.8	59.3
Oldham	–	1,260	56.3	54.1	58.2
Tameside	–	1,225	55.6	53.4	57.5
Bury	–	850	54.1	51.6	56.6
Wigan	–	1,415	48.3	46.5	50.2
Bolton	–	1,350	41.3	39.7	43.1

Figure 5: Greater Manchester comparison- Babies first feed (Breast milk) *Source: OHID, Fingertips*

Challenge

The proportion of new mums initiating breast feeding in Tameside in 2023/24, was 55.6%. This is lower than the England average. (71.9%).[1]

At 6 to 8 weeks, breast feeding decreases with 38.7% of babies being breast fed in Tameside (2023/24). This is lower than the England average of 52.7%.

Implications

Evidence is clear on the benefits to health of breast feeding for both mother and infant. In the short term babies who are not breast fed are more likely to have infections such as gastroenteritis, respiratory and ear infections and are at particular risk of hospitalisation. The infant feeding profile for Tameside supports this as emergency hospital admissions for gastroenteritis and respiratory infections are significantly higher than the England average. In the long term, evidence shows that non-breast fed babies are more likely to be overweight or obese-this can then lead to type 2 Diabetes, higher blood pressure and cholesterol.

Recommendations

NICE guidance to improve breast feeding rates recommends commissioners to:

- Adopt a multi-layered approach or a coordinated programme of interventions across different settings
- Activities to raise awareness of the benefits of, and how to overcome the barriers to, breastfeeding
- Training for health professionals, Joint working between health professionals and peer supporters
- Breastfeeding peer-support programmes
- Education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period
- Work with local partners to ensure mothers can feed their babies in public areas.

[1] Data quality issues reported with this measure.

Child Development at 2 to $2^{1/2}$ years

Challenge

The Ages and Stages Questionnaire-3 (ASQ-3) covers five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development

The proportion of children aged 2 to $2^{1/2}$ yrs. offered ASQ-3 as part of the healthy child programmes (2023/24) was 99.1% for Tameside and 93.3% for England.

Data from the health visiting submission 2023/24 shows that overall 81.6% of 2 to $2^{1/2}$ year olds reached the expected level of development across all five domains. This has risen and is now again above the England average.

Figure 6: Overall Child development outcomes for Tameside compared to England *Source: ONS*

Year	Tameside	GM	England
2021/22	81.5	73.6	81.1
2022/23	78.1	76.6	79.2
2023/24	81.6	78.4	80.4

(Note that the figure for Greater Manchester for 2021/22 is excluding Bury and Rochdale so is not directly comparable to other years)

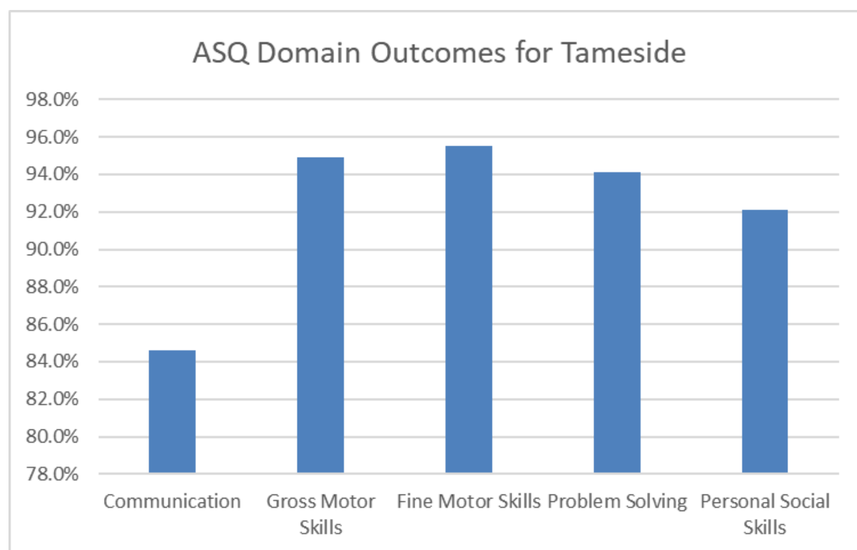


Figure 7: ASQ Outcomes across the five domains 2023/24 *Source: ONS*

The chart shows that the lowest level of achievement was across the communication skills domain where 84.6% of children in this cohort reached the expected level. This means that around 309 children didn't meet the expected level of communication in 2023/24

Implications

Children aged 2 to $2^{1/2}$ years should be offered ASQ-3 as part of the healthy child programme. This measure is important to help monitor child development in order to observe and track changes in outcomes over time. This measure will also help assess the effectiveness and impact of services for 0-2 year olds. The ASQ-3 health and development review is an important way to see how children have developed at this stage of childhood and is a good indicator of potential outcomes later on in childhood such as school readiness.

Recommendations

The ASQ-3 should now be an integral part of the healthy child programme and health visiting services locally. All children should be assessed and health visitors should encourage parents to complete the assessment and offer support to parents who need help to complete the assessment.

The results of ASQ-3 assessment should be used to improve outcomes for children. Locally services to improve child development should be available to support parents and children to improve the areas within ASQ-3, communication, fine & gross motor skills, personal/social skills and problem solving.

Childhood vaccination coverage - (5 years old)

Challenge

The first MMR vaccine is given to children as part of the routine vaccination schedule, usually within a month of their first birthday. They'll then have a booster dose before starting school, which is usually between three and five years of age. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

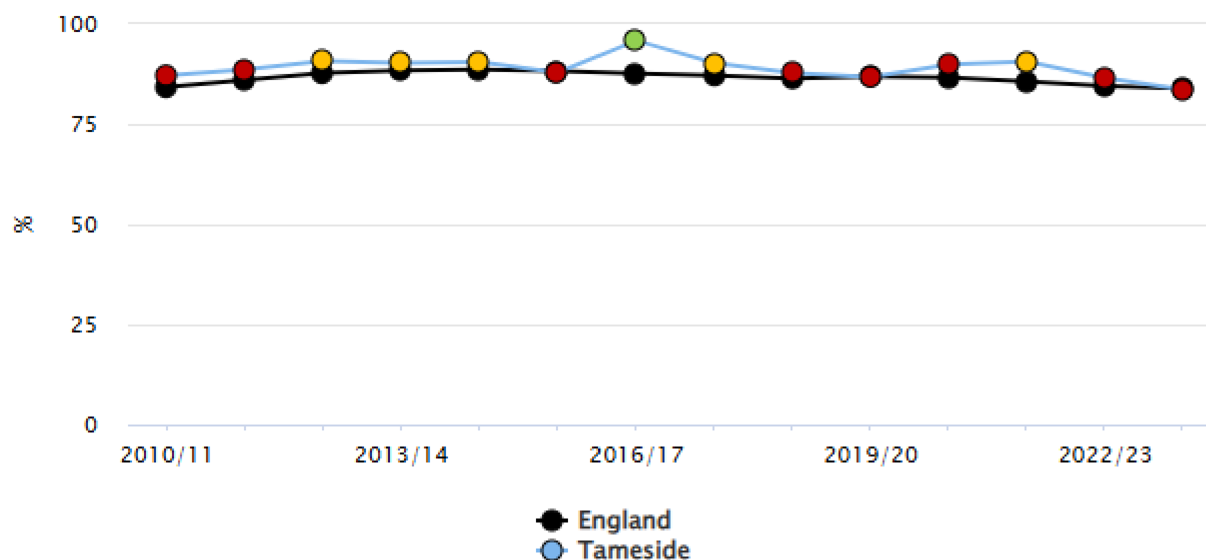


Figure 8: Trends in MMR for two dose (5 years old) coverage *Source: PHE Fingertips*

The chart opposite (figure 7) illustrates the trends in MMR vaccination coverage for two doses at age 5 years. It shows that Tameside's rate has continued to fall in recent years and is now lower than England's

However the remaining gap in coverage means that some children have missed out and may remain vulnerable to serious or even fatal infections that are vaccine-preventable.

Implications

MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

Recommendations

Previous evidence shows that promoting vaccination programmes encourages improvements in uptake levels so continuing to promote information on vaccine safety and effectiveness to tackle concerns about misinformation is key to improving coverage. It is also important to monitor where locally vaccination uptake is low to enable the planning and implementation of a catch up programmes. More convenient appointment times for parents could also help improve coverage. The introduction of new 'primary care networks' nationwide – groups of GP surgeries joining up to help their communities – could mean more access to evening and weekend appointments.

School Readiness

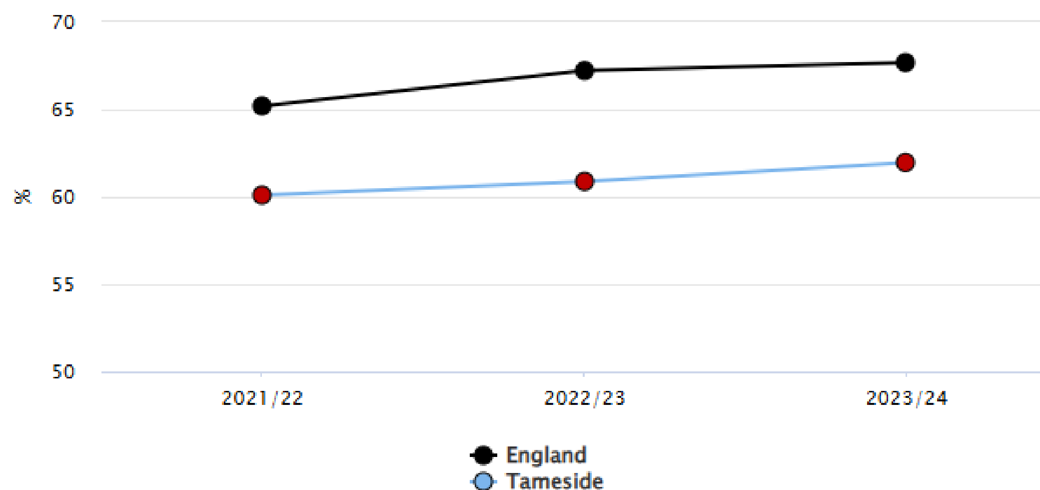


Figure 8: Trends in the proportion of children achieving a good level of development (reception) *Source: PHE Child Health Profiles*

Challenge

The percentage of children achieving a good level of development at the end of reception for 2023/24 shows that Tameside's results have improved again after declining during covid so hopefully this will prove temporary. 2023/24 results show that 62% of children at the end of reception are ready for school based on the early years foundation stage (EYFS). The Early Years Foundation Stage sets the standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe.

Tameside is still significantly worse than the England average with 38% of reception aged children not meeting the required levels of development. The chart above (figure 8) clearly illustrates the previous improvement in school readiness across Tameside and a closing of the gap between Tameside and the England average. However both have fallen significantly during the pandemic.

The chart on the next page (figure 9) illustrates the variation of communication, language and literacy skills across Greater Manchester. The chart shows that Tameside has the 5th lowest level of achievement in Greater Manchester and is clearly worse that the England average.

School readiness: percentage of children achieving a good level of development at the end of Reception 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	411,626	67.7	67.6	67.8
CA-Greater Manchester	–	22,141	63.6	63.1	64.1
Trafford	–	2,007	72.6	70.9	74.3
Stockport	–	2,239	68.7	67.1	70.3
Bury	–	1,404	65.0	63.0	67.0
Wigan	–	2,304	63.9	62.3	65.4
Bolton	–	2,470	63.8	62.2	65.3
Oldham	–	2,038	63.6	61.9	65.3
Rochdale	–	1,834	62.2	60.4	63.9
Tameside	–	1,720	62.0	60.1	63.7
Salford	–	2,034	60.7	59.0	62.3
Manchester	–	4,091	59.6	58.4	60.7

Figure 9: Communication, language and literacy skills at the end of reception *Source: OHID early years profile*

Implications

94% of children who achieve a good level of development at age 5 go on to achieve the expected level of achievement at key stage 1 and 5 times more likely to achieve the highest level . Children who start off in the bottom 20% of development at 5 years are six times more likely to be in the bottom 20% at key stage 1.

Disparities in child language capabilities are recognisable in the second year of life and are clearly having an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential.

Recommendations

There is not one enabler to improve school readiness at age 5 years but many.
3 main evidence based enablers that will improve outcomes at age 5 for children include

- A good early years home learning environment
- Access to good quality pre-schools
- Access to effective primary schools

'What parents DO is more important than who parents are'. http://www.instituteofhealthequity.org/resources-reports/measuring-what-matters-a-guide-for-childrens-centres/measuring-what-matters.pdf

The Office for Health Improvement and Disparities has been allocated funding to train Health Visitors in the use of a new communication and language assessment tool to identify problems at 2 to 2 1/2 years, and to arrange interventions where children are below expected level of development in this area.

As part of the Department for Education (DfE) plan for improving social mobility through education, their ambition to close the 'word gap' focusses on the development of key early language and literacy skills for pupils who are disadvantaged or not achieving their full potential.

Information at a glance

More information about health protection and vaccinations can be found here..

More information on health and care outcomes for the 'Very best Start' can be found here

Opportunity to learn and earn

A recent study from the Prince Trust showed that around three quarters of a million young people in the UK may feel that they have nothing to live for. Our children and young people's futures are at the forefront of national and local policy. Our aspiration is to ensure that Tameside is the best place for our children to grow up. We want our children and young people to be successful learners, healthy and well and confident individuals. Our vision is that together we will realise aspiration, hope and equality for all.

Educational Attainment

Challenge

In 2024 the average Attainment 8 score of pupils in Tameside is slightly below the England average and similar to our statistical neighbours. **42.8** (Tameside), 43.1 (stat neighbours), 46.1 (Eng.). For some children inequalities exist in achieving GCSEs:

- Young people in care in Tameside averaged Attainment 8 scores of 16.5
- Young people in need in Tameside averaged Attainment 8 scores of 19.9
- Pupils from ethnic minority groups fare better than British white pupils (see table below)
- Girls fare better than boys across all ethnic groups, with the exception of those from mixed backgrounds where boys were higher
- Young people on free school meals in Tameside averaged Attainment 8 scores of 33.4
- Young people with an Educational Health Care plan (EHC) in Tameside averaged Attainment 8 scores of 8.7
- Young people receiving SEN support in Tameside averaged Attainment 8 scores of 28.4

Attainment 8 Scores By Ethnic Group (2024)	
Ethnicity	Average Attainment 8 Score
South Asian	49.9
Chinese	64.5
Black/African	50.1
Mixed	43.9
White	41.1

Figure 10: Attainment 8 scores by ethnic group *Source: LAIT*

Implications

A good level of education gives young people the opportunity to earn more and be in more fulfilling careers/jobs. Ensuring children and young people are literate and numerate will also enable them to navigate their way through adulthood better, In the competitive job market, academic and vocational qualifications are increasingly important. Those without qualifications are at higher risk of unemployment and low incomes. More generally, success in acquiring formal qualifications strengthens children's self-esteem and enhances development of identity.

Recommendations

Access to good quality educational establishments and educational teaching is important to ensure all children get a consistent standard of education no matter where they live or go to school. So ensuring all Tameside schools are Ofsted rated 'Good' or above is important.

Reducing the gap between all student attainment and those children that are disadvantaged is important to improving overall standards and reducing inequalities. Understanding the barriers to learning of disadvantaged children and their educational attainment is important while ensuring disadvantaged children have stable schooling. Ensuring children's progress is tracked and intervening where necessary and offering personalised support at school - including one-to-one tuition wherever appropriate is available. Improved access to high quality early years provision for disadvantaged children is essential in ensuring these children in particular start their formal education on a level platform with their peers.

Ensuring children are ready for school at age 5 will ensure no children are disadvantages or left behind and ensuring all children with special educational needs receive the support needed to enable them to learn will also impact on overall educational outcomes for children.

Special Educational Needs and Disability (SEND)

Challenge

There are legal definitions of Special Educational Needs and Disabilities (SEND). A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made. This means they have a significantly greater difficulty in learning than the majority of others of the same age or have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

In 2024 there were 7,660 children and young people aged 0 to 25 years with SEND in Tameside. Of this number, 74% (5,683) are in receipt of SEN support and 26% (1,977) have an EHC plan.

2024	Males	Females	Total
ECH Plan	1461 (74%)	516 (26%)	1977
SEN Support	3479 (61%)	2204 (39%)	5683
Total	4940	2720	7660

Figure 11: Total size of SEND population (0 to 25 years) in Tameside *Source: School Census*

Implications

All children and young people should expect to receive an education that enables them to achieve the best possible educational and other outcomes, and become confident, able to communicate their own views and ready to make a successful transition into adulthood, whether into employment, further or higher education or training.[2]

Recommendations

Identifying children and young people who are struggling is vitally important – with early identification we can make sure that children and young people get the interventions they need at the earliest opportunity. All educational establishments should therefore have a clear approach to identifying and responding to SEN. The benefits of early identification are widely recognised – identifying need at the earliest point and then making effective provision improves long-term outcomes for the child or young person. For a more comprehensive review of SEND in Tameside, the SEND Joint Strategic Needs Assessment 2024-2027 is available, with more detailed recommendations.

[2] Blanden, Hansen & Machin, 2008

Employment and Unemployment

Challenge

Across Tameside between April 2023 and March 2024 there were 106,800 people in employment, 4,000 people unemployed, and 14,000 people on long term sick. In 2022 there were 10,700 workless households.

The chart below (figure 17) illustrates the proportion of economically active, employed and unemployed people in Tameside compared to Greater Manchester and England. The chart illustrates that economically activity is similar to the England and Greater Manchester averages.

