

2013/14

Tameside Health & Wellbeing Board

Tameside Joint Strategic Needs Assessment



Health&Wellbeing
making it happen together in Tameside

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1. Introduction

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

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

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

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

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

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

- Assurance that current priorities, identified in 2013 for action, should remain
- Confirmation that some of the longer term priorities should remain. Examples include teenage conceptions, early identification of people with HIV, dementia, reducing falls & their impact in older people, reducing emergency admissions, reducing cancer mortality, increasing breastfeeding, increasing access to rehabilitation etc
- A benchmarking exercise on a range of areas across the health and social care system that can be used as a reference document around the current position, where progress has been made and recommendations for further action that would improve outcomes. These are wide ranging in nature. This JSNA can then be reviewed at a reasonable interval to determine if measures in place have made a notable difference.
- Gives an overview of the outcomes that public health, social care and the CCG will be specifically responsible for delivering against.
- Provides an outline for a number of thematic areas such as a healthy start in life, support for vulnerable groups, active ageing etc that could be strands in a life-course approach to commissioning.
- Enables areas across the NHS, social care and public health to be seen as part of a range of measures to improve health and support independence. One example is

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

- There is a focus on vulnerable groups who have traditionally not had the same level of access to healthcare, employment and other supportive systems. This review enables a number of indicators to be viewed together to inform joint working.
- There are some indicators on access to primary care and dentistry that are useful markers.
- There are a number of outcomes where there is limited action in place at the moment but where data indicates there is a higher prevalence which will need to be considered: suicide prevention, hospital admissions as a result of self harm, children and adults with autism, domestic violence,

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

Overarching Indicators

Life Expectancy

Outcomes Framework:

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

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

The life expectancy indicators are intended to provide a snap shot of the general health status of the population and an overview of the health inequalities affecting communities.

Health Inequalities is the term used to describe differences in the health and well-being of individuals and groups. It describes the differences in health experiences and health outcomes between different population groups according to: socio-economic status, geographical areas, age, disability, gender, ethnic group, religious belief and sexual orientation.

Benchmarking:

Overall Life Expectancy in Tameside/Tameside and Glossop for both males and females is below the average for Greater Manchester, the North West and England as can be seen on the figure below.

Life Expectancy at Birth (2010-2012); 3 year rolling average



Source: NHS Information Centre, 2012

For the 2010-12 figures, Tameside MBC is ranked at 318 for male life expectancy, and 314 for female life expectancy, out of 324 Local Authorities.

Healthy Life expectancy (HLE)

Health expectancies (HEs) divide predicted lifespan into time spent in given states of health thereby adding a quality of life dimension to estimates of LE. Healthy life expectancy (HLE), estimates lifetime spent in 'Very good' or 'Good' health based upon self-perceived general health and Disability-free life expectancy (DFLE), which estimates lifetime free from a limiting persistent illness or disability based upon a self-rated functional assessment of health.

HLEs are used as a high level outcome to contrast the health status of different populations at specific points in time and to monitor changes in population health over time, giving context to the impacts of policy changes and interventions at both national and local levels. HLEs have value across state, private and voluntary sectors, in the assessment of healthy ageing, fitness for work, health improvement monitoring, and extensions to the state pension age, pension provision and health and social care need.

Healthy life expectancy in Tameside is currently 57.5 years for males and 56.8 years for females, which is significantly lower than the England average of 63.2 years for males and 64.2 years for females.

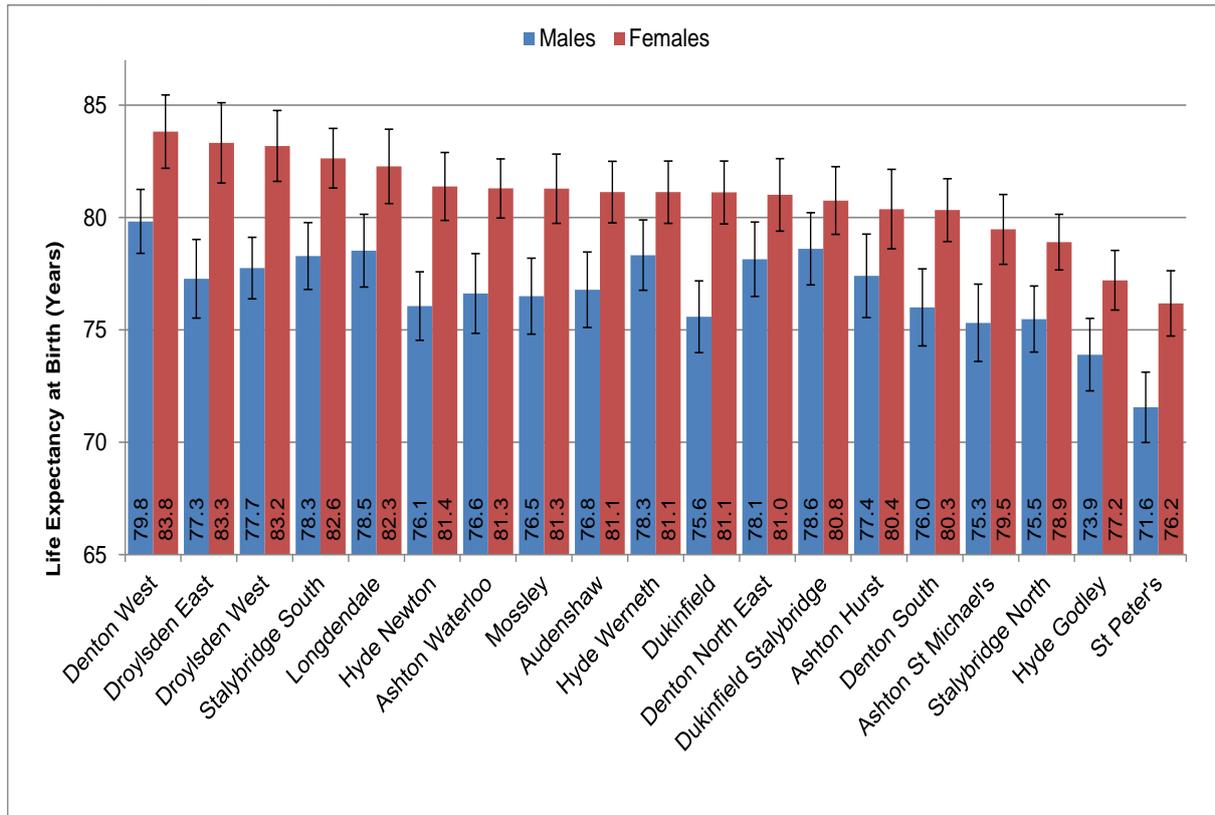
At risk or vulnerable groups:

- People living in deprived areas
- People experiencing financial pressures and insecure employment
- Children and families living in poverty and poor housing
- Black and Minority Ethnic Groups
- Adults with poor educational attainment

Deprivation is a major factor influencing our population's health needs, influencing health inequalities and life expectancy and there is link between areas of higher deprivation and areas with low life expectancy levels. This link can be seen in Tameside: Ashton St Peters and Hyde Godley are two of the most deprived wards and correspondingly they suffer some of the lowest rates of life expectancy.

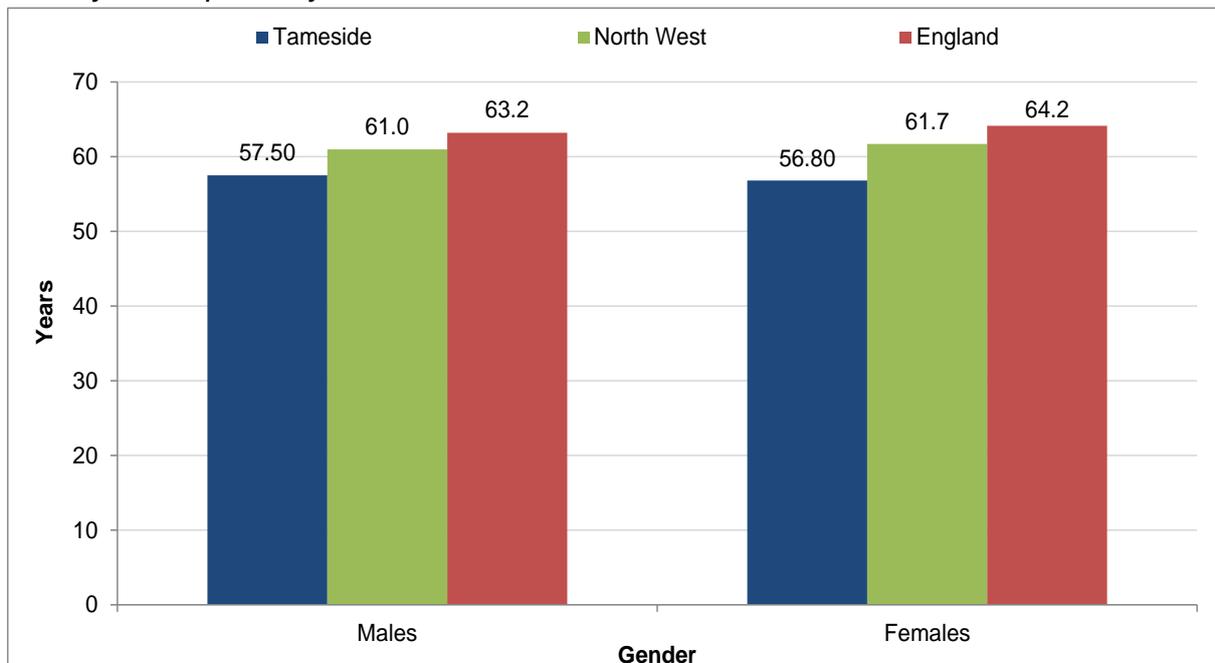
Across Tameside wards there is over an eight year difference in male life expectancy from 71.6 in St. Peter's to 79.8 in Denton West. Across Tameside wards there is over a seven year difference between in female life expectancy from 83.8 in Droylsden West to 76.2 in St. Peter's.

Life Expectancy at Birth (Tameside 2010/2012)



Source: Tameside MBC Public Health Intelligence 2014

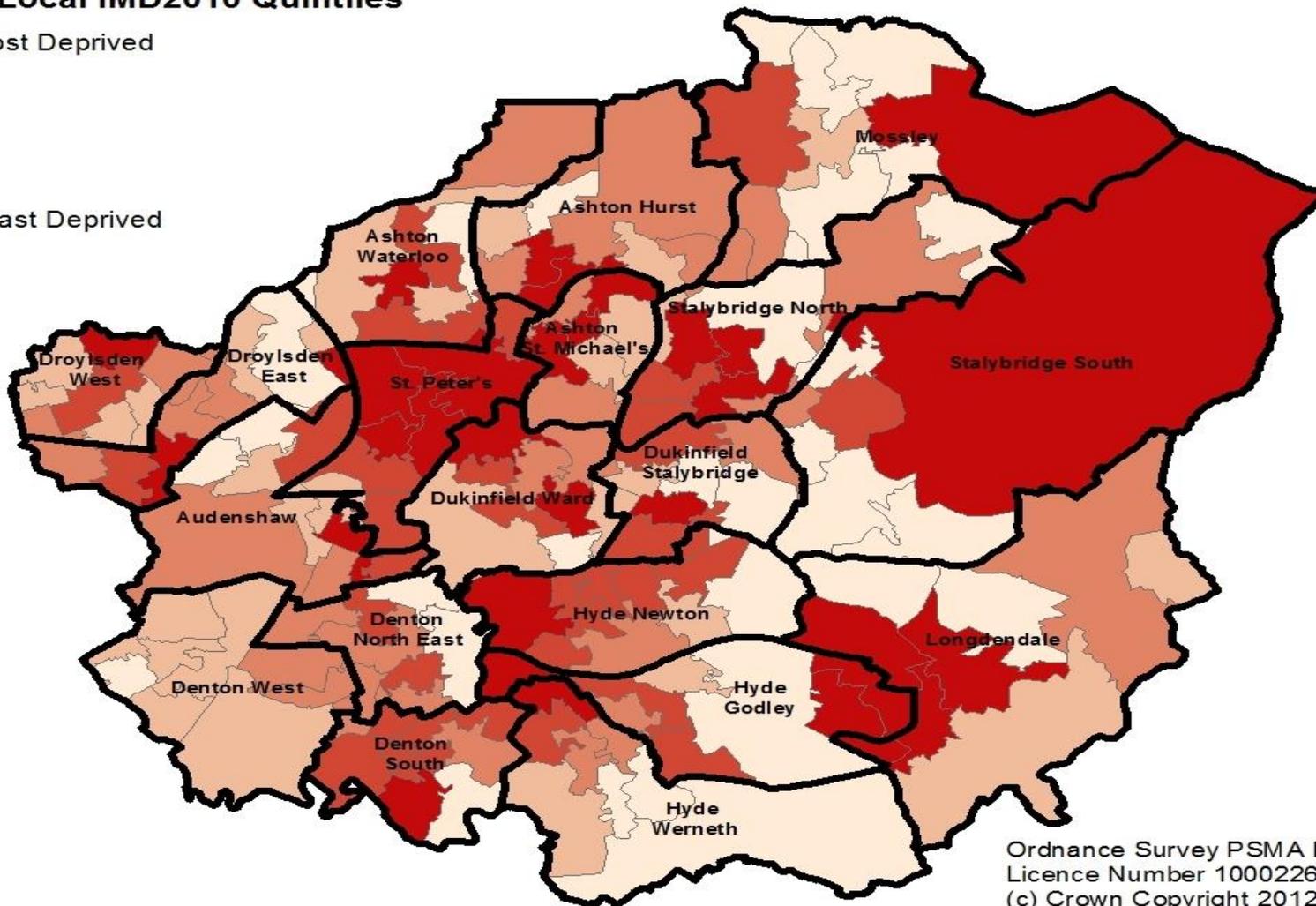
Healthy Life Expectancy at Birth 2009/2011



Source ONS

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

Tameside Local IMD2010 Quintiles



Ordnance Survey PSMA Data
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Source: Public Health Tameside MBC 2014

National and local policy context

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

What interventions work?

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

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

The main causes of death (in all ages) in Tameside mirror those of England and the North West Region. The most recent mortality data shows that circulatory diseases (heart disease and stroke) and cancers remained the main causes of death 34% and 26% respectively. Respiratory Diseases account for 12% of deaths in Tameside.

Deaths in people under-75 years are considered preventable and therefore premature. In Tameside and Glossop a higher percentage of women die prematurely as a result of cancer than men (43% compared to 36%), but cancer is still the main cause of premature death for men. However 28% of men die prematurely from circulatory disease compared to 22% of women. Additionally 10% of deaths in the under 75's are due to respiratory diseases.

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

However lifestyle factors cannot be considered in isolation from the environment in which people live nor the services (including health services) which support communities, families and individuals to better health. Therefore interventions that can significantly reduce an

individual's risk of premature illness are central to improving life expectancy rates across Tameside and Glossop.

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

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

- Facilitate access to universal services
- Build social capital within local communities
- Be embedded in primary and secondary care
- Ensure people have greater choice and control over meeting their needs

What are we doing now?

- Implementing robust partnership structures that are addressing the wider determinants of health
- Promoting financial inclusion and tackling income inequalities
- The Workplace Health Improvement Programme to support people in making healthier choices and in living healthier and longer lives
- Embedding Prevention and Early Intervention into all frontline services
- The Tameside Housing Strategy Action Priorities
- Affordable Warmth Access Referral Mechanism
- Primary Care Services – levelling up quality between practices including early identification of people with risk factors, disease management, expert patient programmes, pathway approach to Long Term Conditions management, vaccination and screening uptake, including dementia screening.
- Lifestyle Very Brief Advice (VBA) and Brief Advice (BA) and Brief Interventions (BI) by frontline practitioners to encourage people to stop smoking, maintain a healthy weight, drink alcohol within recommended levels.
- Provision of Health Improvement and Well-being Services, including:
 - Active Ageing
 - Workplace Health Improvement
 - Smoke Free
 - Stop Smoking Service
 - Weight Matters
 - Health Trainers/Well-being advisors
 - Community Health Development and Community Engagement
 - Oral Health Promotion
 - Physical activity and active recreation

What needs to happen next, and by whom?

- A strategic shift towards and investment in early intervention and prevention
- The development and implementation of Health and Well Being Strategies across Tameside and Glossop through the effective engagement with a wide range of partners and Council departments to improve health and life expectancy
- Social Marketing and Community Engagement Campaign
- Developing a Healthy Schools Programme
- Effective working at Neighbourhood level and building strong relationships with communities
- Programme of Health Equity Audit (HEA) to ensure different population groups get the services they need
- JSNA to identify health needs and work towards more effectively meeting those needs
- Ongoing commitment to improving access to health services and improving outcomes for all
- Refreshed focus on early years maximising appointments to engage with families antenatal and in pre-school years.

Health and Well Being Boards in Tameside and Derbyshire and The Tameside Strategic Partnership and associated partnerships including the Tameside Health Partnership should be responsible for the above actions.



Starting and Developing Well

Starting and Developing Well

Low birth weight and Infant mortality

Outcomes framework: Public Health 2.1; 4.1; NHS 1.6

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

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

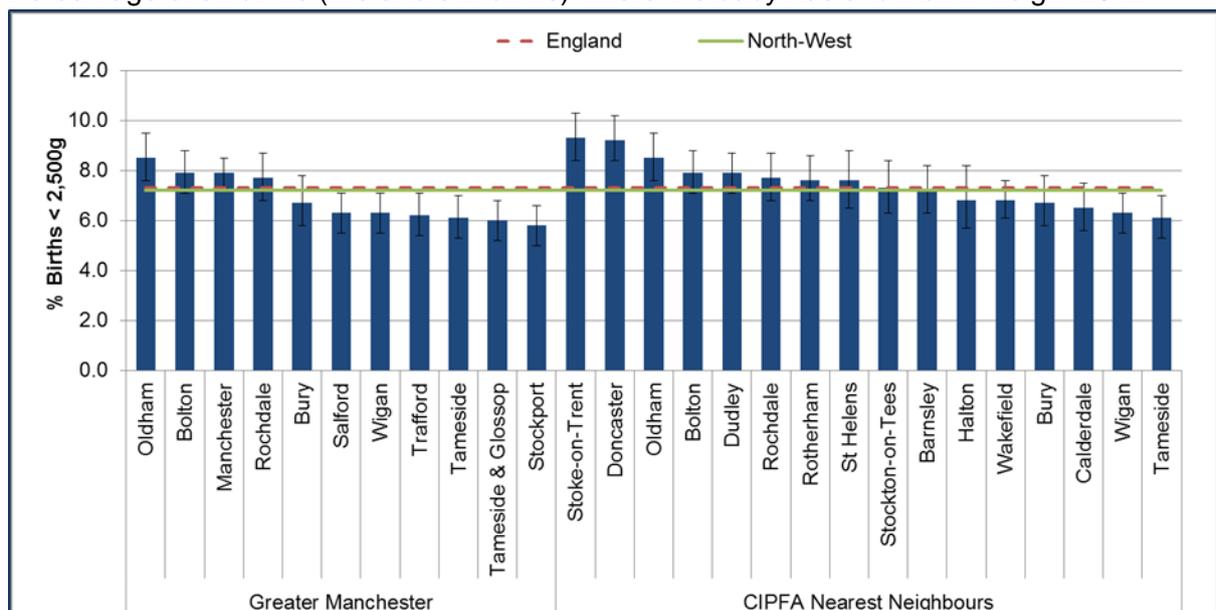
At risk or vulnerable groups:

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

Benchmarking:

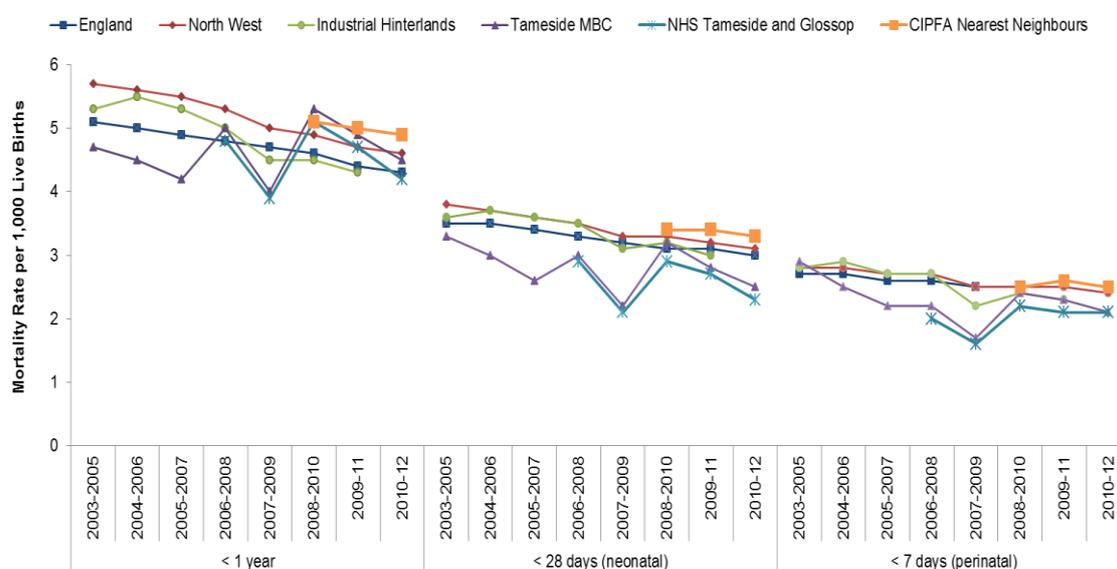
Low birth weight has previously been more common in Tameside than in the North West (NW) and England but in 2012 had improved to be significantly better than national and regional averages, and the best compared to statistical neighbours. Local infant mortality is consistently below the NW and England averages.

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



Source: HSCIC 2013

Infant, neonatal and perinatal* mortality rates** per 1000 live births, 2003-2005 to 2010-2012
 [*including still births] [**each age group excludes the deaths from the younger age groups].



Source: HSCIC, 2013

Policy context:

Low birth weight is highlighted by the [Marmot Review](#) as an important indicator of population health, and is included in the [DH Business Plan for 2011-15](#) within the context of addressing issues of premature mortality, avoidable ill health and inequalities in health, particularly in relation to child poverty.

What interventions work?

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

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

What are we doing now?

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

A pilot programme involving the employment of a community midwife with a specific remit for smoking cessation is being piloted during 2013/14.

What needs to happen next, and by whom?

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

Breastfeeding at 6 to 8 weeks

Outcomes framework: Public Health 2.2

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

There is significant immediate and long term health benefits associated with breastfeeding. Current World Health Organisation (WHO) and Department of Health (DH) policy is to promote exclusive breastfeeding for the first 6 months. Increasing the number of women who initiate and continue to breastfeed at 6-8 weeks will help to realise the following benefits cited by NICE:

- Increasing the number of women who breastfeed exclusively for 6 months
- Reducing the number of hospital admissions for diarrhoea and respiratory infections in infants
- Reducing the risk of ovarian and breast cancer in women who breastfeed
- Reducing the risk of obesity in children, and lowering the risks of developing coronary heart disease and diabetes in later life
- Raising public awareness of the benefits of breastfeeding
- Reducing inequalities and improving access to breastfeeding support for women in low income groups

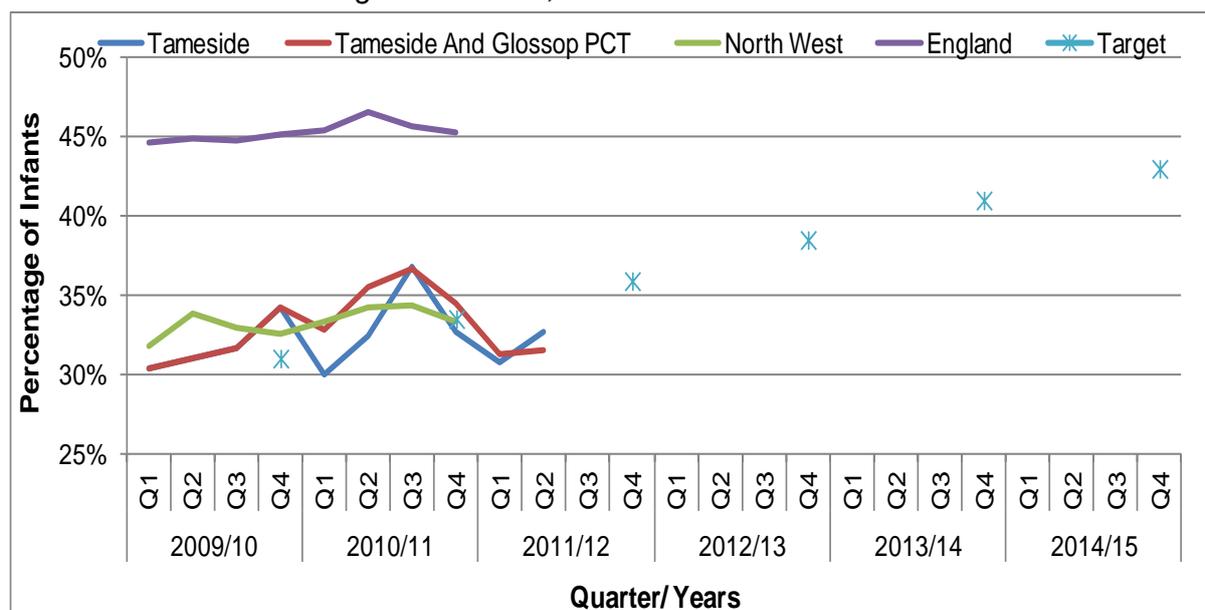
At risk or vulnerable groups:

There is a strong social gradient for initiation and continuation of breastfeeding. Current local priority areas in Tameside and Glossop are Ashton Hurst, Ashton St Michael's, Ashton St Peter's, Denton South, Hyde, Hattersley and Gamesley. Breastfeeding mums can be vulnerable to discrimination, particularly when trying to feed in public. This prevents and discourages many women from breastfeeding.

Benchmarking:

[The Infant Feeding Survey \(2005\)](#) showed that 78% of women in England breastfeed their babies immediately after birth, but by 6 weeks, the proportion had dropped to 50%. In Tameside and Glossop breastfeeding rates are below the national average. Rates are increasing since the establishment of a local Infant Feeding Team, and investment in a peer support programme as part of the local World Class Commissioning process.

Prevalence of breastfeeding at 6-8 weeks, 2009-2011



Sources: Department of Health Statistical Release on Breastfeeding; Tameside and Glossop CHC; NHS Tameside and Glossop

Policy context:

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

What interventions work?

[NICE guidance](#) highlights the impact of peer support as part of a comprehensive strategy to promote breastfeeding. Further effective approaches to promoting breastfeeding are included in [NICE guidance on antenatal and postnatal maternity care](#).

[UNICEF Baby Friendly](#) accreditation requires the adoption of best practice to support initiation and maintenance of breastfeeding, including staff training and audits to demonstrate compliance.

What we did in 2010/11

Key local initiatives to achieve improvements include:

- The work of the Infant Feeding Team, who have also led the work to achieve WHO Baby Friendly accreditation for local services.
- work to achieve UNICEF Baby Friendly Initiative accreditation
- Breast Feeding Peer Support Programme
- listing as a priority area in the current services specifications for Maternity, Health Visiting and Neonatal Care
- enabling public attitudes that are supportive of breastfeeding

- applying for accreditation by National Autistic Society to enable us to provide better support for people with Autism within their own homes

What we did in 2011/12

NHS Tameside and Glossop (NHS T&G) have set a target of 42.5% of babies to be breastfeeding at 6-8 weeks by 2013 and service investments are resulting in good progress towards this.

- NHS Tameside and Glossop/NHS Clinical Commissioning Group (CCG), in collaboration with Tameside MBC, needs to commission a comprehensive range of services to promote and support breast feeding, including a peer support programme and social marketing.
- Tameside and Glossop Community Health Care (T&GCHC) and Tameside Hospital Foundation Trust (THFT) need to continue to provide the Infant Feeding Team service, and lead the UNICEF Baby Friendly accreditation of local services.
- THFT and T&GCHC also need to continue to provide maternity and health visiting services that promote breastfeeding in-line with WHO, DH and NICE guidance.
- TMBC need to regularly review local strategies to breastfeeding promotion through their Health and Well-being Boards, and support breastfeeding within the work of Children Centres.
- All service providers, retail, leisure and catering outlets need to ensure that their facilities are suitable for women to breastfeed.
- Continue to challenge public attitudes that are not supportive of breastfeeding

Children in Poverty

Outcomes framework: Public Health 1.1

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

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

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

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

Programme spend:

Spend on tackling child poverty is difficult to quantify due to the cross-cutting nature of the poverty agenda and can be considered integral to the core work of children's and adult services, health and economic development. As such the policy responses to tackling child poverty will be embedded at a strategic level within a number of service areas including the Economic Strategy, Public Service Reform Plans and Local Health and Well-being Plans.

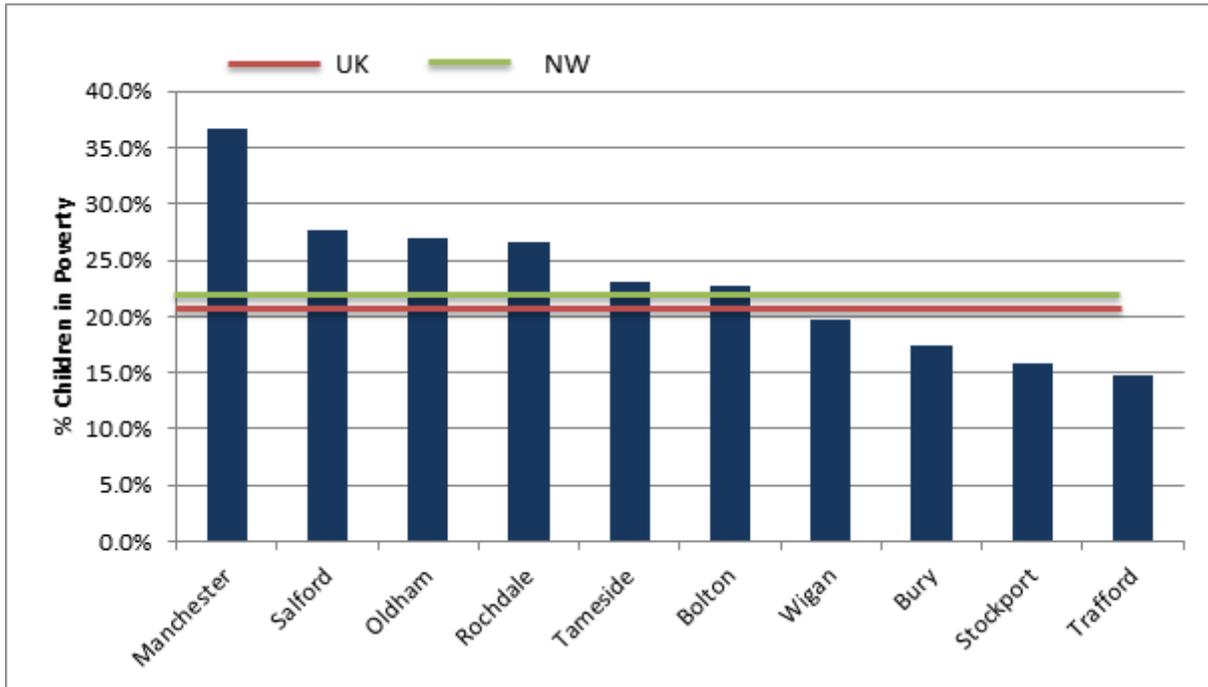
At risk or vulnerable groups:

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

Benchmarking:

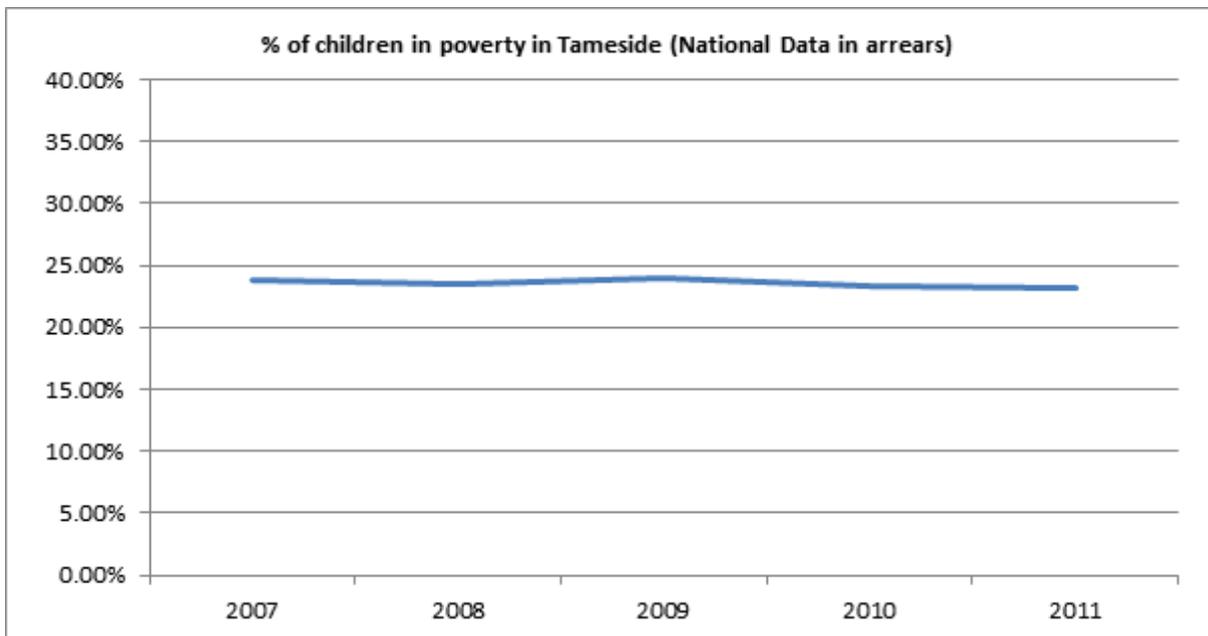
Levels of Child Poverty in Tameside are higher than both the North West and England (national Child Poverty Data from 2011). Local data had indicated that the levels of poverty had climbed over the past 4-5 years. Local data is no longer comparable due to welfare changes. National data from HMRC continues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

Percentage of children living in poverty, Greater Manchester local authorities 2011



Source: HMRC, 2011

Percentage of children living in poverty, Tameside, 2007-2011



Source: HM Revenue and Customs 2014

Policy Context:

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

What interventions work?

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

What are we doing now?

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

What needs to happen next and by whom?

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

Emotional well-being of looked-after children

Outcomes framework: Public Health 2.8

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

Central to young people's ability to fulfil their potential as they develop from childhood and through the teenage years is the need to be well – both physically and emotionally. Good physical and emotional health and well-being are key contributors to broader outcomes such as improved learning and achievement and to the long-term prospects of young people as they move into adulthood.

At 31 March 2013, there were 68,110 looked after children in England. This is an increase of 2 per cent compared to 31 March 2012 and an increase of 12 per cent compared to 31 March 2009.

- More looked after boys than girls have concerning emotional and behavioural health
- Just half of all looked after children have emotional and behavioural health that is considered normal
- There has been very little change over the last three years in looked after children's emotional and behaviour health needs

At risk or vulnerable groups:

All looked after children. This includes children from other areas placed in Tameside. Some children are more vulnerable than others in adapting to difficult situations and challenges that they face on their way to adulthood:

- Looked-after children have poorer educational outcomes than non-looked-after children. A high proportion (67.8%), have special educational needs and their emotional and behavioral health is often a cause for concern. However, despite poor outcomes, there have been improvements for nearly all of the measures in this statistical release.
- The percentage of looked-after children achieving 5 or more A* to C GCSEs or equivalent including English and mathematics has increased from 11.0% in 2009 to 15.3% in 2013.
- The attainment gaps between looked-after and non-looked-after children for the main key stage 1, 2 and 4 measures have decreased or remained the same from 2012 to 2013. However the gaps are still large, especially for key stage 4, where 15.3% of looked after children achieved 5 or more A* to C GCSEs or equivalent including English and mathematics compared with 58.0% of non-looked-after children. Although this gap has narrowed in recent years to 42.7 percentage points, it is still higher than it was in 2009.
- During the year ending 31 March 2013, 6.2% of looked-after children aged 10 to 17 had been convicted or subject to a final warning or reprimand and 3.5% of all looked-after children had a substance misuse problem.

- Looked-after children are twice as likely to be permanently excluded from school and nearly three times more likely to have fixed term exclusion than all children. Around half of all looked after children aged 5 to 16 were considered to be ‘borderline’ or ‘cause for concern’ in relation to their emotional and behavioral health.

Benchmarking:

Total number of Looked After Children (LAC) in Tameside	411
Number of LAC placed in Tameside (from other areas)	260
Number of LAC placed in other areas by Tameside	130
% of LAC with up to date health and dental checks	91.4%
% of LAC who are looked after for more than 12 months with an SDQ completed	97%
Average mean value of the overall SDQ scores	12.1

Source: Tameside MBC data – accurate as at 30th September 2013

Policy context:

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

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

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

What interventions work?

Early intervention and support for vulnerable children placed in care.

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

What are we doing now?

Targeted support for children and young people at risk of developing mental health problems: dedicated looked after children team to support children whose permanency plan is to remain looked after.

Work is ongoing with the CCG regarding commissioning arrangements for specific mental health support through CAMHS. (Child and Adolescent Mental Health Services)

The Goodman Strengths and Difficulties Questionnaire is used with each child who is looked after for 12 months or more and any child who scores above 18 (benchmark for concerns) is discussed with the CAMHS workers. Branching Out Counselling Service is commissioned to work with targeted groups including children in care.

As named health professionals, School Nurses and Health Visitors play an active role in working with looked after children and work with them and their carers to carry out health assessment reviews and develop a health action plan.

What needs to happen next, and by whom?

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

Tooth decay in children aged 5

Outcomes framework: Public health 4.2

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

- Tooth decay causes pain, sepsis, loss of appearance and confidence, loss nights' sleep, missed school, and required avoidable and unpleasant dental treatment including extractions under general anaesthetic which represent an avoidable risk to life.
- Good oral health in five year olds is an indicator of healthy infant feeding and nutrition.
- Decay levels in five year olds are a good indicator of oral health of the population as a whole.
- Decay in five year olds is an indicator of future tooth decay and oral health.

At risk or vulnerable groups:

[Children and young peoples' health indicators published for the North West of England dental health](#), status are related to levels of socio-economic deprivation.

Inequalities exist between communities in Tameside and Glossop, with the severest of decay existing in areas of highest socio-economic deprivation including Ashton St Peters, Hyde North, Hyde Werneth and Hattersley.

Ethnicity - The highest decay levels (severity and prevalence) were found in Bangladeshi children. More than 70% of Bangladeshi children examined had some decay with an average of nearly four teeth affected. Pakistani children also show higher decay levels than white children and other ethnic groups (over 60% of Pakistani children affected with an average of nearly 3 teeth decayed).

Benchmarking:

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

Decayed, missing and filled teeth (dmft) in Tameside and Glossop 5 year olds compared to England and the North West.

Area	Average dmft (severity of decay)		% dmft>1 (Prevalence of decay)	
	2007-08	2011-12	2007-08	2011-12
Tameside and Glossop	1.4	1.08	37.4	33.8
Tameside	1.4	1.08	37.4	33.8
North West	1.5	1.29	38.1	34.8
England	1.1	0.94	30.9	27.9

Note/ Differences in methodologies mean that figures prior to 2007 cannot be compared with figures for the 2007/08 and 2011/12 surveys.

Source: *The Dental epidemiology Programme for England: Oral health Survey.*

There appear to have been big improvements in oral health nationally, in the North West as well as in Tameside and Glossop. The caveat is that due to low participation rates it is possible that the North West or England figures are not accurate and may reflect an improvement where none exists. However in Tameside and Glossop participation rates were high (90% of the sample, highest for England) and therefore the improvement is likely to be a real one.

This is the first time since surveys began that significant improvements in the oral health of five year olds have been seen. Up to 2005-6 there had been only marginal improvements – nationally, regionally or locally - since national surveys began in 1991-2. Tameside and Glossop have also seen an improvement relative to the North West, with 5 year old dental health slightly better than the North West average while traditionally it has been slightly worse. In the 2011/12 survey the level of dental caries in 5 year old children in Tameside was lower than that of most other local authorities in Greater Manchester and compared favourably to England and North-West averages. In most indicators presented an improvement was been observed between the 2007/08 and 2011/12 survey. There is however no room for complacency. The North West has among the poorest levels of oral health in England.

Policy context:

- [Choosing better oral health: an oral health plan for England.](#)
- [Delivering better oral health: an evidence-based toolkit for prevention](#)

What interventions work?

According to [Choosing Better Oral Health](#):

Improving diet and reducing sugars intake: promoting breastfeeding and recommended weaning practices; reducing both the frequency and amount of added sugars consumed in line with Department of Health target; increasing the consumption of fruit and vegetables to at least 5 portions per day; reducing consumption of acidic soft drinks; and promoting use of sugar free medicines.

Improving oral hygiene: encouraging the early adoption of oral hygiene practices in young children; promoting effective oral hygiene self care practices across the population; and supporting parents, health professionals and carers of people who need help in maintaining their oral hygiene.

Optimising exposure to fluorides: promoting water fluoridation in areas with poor oral health and where local communities support this action; encouraging the use of fluoride toothpastes across the population, especially young children in disadvantaged areas.

Professional training and support: developing the health promoting knowledge and skills of the dental team; incorporating oral health input into the training of other health professionals; providing support if implementing and evaluating the oral health component of the LDPs; and developing oral health links with other areas of health improvement.

What are we doing now?

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

What needs to happen next and by whom?

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

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

Excess weight in children

Outcomes Frameworks: Public Health: 2.6 and 2.12

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

In the last twenty years there has been an unprecedented increase in obesity in the UK, and this trend is predicted to continue due to a wide range of factors related to modern day living including our diets, levels of physical activity and inactive leisure pursuits. Latest estimates suggest that a quarter of all adults (24%) and one sixth (16.4%) of children under 16 in England are obese. People who are overweight or obese are at a greater risk of diabetes, coronary heart disease and cancer. On average obesity reduces life expectancy by 11 years.

At risk or vulnerable groups:

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

National and local policy context

- [Choosing Health \(2004\)](#)
- [Foresight report – Tackling obesity: Future choices \(2007\)](#)
- [Healthy Weight, Healthy Lives \(2008\)](#)
- [DH, Healthy Lives, Healthy People: A call to action on obesity in England \(2011\)](#)
- [NICE Clinical Guidelines 43 \(2006\)](#)
- [NICE Guidance PH12 \(2008\)](#)
- [NICE Guidance – Maternal and Child Nutrition \(2008\)](#)
- [NICE Guidance on Prevention of Cardiovascular Disease \(2010\)](#)
- [NICE Guidance on Promoting Physical activity in Children and Young People \(2009\)](#)

The Tameside and Glossop Healthy Weight Strategy (2010 -2015) set out clear objectives for collective action from local partners to tackle obesity which is supported by an annual delivery plan.

Benchmarking:

Within the 2011/12 academic year 15% of reception year children within Tameside were categorised as overweight but not obese, which is higher than both North-West and England

averages. The percentage of children categorised as overweight has increased by approximately 1.6% between the 2009/10 and 2011/12 academic years. The Prevalence of obesity in Tameside reception year children was 9.3% in the 2011/12 academic year, marginally lower than the north-west and England averages. This has declined from 10.5% in the 2009/10 academic year.

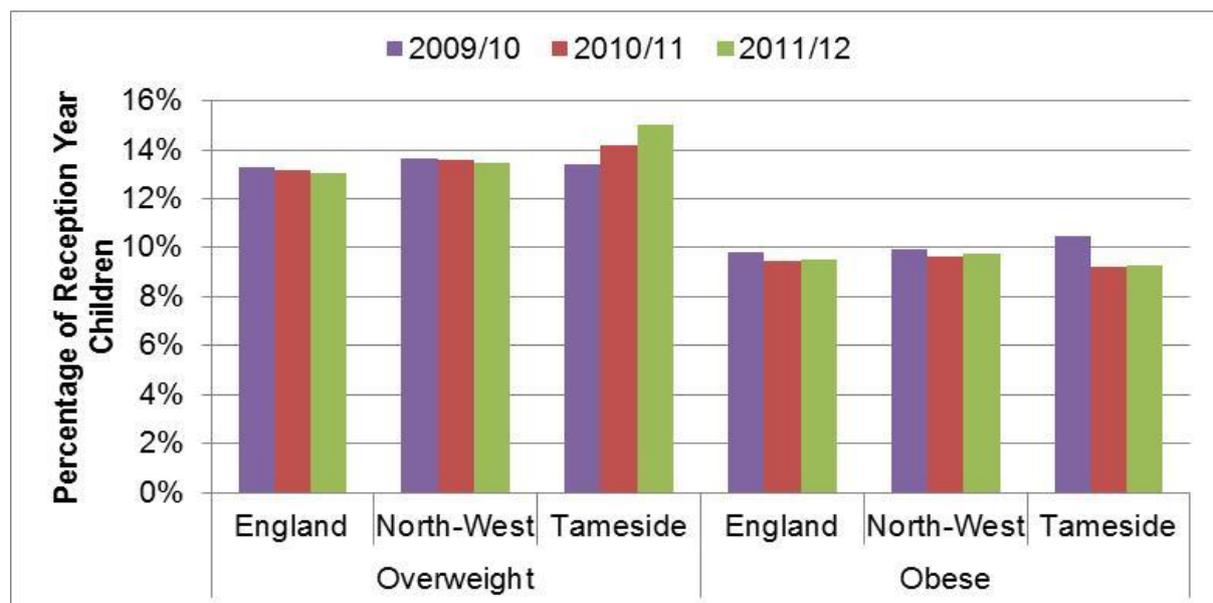
The prevalence of obesity in reception year children varies by ward. Obesity in reception year children for the 2009/10 to 2011/12 academic years combined was highest in Droylsden West Ward at 13.3% and lowest in Dukinfield Stalybridge ward at 6.6%.

In the 2011/12 academic year, the proportion of Year 6 children categorised as overweight but not obese is higher at 15.9% compared to England and North-West averages. This has increased compared to the 2010/11 year, when the proportion of overweight year 6 children was 14.4%. The prevalence of obesity in Year 6 children within the 2011/12 academic year was 19.4% and roughly equivalent to both England and North-West averages. The Year 6 children categorised as obese fell from 20.6% within the 2009/10 academic year.

The prevalence of obesity in year 6 varies by ward. The prevalence varies children for the 2009/10 to 2011/12 academic years combined from 25.2% in Ashton St. Michaels to 14.8% in Stalybridge South Ward. Looking at the prevalence of obesity by ward shows that despite overall levels of obesity close to the North-West and England averages overall, there remains a level of inequality in childhood obesity across localised areas within Tameside.