Indicator	Period	Tameside			Greater Manchester	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Percentage of people in employment (Persons, 16-64 yrs)	2023/24	→	103,300	75.2%	-	75.7%	61.6%		[illegible]
Employment deprivation: score	2019	–	-	0.143	-	0.099	0.209		0.019
Economic inactivity rate (Persons, 16-64 yrs)	2023/24	→	30,800	22.4%	-	21.2%	33.5%		[illegible]
Unemployment (model-based) (Persons, 16+ yrs)	2023	–	3,300	3.0%	-	3.7%	7.2%		2.2%
Long term claimants of Jobseeker's Allowance (Persons, 16-64 yrs)	2023	↓	112	0.8	-	0.9	3.3		0.0

Figure 17: Employment and Unemployment rates across Greater Manchester *Source Office for Health Improvement and Disparities, Fingertips:*

Implications

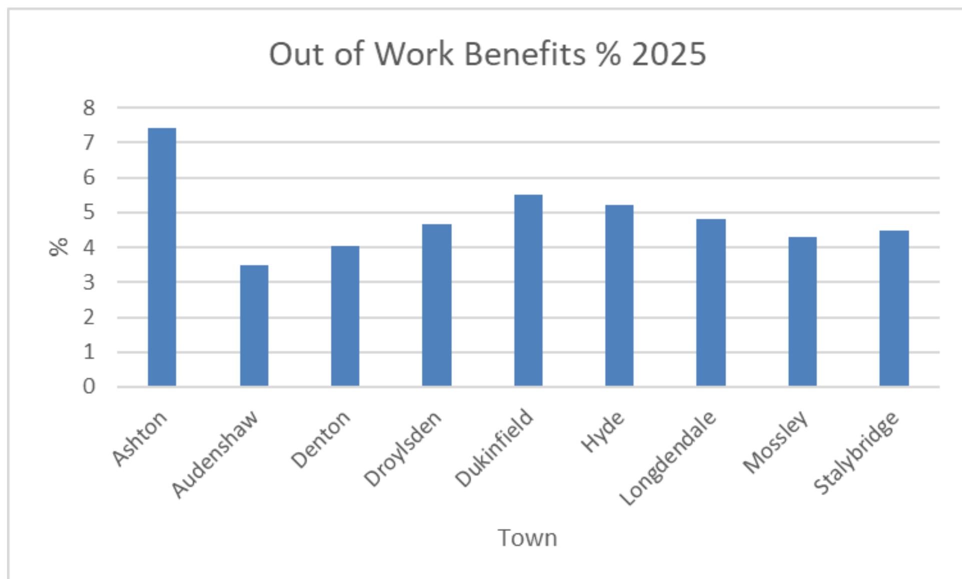
Increasing employment and supporting people into work are key elements of the UK Government's public health and welfare reform agendas. There are economic, social and moral arguments that work is the most effective way to improve the well-being of individuals, their families and their communities. There is also growing awareness that (long-term) worklessness is harmful to physical and mental health, so the outcome might be assumed – that work is beneficial for health.[3]

Employment is generally the most important means of obtaining adequate economic resources, which are essential for material well-being and full participation in today's society.

Employment and socio-economic status are the main drivers of social inequalities in physical and mental health and mortality. Conversely, there is a strong association between worklessness and poor health. There is strong evidence that unemployment is generally harmful to health, including: higher mortality; poorer general health, long-standing illness, limiting longstanding illness; poorer mental health, psychological distress, minor psychological/psychiatric morbidity; higher medical consultation, medication consumption and hospital admission rates.[4]

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209510/hwwb-is-work-good-for-you-exec-summ.pdf
[4] IS WORK GOOD FOR YOUR HEALTH AND WELL-BEING? Gordon Waddell, A Kim Burton 2006

Figure 18: Percentage by Town of Those in Receipt of Out of Work Benefits *Source: NOMIS*



Tameside 9 Towns Summary

Ashton has the highest rate of adults on out of work benefits at 7.4%. In contrast Audenshaw has the lowest at 3.5%. Besides Dukinfield at 5.5%, the remaining towns – Denton, Droylsden, Hyde, Longdendale, Mossley, and Stalybridge, fall into a middle range of between 4 and 5%. This highlights significant disparities in out of work benefits rates across the borough, with one town having more than twice the rate of another.

Recommendations

We can influence people's employment opportunities in many ways, through adopting 'good' employment practices with our own organisations and using the 'Social Value Act' to maximise equitable employment opportunities. Social Value Act

Focus on young people classed as NEET and those least likely able to access the job market. Improve the health of direct employees; Champion and improve the take up of 'supported employment' and job retention schemes for people with learning disabilities and mental health issues; Champion employment issues within Health & Wellbeing Boards; Support and challenge local businesses through business in the community and other schemes and help more people be 'Fit for Work'

Quality of Work

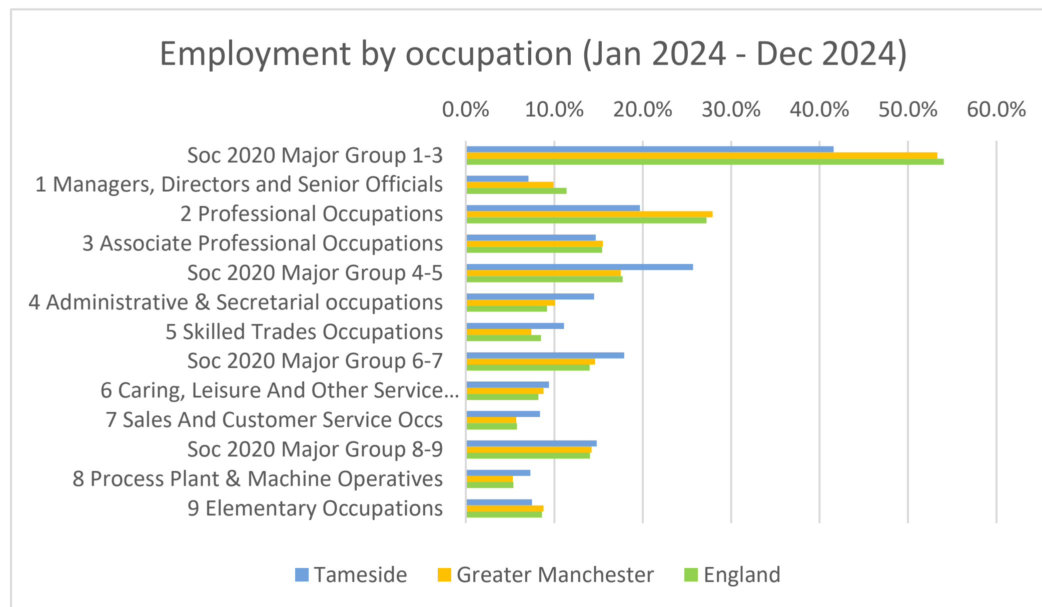


Figure 19: Employment by occupation (2023/24) *Source: NOMIS*

Challenge

The North represents 30% of England's population but has 50% of the poorest neighbourhoods, Tameside being in this 50%.[5] The chart below (figure 18) illustrates the types of occupations people are employed in. It shows that Tameside has less people working in SOC groups 1-3 when compared to Greater Manchester and England. Tameside has higher levels of people working in SOC 4-7 occupations, in particular administrative, skilled trades, caring and service occupations and sales/customer service. Over all 46% of the working population of Tameside work in industries SOC occupations four to seven.

Implications

Poor neighbourhoods in the North tend to have worse health than places with similar levels of poverty in the rest of England. The conditions in which people work have a large impact on health: Good quality jobs can be protective of health, whereas poor quality work can be adverse for health. Poor quality jobs are an issue for health inequalities as they are concentrated at the lower end of social deprivation.[6]

The nature of work affects health inequalities because health-adverse work conditions are concentrated in more disadvantaged social groups.[7] One of the Marmot Review's policy objectives to tackle inequalities in the social determinants of health is to create fair employment and good work for all. Two other related Marmot Review policies are: ensuring a healthy standard of living and creating and developing healthy and sustainable places and communities. The former is closely related to pay, while the latter is closely related to skills basis and local inequalities.

Tameside 9 Towns Summary

Ashton has the lowest proportion of Groups 1-3 at 14%, whilst Mossley has the highest at 24%, the other towns falling into a range of 16-20% (except Audenshaw being slightly higher and Dukinfield slightly lower. Audenshaw has the highest rate of people in Groups 4 and 5 at 12%, and Ashton the lowest at 9%, the rest being around 11% except for Denton being slightly higher and Dukinfield slightly lower. Groups 6 and 7's highest proportion is in Dukinfield at 10%, with Audenshaw being at 8%, the rest being around 9% except Denton and Droylsden are slightly higher and Mossley slightly lower. Ashton had the

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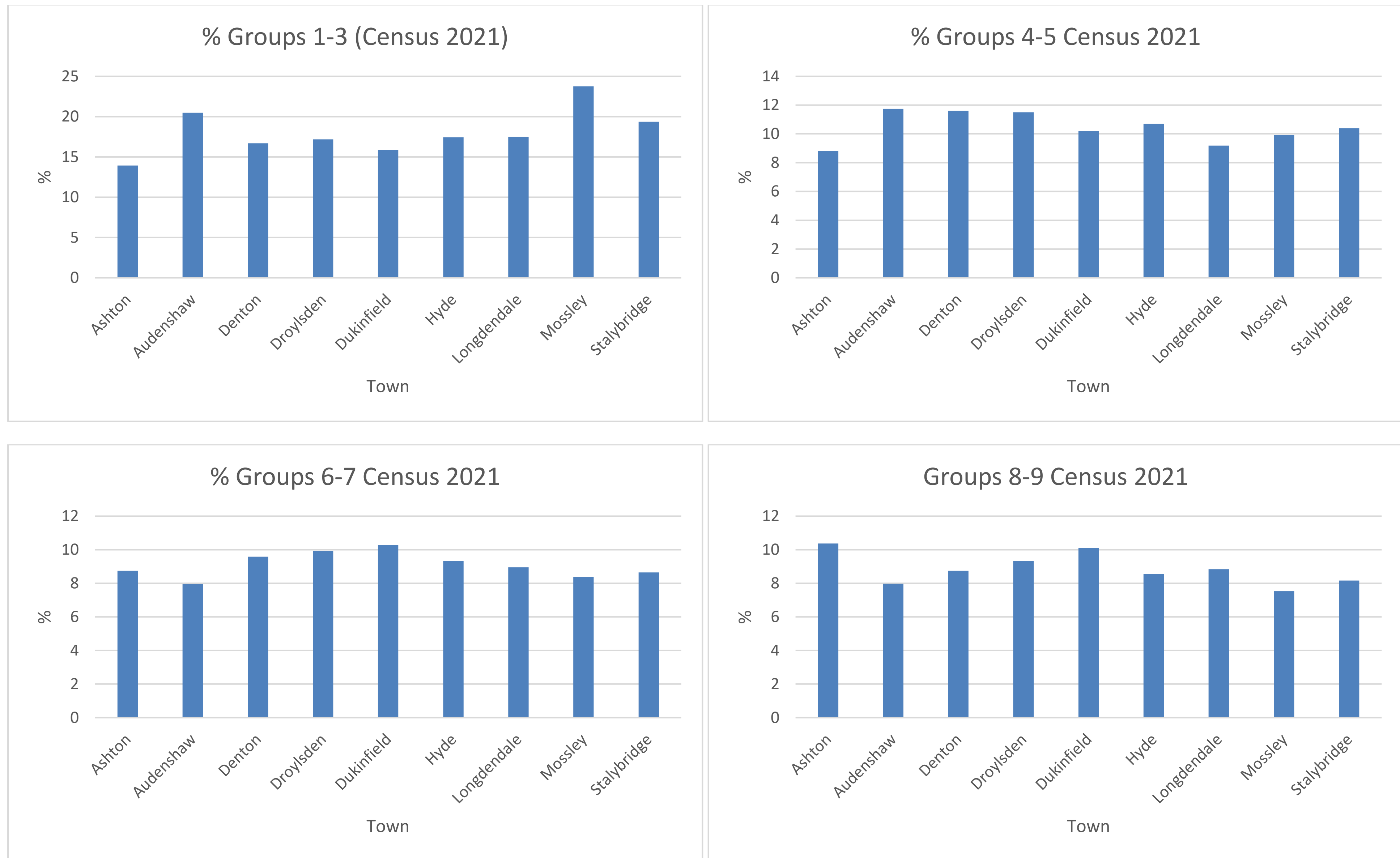
5 http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-promoting-good-quality-jobs-to-reduce-health-inequalities-
6 http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-promoting-good-quality-jobs-to-reduce-health-inequalities-
7 The Marmot Review Team. Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010. London: Marmot Review Team, 2010. 2

highest rate of people in Groups 8 and 9 at 10%, with Dukinfield being about the same and Mossley the lowest at 8% along with Stalybridge and Audenshaw, the rest clustering at 9%. This shows a disparity in the borough as to the occupations of people in each town, especially with more professional occupations, with Mossley and Audenshaw tending to have the most professionals fewest in elementary occupations and Ashton and Dukinfield vice versa.

Figure 20: Employment by occupation group (2021) *Source: NOMIS Census 2021 Data*



Recommendations

There is no generally accepted definition of good work but there are a range of features commonly associated with good jobs: adequate pay; protection from physical hazards; job security and skills training with potential for progression; a good work-life balance and the ability for workers to participate in organisational decision-making. Skilled work typically has more protective elements and less health-adverse conditions.[8]

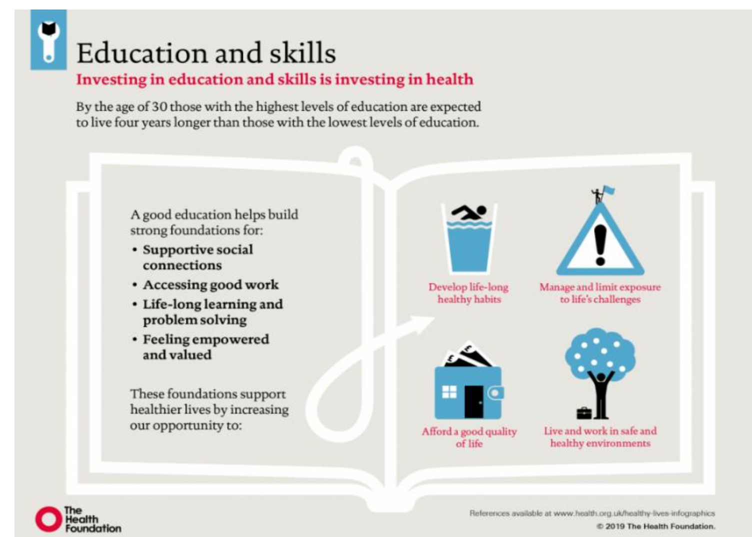
To develop better jobs for our local population, local partnerships need to draw on what is known about the features of good and poor quality work, and learn from emerging strategies that promote good quality jobs with employers. A range of strategies should be used to focus on improving the quality of new and existing low-skilled jobs.

Working to improve the skills base of people in the Tameside labour market may help to attract more skilled employment to the area, and contribute to improving the quality of work. This is particularly important in more economically deprived areas such as Tameside, where a skills deficit already exists and sits side by side with greater health inequalities.

[8] http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-promoting-good-quality-jobs-to-reduce-health-inequalities-

Skills and Qualifications

Challenge



The economic wellbeing of an area is integral to the health of the local population. Skills and qualifications have a considerable influence on the risk of poverty, affecting both employment and pay. Those with higher qualifications are more likely to be employed and to earn more than those without.[9]

In 2021, the proportion of the population aged 16 to 64 years with no formal qualifications in Tameside was 7.5% (10,600 people), this is higher than the England average (6.4%) but lower than the Greater Manchester average (8.3%). Trend data shows that this has been improving over time and is considerably better than 10 years ago.[10]

The proportion of the population who have a level 3 qualification or above in Tameside in 2021 was 49%, this is lower than both the Greater Manchester and England averages (58% & 61.3% respectively). This is the highest level recorded for Tameside.

Implications

Those with no or low skills are far more likely to be in poverty than those with higher levels of skills or qualifications. Over one in three of the working-age population who have no qualifications are in poverty. This figure is just over one in ten for those who have a degree-level qualification.[11]

Skills inequality is one of the drivers of income inequality, which reduces growth and undermines social cohesion. So enhancing skills and educational attainment for poorer households will improve access to stable employment.[12]

Recommendations

It is important to ensure that everyone has the opportunity to enhance their skills, particularly those most distant from the labour market.

Support to employers by better understanding and assessing the skills they need for future success, and ensuring that the supply of skills, training and qualifications can be responsive to this is essential.

Strengthening partnerships and collective responsibility between public, private and third sectors to help improve skills and the contribution they make towards achieving Tameside's social and economic aspirations.

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[9] https://www.jrf.org.uk/data/working-age-poverty-among-people-different-qualification-levels
[10] https://lginform.local.gov.uk/reports/lgastandard?mod-metric=885&mod-period=10&mod-area=E08000008&mod-group=AllSingleTierAndCountyLaInCountry&mod-type=comparisonGroupType
[11] Skills, employment, income inequality and poverty | JRF
[12] Skills, employment, income inequality and poverty | JRF

Inequalities in accessing work

Challenge

One of the important determinants of health inequalities within society is the availability and nature of employment. Employment is linked to the fundamental causes of health inequality – the unequal distribution of income, wealth and power.[13] In terms of employment, people with learning disabilities and mental health conditions appear to be the most disadvantaged group in England.
Figure 19 illustrates the gaps in employment between the general population and those with a mental illness or learning disability. It shows those with a long term physical or mental health condition are more than 13% less likely to be employed and those with learning disabilities over 70%.

Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Proportion of supported working age adults with learning disability in paid employment (%) (Persons, 18-64 yrs)	2019/20	5.6	4.7*	4.6	2.8	0.9	4.0	7.0	4.4	4.5	8.1	10.9	4.5
The percentage of the population who are in contact with secondary mental health services that are in paid employment (Persons, 18-69 yrs)	2021/22	6.0	7.1	11.0	5.0	8.0	3.0	5.0	12.0	4.0	4.0	13.0	5.0
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate (Persons, 18-64 yrs)	2022/23	70.9	-	65.5	79.0	66.9	71.4	61.2	71.5	75.6	68.5	63.0	70.2
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate (Persons, 16-64 yrs)	2022/23	10.4	-	15.4	11.7	13.7	10.2	13.1	8.3	5.9	13.1	10.3	11.2

Figure 21: Employment of people with mental or physical health problem or learning disability: gap in rates (Persons, 16-64 years) *Source: Office for Health Improvement and Disaprities (OHID), Fingertips*

Implications

More disabled people than non-disabled are living in poverty or are materially deprived.[14] UK data from 2017/18 shows that 30% of working-age adults in families where at least one member is disabled were living in households with below 60% of contemporary median income after housing costs, compared with 18% for those living in families with no disabled members.