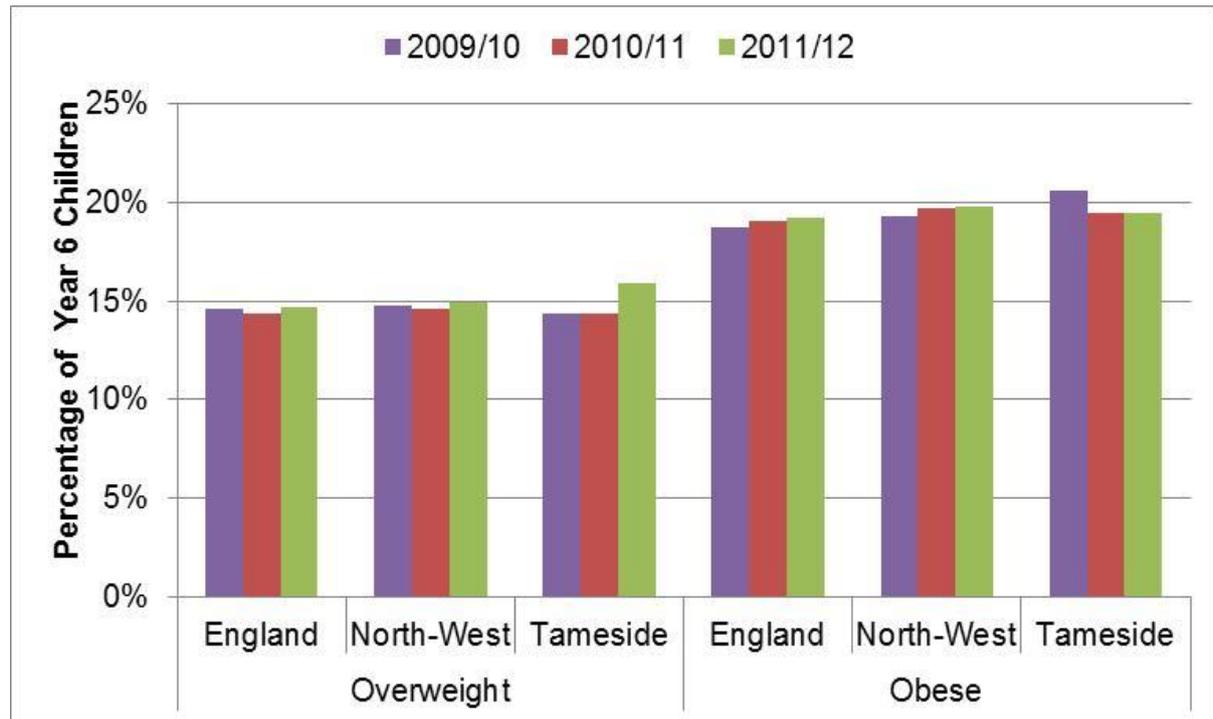
Excess weight in 4 -5 (Reception Year) and 10 -11 year olds (Year 6):

Prevalence of Obese Children in Reception: 2009/10 – 2011/12



Source: NHS Information Centre, 2012

Prevalence of Obese Children in Year 6: 2009/10 – 2011/12



Source: NHS Information Centre, 2012

School Readiness

Outcomes Framework: Public Health 1.2

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

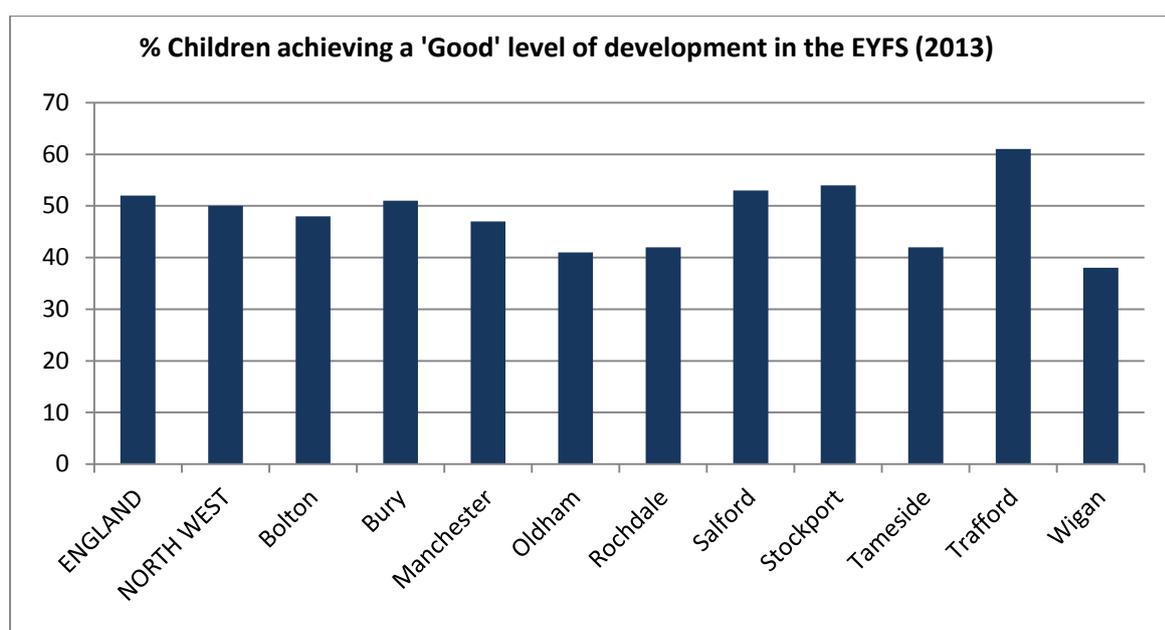
School readiness focuses on whether a child is ready for school based on a range of skills including literacy, numeracy, physical health, social and emotional adjustment, the child's approach to learning and their level of language, cognition and general knowledge. Young children's earliest experiences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

At risk or vulnerable groups include:

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

Benchmarking:

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



Source: TMBC 2014

In 2013, following the new EYFS assessment framework, 42% of children were said to have achieved a 'good' level of development OR to be 'ready for school'.

Rates in School readiness had been increasing in Tameside up until 2013 when the new framework was introduced:

2009 Good level of development - EYFS		2010 Good level of development - EYFS		2011 Good level of development - EYFS		2012 Good level of development - EYFS		2013 Good level of development - EYFS (NEW FRAMEWORK)	
National	Tameside	National	Tameside	National	Tameside	National	Tameside	National	Tameside
52.0	48.5	56	53.9	59	56.8	64	59	52	42

Source: Department for Education/Tameside MBC, 2014.

Policy context:

- **Early Years Foundation Stage Handbook 2014:**

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249995/Early_years_foundation_stage_profile_handbook_2014.pdf

- **PSR Early Years Theme:**

[Association of Greater Manchester Authorities](#)

What interventions work?

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

What are we doing now?

As part of the Early Years theme of Public Service Reform we are now working with the Association of Greater Manchester Authorities (AGMA) to roll-out our new Early Years Delivery Model.

Our new delivery model consists of:

1. A shared outcomes framework (figure 1), across all local partners;

2. A common assessment pathway across Tameside: eight common assessment points for an integrated ('whole child' and 'whole family') assessment at key points in the crucial developmental window, using expanded existing assessment points, and with the remaining Healthy Child Programme visits to continue as standard;
3. Evidence-based assessment tools to identify families reaching clinically diagnosable thresholds for intervention or having multiple risk factors as early as possible;
4. Needs assessment triggers referral into an appropriate evidence-based targeted intervention;
5. A suite of evidence-based interventions is being developed, to be sequenced alongside other public service interventions as a package of transformational support to families, with appropriate step-down packages of support;
6. Ensuring better use of day-care: new 'contract' with parents eligible for targeted twos day-care to drive engagement in education/employment/training/volunteering, and introducing new common terms and conditions to drive improvement in all day-care settings;
7. A new workforce approach, to drive a shift in culture: enabling frontline professionals to work in a more integrated way in support of the 'whole family' and with other services to collectively reduce dependency and empower parents;
8. Better data systems to ensure the lead professional undertaking each assessment has access to the relevant data to see the whole picture, to reduce duplication and confusion, to track children's progress and in particular support the most vulnerable and disadvantaged;
9. Long-term evaluation to ensure families' needs are being addressed and add to national evidence for effective early intervention.

What happens next and by whom?

We have identified two areas within the borough to be pilot areas for early adoption of the new delivery model. We are also working with AGMA to finalise the investment need to sustain this approach in the coming financial years.

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

Outcome Framework: Public Health 1.5

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

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

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

At risk or vulnerable groups:

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

Benchmarking:

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

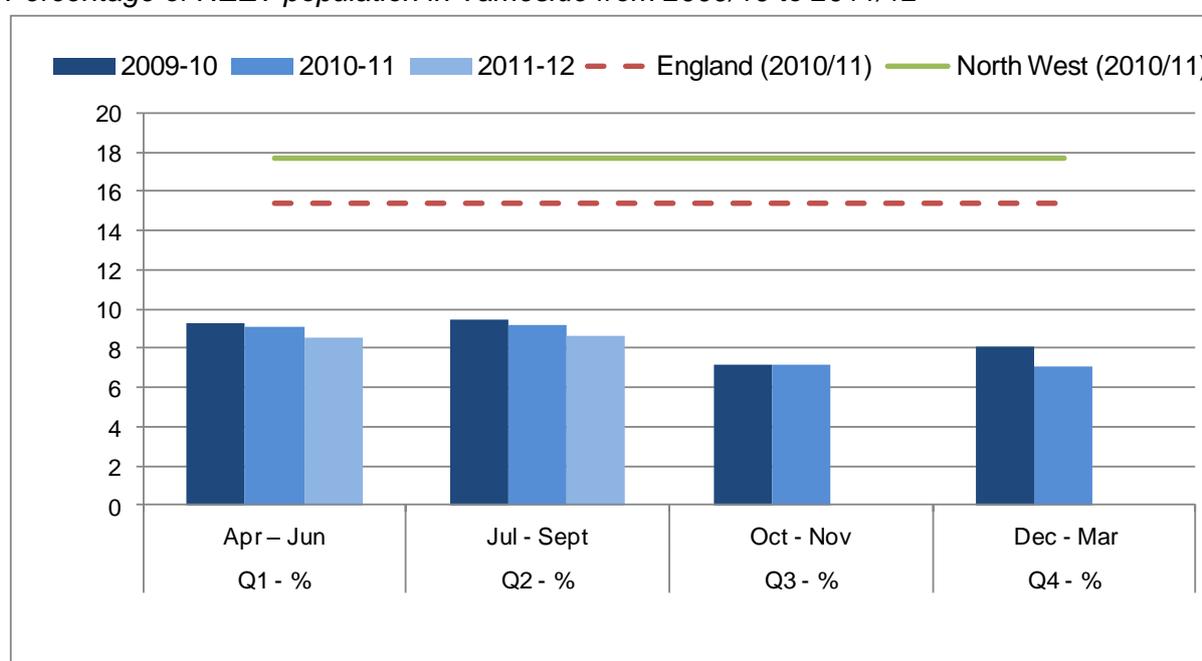
NEET has been reducing since 2006 (8.6%) to a static 4.6% (as of Q3 2014/15). The current economic situation is directly affecting NEET and deterioration might be expected in the data. Unemployment evidence (Department of Work and Pensions) appears to indicate, however, that the greatest impact is on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

Percentage of NEET population in Tameside from 2009/10 to 2011/12

Tameside	Q1 - %	Q2 - %	Q3 - %	Q4 - %
NEET (based on residency)	Apr – Jun	Jul - Sept	Oct - Nov	Dec - Mar
2009-10	9.3	9.5	7.2	8.1
2010-11	9.1	9.2	7.2	7.1
2011-12	8.5	8.6	-	-
England (2010/11)	15.4	15.4	15.4	15.4
North West (2010/11)	17.7	17.7	17.7	17.7

Source: Tameside MBC 2012

Percentage of NEET population in Tameside from 2009/10 to 2011/12



Source: Tameside MBC 2012 & Department of Education 2012

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

Policy context:

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

What interventions work?

- Increasing apprenticeship opportunities (16-18 apprenticeships in learning currently 20.4% (2011) against a baseline of 13.8% (2008))
- Increasing post 16 education participation (currently 86% (2011) against a baseline of 74% (2005). Overall EET stands at 90% (2011)
- Bespoke programmes for re-engagement in learning, personal development programmes, pre-vocational learning, supported employment for LLDD (Learner with Learning Difficulties or Disabilities).
- Bespoke cohort programmes for designated vulnerable groups (e.g. LAC EET (69% (2011) compared to 43% (2009)

What are we doing now?

- Employer engagement in apprenticeship provision - supported work experience, financial incentives, brokerage, awareness raising etc.
- Revised TMBC service unit focus on designated vulnerable groups only (see above)
- Strategic focus on locality based interventions in a holistic context – Family Intervention teams, Local Integrated Service Pilots, Youth and Family teams

What needs to happen next, and by whom?

- Continuation of the above
- Increased focus on Tameside post 16 retention in education
- Increased focus on small and medium employers to engage in apprenticeships
- Direct intervention work with vulnerable groups
- Reduction in teenage pregnancy
- Reduction in alcohol and drug misuse – particularly Alcohol

Under 18 conceptions

Outcomes Framework: Public Health 2.4

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

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

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

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

At risk or vulnerable groups:

Young people:

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

Benchmarking:

Tameside's under-18s conception rate has fallen over the past years, but remains much higher than comparator areas. TMBC are responsible for provision in Glossopdale until 2015 and continue to secure geographical coverage. However, under-18 conception data is restricted to authority boundaries.

Key Points:

- The under 18 conception rate for Tameside fell from 48.3 per 1,000 15-17 year old women in 2010 to 45.2 per 1,000 in 2011, down 6.4%
- The number of under 18 conceptions in Tameside in 2011 was 183
- In line with the overall trend for England, both the numbers and rates of under 18 conceptions have reduced in Tameside, with an overall reduction rate of -16% since 1998
- With the exception of Manchester, Tameside has seen its rate reduce the least in Greater Manchester between the 1998 reference year and 2011

Trend in teenage conceptions, rolling average rate per 1,000 women aged 15-17 years, 1998-2000 to 2008-10.

Under 18 conception trends for Greater Manchester authorities								
	Under-18 conception rates and numbers						% rate change	
	1998		2010		2011		2010-2011	1998 - 2011
	No.	Rate	No.	Rate	No.	Rate		
Gtr. Manchester	2,642	54.5	2,052	44.0	1,848	37.8	-14%	-31%
Bolton	249	50.3	198	39.3	213	39.6	+1%	-21%
Bury	177	55.6	145	41.1	115	32.9	-20%	-41%
Manchester	540	61.3	398	57.2	411	52.5	-8%	-14%
Oldham	290	66.1	183	42.1	167	36.5	-13%	-45%
Rochdale	256	61.9	152	37.5	137	31.7	-15%	-49%
Salford	250	61.5	223	57.9	174	41.9	-28%	-32%
Stockport	230	43.2	168	33.2	145	28.4	-14%	-34%
Tameside	216	53.6	197	48.3	183	45.2	-6%	-16%
Trafford	137	34.0	112	28.7	101	24.2	-16%	-29%
Wigan	297	53.6	276	47.4	202	34.7	-27%	-35%

Source: Office of National Statistics and Department of Education, 2012

Policy context:

The Department of Health produced [“A Framework for Sexual Health Improvement for England”](#) in March 2013 adding to the national teenage pregnancy strategy update in 2010 [‘Teenage Pregnancy Strategy: Beyond 2010’](#). The Local Government Association

Clarified the emerging roles of the local authority in [‘Tackling teenage pregnancy Local government’s new public health role’](#)

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

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

What interventions work?

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

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

What are we doing now?

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

- We have doubled the access to FREE emergency hormone contraception in pharmacy in 2013

What needs to happen next?