The disability pay gap in Britain continues to widen. In 2018, median pay for non-disabled employees was £12.11 an hour whilst for disabled employees it was £10.63 an hour, resulting in a pay gap of 12.2%. Disabled young people (age 16-24) and disabled women had the lowest median hourly earnings. Very low numbers of disabled people are taking up apprenticeships, and there has been little improvement in that situation across England.[15]

Recommendations

We need to reduce educational attainment gaps and employment gaps for people with long term conditions and disability, this could be achieved by establishing more effective joined-up employment pathways for people with a disability or long term condition and securing extra resources/funding for disability employability services. Evidence suggests that personalised, tailored support is effective in helping people with disabilities or long-term conditions into work. There is good evidence that individual placement and support programmes are effective for out of work people with severe mental health problems. A 'health-first' approaches that aims to improve health to increase the employability of incapacity benefit claimants is showing early promise.[16]

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[13] http://www.healthscotland.scot/health-inequalities/fundamental-causes/employment-inequality
[14] https://www.base-uk.org/news/disability-employment-gap-report-published
[15] https://www.base-uk.org/news/disability-employment-gap-report-published
[16]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/355781/Briefing5c_Employment_of_disabled_people_health_inequalities.pdf

Sickness Absence

Challenge

From an employer perspective, the benefits of a healthy workforce are clear. Healthy staff are more productive, take less time off sick and do not necessarily need to retire early.

An unhealthy workforce negatively impacts our economy and society due to:

- lost productivity
- a reduction in income tax receipts
- increases in long-term sickness
- increased informal caregiving
- increased healthcare costs

Across Tameside sickness absence is lower at 1.0% when compared to the England and North West averages (1.2% for both), with 1.7% of people here reporting they'd had at least one day off in the previous week (PHOF data 2021-23) compared to 2% in the North West and 2.2% in England However as of 2017-19 people from the most deprived decile in England had lower rates of sickness absence than the average (1.9% vs 2.1%).

Implications

Looking at the wider economy, combined costs from worklessness and sickness absence amount to approximately £100 billion annually, so there's a strong economic case for action. The costs of ill health to the UK government is estimated to be around £50 billion a year, as a result of benefit payments, additional health costs, taxes and national Insurance.[17]

Recommendations

Enabling people with health issues to obtain or retain work, and be productive within the workplace, is a crucial part of the economic success and wellbeing of every community and industry. Collaborative work between partners from across the private, public and third sector is essential for creating pathways to good jobs. Local government plays an important role in bringing these partners together, as well as leading by example within their workforce. Creating healthy workplaces entails supporting disabled people and people with long-term health conditions. It is also important to ensure the health and wellbeing of healthy employees who do not have existing health conditions is maintained, as work and the workplace also play a pivotal role in this.

[17] https://www.gov.uk/government/publications/health-matters-health-and-work/health-matters-health-and-work

Further reading

https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability

https://www.gov.uk/government/topical-events/the-uks-industrial-strategy

https://www.gov.uk/government/publications/movement-into-employment-return-on-investment-tool

https://www.gov.uk/government/publications/workplace-health-needs-assessment

https://www.local.gov.uk/health-work-and-health-related-worklessness-guide-local-authorities

https://www.gov.uk/government/publications/work-worklessness-and-health-local-infographic-tool

https://www.gov.uk/government/publications/work-worklessness-and-health-local-infographic-tool

Safe, green and supportive communities

Healthy Weight

Challenge

The proportion of 4 to 5 year olds (reception) who are of a healthy weight in 2023/24 in Tameside was 77%. This remains lower than the England average but is a continuing improvement. For year 6 (ages 10-11 years), the proportion of young people who are of a healthy weight in 2023/24 in Tameside was 63%, another improvement that remains close to England and Greater Manchester averages.

Figure 22: Reception: Prevalence of overweight (including obesity)2023/24
Source: NCMP

Reception prevalence of overweight (including obesity) 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	123,709	22.1	22.0	22.2
CA-Greater Manchester	↓	6,950	22.1	21.6	22.5
Wigan	→	775	24.2	22.8	25.8
Tameside	→	560	23.3	21.6	25.0
Rochdale	→	645	22.9	21.3	24.4
Manchester	→	1,380	22.7	21.7	23.8
Oldham	→	645	22.1	20.7	23.7
Bolton	→	750	21.7	20.4	23.2
Salford	↓	635	21.6	20.1	23.1
Stockport	→	665	21.4	20.0	22.9
Bury	↓	430	21.1	19.5	23.0
Trafford	→	465	18.3	16.8	19.8

Figure 23: Year 6: Prevalence of overweight (including obesity) 2023/24
Source: NCMP

Year 6 prevalence of overweight (including obesity) 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	217,532	35.8	35.7	36.0
CA-Greater Manchester	→	13,195	37.5	37.0	38.0
Manchester	→	2,835	40.6	39.5	41.8
Salford	→	1,235	40.4	38.7	42.2
Oldham	→	1,280	38.6	37.0	40.3
Rochdale	→	1,205	38.4	36.7	40.1
Bolton	→	1,475	37.8	36.4	39.4
Tameside	→	940	37.2	35.4	39.1
Wigan	→	1,270	36.4	34.8	38.0
Bury	→	820	35.5	33.5	37.4
Stockport	→	1,165	33.6	32.0	35.1
Trafford	→	970	31.9	30.3	33.6

Implications

Childhood obesity, and excess weight, are significant health issues for individual children, their families and population health. It can have serious implications for the physical and mental health of children, which can then follow on into adulthood. The numbers of children, who continue to have an unhealthy, and potentially dangerous, weight, is a national public health concern.

Public Health England

Obesity harms children and young people

Emotional and behavioural

- Stigmatisation
- bullying
- low self-esteem

School absence

- High cholesterol
- high blood pressure
- pre-diabetes
- bone & joint problems
- breathing difficulties

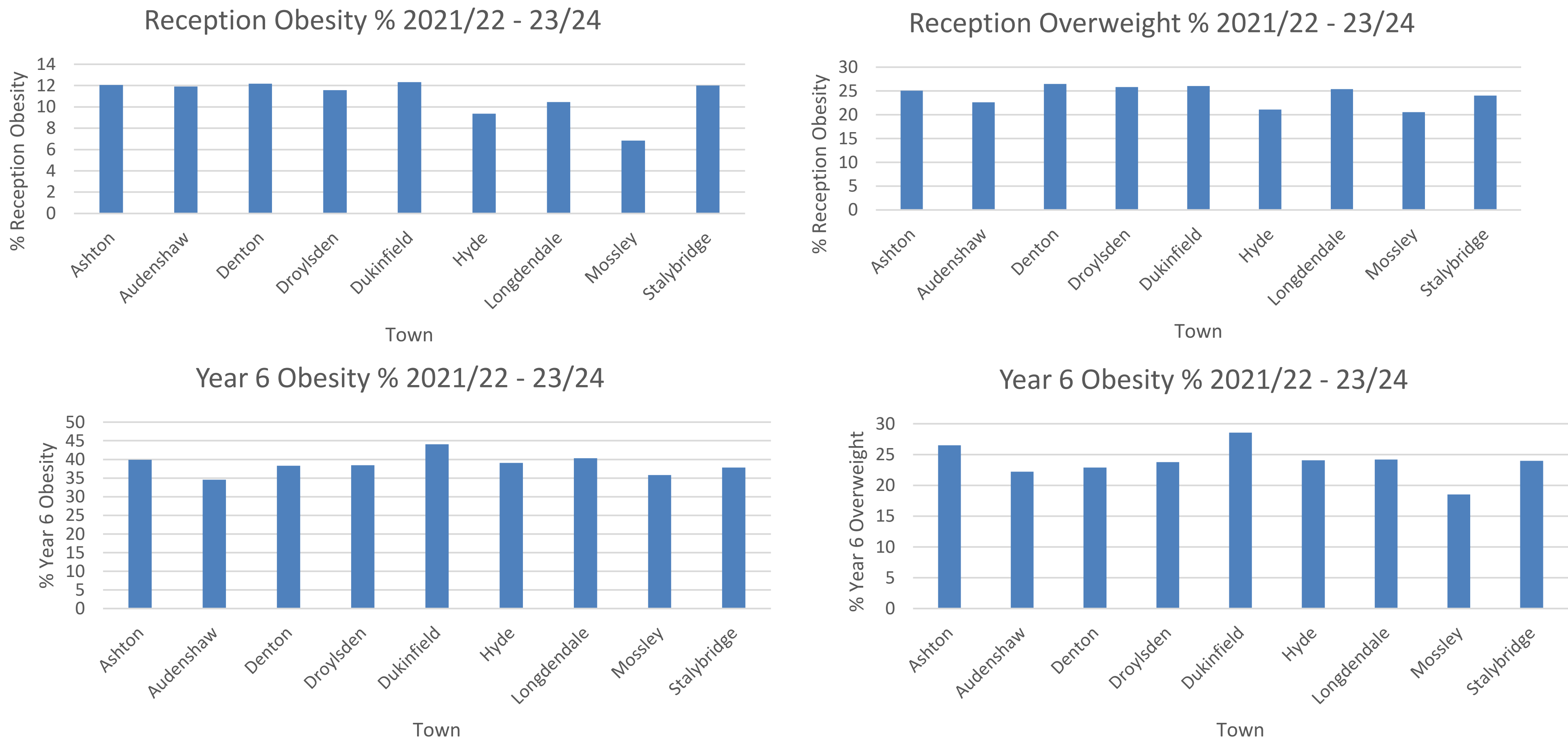
Increased risk of becoming overweight adults

Risk of ill-health and premature mortality in adult life

Tameside 9 Towns Summary

Dukinfield has the highest rates of obesity in Reception at 12.3%, with the lowest being Mossley at 6.8%, followed by Hyde and Longdendale at 9.4 and 10.4% respectively, the other towns clustering at about 12%. There are similar dynamics with rates of Reception children being overweight – only Denton and Dukinfield are (marginally above 26% and Audenshaw, Hyde and Mossley below 24% (at 22.6%, 21.1%, and 20.5%). For obesity in Year 6, Dukinfield is highest at 29%, Mossley lowest at 19%, and others are at23-24% except Ashton at 26% and Audenshaw at 22%. Finally, Dukinfield also has the highest rates of overweightness in Year 6 at 44%, whilst Audenshaw is lowest at 35% and Mossley 36%, the remaining towns being from 38 to 40%. This shows significant variation between towns as to childhood BMI, with the most overweight and obese children being in Dukinfield and Ashton and the least in Audenshaw and Mossley.

Figure 24: Reception and Year 6: Prevalence of overweight (including obesity) by Town *Source: NCMP*



Recommendations

There are many interventions to help promote healthy outcomes for children that are both individual and population based. The following link takes you to Childhood obesity: applying All Our Health It gives facts and figures on childhood obesity and principles and interventions that support individuals, professionals, communities and populations to remain a healthy weight. Being overweight and obesity is a complex problem with many drivers, including our behaviour, environment, genetics and culture. However, at its root obesity is caused by an energy imbalance: taking in more energy through food than we use through activity. Physical activity is associated with numerous health benefits for children, such as muscle and bone strength, health and fitness, improved quality of sleep and maintenance of a healthy weight.[18] There is also evidence that physical activity and participating in organised sports and after school clubs is linked to improved academic performance.[19]

Long-term, sustainable change will only be achieved through the active engagement of schools, communities, families and individuals.

The England Childhood obesity: a plan for action can be found here

[18] 12.Start Active, Stay Active: A report on physical activity from the four home countries' chief medical officers, July 2011

[19] PHE (2014): The link between pupil health and wellbeing and attainment
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf

Health and Disability

Challenge

Tameside has significantly worse health outcomes for our children and young people including urgent care hospital admission rates across a number of conditions including substance misuse, injuries and accidents, asthma, mental health and self-harm, diabetes, epilepsy and gastroenteritis. (More statistics can be found here

Emergency admissions (under 18 years) 2023/24 — Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	829,009	69.1	68.9	69.2
CA-Greater Manchester	→	46,180	68.8	68.2	69.5
Oldham	→	6,795	107.9	105.3	110.5
Bolton	↑	6,800	92.1	89.9	94.3
Stockport	→	5,855	91.3	89.0	93.7
Tameside	→	4,550	87.4	85.0	90.1
Rochdale	→	4,825	85.6	83.2	88.0
Salford	→	3,370	54.9	53.1	56.8
Wigan	↓	3,750	53.2	51.5	54.9
Manchester	↓	6,300	48.5	47.4	49.8
Bury	↓	2,055	46.7	44.7	48.8
Trafford	↓	1,880	33.6	32.1	35.1

Figure 25: Emergency Hospital Admissions for children and young peoples under 18 years *Source: Office for Health Improvement and Disaprities (OHID), Fingertips*

Figure 25, clearly illustrates the high levels of urgent care admissions for children and young people across Tameside compared to the rest of England. Illnesses such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, and poor oral health are the leading causes of attendances at A&E and hospitalisation amongst children and young people here.

Implications

As well as the inevitable human cost, such as stress and worry, separation from parents/child, time off school or work; there is also the significant financial cost for the Tameside health care economy. High levels of urgent care admissions are strongly correlated to deprivation with these inequalities impacting worse in areas with higher deprivation levels.

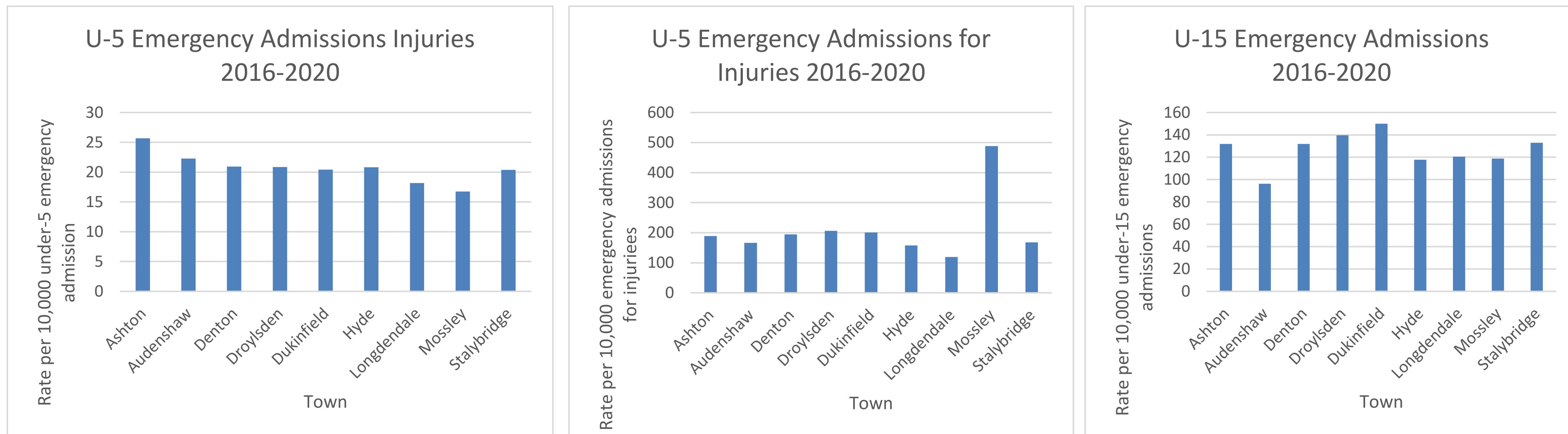
A large proportion of these urgent care admissions were avoidable and therefore there is huge potential to improve quality of care and experience for children and their parents/carers outside of the acute health care sector.

Tameside 9 Towns Summary

The highest rate of under-5 emergency admissions for injuries in Tameside is in Ashton at 26 per 10,000, whilst the lowest are in Mossley at 17 per 10,000 and Longdendale at 18 per 10,000, the rest being between 20 and 21 per 10,000 except Audenshaw at 22 per 10,000. For under-5 emergency admissions overall, Mossley is by far the highest at 489 per 10,0000, the lowest being Longdendale at 119 per 10,000, with the remainder ranging 157 to 206 per 10,000. The highest rate of under-15 emergency admissions is Dukinfield at 150 per 10,000, and the lowest Audenshaw at 96 per 10,000, all others being between 117 and 133 per 10,000, except Droylsden at 140 per 10,000.

There is clearly significant variation amongst the towns, in particular Mossley's much higher rate of emergency admissions for injuries.

Figure 26: Emergency Hospital Admissions for children and young people by Town *Source: Office for Health Improvement and Disaprities (OHID), Local Health*



Recommendations

Designing and implementing policies that help reduce deprivation and improve social determinants of health should remain the overall long-term objective for Tameside. In the short term, the inequality of health outcomes should be the basis for a renewed emphasis on health care policies that specifically engage and focus on deprived children and young people with ongoing health needs and their families.

Health visitors, school nurses, GPs and pharmacists can play an essential role in educating parents, children and family members in the importance of health literacy to manage minor illnesses and injuries. The health visitor's role in particular is invaluable in improving uptake of immunisations and educating new parents around managing minor illness and injuries.

Cared for Children

Challenge

The number and rate of children who are cared for across Tameside in 2024 was 645 or 124 per 10,000 children. This is significantly higher than both the North West and England averages of 94/10,000 and 71/10,000 respectively. This is a slight decline from 2023 but remains a lot higher than a decade ago.

Implications

Children in care are some of the most vulnerable members of society. They have often suffered traumatic events which have led to them being placed in care and lack the family support networks that others might take for granted.[20] The responsibility of caring for children ultimately falls on Local Authorities who are also responsible as the "corporate parent", with a commitment to act in the child's best interests and provide safety and stability for them in their home lives. However, it is also an inescapable fact that cared for children and those leaving care face a variety of lower outcomes compared to their peers. Children in care are 4 times more likely than their peers to have a mental health difficulty and tend to do less well in school than their peers. In education, only 20% achieved grade 4 or above GCSEs in English and maths in 2019. Children who are cared for are also hugely over represented in the youth justice system with cared for children being four times more likely to be involved with the youth justice system. Care leavers are less likely to be in Employment, Education or Training than their peers and a disproportionate number of children and young people in care are from black and minority ethnic backgrounds and have particular needs. Approximately one in ten children in care have to move more than three times. One in four homeless people have been in care at some point and a one in five females in care become teenage parents (<18 years). More information about the outcomes for cared for children can be found here.

Recommendations

Recommendations for commissioning and delivering services for cared for children should enable organisations, professionals and carers to work together to deliver high quality care, stable placements and nurturing relationships. The National Institute for Health and Care Excellence (NICE) has produced a set of principles, guidance and recommendations to achieve better outcomes for cared for children https://www.nice.org.uk/guidance/ph28/chapter/1-Recommendations. Edging away from care – how services successfully prevent young people entering care is a report that looks at a small sample of local authorities and their partner agencies and looks at how services successfully support young people who are at risk of entering care to remain living at home. https://www.gov.uk/government/publications/how-services-prevent-young-people-entering-care-edging-away-from-care Early Intervention programmes are an approach for helping families, children and young people. Early help, also known as early intervention, is support given to a family when a problem first emerges. It can be provided at any stage in a child or young person's life. Early help services can be delivered to parents, children or whole families, but their main focus is to improve outcomes for children. Evidence suggests that providing timely support to address a child or family's needs early on can reduce risk factors and increase protective factors in a child's life.[21] Early intervention can also prevent further problems from developing – for example, as part of a support plan for a child and their family when a child returns home from care.[22]

[20] http://www.smf.co.uk/wp-content/uploads/2018/08/Silent-Crisis-PDF.pdf
[21] https://learning.nspcc.org.uk/safeguarding-child-protection/early-help-early-intervention/
[22] Department for Education, 2018

Vulnerability

Challenge

Vulnerabilities are a diverse range of social, economic and environmental factors which influence people's life chances and outcomes. Vulnerability is made up of the characteristics of a person or group and their situation that influence their capacity to anticipate, to cope with, resist and recover from the impact of a crisis or adverse event. Poverty, occupation, ethnicity, exclusion, marginalisation, inequities and social isolation can enhance social vulnerability.

People across Tameside who might need extra help are adults and children with a learning disability or mental health conditions; people who care for others, cared for children or care leavers, people who are in a relationship where domestic abuse exists, people living in poverty or from a deprived background, children and young people going through adverse experiences and people from ethnic minority backgrounds or the LGBT community. The local evidence is profound and makes it clear that the numbers of people in Tameside that are facing multiple disadvantages which damage their life chances, and those of their children, is unacceptably high. Figure 16 illustrates some examples of the different vulnerabilities for our population compared to the rest of Greater Manchester and England. It illustrates that Tameside has high levels of people who could be vulnerable and at risk of future health and wellbeing needs.

Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Adults (18+ yrs) with learning disability receiving long- term support from local authorities (per 1,000 population) (Persons, 18+ yrs)	2019/20	3.46	3.63*	3.83	4.03	3.02	4.70	3.78	3.33	3.74	3.92	2.93	3.79
Children with learning difficulties known to schools (Persons, School age)	2020	34.4	41.4*	51.1	34.7	40.1	31.2	39.2	52.7	37.7	41.8	31.0	51.8
Homelessness: households in temporary accommodation	2022/23	4.2	-	1.6	1.3	13.6	3.2	1.9	*	0.9	2.0	1.4	1.1
Statutory homelessness - Eligible homeless people not in priority need (Persons)	2017/18	0.8	-	0.6	2.2	1.8	1.4	*	4.6	1.7	1.5	*	0.2
Children in care (Persons, <18 yrs)	2022/23	71	-	78	80	104	86	108	92	76	127	63	98
Children who started to be looked after due to abuse or neglect: rate per 10,000 children aged under 18 (Persons, <18 yrs)	2018	16.4	25.2*	22.7	24.1	29.3	25.1	28.2	28.7	21.1	41.5	10.4	20.3
Unaccompanied Asylum Seeking Children looked after: count (Persons, <18 yrs)	2018	4480	140*	9	8	71	6	8	18	*	9	*	11
Children leaving care: rate per 10,000 children aged under 18 (Persons, <18 yrs)	2017/18	25.2	30.1*	24.9	34.1	38.9	34.5	30.5	30.4	26.5	29.6	23.5	21.9

Figure 27: Examples of vulnerabilities that exist in the population across Greater Manchester *Source: Office for Health Improvement and Disaprities (OHID), Fingertips*

Implications

On health- Not all our population are aware of the health issues and risks most people might take for granted, or know how to lead the healthy lifestyles most people might think are obvious. This can leave them vulnerable to increased future ill health and issues like obesity, infections, accidents and injuries. Vulnerable individuals are often worst affected, deprived of the information, money or access to health and care services that would help them prevent and treat disease.

On life chances - From a social perspective, people might find themselves in situations that lead to increased personal risk such as violence both physical and sexual, drug and alcohol misuse, exploitation or bullying and involved with the justice or social care and safeguarding system.

All this can lead to crisis, longer term issues and poor outcomes for the individuals involved and the wider population and community.

Recommendations

Improving the life chances of our most vulnerable residents should be a key strategic priority for Tameside. Crisis intervention for people with complex health and social issues is costly so investing in prevention and early intervention can reduce, delay or end the need for costly crisis intervention in the long term. Therefore in order to avert poor outcomes for vulnerable and high-risk populations it is essential that these populations can be identified at the earliest opportunity. Where problems do arise, it is also important to concentrate interventions on improvement, recovery and independence, not maintenance. Therefore effective commissioning needs to be implemented that applies evidence of what works to improve outcomes for local people and this will become increasingly important as budgets become more constrained.

Air Quality and Air Pollution

Challenge

Air quality is the term we use to describe how polluted the air we breathe is. When air quality is poor, pollutants in the air may be hazardous to people, particularly those with lung or heart conditions. Clean air is a basic requirement of a healthy environment for us all to live in, work, and bring up families.[23]

Air pollution related to fine particulate matter is the concentration of human-made fine particulate matter and is also known as $PM_{2.5}$ and has a metric of micrograms per cubic metre (µg/m3). Data for the annual concentration of human-made fine particulate matter at an area level, adjusted to account for population exposure for Tameside (figure 20) shows that Tameside has the 3rd highest level of particulate matter in Greater Manchester and higher than the overall England average. Trend data indicates that levels have fluctuated over the last decade. In 2022 it is estimated that 5.9% of deaths were attributed to particulate air pollution, this equates to around 51 deaths. This is an increase on previous years.

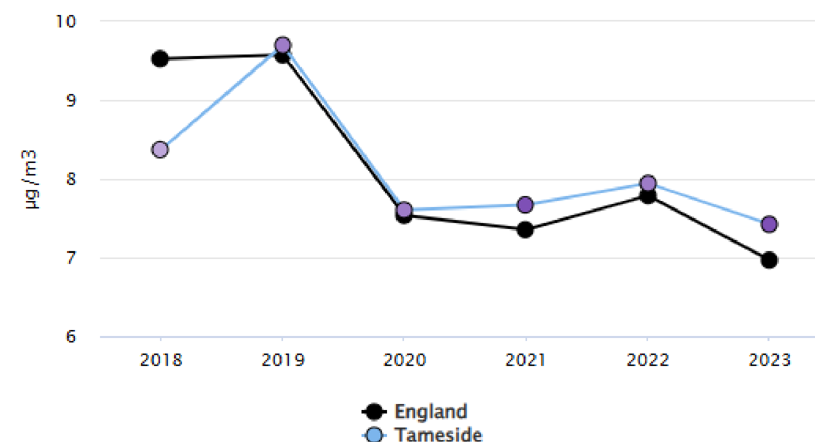
Figures 28 & 29: Fraction mortality and Air pollution: Fine particulate matter (Mean - µg/m3) and trends in Fraction Mortality for Tameside *Source: Public Health Outcomes Framework (PHOF)*

Air pollution: fine particulate matter (new method - concentrations of total PM2.5) 2023 — Mean - µg/m3

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	7.0	-	-
CA-Greater Manchester	–	-	-	-	-
Manchester	–	-	7.5	-	-
Oldham	–	-	7.5	-	-
Tameside	–	-	7.4	-	-
Salford	–	-	7.3	-	-
Rochdale	–	-	7.2	-	-
Stockport	–	-	7.1	-	-
Bury	–	-	7.1	-	-
Wigan	–	-	6.9	-	-
Bolton	–	-	6.9	-	-
Trafford	–	-	6.9	-	-

Air pollution: fine particulate matter (new method - concentrations

Show confidence intervals Show 99.8% CI values



Implications

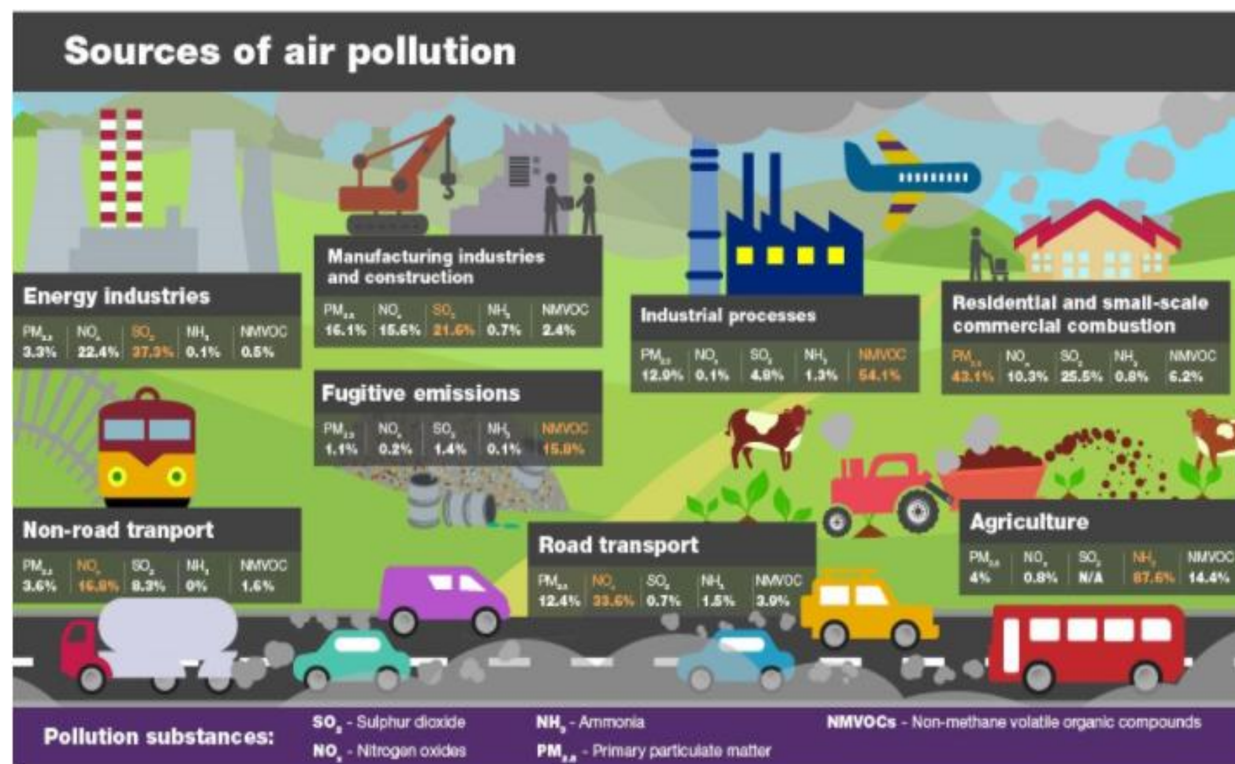
Air pollution can have harmful effects on health, the environment, and the economy, and is the largest environmental risk to the public's health. The major pollutants are particulate matter (e.g. $PM_{2.5}$) and nitrogen oxides (e.g. NO_2). Sources include natural and man-made processes, including construction, industry, power generation, agriculture, home heating, as well as motorised transport by road, rail, sea, and air.

[23] https://www.gov.uk/government/publications/air-quality-explaining-air-pollution/air-quality-explaining-air-pollution-at-a-glance

There is no evidence for a safe level of various air pollutants, and adverse health effects are felt well below the legal concentration limits. Car drivers are exposed to twice as much air pollution as pedestrians, and nine times as much as cyclists. Air pollution contributes to early death, cardiovascular disease, lung cancer and other respiratory diseases. Other impacted conditions include type 2 diabetes, bladder cancer and dementia.[24]

Recommendations

Taking action to improve air quality is crucial to improve population health, and to optimise the public's ability to benefit from Tameside's growth and prosperity. A combination of local and national approaches is needed, for which the action of the local authorities is crucial.



Active travel is one of the most important actions individuals can take to reduce their personal contribution to air pollution, as well as minimise their exposure to air pollutants, and gain from the other wide-ranging health benefits conferred by physical activity.

National Clean Air Day is an opportunity to push forward air quality in the public eye and the political agenda, and to increase the uptake of individual action to reduce air pollution and to avoid the personal harmful impacts of air pollution.

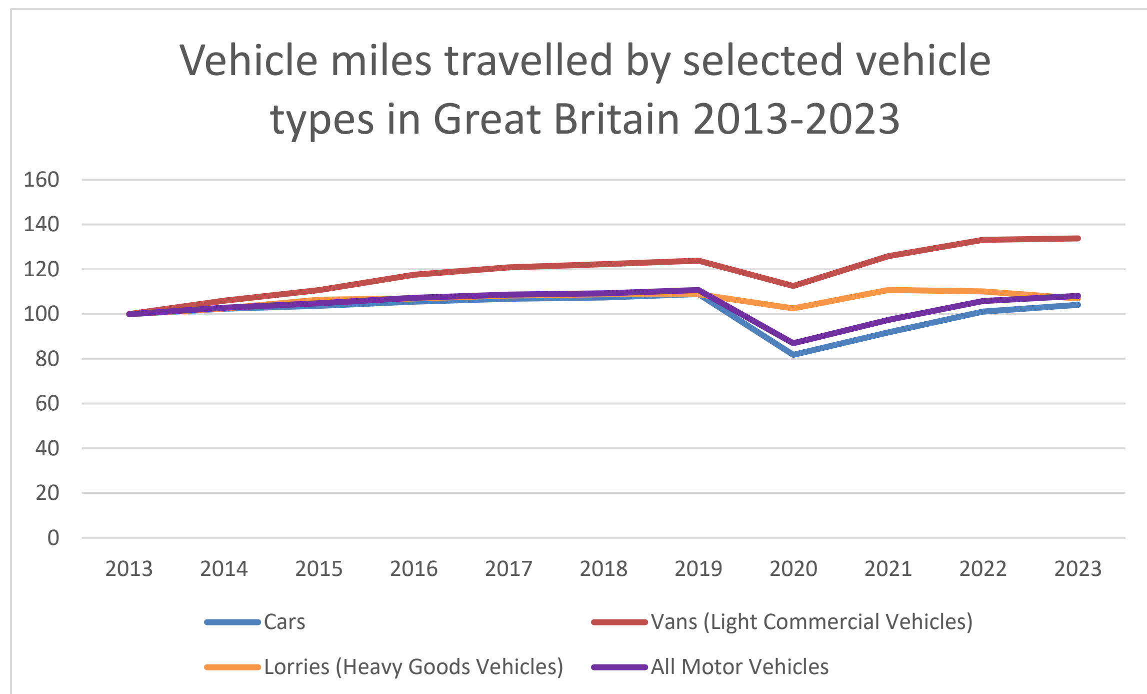
Population Health Tameside could commit to becoming a leader in the local authority for pushing air quality improvement across the public sector. Population health could also then influence the councils and Integrated Care Boards (ICB) communication strategy in relation to air quality, and support with focussed and effective communication delivery to the public, as well as engaging with community members to facilitate partnership and local initiatives.

[24] https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution

Transportation

The Challenge

Figure 30: Trends in road traffic across Britain *Source: Department of Transport*



Index of vehicle miles, 2013 = 100

Provisional estimates show motor vehicles travelled 330.8 billion vehicle miles (bvm) in Great Britain for the year ending December 2023. This was an increase of 2% on the previous year, but still lower than the pre-pandemic peak of 338.6 bvm. Car traffic, which fell the most during the pandemic, increased by 3% to 251.3 billion vehicle miles (as compared to a pre-pandemic peak of 262.9. Van traffic grew by 0.5% to 57.8 billion vehicle miles (bvm), a new peak level, and lorry traffic fell by 3% to 16.9 bvm

Growing traffic levels should concern us all. The apparent growth in cars on the road masks some important trends. While people who drive for their jobs are driving more and further, we are also seeing an overall fall in trips, with city dwellers and younger adults in particular relying less and less on cars for everyday travel.[25]

Implications

The most significant change in travel behaviour over the last few decades has been in car use, which is seen by many as their primary means of transportation. Cars have become relatively affordable compared to other transport alternatives and land use policies have prioritised mobility over accessibility.

While the expansion in car use has brought many social and economic benefits, increased vehicle numbers and traffic volume has also had negative impacts on health:[26]

- greater risk of road traffic crashes, with pedestrians and cyclists being particularly vulnerable
- long-term exposure to air pollutants decreases life expectancy
- areas of high deprivation suffer most from air-pollution-related morbidity and mortality and the effects of noise pollution
- Increased community severance as a result of poor urban planning.

[25] Provisional road traffic estimates, Great Britain: October 2021 to September 2022 - GOV.UK (www.gov.uk)
[26] https://www.bmj.com/content/372/bmj.n443

Long-term exposure to air pollutants from road traffic has been found to decrease life expectancy by an average of six months, due to an increased risk of cardiovascular morbidity and mortality. Prenatal exposure to air pollution is associated with a number of adverse outcomes in pregnancy, including low birth weight, intrauterine growth retardation, and an increased risk of chronic diseases in later life. Individuals who reside or work near busy roads or airports are at particularly high risk of exposure to the health harms of air pollution. Areas of high deprivation are known to suffer a greater burden from air-pollution-related morbidity and mortality.[27]

The unintended consequence of increased car use has been the suppression of walking and cycling levels in the UK. The suppression of active travel in the UK is associated with generally higher levels of physical inactivity and sedentary lifestyles. This in turn can contribute to higher levels of morbidity and mortality through an increased risk of clinical disorders such as cardiovascular disease, overweight and obesity, metabolic disorders, and some cancers.

Recommendations

Encouraging the population to use the car less is a real challenge. People have different reasons for consciously deciding whether or not to use a car. Therefore there needs to be reliable and cost effective alternatives to the car to encourage less usage. Measures that discourage car use have been shown to be effective in reducing demand for car transportation.[28] The majority of car journeys in urban areas are less than five miles, so there is scope to reduce the number of shorter car journeys by shifting to active travel, with longer journeys moved to public transport.