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

Chlamydia diagnoses (15-24 year olds)

Outcomes Framework: Public Health 3.2

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

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

Programme spend:

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

At risk or vulnerable groups:

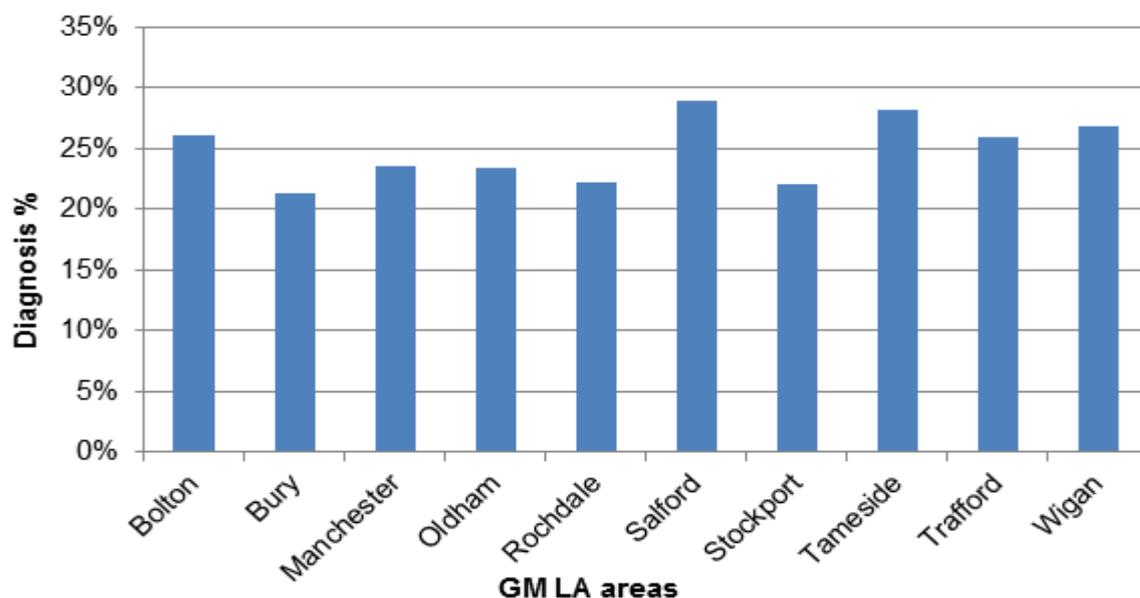
Chlamydia is most common in sexually active young people under the age of 25 years, although people of any age may acquire chlamydia infection if they are sexually active and not practising safer sex. Locally we must ensure that we are tailoring the Chlamydia screening offer to young people who face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

Benchmarking:

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

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

Reduced Late Diagnosis, Chlamydia, Local Authority,



January-December 2012 CTAD [ctadlink](#)

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

Policy context:

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

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

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

What interventions work?

Screening should be embedded in the normal healthcare that young people receive when accessing health services, e.g. GPs, pharmacies, CaSH and Termination of Pregnancy (TOP) services. Opportunistic screening of young people who are sexually active.

Outreaching to marginalised groups and taking opportunities to screen e.g. repeat oral contraception review.

What are we doing now?

- We commission: triage, postal and the training offer collaboratively across GM via RUClear www.ruclear.co.uk
- YOUthink is a sexual health outreach team jointly commissioned by the local authority and NHS, which delivers sexual health workshops in schools and colleges and delivers more targeted work with vulnerable young people. YOUthink promote, and carry out, screening.
- The Lesbian and Gay Foundation promote Tameside and Glossop sexual health services so local young people know where to access quality services.
- The Tameside Pregnancy Advisory Service (TPAS) based at Tameside General Hospital only performs TOP treatment if chlamydia screening has been carried out.
- A [SAFE](#) (Sexual health Advice for Everyone) delivers new campaigns each year [CHLAMYDIA 2013](#).
- A GP lead will be championing sexual health within primary care.

What needs to happen next, and by whom?

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

Hospital admissions caused by unintentional and deliberate injuries in the under 18s

Outcomes framework: Public Health 2.7

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

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

The National Indicator NI70 is a 'Stay Safe' indicator defined as 'The number of finished in-year emergency admissions of children and young people to hospital as a result of unintentional and deliberate injury per 10,000 children and young people. Childhood Injuries are the cause of 20% of all child deaths in UK.

In 2008/11 in Tameside, the commonest cause for injury admissions are due to falls followed by intentional self-poisoning. However, in 2010/11, the commonest injury was fracture of forearm (7% of all injury admissions).

In Tameside, over a third of all injuries took place in the home and most of these were in the 0-4 age group.

At risk or vulnerable groups:

In general, across all the age groups, boys in Tameside are more likely to be admitted with injuries than girls. In 2010/11-the commonest injury among all boys in Tameside was fracture of forearm (5% of all injury admissions), and the commonest injury among all girls in Tameside was intentional self-poisoning (3% of all injury admissions).

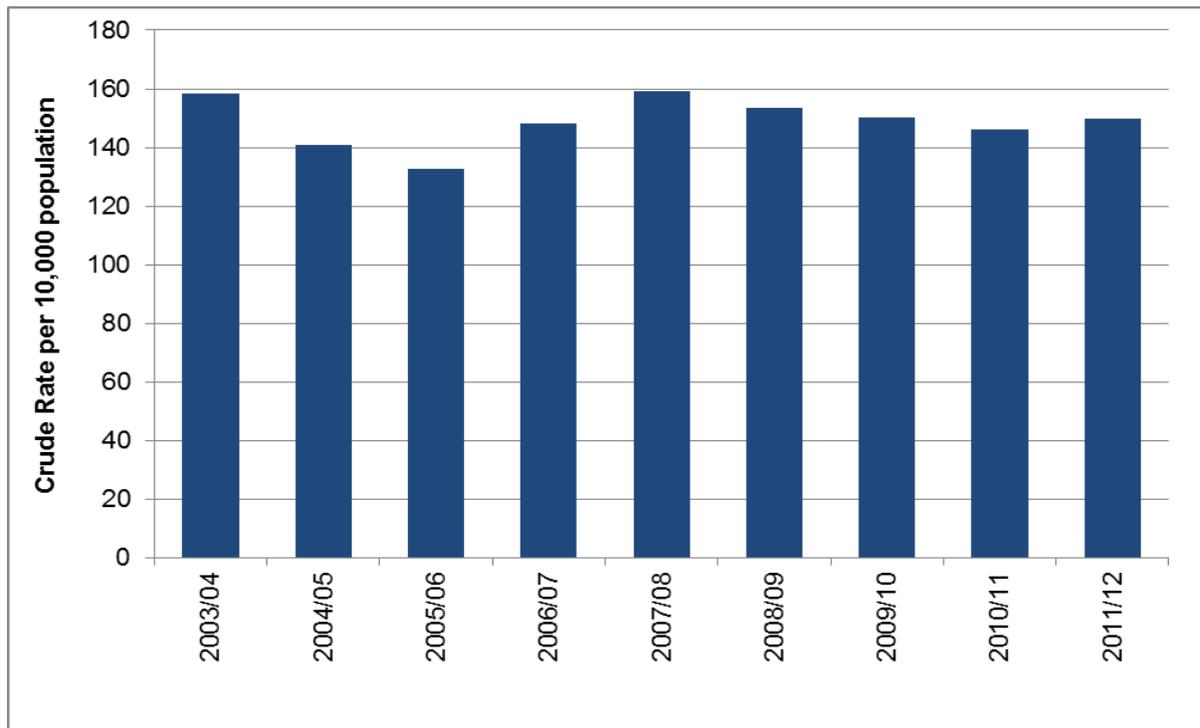
Childhood injuries disproportionately affect children from lower socioeconomic groups.

Benchmarking:

In Tameside, between 2008/09 to 2010/11 there were 2,164 emergency hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-17. For 2011/12 the number of admissions was 723, a small increase on 704 for the previous year.

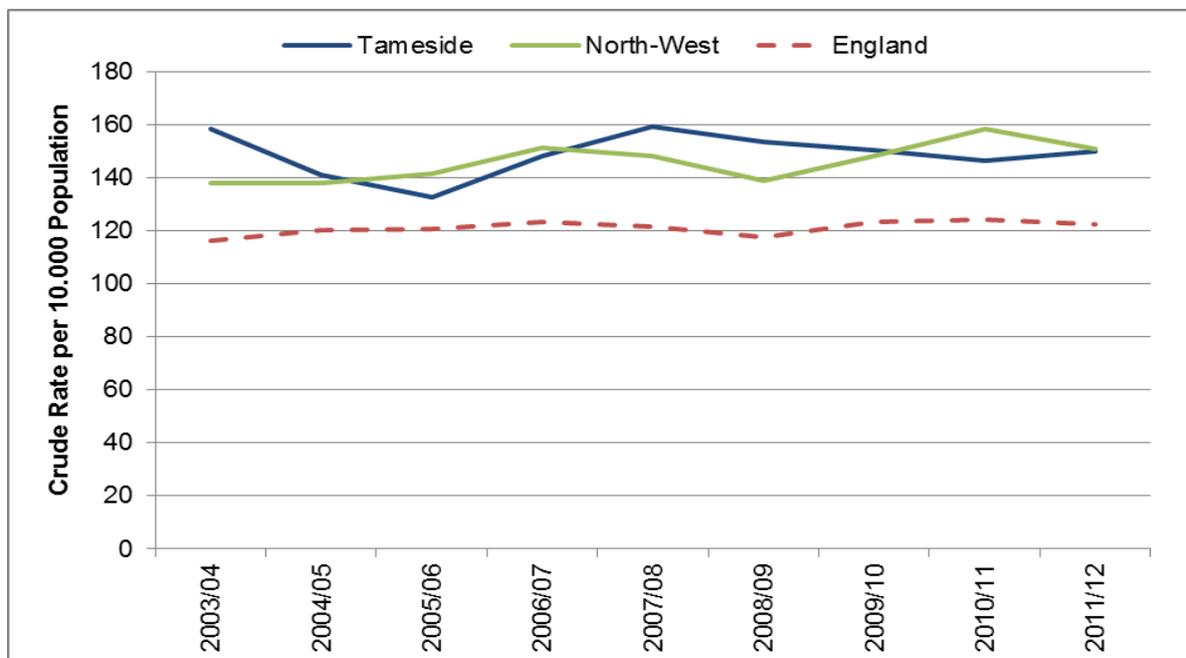
The rate of admissions (per 10,000 population) reached a peak in 2007/08, and since then has decreased most years, and although remaining higher than England, has been better than the North West for three years running. For performance against statistical neighbours Tameside was ranked in 7th position when comparing admission rates (out of 16 other statistical neighbours).

Admission rates for deliberate and unintentional injury for 0-17 year olds in Tameside 2003/4 to 2011/12



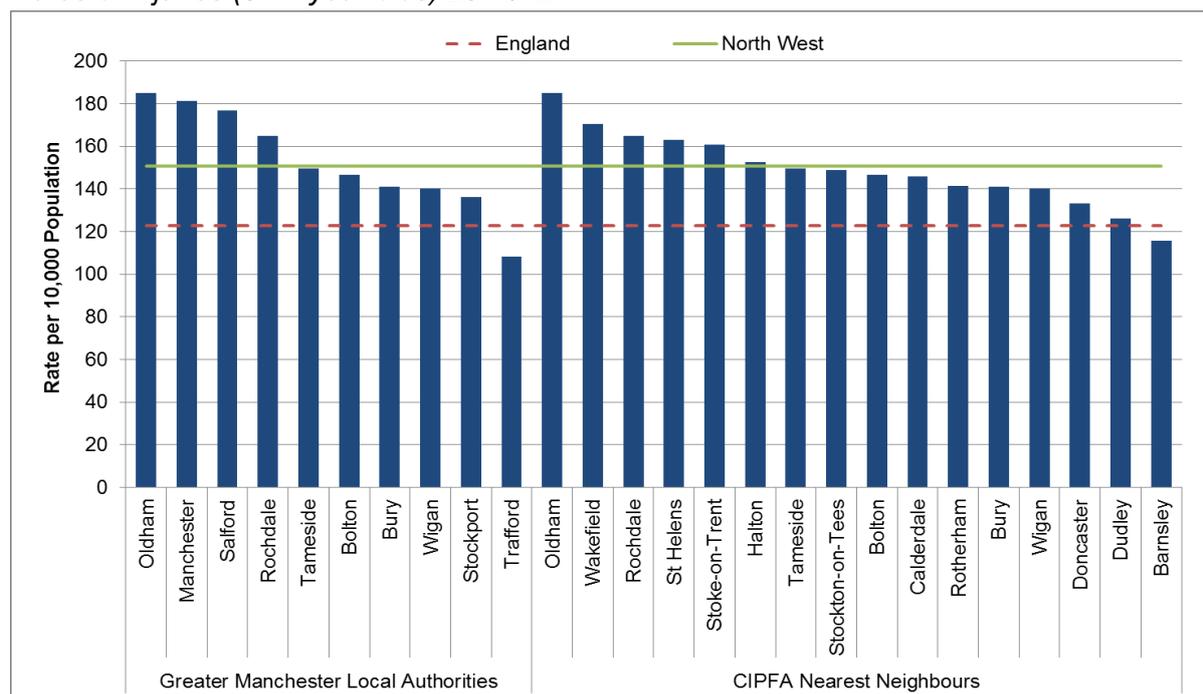
Source: HSCIC 2013

Comparative admission rates for deliberate and unintentional injury for 0-17 year olds 2003/04 to 2011/12



Source: HSCIC 2013

Rates of Injuries (0-17 year olds) 2011/12



Source: HSCIC 2013

Policy context:

The most recent national guidance available is NICE Guidance 2010 on the prevention of unintentional injuries in 0-15 year olds for local authorities, Safeguarding Boards, NHS Trusts, the fire service and police, published in three sets:

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

During 2011/12, in response to the high number of hospital admissions, a review of 3 year data from 2008/09 to 2010/11 was undertaken in Tameside as well as a review of local compliance with NICE guidance. A report was received by the Tameside Safeguarding Children Board, and the recommendations referred to the Tameside Children's Trust for consideration. A review of local home safety arrangements was commissioned by NHST&G and received in Dec 13, and outlines options for local developments.

What interventions work?

The main points of the national guidance listed above are -

- General measures-planning & co-ordination:
 - Local plans should commit to preventing injuries among under-15s, focusing on those most at risk
 - Trained child and young person injury prevention coordinator in each locality
 - Provide a wider childcare workforce with access to injury prevention training
- Home safety:

- Identify and prioritise households most at risk and offer home assessments
- Ensure the assessment, supply and installation of equipment is tailored to need and includes the provision of information and advice
- Provide practitioners who visit children and young people at home with mechanisms for sharing information
- Outdoor play:
 - Ensure a prevention policy is in place which balances fun, physical activity and learning
 - Encourage cycle training and promote use of cycle helmets
 - Conduct local injury prevention campaigns for all events where fireworks may be used
- Road safety:
 - Partnerships: Maintain road safety partnerships to help plan, coordinate and manage road safety activities
 - Speed reduction:
 - Engineering measures to reduce speed in streets primarily residential or where pedestrian and cyclist movements are high
 - Introduction of [20 mph zones](#)

What are we doing now?

A review of currently local activity against the NICE recommendations was very positive, highlighting good coverage of most elements and scope for increasing input on home safety.

Service user or public engagement or consultation:

The home safety review included interviews with parents at local Children Centres which supported the need for enhancement of local arrangements.

What needs to happen next, and by whom?

The initial review included recommendations for further local and strategic action-

Local actions:

- Need for high quality data from Tameside Trauma and Injury Intelligence Group (TIIG)
- Targeted and universal approaches by frontline health and early years staff, and schools
- Focus on injury prevention work, home safety, falls on stairs and steps among 0-4
- Need for training in injury prevention
- Strategic actions:
 - Opportunities for local partnership work
 - Engage children & families & wider community (1/3 families want advice)
 - LAs leadership opportunities arising in a new Public Health landscape
 - Enable frontline health staff to implement the recommendations
 - Development of programmes for environmental improvements including homes, play areas and roads
- Home Safety arrangement should be consolidated within the Early Years and Wellness Offers.

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

Outcomes frameworks:

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

Implication for the population's health and well being:

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

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

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

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

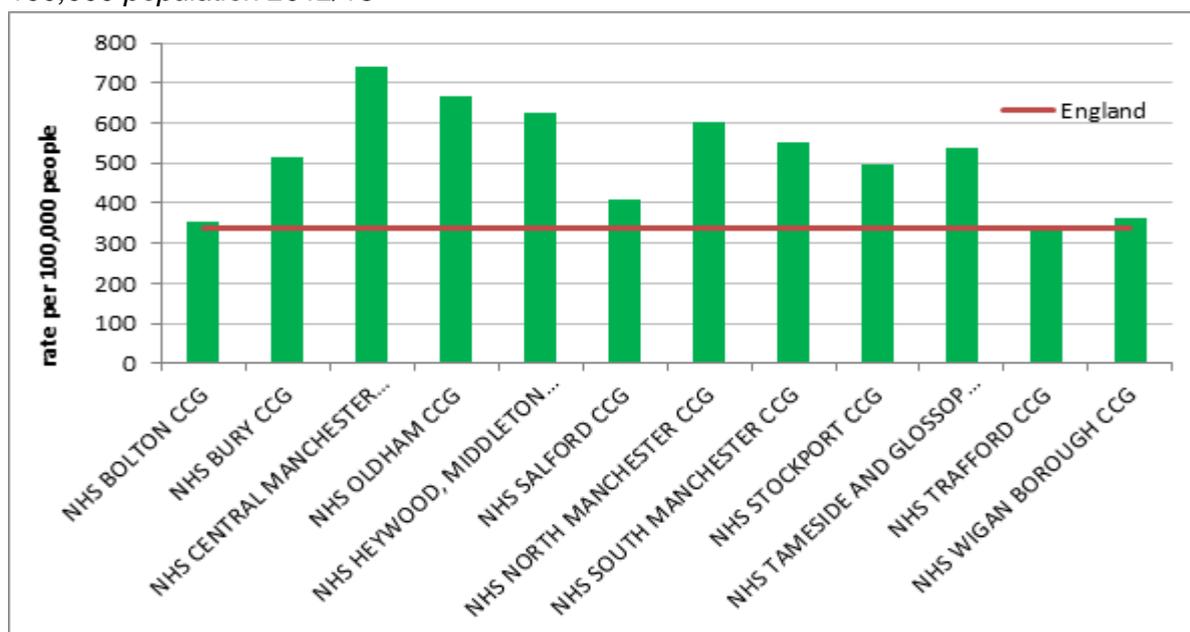
At risk or vulnerable groups:

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

Benchmarking:

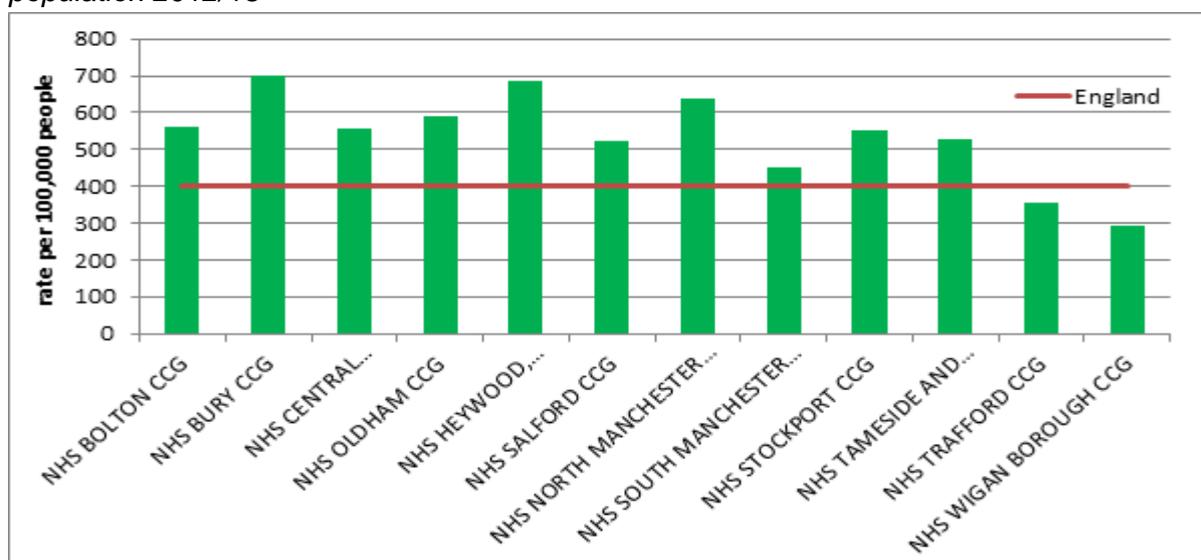
Benchmarked information is available on all three conditions as detailed in the following charts.

Rate of emergency hospital admissions for asthma, diabetes and epilepsy (<19 years) per 100,000 population 2012/13



Source: Health and Social Care Information Centre

Rate of emergency hospital admissions lower respiratory conditions (<16 years) per 100,000 population 2012/13



Source: Health and Social Care Information Centre

Policy context:

- [NICE Guidance - TA 133 Asthma Uncontrolled](#)
- [NICE Guidance – IPG419 Bronchial thermoplasty for severe asthma](#)
- [NICE Pathway - Epilepsy](#)
- [NICE Guidance – The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care](#)

- [NICE Guidance – Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults](#)
- [NICE Guidance CG69 - Prescribing of antibiotics for self-limiting respiratory tract infections in adults and children](#)

What interventions work?

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

What did we do in 2011/12?

A detailed analysis of activity in these areas has been carried out to support the work to be done in 2012-13. With an emergency admission rate and bed day rate higher than the national average, Asthma has been identified as the priority for action in the first year.

What were our plans in 2012/13?

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

Asthma: The NHS Clinical Commissioning Group (CCG) has prioritised action on asthma for 2012/13. The following plan is underway:

- Full data analysis of activity over last five years
- Repeat admissions identified and case notes scrutinised
- Local pathway developed to cover primary and secondary care and the community, notably in schools.
- Clinical guidance developed as required

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

What were our plans for 2013/14?

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

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

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

We are developing Diabetes and Epilepsy services for patients who are moving out of childhood into adulthood and THFT are extending the paediatric service to young people up to their 19th birthday.

First-time entrance to the youth justice system

Outcome Framework: Public Health 1.4

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

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

An offence is defined as a first offence if it results in the offender receiving their first reprimand/warning (no longer given LASPO Act 2013), caution or conviction – i.e. they have no previous criminal history recorded on the Police National Computer (PNC). Offences resulting in further reprimands, warnings, cautions or convictions are known as further offences since the offender already has a recorded criminal history.

At risk or vulnerable groups:

Research findings describe common characteristics of offenders:

- Personal: usually male; often with learning difficulty; is addicted to drugs or alcohol, frequently from an early age.
- Background: experience of poverty, poor housing, instability, association with delinquent peers and unemployment.
- Family: parental conflict and separation; a lack of parental supervision; harsh or erratic discipline; and evidence of emotional, physical or sexual abuse.
- School: no qualifications attained; will probably have been aggressive and troublesome, often leading to his expulsion or to truancy.

Contact with the YJS can bring extra problems for some children and young people, including those with learning difficulties, communication needs and mental health problems.

The sexual health of young people who are supported by the YOT needs to be addressed through its interventions. There are also a disproportionate numbers of young people that offend sexually within the geographical area, with a number of young victims.

Benchmarking:

Nationally, the number of FTEs has fallen by 67 per cent from 83,312 in 2002/03 to 27,854 in 2012/13. The number of FTEs has fallen by 75 per cent, since the peak in 2006/07. In the last year, the number of FTEs has fallen by 25 per cent from 36,920 in 2011/12 to 27,854 in 2012/13. Locally, Tameside's rate during the most recent period (Jul 12- Jun 13) there were 104 FTEs as compared with 132 in the previous period (Jul 11 –Jun 12). This is a reduction of 24.6%

Policy Context:

- [Healthy Children, Safer Communities](#) – A Strategy to promote the health and well-being of children and young people in contact with the Youth Justice System.
- [Lord Bradley's review](#) of people with mental health problems or learning disabilities in the criminal justice system.

What interventions work?

The task is to intervene more effectively, providing the right help at the right time and in the right place. When diversion from the YJS has failed, we need to use the opportunity of young people's contact with it to give them better support. However, the YJS itself is different to the adult criminal justice system in many respects and this has implications for how diversion for children and young people should best be approached. Effective interventions have the potential to impact immediate offending and re-offending rates, but also to influence children and young people away from an adulthood of offending.

There is a clear causal link between youth offending and substance misuse whether by offending whilst under the influence or through acquisitive crimes to maintain habits. Dual diagnosis has shown that children and young people use alcohol and drugs to mask mental health issues, however, once weaned the 'merry go round' begins of coming off and going back to substance misuse.

A number of factors have contributed to the downward trend in FTEs, although it is not possible to attribute specific gains, or scale of gain, to any specific intervention. Nevertheless, it is thought the main factor is the Offences Brought to Justice Target (OBTJ), which created targets for the police around the number of offences reported to them that should be "brought to justice", i.e. resolved and an offender given a caution/conviction. The number of FTEs peaked in 2007 and the subsequent large fall in offending coincides with the replacement of the target in April 2008 with one that placed more emphasis on bringing more serious crimes to justice. In December 2010 it was dropped entirely. It is also possible that work by YOT and other partners to divert young people into alternatives, such as restorative justice disposals and Triage schemes has also contributed to the fall.

What are we doing now?

Under the former Government's "Youth Crime Action Plan" the YOT established, with colleagues in Greater Manchester Police (GMP), a triage service to provide alternatives interventions that diverted young people from being charged. This has been extended by YOT and has attracted funding from the Department of Health to undertake Health Triage (Youth Justice and Liaison Diversion). This extended the health services provided to young offenders (Speech and Language Therapy; Mental Health and Generic Health). GMP has introduced Restorative Justice and again this has diverted young people away from the criminal justice system by mediating between the young person and the victim to find an alternative to charge. This funding has now ceased, however there are plans to continue this approach

What needs to happen next and by whom?

- Intervene early to address emerging health and well-being needs to preventing offending, with clear pathways into health provisions.
- Underpin interventions with specialist health assessments.
- Engage the Police and Crime Commissioner re: Commissioning of Youth Offending early intervention programmes.
- Ensure that those young offenders' health needs are known, enabling the Police and Courts to make informed decisions to divert children and young people from the YJS.
- Embed Multi Systemic Therapy (MST) to provide intensive family based interventions to young people primarily at the edge of care and custody and include those that are also displaying anti-social behaviour.
- Ensure referral pathways from the Neighbourhood Resolution Panels.
- Ensure referral pathways from and to the Local Authority Early Intervention Service.



Living and Working Well

Diet

Outcomes Framework: Public Health 2.11

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

Britain is in the grip of an obesity epidemic. A third of all children and over half of all adults are now either overweight or obese. Obesity is one of the leading threats to achieving a healthier Tameside and Glossop.

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

Patterns of growth early in life contribute to excess weight, e.g. if there are low breastfeeding rates. Eating practices are also influenced by social and psychological stress. There is a need for a systematic approach to tackling lifestyle issues across Tameside and Glossop including improving diet as the underlying cause of obesity, a major risk factor for Type 2 diabetes and heart disease.

At risk or vulnerable groups:

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

Policy context:

The Tameside and Glossop Healthy Weight Strategy (2010 -2015) set out clear objectives for collective action from local partners to tackle obesity which is supported by an annual delivery plan.

- [Choosing Health \(2004\)](#)

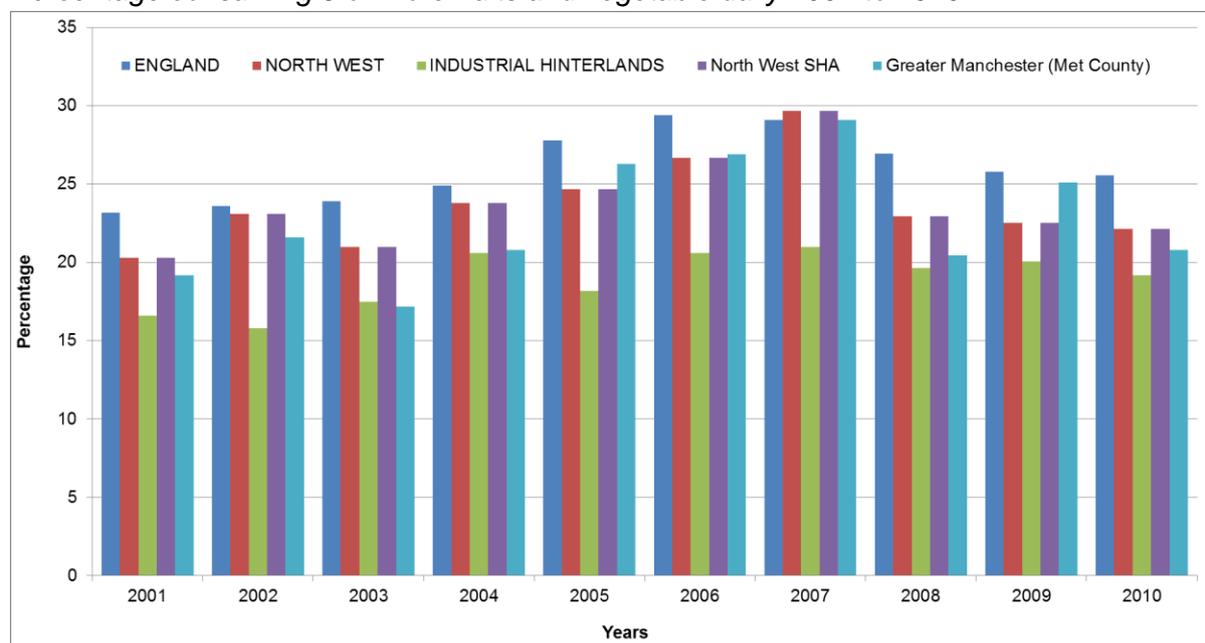
- [Foresight report – Tackling obesities: Future choices \(2007\)](#)
- [Healthy Weight, Healthy Lives \(2008\)](#)
- [DH, Healthy Lives, Healthy People: A call to action on obesity in England \(2011\)](#)
- [NICE Clinical Guidelines 43 \(2006\)](#)
- [NICE Guidance PH12 \(2008\)](#)
- [NICE Guidance – Maternal and Child Nutrition \(2008\)](#)

Benchmarking:

The National Diet and Nutrition Survey is jointly funded by the Department of Health and UK Food Standards Agency and investigate the nutritional status and nutrient intake of the UK population. Key findings from years 1 and 2 (2008/09 – 2009/10) of the Survey are as follows:

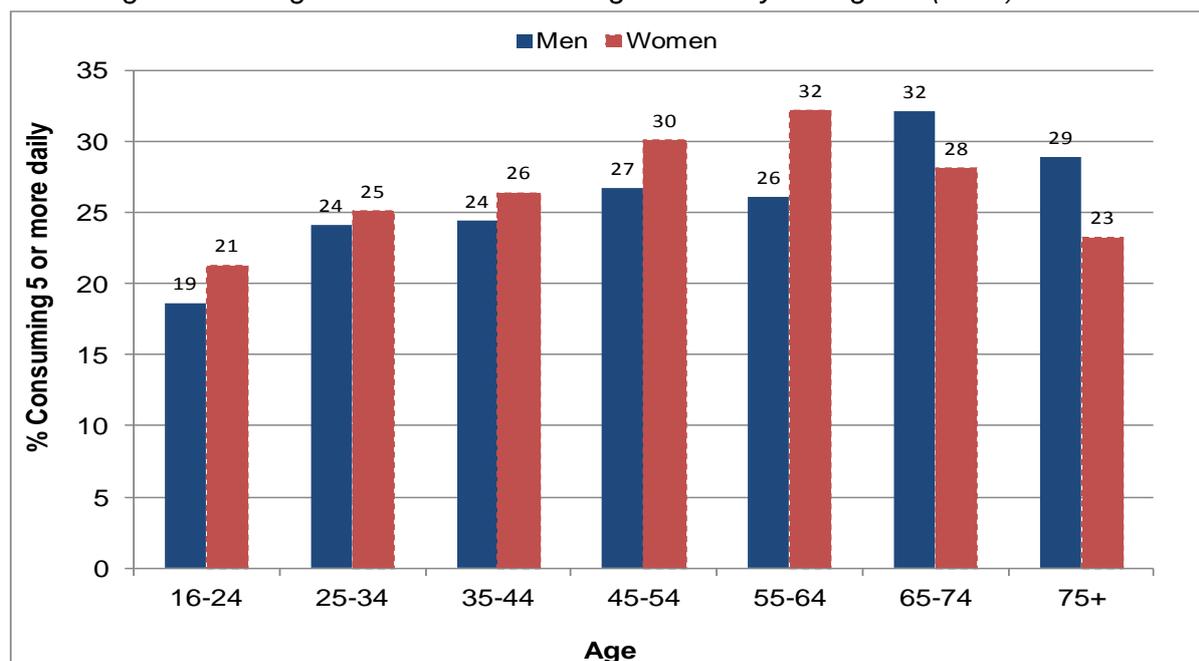
- 30% of adults aged 19 to 64 and 37% of adults 65 and over met the recommended five portions of fruit and vegetables daily.
- Consumption of oily fish is well below the recommended one portion per week.
- The recommended mean daily intake of total fat (thirty five % of total energy consumption) was met by all age/gender groups, except women and men over 65 years.
- Mean intake of saturated fat exceeded the recommended daily amount in all age groups.
- The recommended daily intake of vitamins was met or exceeded in all groups.
- Mean intakes of minerals was below the recommended daily intake in some age groups, particularly women aged 11-18 years.