Public transport can be a real alternative to the car for many commuter and business journeys. Modern public transport is more reliable than ever, with bus lanes and express services. Buses and trains also produce less CO2 per passenger than single occupancy cars and cause less congestion. However, transport policy in the UK over the last two decades has contributed to a situation where travelling by car is more attractive than travelling actively or by using public transport. This needs to change; policy decisions that reduce demand for car use, while at the same time encouraging a cultural shift to more active and sustainable forms of transport, are vital. Maintaining a commitment to reducing road capacity will be necessary to ensure the benefits of this cultural shift are realised.

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[27] Regulation Briefing Paper (cycling-embassy.org.uk)

[28] Department for Energy and Climate Change (2009) Low carbon industrial strategy: a vision. London: Department for Energy and Climate Change.

Housing

The challenge

Over the next 20 years the population in the UK is set to increase by 10 million, for Tameside the growth is estimated to be around 17,000 people. Population growth and particularly a growth in the number of households, leads to a growth in housing demand. Projections suggest that nationally household numbers are expected to rise by 12% over the next 20 years. For Tameside the projection is lower at 10.2%, this could mean an increase of around 10,267 households or 513 additional households each year for the next 20 years.[29]

Households headed by someone aged 65 years and over are projected to increase by 34% compared to 2018 by 2043, while those headed by someone aged under 65 years are projected to grow by just 5%.[36]

Implications

Houses are more than physical structures providing shelter. They are homes – where we bring up our families, socialise with friends, our own space where we can unwind, keep our possessions safe and take refuge from the rest of the world. They're where we spend most of our time.[30]

The right home environment is essential to health and wellbeing, throughout life. It is a key wider determinant of health. The right home environment protects and improves health and wellbeing, and prevents physical and mental ill health.[31] The estimated cost of poor housing to the NHS in England is £1.4 billion per year. The end of a tenancy in the private rented sector is the main reason for homelessness. (31% of all statutory homelessness) [38]

[29]https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/2016basedhouseholdprojectionsinengland/2016basedhouseholdprojectionsinengland
[30] https://www.health.org.uk/infographic/how-does-housing-influence-our-health
[31] https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home

Recommendations

The right home environment protects and improves health and wellbeing, and prevents physical and mental ill health. It also enables people to:[32]

- manage their own health and care needs, including long term conditions
- live independently, safely and well in their own home for as long as they choose
- complete treatment and recover from substance misuse, tuberculosis or other ill-health
- move on successfully from homelessness or other traumatic life event
- access and sustain education, training and employment
- participate and contribute to society

Future housing needs to be affordable and mixed, taking into consideration the aging population, active travel and the wider needs of the population. The Development of a housing strategy that addresses the health consequences of housing and considers health issues and disability to ensure people can stay at home and live as independently as possible for as long as possible is important if we want to have a sustainable local health and care system.

The 'Improving Housing Quality' strategic theme includes the following key priorities which local authorities and health and care partners should ensure happens

- Bring all social housing up to the decency standard
- Identify future investment options for council housing
- Increase the number of private homes that meet the decency standard
- Improve the long-term sustainability of private housing
- Continue to improve standards in the private rented sector
- Improve the standard of temporary accommodation leased through the private sector

[32] https://publichealthmatters.blog.gov.uk/2018/03/20/improving-health-and-care-through-the-home/

Homelessness

The Challenge

The definition of homelessness means not having a home. This could include rough sleeping (sleeping on the streets), living in temporary accommodation or staying with family or friends on a temporary basis.

People can become homeless for many different reasons such as being evicted, splitting up with your partner, family or friends asking you to leave, domestic violence or abuse, harassment by neighbours, a disaster such as a fire or flooding.

Homelessness in England in each of its various forms has increased in recent years. The number of rough sleepers stood at 16,680 in the first quarter of 2025. The number of homeless households in temporary accommodation has also increased, In the first quarter of 2024: 117,450 households were in temporary accommodation; of those in temporary accommodation 74,530 households or 63.4% included dependent children.

Under the Housing Act 1996, Local Authority housing departments have a duty to prevent homelessness and provide free advice and assistance to those who are in a situation of homelessness or are at risk of becoming homeless within 28 days.

Across Tameside local information tells us that in 2022/23[33]

- The number of households who received an initial assessment for homelessness was 1,272
- 1,271 were owed a prevention or relief duty
- 103 had no fixed abode
- 445 were staying with family or friends
- 108 were rough sleepers

Implications

Homelessness has an effect on both individuals and society. The health and wellbeing of people who experience homelessness are poorer than that of the general population. They often experience the most significant health inequalities. The longer a person experiences homelessness, particularly from young adulthood, the more likely their health and wellbeing will be at risk.[34] The causes of homelessness are typically related to:

- Structural factors; such as poverty, inequalities, housing supply and affordability and unemployment or access to secure employment
- Individual factors; such as poor physical health, mental health issues, experience of abuse or violence, drug and alcohol problems and relationship breakdown

For most people who are at risk of, or experiencing, homelessness and rough sleeping there isn't a single intervention that can tackle this on its own, at population, or at an individual level.

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[33] Live tables on homelessness - GOV.UK (www.gov.uk)

[34] https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

Recommendations

Action is required to support better-integrated health and social care, and to help people to access and navigate the range of physical and mental health and substance misuse services they require in order to sustain stable accommodation.

There needs to be clear local action, partnership working (across the local authority, clinical commissioning group and other local organisations) and understanding and alignment of commissioning decisions to prevent and respond to homelessness across the life course. This can include:

- reducing the risk of homelessness to children and young people to strengthen their life chances
- enabling working-age adults to enjoy social, economic and cultural participation in society
- breaking the cycle of homelessness or unstable housing by addressing mental health problems, or drug and alcohol use, or experience of the criminal justice system

Domestic Abuse

Challenge

Domestic abuse which includes an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence[35] is a significant issue for Tameside. In 2023/24, there were 5,872 incidents of domestic abuse reported to the police across Tameside and 3,211 referrals to children's social care relating to domestic abuse. Of all violent and anti-social behaviour type crime reported to the police for Tameside in 2019/20, nearly 55% was related to domestic abuse.

The Domestic Violence Disclosure Scheme (DVDS, commonly known as Clare's Law) was brought into effect in March 2014. The scheme has two routes: "right to ask" – this enables someone to ask the police about a partner's previous history of domestic violence or violent acts and "right to know" – the police can proactively disclose information in prescribed circumstances

In 2023/24 there were 383 requests made under the scheme across Tameside, with almost half of these (184) resulting in positive disclosures, meaning a history of domestic abuse was present.

Implications

Domestic abuse, impacts on the mental, emotional, physical, social and financial aspects of the individual survivor and their family and children. It also has wider societal costs including the costs of police, health and other service responses, and time off having to be taken by survivors from paid employment and caring responsibilities.[36]

Physical and sexual abuse can cause short term, long term and permanent injuries or conditions. Psychological abuse can lead to a variety of problems such as low self-esteem; disturbed patterns of eating and sleeping; lack of confidence; depression; extreme anxiety; alcohol and substance misuse; self-harm and suicide.

The social and economic consequences of violence can include homelessness, loss or separation from family friends, isolation, loss of employment, debt and destitution.[37]

Living in a home where domestic abuse happens can have a serious impact on a child or young person's mental and physical wellbeing, as well as their behaviour. And this can last into adulthood.[38] The correlation between domestic violence and abuse and safeguarding children is widely recognised and

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[35] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/
[36] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-nature-and-impact-of-domestic-abuse/
[37] https://www.leeds.gov.uk/domesticviolence/Documents/Men%20-%20Impact%20of%20domestic%20violence%20and%20abuse%20on%20women.pdf
[38] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/domestic-abuse/#effects

accepted. Domestic violence is an indicator of child abuse and has featured significantly in child protection proceedings and serious case reviews. Children are affected by domestic violence in a number of ways, both physically and emotionally.

Recommendations

The National Institute for Clinical Excellence (NICE) have published guidelines that cover planning and delivering multi-agency services for domestic violence and abuse. It aims to help identify, prevent and reduce domestic violence and abuse among women and men in heterosexual or same-sex relationships, and among young people.

Some of the recommendations for commissioners identified include:

- Establishing an integrated commissioning strategy around domestic abuse, that should include input from domestic violence and abuse services, other relevant services and from people who have experienced domestic violence and abuse.
- Ensure there are integrated care pathways for identifying, referring (either externally or internally) and providing interventions to support people who experience domestic violence and abuse, and to manage those who perpetrate it.
- Ensure people who misuse alcohol or drugs or who have mental health problems and are affected by domestic violence and abuse are also referred to the relevant health, social care and domestic violence and abuse services.
- Ensure the information on where to get support is available in a range of formats and locally used languages. The former could include braille and audio versions and the use of large font sizes. There may also be more discreet ways of conveying information, for example, by providing pens or key rings with a helpline number.

Read more NICE recommendations here

Community safety and Crime

The Challenge

In 2024 there were 323,954 crimes recorded across Greater Manchester; 23,996 of these crimes recorded by Greater Manchester police occurred in Tameside. Figure 24 illustrates the percentage breakdown of the 323,954 crimes that occurred in Greater Manchester by local authority areas. Tameside ranks 4th lowest in Greater Manchester for reported crime in 2024.[39]

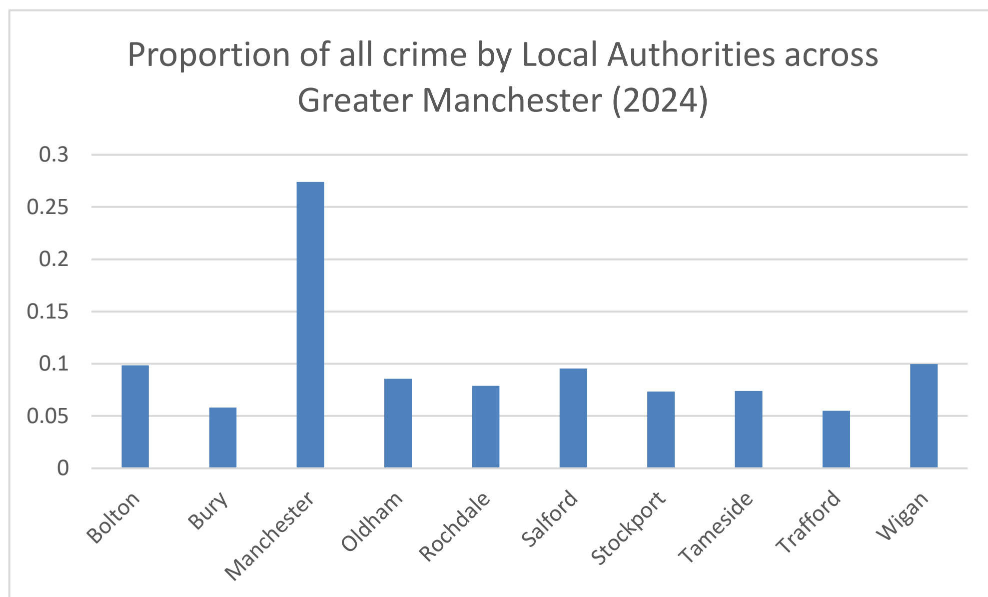

Figure 31: Proportion of all Greater Manchester reported crime in 2024 by local authority areas *Source: ONS Crime and Justice*

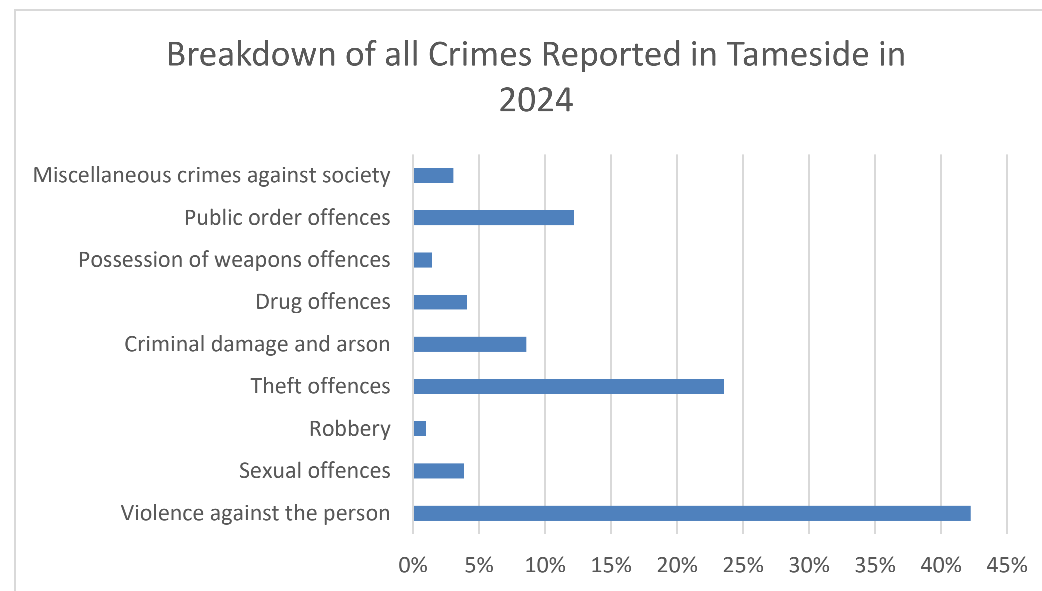

Figure 32: Types of crimes reported to the police for Tameside *Source: ONS Crime and Justice*

Implications

Feeling safe and secure in the communities where we live is an important public health issue. Crime can have a wide ranging effect on people's health. Crime affects physical and mental health in many ways.[40] Violence against people is the most direct link, while the psychological effects of experiencing crime, whether violent or not, can also have far reaching consequences. Through less direct channels, the fear of crime can not only have psychological effects but directly reduce health promoting behaviours such as physical activity and social contact. Furthermore, the economic cost of crime to both individuals and public services may reduce resources available for health improvement. Perpetrators of crime are also more likely to have worse health across a range of conditions than the general population.

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[39] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/userguidetocrimestatisticsforenglandandwales

[40] Lorenc T and others. (2014) Crime, fear of crime and mental health: Synthesis of theory and systematic reviews of interventions and qualitative evidence. Public Health Research, 2(2). ↩

Recommendations

Addressing crime is not a single agency issue, as it is the culmination of many different issues. It is only by pursuing a strategic, coordinated approach involving a range of agencies, including partnerships between statutory and voluntary organisations, that crime can be effectively addressed.

There are three ways to tackle and reduce crime in Tameside

1. **A population health approach** takes a wider lens on the problem, looking at its magnitude, scope, characteristics and consequences across the larger population, normally defined as residents of a town, city or country.[41]
2. **Primary prevention** which focuses on preventing problems before they have occurred, as opposed to secondary prevention (focused on tackling problems once they have occurred and preventing their re-occurrence) and tertiary prevention, which focuses on managing and ameliorating problems once they have become entrenched.[42]
3. '**Whole system' approach**, involving all relevant agencies and actors at different levels. This involves looking at all the possible risk factors that might increase or decrease the incidence of a problem and mobilising all those who have some influence over those risk factors.[43]

[41] 'The public health approach' World Health Organisation 2019 https://www.who.int/violenceprevention/approach/public_health/en/
[42] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf
[43] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862794/multi-agency_approach_to_serious_violence_prevention.pdf

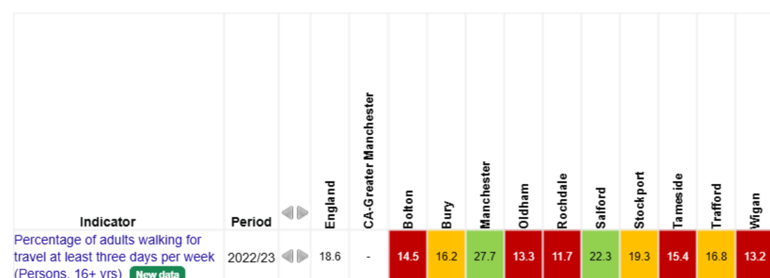
Healthy and Active lives

Active Transport

Challenge

Walking and cycling are good for our physical and mental health. Switching more journeys to active travel will improve health, quality of life, the environment, and local productivity, while at the same time reducing costs to the public purse.[44] Active travel means walking or cycling to get from place to place rather than solely for leisure or fitness – such as walking to school or cycling to work. For many people this offers a convenient and accessible way to build physical activity into their lives.[45]

Figure 33: Active Travel levels across Greater Manchester *Source: OHID fingertips*



Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Percentage of adults walking for travel at least three days per week (Persons, 16+ yrs) New data	2022/23	18.6	-	14.5	16.2	27.7	13.3	11.7	22.3	19.3	15.4	16.8	13.2

Statistics for 2022/23 (figure 33) illustrate the levels of active travel by local authorities across Great Manchester. For Tameside the data showed that levels of people walking to travel the proportion was significantly lower than the England averages. For walking Tameside ranked 6th in Greater Manchester.

Overall physical activity levels across Tameside are low when compared to the England and the rest of Greater Manchester. Around 29.5% of our adult are physically inactive and have the 2nd highest rate of inactivity in Greater Manchester.

Implications

Physical inactivity directly contributes to 1 in 6 deaths in the UK and costs £7.4 billion a year to business and wider society with the growth in road transport having been a major factor in reducing levels of physical activity and increasing obesity.[46]

Long term conditions such as diabetes, cardiovascular and respiratory disease lead to greater dependency on home, residential and ultimately nursing care. This drain on resources is avoidable, as is the personal strain it puts on families and individuals.

One of the major attractions of cycling and walking is the positive benefits for population health and wellbeing. Active travel is an important means of building physical activity into our daily routines, while also improving air quality and mental health.