Percentage consuming 5 or more fruits and vegetable daily 2001 to 2010



Source: HSCIC 2013

Percentage consuming 5 or more fruits and vegetable daily in England (2010)



Source: Health Survey of England 2012

What works?

- Focus on promoting healthy eating in children through a range of programmes targeted at children and families, and through schools
- Promoting healthier food choices by working with food and drinks industry
- Creating incentives for better health through workplace health programmes
- Personalised advice and support for people to make healthy choices
- Effective and accessible weight management services
- Healthy eating in pregnancy
- Consistent information on weaning

What are we doing now?

- Child and family weight management courses
- Prevention programme e.g. healthy lifestyle courses focussing on children aged 18 months to 5 years and their families
- Programmes to prevent obesity in childhood e.g. promoting evidence based infant feeding, weaning and pre-school nutrition guidelines
- Promoting breastfeeding e.g. Baby Friendly Initiative
- Provide Food and Nutrition Training in schools
- Promoting Healthy Start scheme
- Early Years Food and Nutrition Training
- Healthy Choice for Kids Award to premises aimed at children and families
- Nutrition and Oral Health Award Scheme for under 5s child care providers
- Primary school family 'cook and be active' programmes at school sites
- Helping people to make healthy food and drink choices

- Weight management service in GP practices
- Weight Matters – community weight management programme
- Transforming the environment for health and the economy through initiatives such as healthy workplace, maximising the potential of planning system to support health and economic development and speaking directly to families through initiatives such as Change4Life.
- Delivery of maternal, adult and children’s healthy weight pathways
- Dieticians work with adults through specialist clinics and also provide support to mental health and ante-natal clinics. They offer visits to provide specialist support, e.g. to learning disabilities group.
- The dietetics team also provides support for patients with co-morbidities (and BMI of over 30) e.g. patients with diabetes, celiac disease.

Service user or public engagement or consultation:

Healthy diet was endorsed as a priority for both Tameside Health and Wellbeing Strategy during public consultation in 2013.

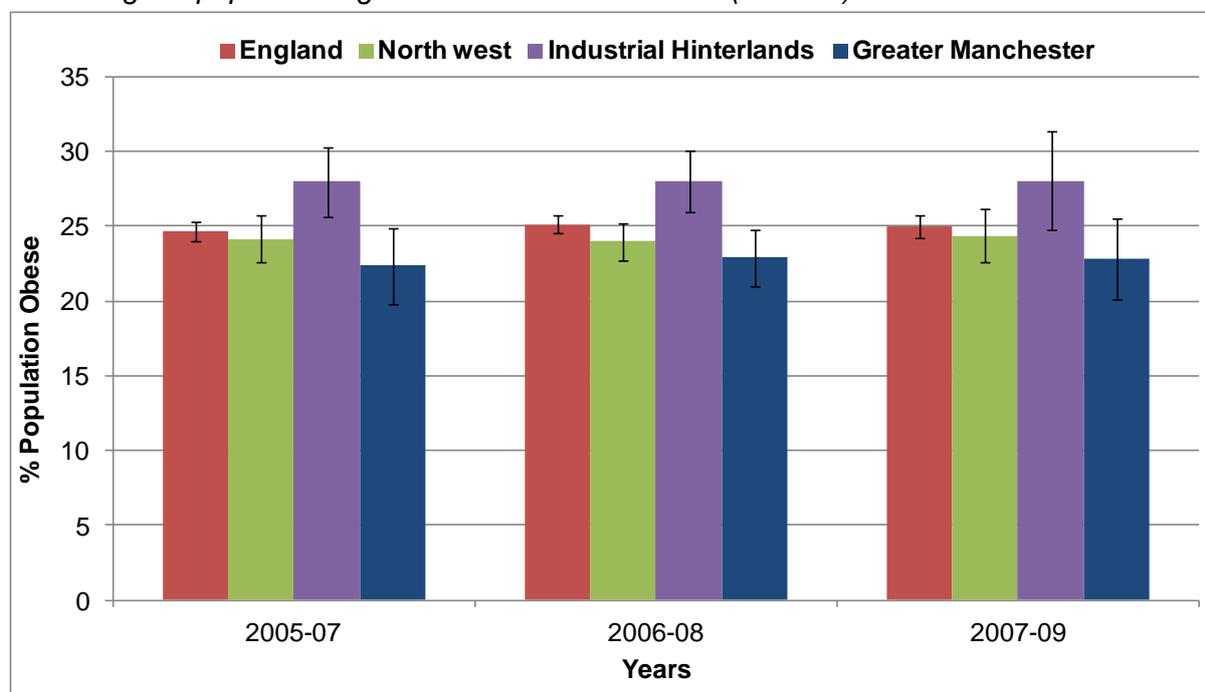
What needs to happen next, and who needs to do it?

The T&G Obesity Strategy Group is committed to the delivery of the local strategy. There is need for continued commitment from partners and for a more joined up approach on tackling healthy eating. Public Health and partners are currently in the process of developing an integrated wellness offer for adults that will provide more choice and access to a range of services focussing on information and advice related to healthy diet as well as access to physical activity.

Excess weight adults:

The percentage of obese adults is lower in Greater Manchester in comparison to regional and England average.

Percentage of population aged 16+ classified as obese (BMI>30)



Source: Health Survey of England 2012

What interventions work?

- Empowering individuals through guidance, information, encouragement and a tailored approach on weight management and behavioural change
- Helping people to make healthy food and drink choices, and to be active
- Promoting healthy growth and healthy weight in children
- Commissioning a comprehensive and integrated range of interventions which will focus on prevention, brief advice, weight management service and clinical interventions
- Transforming the environment for health and the economy through initiatives such as healthy workplace, maximising the potential of planning system to support health and economic development and speaking directly to families through initiatives such as Change4Life.
- Promoting active travel
- Breastfeeding initiatives

What are we doing now?

- Various children's programmes such as – promoting infant feeding, weaning and pre-school nutrition guideline, Leap4Life, nutrition training, awards scheme for under 5s care providers, promoting the uptake of Healthy Start vitamins, primary school cook and eat

and brief intervention healthy weight in children, Leap 4 Life under 5s prevention programme, Change 4 Life in primary schools, coaches in school programme

- Child and Family Weight Management Services
- Local breastfeeding initiative and peer support programme to women in the hospital and community across the borough in areas where breastfeeding rates are low have been identified as target areas.
- Promote healthy lifestyles to workplaces via workplace health improvement programme to increase the responsibility of organisations for the health of their employees.
- Health Trainer service and Family Health Mentors support people to adopt healthy behaviours
- Well-being Advisors supporting healthy behaviour change in older adults, people with disabilities and mental illness
- Brief intervention training on lifestyle
- Provision of adult exercise facilities in community settings and priority neighbourhoods
- Provision of Weight Matters programme for overweight/obese
- Provision of Weight Management LES via GP specialist weight management services
- Dieticians work with adults through specialist clinics and also provide support to mental health and ante-natal clinics.
- A weekly programme of mainstream; swim, sport, health & fitness gyms and workout classes per week, including low impact and 'back to' sessions.
- Discounted mainstream sport & physical activity sessions across all Sports Trust sites for adults and a range of health & fitness membership packages across for adults to provide an affordable way of participating in regular, varied exercise.
- The My Active Life, 3 month physical activity behaviour change programme for local people aged 40-74 who are not currently meeting recommended physical activity guidelines.

Service user or public engagement or consultation:

Reducing obesity was endorsed as a priority for both Tameside and Derbyshire Health and Wellbeing Strategies during public consultation in 2013.

What needs to happen next and by whom?

The T&G Obesity Strategy Group with its wide representation is committed to the delivery of the local strategy. Some of the key areas around which more work needs to happen includes:

- Active travel programme to promote walking and cycling
- Teenage Healthy Weight Pathway
- Health checks pathway
- Development of supplementary planning guidance (controlling takeaways etc) and promotion of healthy environment
- Social marketing campaign
- Promotion of the Responsibility Deal with local retailers and a need for greater involvement from the private sector in the local strategy

- Importance of healthy weight built in all care pathways
- Increased access to NHS (Clinical Commissioning Group) funding for healthy weight services
- Better recording and access to data on adult prevalence of overweight and obesity
- Ensure that all parents are able to access weaning advice that is equitable across Tameside

Proportion of physically active and inactive adults

Outcomes Framework: Public Health 2.13

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

Over the last 50 years, physical activity levels have declined by 20 per cent in the UK, with projections indicating a further 15 per cent drop by 2030. Experts predict that if trends continue, by 2030 the average British person will use only 25 per cent more energy than they would have done had they just spent the day in bed. The government's latest physical activity survey shows that 12.5 million people in England failed to achieve 30 minutes of moderate intensity physical activity per week within a 28-day period during 2013. This remains the case even though people could achieve that half an hour in three ten-minute bites.

The national cost of inactivity in England is £8.2 billion a year. This figure includes the direct costs of treating diseases linked to inactivity and the indirect costs caused by sickness absence. The health cost of inactivity in Tameside is £21.5m per year (Turning the Tide of Inactivity, 2014).

At risk or vulnerable groups:

It is important that all groups have the opportunity to be physically active in order to achieve a population shift in participation. There is a significant reduction in participation post 16 with levels of physical activity declining with age in both genders, with women and girls being less physically active than men at all ages. Levels of physical activity are also lower in low income households as well as people from BME groups.

Benchmarking:

The latest Active People Survey (APS6) result for Tameside shows that 32.81% of adults are classed as inactive. 50% of adults participate in sport or physical activity once per week.

Northwest results for APS6

Authority name		National rank	Proportion inactive	Premature deaths	Cost of inactivity
Trafford		23	24.75	228.5	£16,226,251
Cheshire East		28	25.45	228.5	£16,688,643
Stockport		34	25.87	218	£16,958,349
Warrington		39	26.15	220.2	£17,147,461
Cheshire West & Chester		44	26.43	280.1	£17,327,720
Bury		60	27.87	293.7	£18,273,957
Wirral		77	28.83	297.5	£18,902,698
Cumbria CC		95	29.94	250.3	£19,629,409
Lancashire CC		103	30.41	284.5	£19,938,307
St. Helens		105	30.49	299.9	£19,987,008
Bolton		108	30.76	233.9	£20,169,246
Sefton		110	31.20	297.8	£20,455,296
Halton		111	31.34	297.4	£20,544,755
Liverpool		113	31.63	235.5	£20,736,397
Tameside		118	32.81	351.7	£21,513,849
Knowsley		119	32.83	359.6	£21,523,050
Wigan		123	33.22	324.3	£21,779,819
Rochdale		130	34.12	350.4	£22,368,946
Blackpool		135	34.85	432.4	£22,851,824
Oldham		141	36.28	350.3	£23,786,780
Blackburn with Darwen		143	36.95	354.4	£24,225,029
Salford		148	39.07	382	£25,616,131
Manchester		150	40.24	455	£26,385,799

Most Deprived  | More deprived  | Average  | Less deprived  | Least Deprived 

Policy context:

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

The DCMS and Sport England aim to do this by:

- Building a lasting legacy of competitive sport in schools

- Improving links between schools and community sports clubs.
- Working with the sports governing bodies: focusing on youth
- Investing in facilities
- Communities and the voluntary sector

In July 2011 the Department of Health produced the new [physical activity guidelines](#) for all four UK countries covering early years; children and young people; adults; and older adults.

The guidelines highlight that physical activity should be encouraged across the population and that the risks of poor health resulting from inactivity are high. There is a clear link between physical activity and chronic disease.

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

What interventions work?

- Early intervention and prevention models that encourage people to be more regularly active that provides outcomes around positive mental health and well-being and maintaining healthy weight.
- Interventions that reduce barriers to participation. Provision tailored to local need using market segmentation data, widen access and entry level provision available to new starters at affordable cost to encourage regular participation, effective marketing campaigns including the use of social media, providing expertise and resources to pump prime and sustain voluntary groups/clubs who provide sport and physical activity opportunities.

What are we doing now?

Targeted Interventions:

- The Trust in partnership with the public health team are re-introducing the 'My Active Life' programme a physical activity behaviour change programme for 40 – 74 year olds
- The Trust is commissioned by TGH to deliver a programme of phase IV Cardiac rehab sessions.

Population level interventions:

- The Trust delivers a weekly programme of activities across its 10 facilities and in community settings for young people, families and adults of all ages and abilities.
- The Trust delivers a coaching in primary schools scheme and evening/weekend community programme which engages around 7,000 people a week.

- The Sports Trust has a wide range of health and fitness memberships for adults and young people which promote regular physical activity. The membership packages provide a flexible, broad, low cost and high quality offer to meet the needs of most residents.

What needs to happen next, and by whom?

- The local authority and public health need to ensure that everyone receive quality information about sport and physical activity opportunities
- GPs and their practice staff should provide information to their patients about the benefits of physical activity and signpost them to local services
- The re-establishment of the Sport & Physical Activity Alliance (SPAA) which engages providers to ensure limited resources are targeted effectively, using best practice models to ensure maximum impact and value for money. The SPAA would enable a strategically coordinated approach to delivery and intervention avoiding duplication and identify effective commissioning opportunities.
- The Sports Trust to work with National Governing Bodies of Sport, sports clubs, community groups and health organisations to develop programmes which contribute to the DCMS 'Creating a Sporting Habit for Life' strategy.
- Development of the Tameside built environment to facilitate an increased take up of sport and physical activity, including establishing the urban parks as activity hubs and encouraging the development of walking and cycling routes to increase the number of journeys made by walking and cycling.

Smoking prevalence

Outcomes Framework:

- Public Health 2.3: Smoking status at time of delivery
- Public Health 2.9: Smoking prevalence in 15 year olds
- Public Health 2.14: Smoking prevalence in adults (over 18)
- NHS Operating Framework PHQ 30: Smoking Quitters

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

26% of adults in Tameside and Glossop smoke (about 59,000 people); this is higher than North West (23%) and England (21%). Each year smoking costs Tameside £66 million and causes over 500 deaths and 2,500 hospital admissions. Smoking-related deaths are a major contributor to the low male and female life expectancy in Tameside and Glossop.