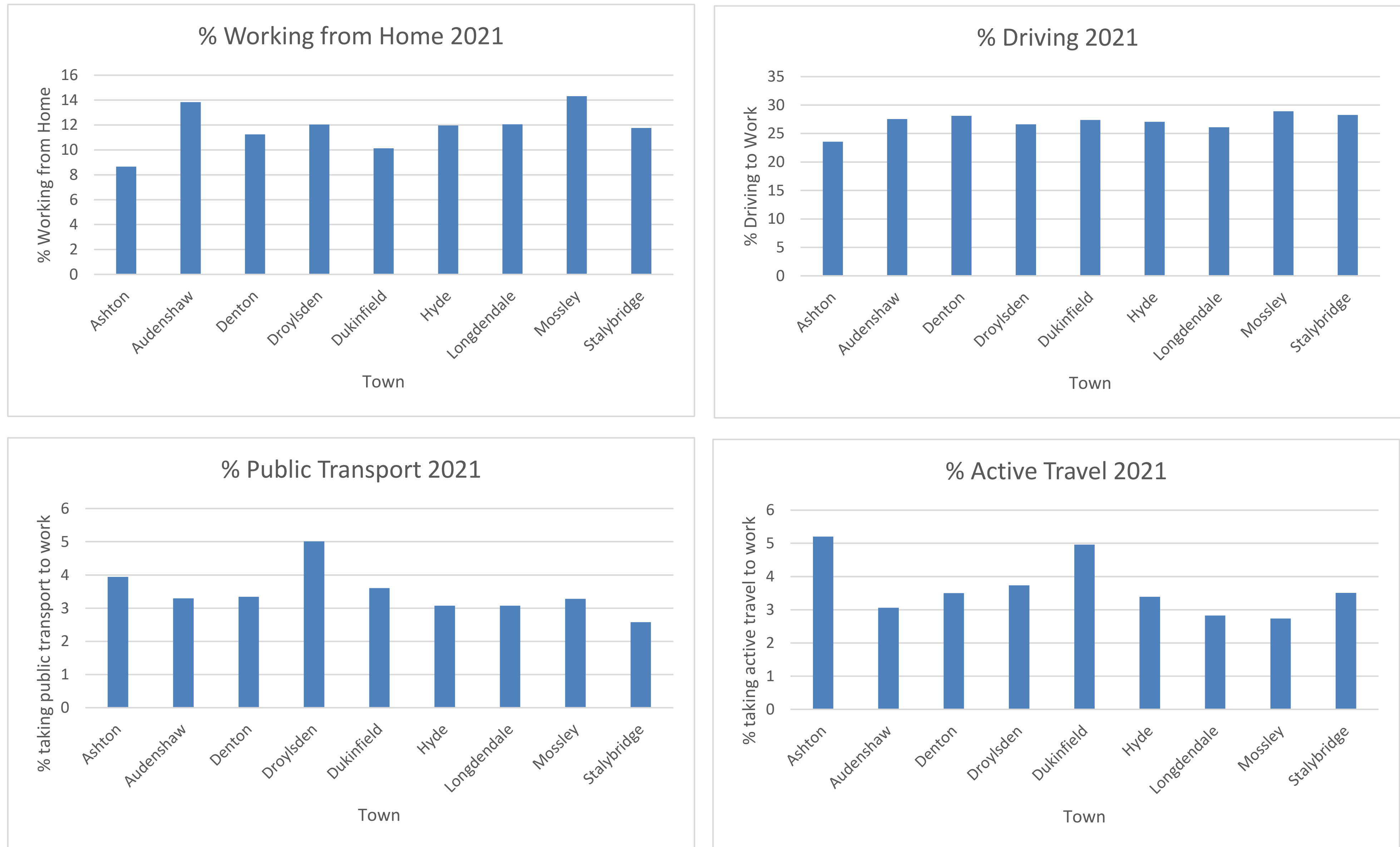
Tameside 9 Towns Summary

Audenshaw has the highest rate of working from home at 14% of the population whilst Ashton has the lowest at 9%. Ashton also has the fewest driving at 23.5% whilst Mossley has the most at 29%. The lowest rate commuting by public transport is Stalybridge at 2.6% and Droylsden the highest at 5%, whilst on

[44] https://www.gov.uk/government/publications/active-travel-a-briefing-for-local-authorities
[45] https://www.sportengland.org/research/understanding-audiences/active-travel/
[46] https://www.gov.uk/government/publications/active-travel-a-briefing-for-local-authorities

active travel Mossley is the lowest at 2.7% and Ashton the highest at 5.2%. These figures show wide variations amongst the nine towns in how people tend to commute.

Figure 34: Transport Usage and Working from Home by Town *Source: ONS Census 2021*



Recommendations

The Tameside population was expected to increase by around 17,000 over the next 20 years (as of 2018). Linking housing growth with walking, cycling and public transport will help ensure new developments are built in the right places and with the right infrastructure to enable efficient and sustainable mobility that is attractive for people and businesses.

Being active every day needs to be embedded across every community in every aspect of life. The association between physical activity and leading a healthy, happy life means that issues of cost, access or cultural barriers need to be tackled.[47] Thoughtful urban design, understanding land use patterns, and creating transportation systems that promote walking and cycling will help to create active, healthier, and more liveable communities.[48] Pedestrians, cyclists, and users of other modes of transport that involve physical activity need the highest priority when developing or maintaining streets and roads.

[47] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf
[48] https://www.gov.uk/government/publications/everybody-active-every-day-a-framework-to-embed-physical-activity-into-daily-life

Healthy Life Expectancy

The Challenge

Healthy Life Expectancy (HLE) is an extremely important summary measure of mortality and morbidity in itself. Healthy life expectancy shows the years a person can expect to live in good health (rather than with a disability or in poor health). HLE measures the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health.

Healthy life expectancy in Tameside for females in 2021/23 was 55.6 years and for males 56.2 years. For males this is similar to the England average but significantly lower for females.

Males in Tameside had seen an improvement in healthy life expectancy over the previous few years but the figures for females are less positive and remain stubbornly low, with little movement over the last decade.

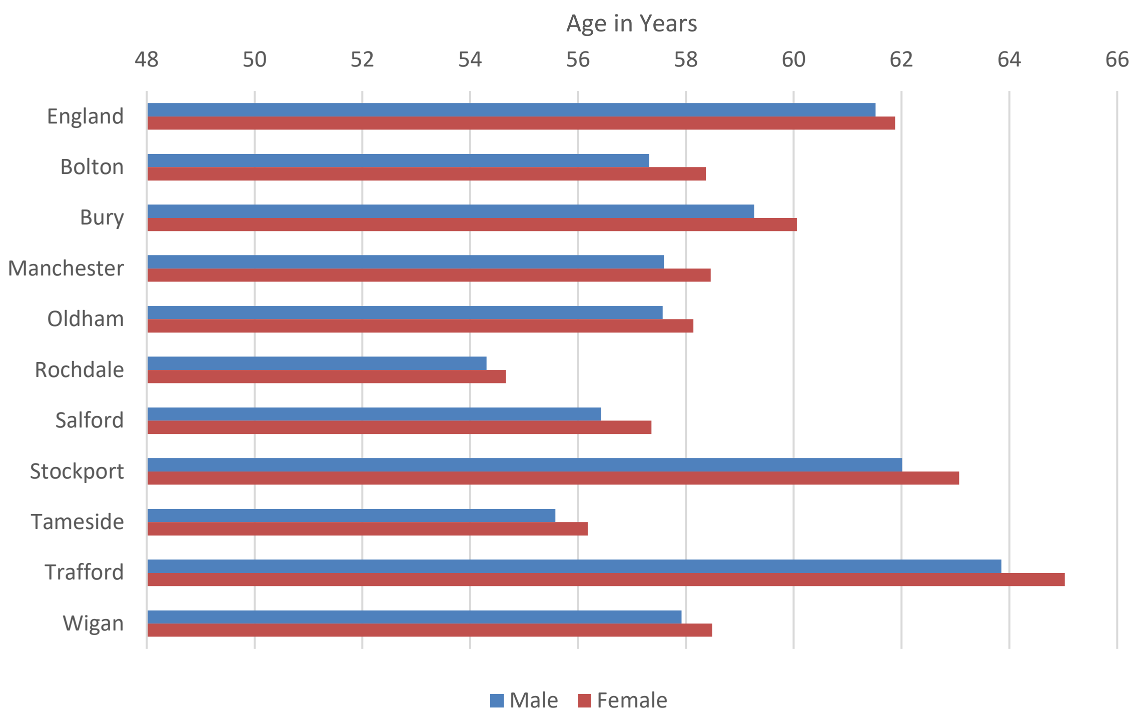


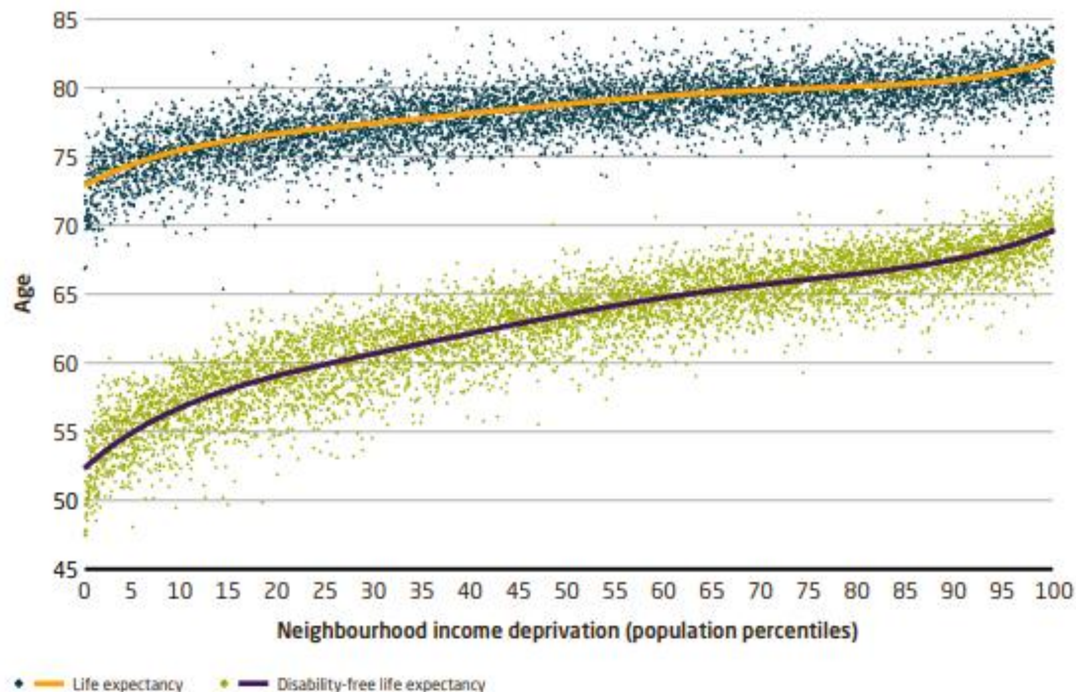
Figure 35: Healthy Life Expectancy across Greater Manchester 2021/23 *Source: Office for Health Improvement and Disaprities (OHID), Fingertips*

Implications

Healthy Life expectancy, is influenced by many factors – our family background, our lifestyles, the health and other services we receive and the wider physical, social and economic environment in which we are raised, live and work.

Fair society, healthy lives, more widely known as 'The Marmot Review' after its author Professor Sir Michael Marmot, has been highly influential in debate on health inequalities policy since its 2010 publication, especially among local authorities and health and wellbeing boards. One of the iconic charts in the review, was 'the Marmot curve', which shows how life expectancy and disability-free life expectancy are systematically and consistently related to differences in income deprivation across thousands of small areas in England.

Figure 27: The Marmot Curve



The Marmot curve show a number of important features of the systematic relationship between health and area deprivation. Firstly, there is a clear social gradient in life expectancy and disability-free life expectancy. Secondly, the social gradient in disability-free life expectancy is steeper than the gradient in life expectancy. As a result, people living in areas with more disadvantage not only expect to live a shorter life but also to spend more of that shorter life with a limiting long-term illness.[49]

Recommendations

The aim should be for everyone in society to have the good health and length of life of those at the top – to level up. We should call for two societal goals: improve health for everybody and reduce inequalities.[50] Therefore implementing the key recommendations from the Marmot review '10 years on' 2020 both locally and nationally is key to improving outcomes for people across Tameside.[53]

[49] file:///C:/Users/Jacqui.dorman/Downloads/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf
[50] file:///C:/Users/Jacqui.dorman/Downloads/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

Adult Smoking

The Challenge

Smoking prevalence in adults across Tameside is significantly worse than the England averages. Adult smoking prevalence in 2023 was 15.9% (Tameside); 12.5 (GM), 11.6% (Eng.). The socio-economic gap for smoking prevalence, between those in routine and manual occupations and the general population shows that people from routine and manual occupations in Tameside are almost twice as likely to smoke as the general population.

Smoking attributable mortality in Tameside was also significantly higher than the England average at 351.0/100,000 versus 202.2/100,000 (Eng.) this equates to approximately 413 deaths a year.

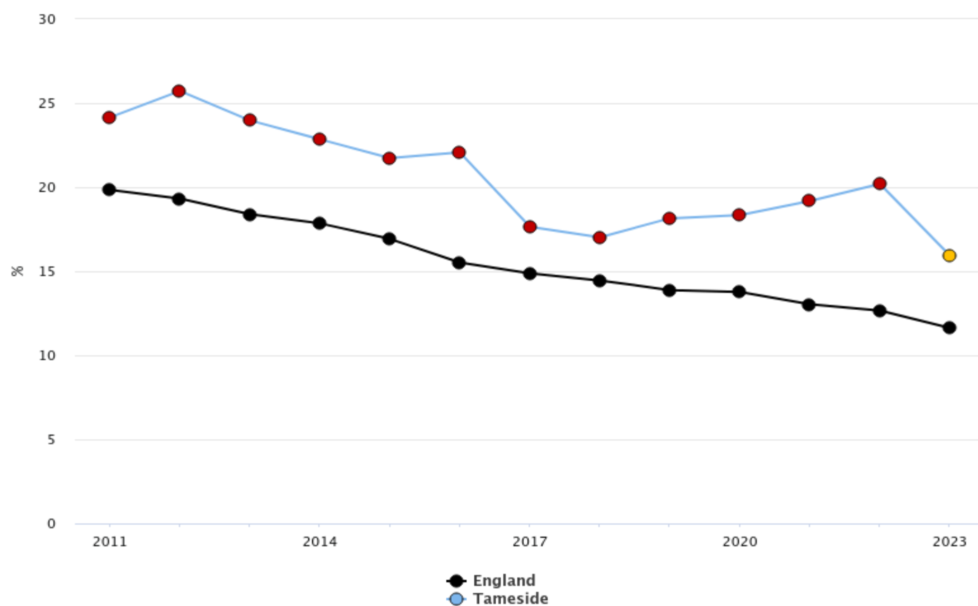


Figure 36: Trends in adult smoking prevalence *Source: OHID Tobacco Profiles*

Implications

Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking and the harm it causes aren't evenly distributed. People in more deprived areas are more likely to smoke and are less likely to quit. Smoking is increasingly concentrated in more disadvantaged groups and is the main contributor to health inequalities in England. Men and women from the most deprived groups have more than double the death rate from lung cancer compared with those from lung cancer compared with those from the least deprived. Smoking is twice as common in people with longstanding mental health problems.

Recommendations

Helping smokers to quit is one strand of the government's tobacco control plan for England. The other elements are:

- making tobacco less affordable
- preventing the promotion of tobacco
- Effective regulation of tobacco products
- improving awareness of the harm
- reducing exposure to second hand smoke

These actions need to take account of the wider issues people face in their lives. Many factors, from lack of opportunity to social isolation, can increase the risks of unhealthy behaviours in particular smoking.

Most smokers want to stop but quitting is hard. Many people make several attempts before they succeed. It's even harder when people are dealing with stress in their lives. To improve the chances of quitting, all smokers need:

- Effective services and therapies
- Supportive social networks
- SmokeFree environments

Alcohol Harm

Challenge

Emergency hospital admissions for alcohol related conditions are a major burden for the health and social care economy. With 2,236 alcohol related admissions occurring in 2023/24; (988/100,000); compared to 812/100,00 (Greater Manchester) and 612/100,000 (Eng.) This makes Tameside significantly worse than the England average and ranks us 2nd across Greater Manchester's 10 local authority areas.

Admission episodes for alcohol-specific conditions (Persons) 2022/23 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	320,082	581	579	583
CA-Greater Manchester	↓	19,597	745	734	755
Salford	↓	2,504	1,128	1,083	1,173
Tameside	→	1,921	856	818	896
Manchester	↓	3,432	842	813	872
Wigan	→	2,559	771	741	801
Rochdale	→	1,568	745	709	783
Stockport	→	2,188	743	712	775
Oldham	↓	1,529	695	661	731
Trafford	↓	1,303	579	548	611
Bolton	↓	1,595	575	547	604
Bury	↓	998	532	499	566

Figure 37: Alcohol related hospital admissions 2023/24 *Source: OHID Alcohol profiles*

Between 2018 and 2021 there were 47 (22.3/100,000) admissions for alcohol specific conditions in young people under 18 years: This is slightly higher to the England average (22.1/100,000). Trends show that there has been a marked reduction in hospital admissions for young people under 18 years in Tameside. (Figure 30 on the next page)

Implications

An analysis of 67 risk factors and risk factor clusters for death and disability found that alcohol is the third leading risk factor for death and disability after smoking and obesity.[51] Alcohol misuse, binge and chronic drinking are associated with a wide range of problems including personal impairment of physical and mental health and problems at a community level such as anti-social behaviour.

[51] https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

Admission episodes for alcohol-specific conditions (under 18 years) (Persons) 2021/22 - 23/24

Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	8,043	22.6	22.1	23.1
CA-Greater Manchester	–	-	-	-	-
Tameside	–	47	30.4	22.3	40.4
Wigan	–	54	26.0	19.5	33.9
Stockport	–	48	25.3	18.6	33.5
Salford	–	42	23.3	16.8	31.5
Rochdale	–	32	19.2	13.1	27.1
Bolton	–	39	17.9	12.7	24.5
Manchester	–	54	14.0	10.5	18.3
Trafford	–	20	12.0	7.3	18.6
Oldham	–	20	10.7	6.5	16.5
Bury	–	13	9.9	5.3	16.9

Figure 38: Hospital admissions for alcohol specific conditions- under 18 years (2020/21 – 2022/23) *Source: Office for Health Improvement and Disaprities (OHID), Fingertips*

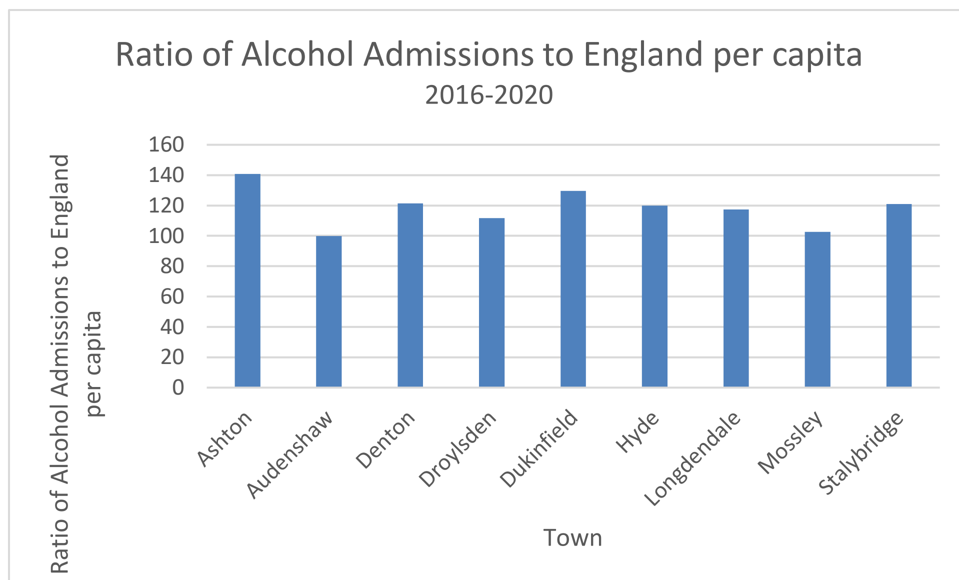


Figure 39: Hospital admissions Ratio for alcohol specific conditions (2016-2020) *Source: Office for Health Improvement and Disaprities (OHID), Local Health*

Tameside 9 Towns Summary

Ashton has the highest rate of alcohol admissions per capita in Tameside at 141 compared to the England ratio of 100, whilst Audenshaw is the lowest of all nine towns at 100, so the same as expected in England. This shows a disparity amongst the towns in the borough with Ashton being over 1.4 times the rate of Audenshaw.

Recommendations

There are many interventions and strategies to reduce alcohol harm on the individual, communities and at a societal level. We do know that the impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation.

The reasons for this are not fully understood. People on a low income do not tend to consume more alcohol than people from higher socio-economic groups. The increased risk is likely to relate to the effects of other issues affecting people in lower socio-economic groups.[52] Tackling alcohol related harm is an important route to reducing health inequalities in general.

[52] https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

Not all people estimated to have some level of alcohol dependence will need specialist alcohol treatment. Some will benefit from a brief intervention consisting of a short alcohol health risk check in a range of health and social care settings. However, alcohol treatment is effective for those who need it. Among those who received treatment, 61% of service users reported being free of alcohol dependence when they left treatment.[53]

Reducing alcohol-related harm: a blueprint for Government (BMA, 2018) lists a set of measures that should form part of the forthcoming alcohol strategy in England and is an important opportunity for the Government to commit to a comprehensive and effective range of measures to tackle alcohol-related harm at a population level.

[53] https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

Self-reported wellbeing

Challenge

Well-being is a key issue for the Government. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

The Annual Population Survey (APS); asks a number of questions relating to wellbeing. It is important to remember that the indicators are just an estimate, based on a sample of the population from each area.

1. Overall, how satisfied are you with your life nowadays?

2. Overall, how happy did you feel yesterday?

3. Overall, how anxious did you feel yesterday?

4. Overall, to what extent do you feel the things you do in your life are worthwhile?

The results for Tameside (2021/22) showed that

- 8% of the population had a low happiness score
- 5% of the population had a low satisfaction score
- 21% had a high anxiety score
- 4% had a low worthwhile score

Implications

Personal well-being is a subjective assessment of how people feel about their own lives. The measures of personal well-being focus on overall satisfaction with life, the extent to which we feel the things we do are worthwhile and daily emotions such as happiness and anxiety. These measures are strongly related to other important aspects of quality of life such as our health, relationships and employment.[54] Wellbeing can be defined as the extent to which an individual or group experiences their life as going well, based on experiencing positive emotions and meeting basic psychological needs. Many factors such as the availability of employment, access to personal space and social cohesion have an impact on individuals' subjective wellbeing.

There is increasing evidence that wellbeing leads to a number of positive health outcomes. This is best established in the case of length of life, with a number of longitudinal studies finding relatively large effects of wellbeing on life expectancy. Therefore poor personal wellbeing would lead to poorer health outcomes.

[54] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/qualityoflifeintheuk2018

Not only does wellbeing lead to longer lives, but it also seems to lead to healthier lives. A review and meta-analysis of 150 longitudinal and experimental studies in 2007 found compelling evidence of a positive effect of wellbeing on a range of other health outcomes as well as life expectancy.[55]

Recommendations

Research has identified a number of personal, social and economic variables that are associated with wellbeing. Strong social networks and personal relationships play an important role, and other measures of social capital, for example volunteering, membership of organisations and social trust also show an association with wellbeing. Having a good income and being employed are associated with higher wellbeing, while being in debt is bad for wellbeing. Both physical and mental health are also strong predictors of wellbeing.[56] The links to personal wellbeing and the wider determinants of health are intrinsically connected and therefore measures to improve opportunities, education, income, social mobility etc. will help improve people's personal wellbeing as well as overall health outcomes.

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[55] Howell, R. T., Kern, M. L., & Lyubomirsky, S. (2007). Health benefits: Meta-analytically determining the impact of well-being on objective health outcomes. Health psychology Review, 1(1), 83-136

[56] Stoll, L., Michaelson, J., & Seaford, C. (2012). Wellbeing evidence for policy: a review. London: New Economics Foundation

Preventable and premature mortality

Challenge

Under 75 mortality from causes considered preventable (2019 definition)[57] is significantly higher in Tameside than the England average: 251.0/100,000 versus 183.2/100,000. This equates to approximately 61 more deaths **across Tameside than the England average.**

Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Under 75 mortality rate from cardiovascular disease (Persons, <75 yrs)	2023	77.4	-	106.8	98.1	112.6	106.8	99.8	109.7	78.4	98.6	83.9	95.0
Under 75 mortality rate from cancer (Persons, <75 yrs)	2023	120.8	-	131.5	142.6	162.1	147.7	123.3	129.1	114.9	139.8	116.8	130.1
Under 75 mortality rate from liver disease (Persons, <75 yrs)	2023	21.9	-	24.7	30.3	32.4	37.6	38.2	23.8	24.2	28.5	21.9	40.0
Under 75 mortality rate from respiratory disease (Persons, <75 yrs)	2023	33.7	-	44.5	35.0	66.7	49.3	48.4	64.3	28.3	59.1	33.9	47.6

Figure 40: Mortality rate from causes considered preventable *Source: OHID Fingertips*

The main causes of preventable deaths can be seen in figure 31 which shows that Cancer is the highest contributor to preventable premature mortality, followed by cardiovascular disease.

Tameside ranks 6th highest for cardiovascular disease in Greater Manchester; 4th highest for cancer; 6th highest for liver disease and 3rd highest for respiratory deaths.

Across Tameside the rate of deaths per 100,000 from Coronary Heart Disease (CHD) was 54.3/100,000 (377 deaths), (2017/19) 5th highest across Greater Manchester boroughs. For Chronic Obstructive Pulmonary Disease (COPD), the rate was 103.6/100,000 (612 deaths), (2017/19), ranked highest across Greater Manchester boroughs.

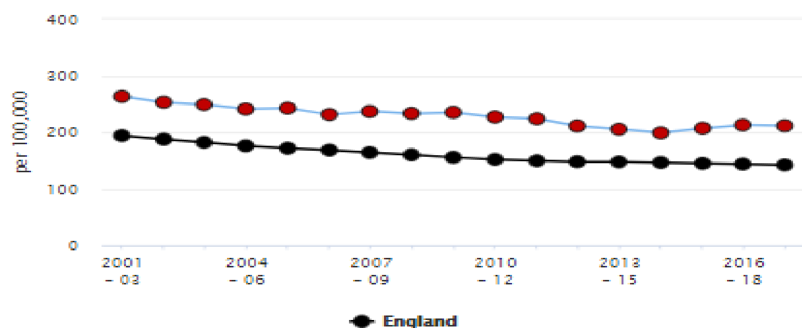


Figure 41: Trends in preventable mortality *Source: Public Health Outcomes Framework*

As of 2021 Tameside had 251 preventable deaths per 100,000 people compared to an English rate of 183.2, but due to a change in method these figures are not directly comparable to those previous.

Implications

Between 2017 and 2019 approximately 50% of all deaths under the age of 75 years were deemed preventable. Although preventable mortality has been reducing, the rate of decline has fluctuated somewhat when compared to the rest of England and has increased since 2014/16.

Preventable mortality is defined as deaths that can be mainly avoided through effective public health and primary prevention interventions. These include a wide variety of causes of death such as; suicide and self-inflicted injuries and homicide/assault; ischaemic heart disease (IHD), some cancers, HIV/AIDS; tuberculosis,

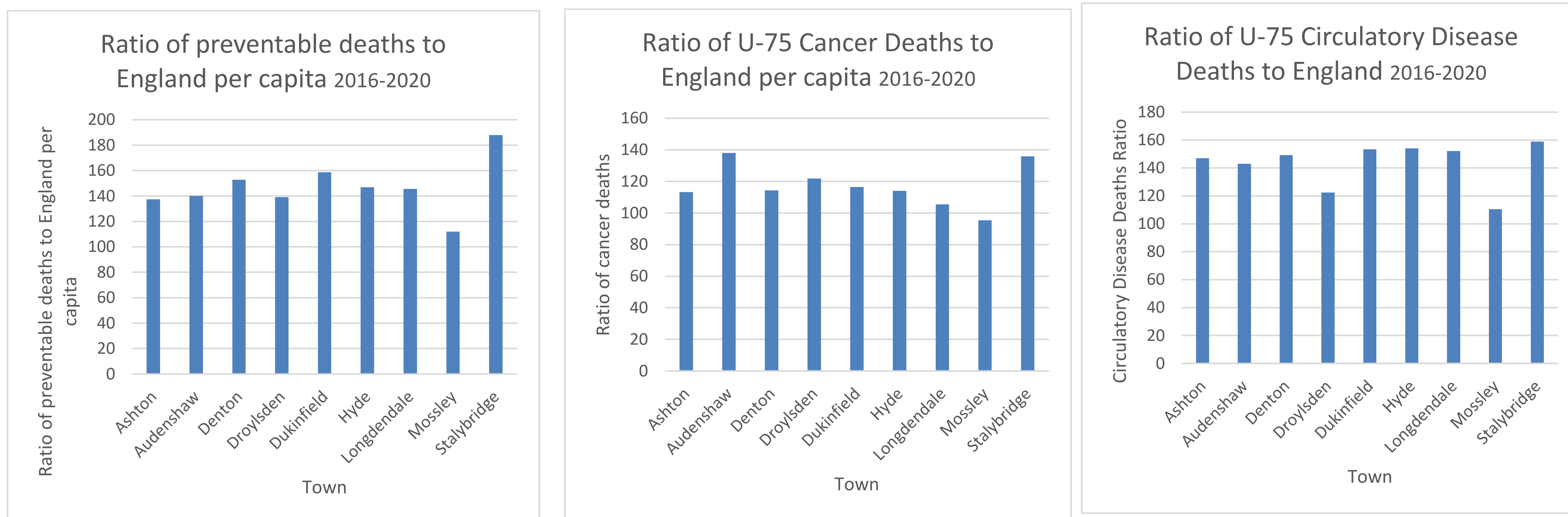
[57] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000044/pat/126/par/E47000001/ati/302/are/E08000008/iid/93721/age/163/sex/4/cid/4/tbm/1/page-options/car-do-0

Hepatitis C, diabetes, alcohol related diseases, illicit drug use disorders, deep vein thrombosis (DVT), aortic aneurysm, influenza, chronic obstructive pulmonary disorder (COPD), transport accidents and accidental injury.

Premature deaths is a strong indicator of inequality. The Marmot Review identified a clear social gradient for mortality and morbidity where the poorer are sicker and die earlier. Mortality and morbidity, along with life expectancy and healthy life expectancy are influenced by the conditions in which one is born, lives and dies. The Review showed that people living in the most deprived areas will on average, die seven years earlier than people living in the least deprived areas. Key drivers that affect the chances of an individual dying prematurely from preventable conditions include behaviour, social, economic and environmental factors, and location, all of which have a direct impact on health status and exacerbate existing ill health.[58]

Tameside 9 Towns Summary

Figures 42,43 & 44: Trends in preventable mortality by Town *Source: Public Health Outcomes Framework*



For preventable deaths, Stalybridge has the highest ratio with Mossley the least. All towns however have a higher ratio than the England average of 100. For cancer related under 75 deaths Audenshaw has the highest ratio at 1.5 times the England average, conversely Mossley is the only town to have a lower ratio

[58] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

than the England average of 100. In regard to under 75 circulatory disease deaths, Mossley has the lowest ratio, with Stalybridge having the highest. All towns were above the England average ratio of 100.

Recommendations

When looking at the causes of preventable deaths, it is easy to blame the individual and focus on how things like smoking, drinking, lack of exercise or poor diet can contribute to disease. But doing so fails to recognise that the conditions in which people live, work and age can make it harder for people to live healthier lives and in turn drive these huge differences in avoidable deaths.

Avoiding early deaths in our population is challenging. However the main areas of focus should be to

- Reduce inequalities across all areas, in particular health inequalities
- Tackle the wider determinants of health
- Boost the local economy so that everyone as access to good quality employment and decent incomes
- Adopt a population wide approach to tackling premature mortality
- Prevent, detect early and mange effectively infectious and chronic conditions more effectively

Self-Harm and Suicide

The challenge

Nationally rates of self-harm and suicide have remained fairly static over the last 10 to 15 years; where as in Tameside, suicide rates have fluctuated somewhat and for the most time have been significantly higher than the England averages. The rates in suicide and the significance for Tameside is in the male population, where suicide rates are 4 times higher in males than female's locally. In 2020/22 rates of suicide for both males and females rose slightly compared to 2019/21 – the lowest levels in the last 20 years – but remained similar to 2018/20, with rates now also being lower than the England average for both males and females. Across Greater Manchester Tameside ranks 8th out of 10 for suicides in males and as the lowest rate for females.

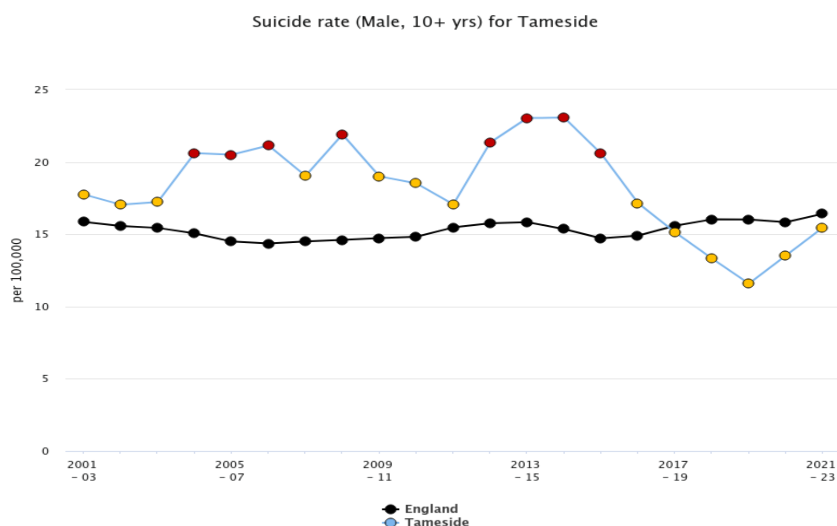


Figure 45: Trends in male suicide rates *Source: OHID Suicide prevention profiles*

Implications

Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

Recommendations

While factors contributing to suicide vary; the most vulnerable in society, such as the young, the elderly, those with mental health issues and the socially isolated are at the greatest risk.

- We need to strengthen our focus on men
- We need to raise awareness of support for people who are struggling-in particular to those who are most vulnerable to the risk of suicide.
- We need to ensure transport staff and those working in hotspot areas have appropriate suicide prevention training.
- We need to tailor approaches to improve mental health and wellbeing in specific groups and make communities more resilient.
- Increase access to taking therapies in areas where high risk populations live.
- We need to reduce access to means of suicide

Further reading

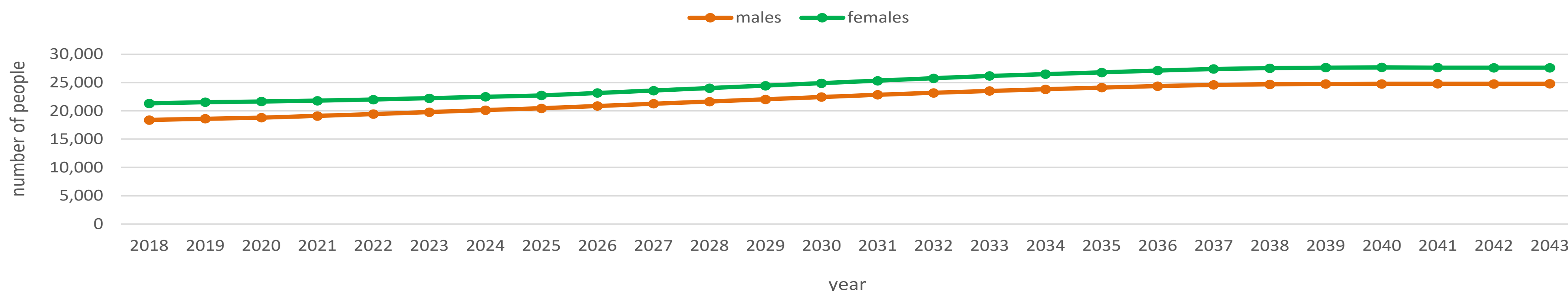
Tameside suicide prevention strategy: ITEM 5 - Suicide Prevention FINAL.pdf (moderngov.co.uk)
PHE suicide prevention profile for Tameside: Tameside Suicide Prevention Profile
Preventing suicide. A community engagement toolkit WHO: http://apps.who.int/community engagement toolkit
Suicide prevention: resources and guidance: https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

The ageing population

The Challenge

In 2021 the census estimated to be 40,509 people aged 65 years and over resident in Tameside (17.6% of the whole population) 6,000 more over 65s than 10 years ago (2010). Of this population approximately 54% are female and 46% male and this gap widens with each five year interval age increase.
Whilst there was a small drop in 2020 due to covid-19, population projections show that the rise in people aged 65 years and over will continue to rise in the future over the long term

Figure 46: Population projections for people age 65 years and over *Source: ONS Population Projections 2020 Based*



Source: ONS

Implications

Healthy life expectancy was as of 2018-20 57.9 years for males and 57.4 years for females. Given this is significantly lower than life expectancy at the same time, this means that a high proportion of our over 65 year old population will be living with a long term condition or disability.
The combination of extending life expectancy and the ageing of those born just after the 2nd world war, means that the population aged over 65 years is growing at a much faster rate than those under 65.
Men and women from the highest socio-economic class on average expect to live 7 years longer than those from the lowest socio-economic class and more of those years will be disability free. So health inequalities will also persist. Older people could be the driver of economic growth and social wellbeing or place a significant burden on the younger population. The number of older people living on their own is also set to rise, which increases the risk of people experiencing loneliness and isolation.
The impact of the ageing population will be felt the most by health and social care services, as the cost of health and social care are significantly greater for older people. The number of older people with care needs is expected to rise by more than 60% in the next 20 years.[59]

[59] https://www.kingsfund.org.uk/projects/time-think-differently/trends-demography

Recommendation

Ensuring we keep our population well and illness and disability free for as long as possible is key to ensuring age does not put a burden on people and communities. When long term conditions and disability do become an issue, integrated multidisciplinary health and care teams are the most beneficial to individuals and the most cost effective way to manage people and long term conditions.[60]

Implementation of social subscribing[61] programmes that support 'Healthy Ageing', such as 'Men in Sheds', physical activity programmes aimed at older people, community cafes and neighbourhood schemes are key to enabling older people to stay active in the community.

Development of a society/communities that are age friendly such as age friendly transport, housing, outdoor spaces, community support and activities. Age-friendly communities are places where age is not a barrier to living well and where the environment, activities and services support and enable older people to:[62]

- have opportunities to enjoy life and feel well
- participate in society and be valued for their contribution
- have enough money to live well
- feel safe, comfortable and secure at home
- Access to quality health and care.

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[60] https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/

[61] https://www.kingsfund.org.uk/publications/social-prescribing

[62] https://www.ageuk.org.uk/our-impact/politics-and-government/age-friendly-communities/

Dementia

The Challenge

There are an increasing number of people over 65 years with a diagnosis of dementia. As of 2020 1,618 (4%) of the over 65 population in Tameside were registered with Dementia. This had been increasing year on year for 10 years. However the estimated prevalence of Dementia locally was 76 higher than the recorded rate (1,694 people with dementia). Emergency hospital admissions for dementia have also increased and in 2019/20 there were 5,453 emergency admissions compared to 5,199 in 2018/19.

Implications

Dementia is an umbrella term used to describe a range of progressive neurological disorders, that is, conditions affecting the brain. There are many different types of dementia, of which Alzheimer's disease is the most common. Some people may have a combination of types of dementia. Regardless of which type is diagnosed, each person will experience their dementia in their own unique way. Symptoms of dementia include memory problems, communication issues and cognitive ability deterioration.

The total cost of care for people with dementia in the UK is £34.7billion.[63] These costs are made up of healthcare costs (costs to the NHS), social care costs (costs of homecare and residential care), and costs of unpaid care (provided by family members). The largest proportion of this cost, 45%, is social care, which totals £15.7billion. Social care costs are set to nearly triple over the next two decades, to £45.4billion by 2040.

Recommendations

Women are more likely than men to develop dementia in their lifetimes. One of the main reasons for the greater prevalence of dementia among women is the longer life expectancy of women. (65% versus 45%)

There's no certain way to prevent all types of dementia, as researchers are still investigating how the condition develops. However, there's good evidence that a healthy lifestyle can help reduce your risk of developing dementia when you're older. A healthy lifestyle can also help prevent cardiovascular diseases, such as stroke and heart attacks, which are themselves risk factors for Alzheimer's disease and vascular dementia (the 2 most common types of dementia). Ageing is the biggest risk factor to Dementia so ensuring people are ageing well (active ageing) is important in preventing Dementia. Having a healthy younger life can reduce the risk of dementia so choosing healthier lifestyles such as not smoking, being physically active and eating well are key.[64]
Dementia in England is under diagnosed and this is important in reducing emergency hospital admissions, so diagnosing Dementia at the earliest opportunity is key to improving dementia care and outcomes.

Further reading:

Dementia profile for Tameside: Dementia Profile - OHID (phe.org.uk)
Dementia NICE reports and guidance: https://www.nice.org.uk/guidance/conditions-and-diseases/neurological-conditions/dementia

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[63] https://www.alzheimers.org.uk/about-us/policy-and-influencing/dementia-scale-impact-numbers
[64] https://www.nhs.uk/conditions/dementia/dementia-prevention/

Falls

The Challenge

Falls in Tameside residents over 65 years pose a real risk to health. In 2022/23 Tameside had a somewhat higher emergency admission rate for falls in people aged 65 years and over than the England average, whilst being only the 7th[th] highest in Greater Manchester. (2,040/100,000 or 785 admissions compared to 2100/100,000 (Eng.) Over the same time frame, hip fractures in Tameside were the 5th highest in Greater Manchester and are higher than the England average. (661/100,000 or 255 emergency admissions for hip fractures versus 558/100,000 (England)). Therefore the conversion rate of a fall to hip fracture is very high for people in Tameside.

Implications

Falls and fall-related injuries are a major challenge to health and care systems and to the older people who suffer them. Around one in three people over 65 and one in two people over 80 fall at least once each year. Falls account for around 40 per cent of all ambulance call-outs to the homes of people over 65 and are a leading cause of older people's use of hospital beds.[65] Each year there are around twice as many fractures resulting from falls as there are strokes in the over 65s. Fractures are an important cause of disability in the elderly. Due to decreased bone mass among this age group, fractures are more common and tend to have a profound effect on ability to perform activities of daily living. In addition to broken bones, falls may lead to prolonged lies on the floor, with resulting complications, and they are a common precipitant for people moving into long-term care, or needing more help at home. Hip fractures are associated with significant morbidity, mortality, loss of independence, and financial burden. The reported 1-year mortality after sustaining a hip fracture has been estimated to be between 14% and 58%.[68]

Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Emergency hospital admissions due to falls in people aged 65 and over (Persons, 65+ yrs)	2022/23	1933	2280	1989	1910	2506	1996	2197	2770	2346	2040	2119	2645
Emergency hospital admissions due to falls in people aged 65 to 79 (Persons, 65-79 yrs)	2022/23	928	1114	990	951	1326	1075	1137	1285	1033	878	1037	1300
Emergency hospital admissions due to falls in people aged 80 plus (Persons, 80+ yrs)	2022/23	4845	5664	4887	4690	5929	4668	5272	7079	6153	5411	5257	6544
Hip fractures in people aged 65 and over (Persons, 65+ yrs)	2022/23	558	653	669	699	648	611	670	703	631	661	635	630
Hip fractures in people aged 65 to 79 (Persons, 65-79 yrs)	2022/23	243.8	293.6	313.0	362.8	325.3	311.5	280.9	300.1	272.0	242.9	288.5	261.1
Hip fractures in people aged 80 and over (Persons, 80+ yrs)	2022/23	1469	1695	1703	1674	1585	1480	1797	1871	1671	1875	1640	1698

Figure 47: Overview of falls and fractures in older people across Greater Manchester *Source: Office for Health Improvement and Disparities (OHID), Fingertips*

Recommendations

Hip fractures contribute to significant loss in productive years among older people. Changing modifiable risk factors such as smoking and physical inactivity may help in reducing DALYs lost after hip fracture in particular. Programmes and measures which prevent the incidence of falls among this

[65] https://www.kingsfund.org.uk/blog/2013/09/what-are-real-costs-falls-and-fractures#:~:text=Around%20one%20in%20three%20people,people%27s%20use%20of%20hospital%20beds.

age group may also help improve quality of life. Preventing falls in older people is key to preventing hip fractures and reducing emergency hospital admissions. NICE guidelines covers assessment of fall risk and interventions to prevent falls in people aged 65 and over. It aims to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and mortality.[66]

Further reading:

Falls: All Our Health https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health
Falls and fractures: consensus statement and resources pack; https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement

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[66] https://pathways.nice.org.uk/pathways/preventing-falls-in-older-people

Vaccination Coverage

The Challenge

Flu vaccination coverage for people aged 65 years and over in Tameside was 70.5% (2023/24). This has now fallen below the national target of 75% after a decline a decline following a consistent increase that happened since the beginning of the Covid-19 pandemic. For Shingles vaccination coverage the proportion of those aged 70 years and older receiving the vaccine was 43.9% of the eligible population (2022/23), this is a rise after a fall during the pandemic.

Figure 48: Trends in flu vaccination coverage

Source: Health protection profiles, OHID Fingertips

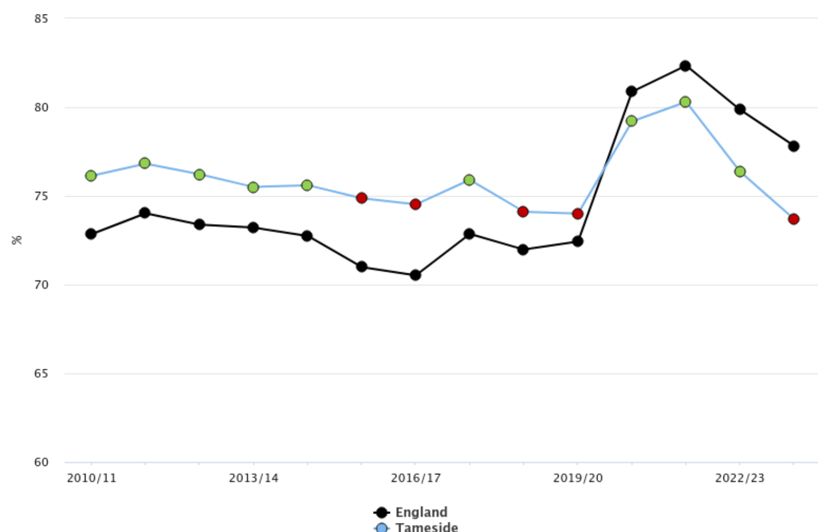


Figure 49: Vaccination coverage across Greater Manchester

Source: Health protection profiles, OHID Fingertips

Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Population vaccination coverage: PPV (Persons, 65+ yrs) <65% 65% to 75% ≥75%	2022/23	71.8	-	74.0	64.5	69.5	72.5	73.2	68.9	79.8	70.5	75.0	73.1
Population vaccination coverage: Flu (aged 65 and over) (Persons, 65+ yrs) New data <75% ≥75%	2023/24	77.8	-	76.1	77.5	67.8	76.8	76.1	73.4	83.2	73.7	79.3	78.5

Implications

Vaccination as a public health intervention has had a positive impact on health and wellbeing that is almost unprecedented, drastically reducing the global burden of infectious disease. The World Health Organisation has estimated that, globally, around two to three million deaths are prevented each year through vaccination programmes.

As the life expectancy for people in Tameside increases, the health and wellbeing of older people is becoming an increasingly important issue for the sustainability of the health system. Older people can spend many years in poor health and require the use of health services. With an ageing population, the

ability for older people to maintain their independence and retain quality of life will become one of the crucial health Issues of the 21st century. Vaccines have an important role to play.[70]
Infection is one of the leading causes of disability in older age, which can mean a loss of independence. While strokes and chronic heart failure are the top causes; pneumonia and flu follow closely behind.[67] Vaccines can help to prevent older people, who may cope less well with infection, from falling ill. Key vaccines for older people include seasonal flu vaccine, the shingles vaccine and the pneumococcal vaccine.

Recommendations

The national flu immunisation programme is a key part of winter planning. The flu programme is there to offer protection to those who are most at risk from the consequences of the flu virus.

To increase uptake of all vaccinations in older people. It is important to

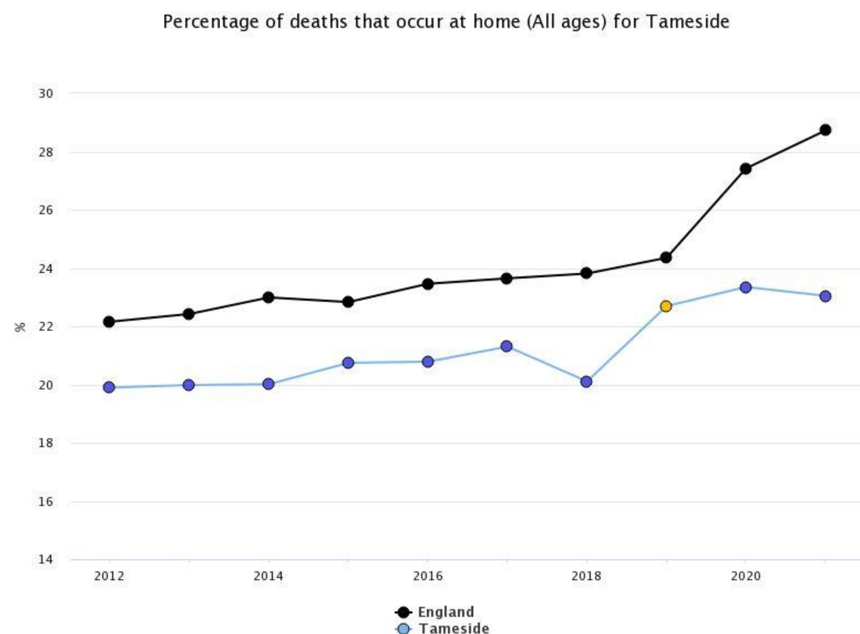
- Make access to the flu vaccination as accessible as possible
- Implement clear and timely communications especially those involved in managing the immunisation programmes so that they understand their roles and responsibilities.
- General flu, shingles and Pneumococcal disease awareness through campaigns and communication plans so the messages get through to the population. For example the National Flu marketing campaign.
- Support to general practice to encourage take up of all vaccinations and to practices that need support in improving take up rates.

Further reading:

Increasing uptake for vaccinations: LGA_Increasing vaccination uptake
Moving the Needle: https://www.rsph.org.uk/static/uploaded/3b82db00-a7ef-494c-85451e78ce18a779.pdf
Flu vaccination: increasing uptake: https://www.nice.org.uk/guidance/ng103

[67] World Health Organization, Advancing the agenda: vaccines for older adults (Presentation), Hyderabad: WHO, 2014.

End of life planning



The Challenge

Figure 50: Trends in the proportion of deaths in usual place of residence *Source: OHID End of Life profiles*

Approximately 2,100 people die in Tameside each year (with a spike during COVID-19). People with advanced life-threatening illnesses and their families should expect good end of life care, whatever the cause of their condition. In addition to physical symptoms such as pain, breathlessness, nausea and increasing fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual difficulties. The proper management of these issues requires effective and collaborative, multidisciplinary working within and between generalist and specialist teams, whether the person is at home, in hospital or elsewhere.[68]
In 2021, 23% of people who died in Tameside died in their usual place of residence. This is higher than previous years, but this seems to have been a general trend during COVID-19. Tameside has a lower proportion of people dying in their usual place of residence than both Greater Manchester and England.

People with conditions such as cancer or heart disease have a higher proportion of people dying in their usual place of residence (35%) where as people with respiratory conditions have a lower proportion of deaths in their usual place of residence. (22%).

Implications

Providing care at the end of life often involves the interaction of many different care agencies. Effective end of life care improves the quality of life of the dying person and those important to them.
Although many people may have a different ideas of what constitutes a 'Good Death', for many being treated as an individual, with dignity and respect, being without pain or symptoms, being in familiar surroundings and around close family and friends are the main needs.
Some people do get to make a choice but many don't. Some people experience great care but too many people experience unnecessary pain and discomfort, are left alone or in public view. Some people do not get treated with dignity and respect and many people do not die where they wish to.[69]

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[68] https://www.nice.org.uk/guidance/qs13/chapter/introduction-and-overview
[69] https://www.cqc.org.uk/sites/default/files/20160505%20CQC_EOLC_OVERVIEW_FINAL_3.pdf

The National Care of the Dying Audit for Hospitals (NCDAH), England, found significant variations in care across hospitals in England. The audit showed that major improvements need to be made to ensure better care for dying people, and better support for their families, carers, friends and those important to them.[70] 'Dying without Dignity' reveals several examples of where patients and their families had negative experiences at the end of their life due to such things as poor communication, a lack of out of hours support and a lack of recognition that the person was dying.[71]

Recommendations

Good palliative and end of life care should focus on the perspective of the dying person and the people closest to them and should be at the heart of our commitment to everyone at the end of life.
Efforts should focus on improving care co-ordination, sharing data and information and building exemplar care pathways and innovative hospice led interventions. The 'Choice' review was a product of extensive public consultation and engagement that set out elements of end of life care that people most cared about.[72]
It states that choice in end of life care should mean:

- Practical help at an individual level that will help every dying person express their preferences, should they wish to do so;
- A commitment to involve those important to the individual in discussions about the dying person's care and preferences, to the extent that the dying person has agreed;
- Support for staff and organisations whose responsibility it is to deliver high quality, compassionate care and implement the preferences and decisions people have articulated
- Action, from Government and statutory agencies to create an environment where people are informed and empowered to express their preferences and that these preferences can be met as far as possible
- Recognition that good end of life care is not delivered in isolation – it depends on support and awareness in communities and in wider society.

Palliative and end of life care must be a priority. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

Further reading:

- Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 endoflifecareambitions
- What's important to me? A Review of Choice in End of Life Care CHOICE_REVIEW_FINAL
- A different ending. https://www.cqc.org.uk/sites/default/files/20160505%20CQC_EOLC_OVERVIEW_FINAL_3.pdf
- Palliative Care and End of Life profiles: fingertips.phe.org.uk/profile/end-of-life

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[70] https://www.hqip.org.uk/wp-content/uploads/2019/07/National-Audit-of-Care-at-the-End-of-Life-National-Report-2018-FINAL.pdf
[71] https://www.ombudsman.org.uk/sites/default/files/Dying_without_dignity.pdf
[72] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407244/CHOICE_REVIEW_FINAL_for_web.pdf