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

At risk or vulnerable groups:

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

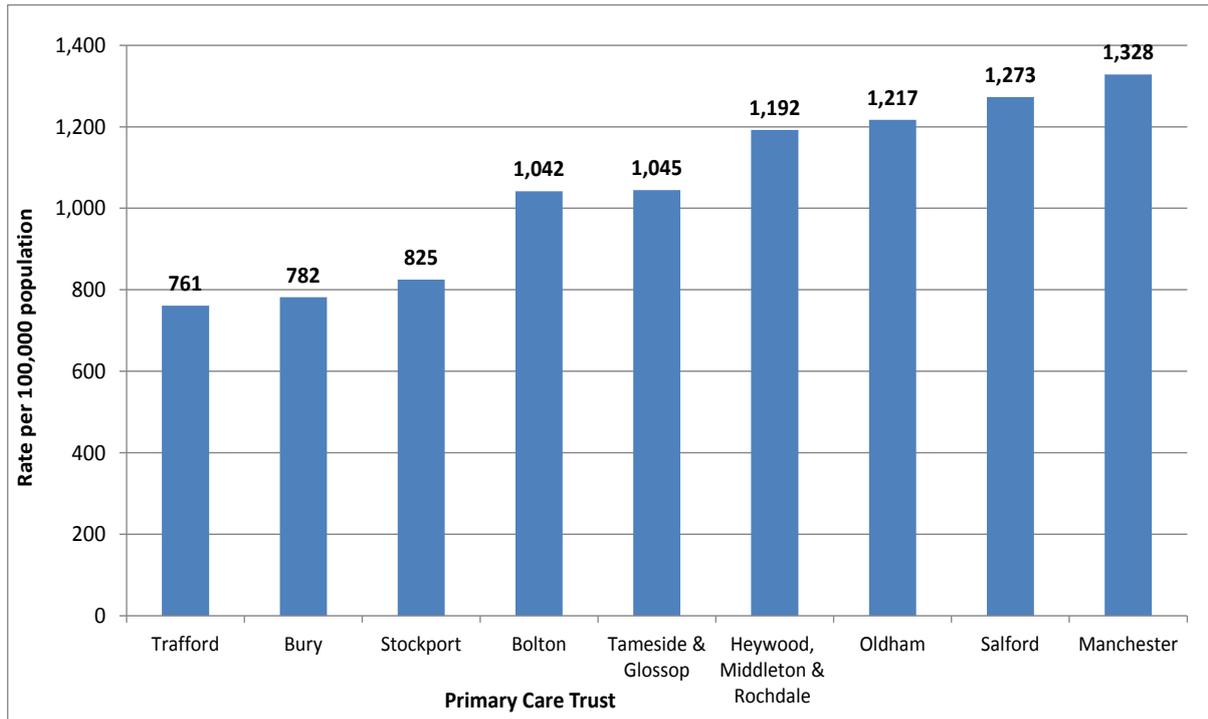
Children exposed to SHS are at much greater risk of cot death, meningitis, lung infections and ear disease. Children from more deprived households are more likely to be exposed to SHS. If both parents smoke children are four times more likely to start smoking than if neither parent smokes.

Smoking during pregnancy is strongly associated with age and social economic position. Pregnant women under 20 are five times more likely to smoke than those aged over 35 (45% and 9%) ([Market Research Bureau, 2007](#)). Pregnant women in routine and manual occupations are over four times as likely to smoke as those in managerial and professional occupations (29% and 7%). Pregnant women are also more likely to smoke if they are less educated, live in rented accommodation, are single or have a partner who smokes.

Benchmarking:

26% of adults in Tameside and Glossop smoke (about 59,000 people); this is higher than the North West (23%) and England (21%). This has fallen from 32% in 2006/07, but the gap between Tameside and Glossop and England as a whole has not been closed. Last year our stop smoking service (SSS) helped 2,037 people quit.

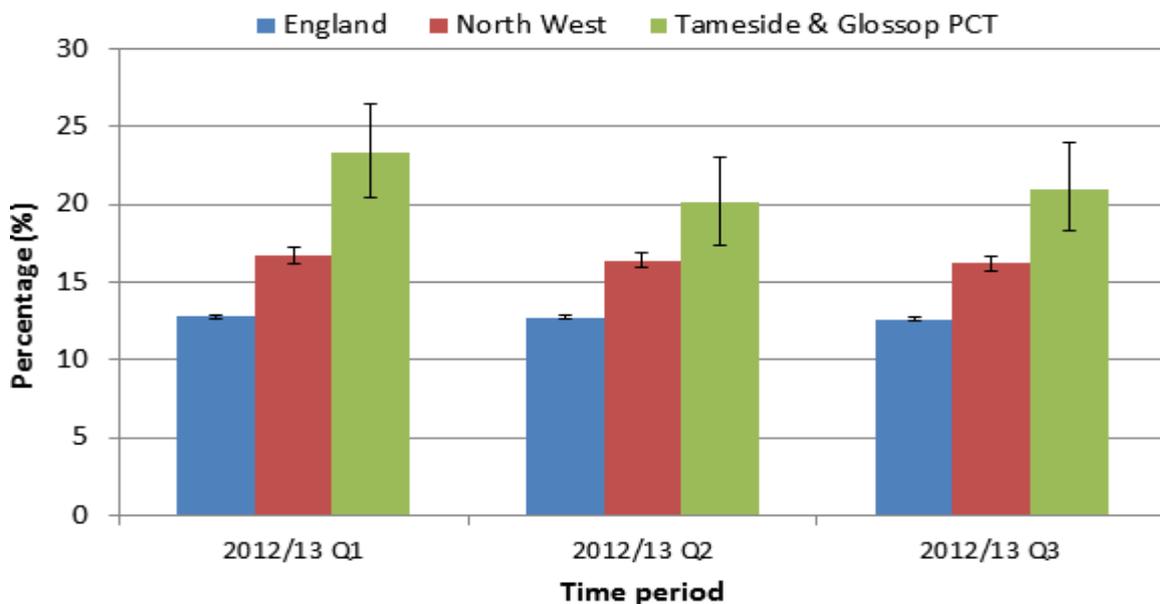
Smoking Quitters per 100,000 aged 16 yrs. and over 2012



Source: *The Health and Social Care Information Centre, Lifestyle Statistics, 2012*

In 2010/11 23% (692/3023) of pregnant women in Tameside smoked at the time of delivery (SATOD). This is the highest rate in Greatest Manchester, and much higher than England (14%). We have achieved a small fall in the SATOD rate from 25% in 2006/07 but we are failing to close the gap between Tameside and Glossop and the regional and England average.

Smoking at time of delivery for Tameside and Glossop, North West and England, Q1 to Q3, 2012/13



Source: *Health and Social Care Information Centre, 2013*

Policy context:

- [DH Healthy Lives; Healthy People](#): a tobacco control plan for England
 - To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% by 2015
 - To reduce rates of regular smoking among 15 year olds in England to 12% 2015
 - To reduce rates of smoking throughout pregnancy to 11% by 2015
- [\(NICE guidance, PH1\)](#)
- [\(NICE guidance, PH 14\)](#)
- [Tameside Tobacco Control Strategy](#)

What interventions work?

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

What are we doing now?

- Very brief advice training for front line staff Roll out of Making Every Contact Count programme
- Trading Standards are working acting on any intelligence they receive regarding illegal and illicit tobacco and the number of complaints and intelligence coming into Tameside MBC has risen.
- Trading Standards work with Greater Manchester Police, where necessary, in executing warrants on premises that may be storing or selling illegal and/or illicit cigarettes. A number of investigations are ongoing.
- Opt-out system of referring all pregnant smokers to SSS is in place
- A Workplace Health Improvement Officer supports employers who want to help their employees to stop smoking.
- Take 7 Steps Out smoke free action plan for Children's Centres as part of Youth and Family team including Youth & family apprentices targeting baby clinics to give out messages
- Pilot of Smoking Cessation Midwife

What needs to happen next, and by whom?

Priority area	Activity
Preventing young people from starting to use tobacco	<p>Communicate the results of the North West Trading Standards survey of 14-16 year olds that show that the majority of young people in Tameside do not smoke in order to change the perception among young people that smoking is common</p> <p>Work with music venues to promote smokefree areas and cessation services</p>
Protecting children from second hand smoke	<p>Promote national smokefree homes and cars campaigns locally</p> <p>Work with maternity and children's service to continue to promote Take 7 Steps Out campaign</p> <p>Continue to roll out smokefree school gates across primary schools</p> <p>Advocate for extended implementation of smokefree policies, including outside public spaces</p>
Target cessation support on routine and manual workers and deprived communities	<p>Embed brief advice in delivery of services that work with deprived families e.g. social workers, CAB, debt advisers</p> <p>Work with employers to promote cessation support within the workplace</p>
Target cessation support on pregnant women	<p>Evaluate impact of pilot smoking cessation midwife post</p>
Preventing the sale of illicit and illegal tobacco products	<p>Work closely with HMRC to enforce legalisation</p> <p>Raise awareness among the public of the adverse effects of illicit and illegal tobacco sales</p> <p>Promote Crimestoppers phone line to the public for reporting suspected illicit and illegal tobacco sales</p>
Raising awareness of the health harm associated with new and niche tobacco products	<p>Develop an awareness raising campaign targeted at young people about the health risks associated with shisha tobacco.</p>
Target cessation support on	<p>Continue to roll out Make Every Contact Count and Brief</p>

<p>people with long term health conditions exacerbated by tobacco use</p>	<p>Advice training to all frontline staff across Tameside</p> <p>Ensure all tobacco users with long-term conditions are referred for appropriate cessation support</p> <p>Roll out automated referral to NHS SSS from secondary care for people with smoking-related LTC</p>
<p>Helping all current tobacco users to quit</p>	<p>Promote and market the NHS specialist stop smoking service</p> <p>Link cessation service promotion with national campaigns, such as Stoptober and No Smoking Day</p>

Alcohol related illness

Outcomes Framework:

- Public Health 2.18: Alcohol related admissions to hospital
- Public Health 4.6(i): Mortality from liver disease for persons aged U75 per 100,000
- Public Health 4.6 (ii): Mortality that is considered preventable from liver disease in persons less than 75 years per 100,000
- NHS 1.3: Under 75 mortality rate from liver disease

Implications for the population's health and well being:

Young people today are growing up in a different environment than even 20 years ago with regards to alcohol availability, marketing and affordability:

- Alcohol is 45% more affordable today, in relative terms, than it was in 1980.
- It is estimated that the cost of alcohol related harm to the NHS in England is £3.5 billion (Parliamentary Answer October 2012)
- Almost half of all violent crime is alcohol related
- There were 8,790 alcohol related deaths in the UK in 2010.
- Alcohol is linked to 40% of domestic violence cases.
- Alcohol related illness or injury accounted for more than 1.1m hospital admissions during 2010/11, up 11% since 2009/10.
- The impacts of alcohol harm are particularly acute in deprived areas, where mortality and admissions to hospital related to alcohol are at their highest.

Alcohol Harm - a national issue:

Nationally alcohol misuse costs society an estimated £22.1 billion per Year:

- £7.6 billion caused by crime and licensing
- £8.4 billion in costs to the workplace/wider economy
- £1.9 billion on social services for children and families affected by
- Alcohol misuse.
- The equivalent of £419 per person every year.

Alcohol Harm - a local issue:

Alcohol harm in Tameside and Glossop is extensive and is an important factor adversely affecting overall quality of life and in perpetuating inequalities. In annual profiles released in 2011 Tameside was identified as being in the 'top five' nationally for alcohol related harm in relation to health. This definition included admission to hospital, months of life lost, levels of consumption and levels of incapacity benefit linked to alcohol.

Tameside Alcohol Headlines

- An estimated 19.4% of Tameside's drinking population are hazardous drinkers, defined as drinking 22-50 units per week for men and 15-35 units per week for women. Hazardous drinking is pseudonymous with 'at risk' drinking where an individual is drinking above recommended levels but may not be experiencing alcohol related harm.

- An estimated 6.4% of Tameside's drinking population are harmful drinkers, defined as drinking 51 or more units of alcohol per week for men and 36 or more units for women.
- An estimated 25.6% of Tameside's population are regular binge drinkers, defined as drinking 8 units or more within a single day in men or drinking 6 units or more within a single day in women.
- The claimant rate of Incapacity benefit for those whose main medical reason for claiming is alcoholism was 187 per 100,000 per working age population in Tameside in 2011, approximately twice that of the England average.
- There were 60 male and 31 female deaths attributable to alcohol in Tameside in 2010, accounting for 5.6% and 2.8% of total male and female deaths in Tameside respectively.
- The male age-standardised rate of alcohol attributable mortality in Tameside is 51 per 100,000 male population, which is 44% higher than the England average. The female age-standardised rate of alcohol attributable mortality in Tameside is 22 per 100,000 female population, which is 50% higher than the England average.
- If all premature mortality due to alcohol was prevented it would add an additional 14.6 months to life expectancy in Tameside males and an additional 6.6 months to life expectancy in Tameside females. (This is based upon calculations using mortality data between 2008 and 2010). For months of life lost due to alcohol Tameside ranks the 6th worst local authority nationally for males and the 11th worst local authority nationally for females.
- The rate of alcohol related admissions in Tameside in 2011/12 was 2,648 per 100,000 population, which is 34% higher than the rate for England as a whole. Tameside ranks 19th worst local authority out of 326 local authorities nationally for alcohol related admissions.
- Approximately 800 people in Tameside accessed specialist services for alcohol misuse in 2012/13.

At risk or vulnerable groups:

- Children and Young People
- Young men involved in binge drinking and Under 15s including girls
- Chronic drinkers at risk of developing alcohol related ill health
- Those living in areas with the highest deprivation scores
- Children and Families with Multiple need
- Adults with Multiple needs and those in the Criminal Justice System
- Lesbian, gay, bisexual and transgender (LGBT) communities
- Victims of Domestic Abuse
- Pregnant Women
- People recovering from Drug Addiction

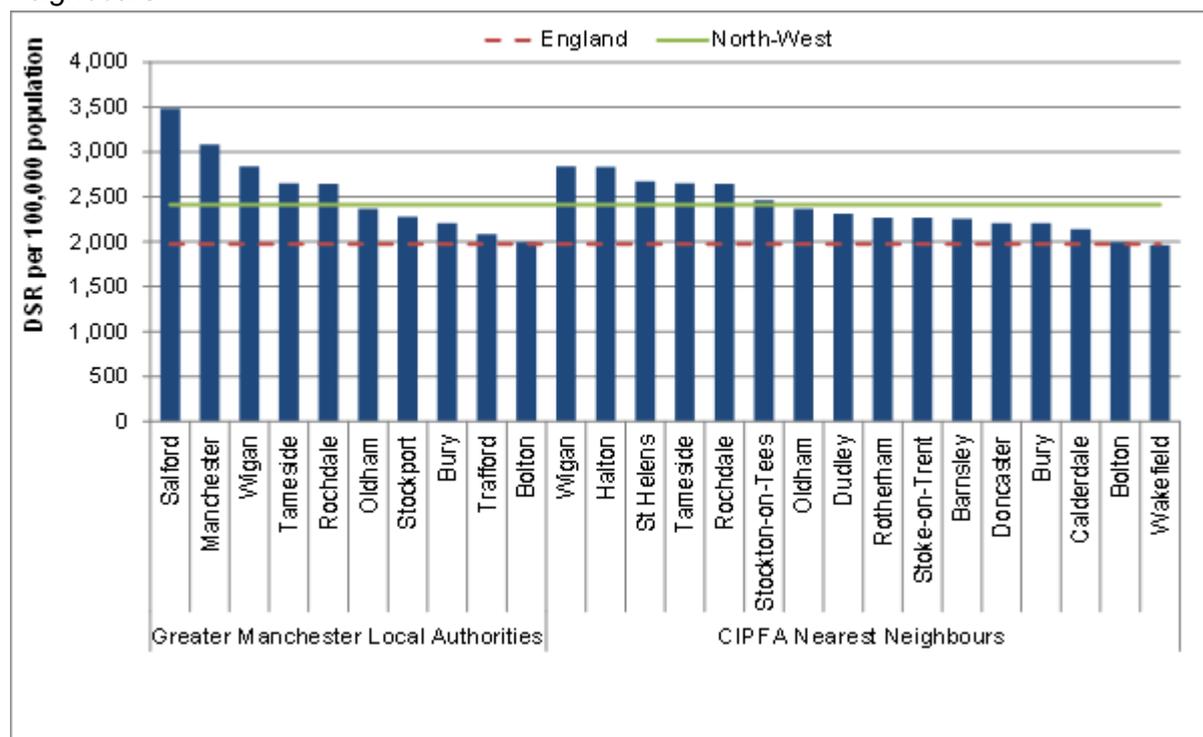
Benchmarking:

Table: Alcohol Related Admissions, Directly Standardised Rate per 100,000 Population, 2002/03 to 2011/12

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
England	926	1,023	1,145	1,291	1,389	1,473	1,582	1,743	1,895	1,974
North West	1,235	1,362	1,510	1,697	1,840	1,940	2,068	2,295	2,425	2,413
Tameside	901	1,121	1,485	1,660	1,854	2,052	2,188	2,435	2,543	2648

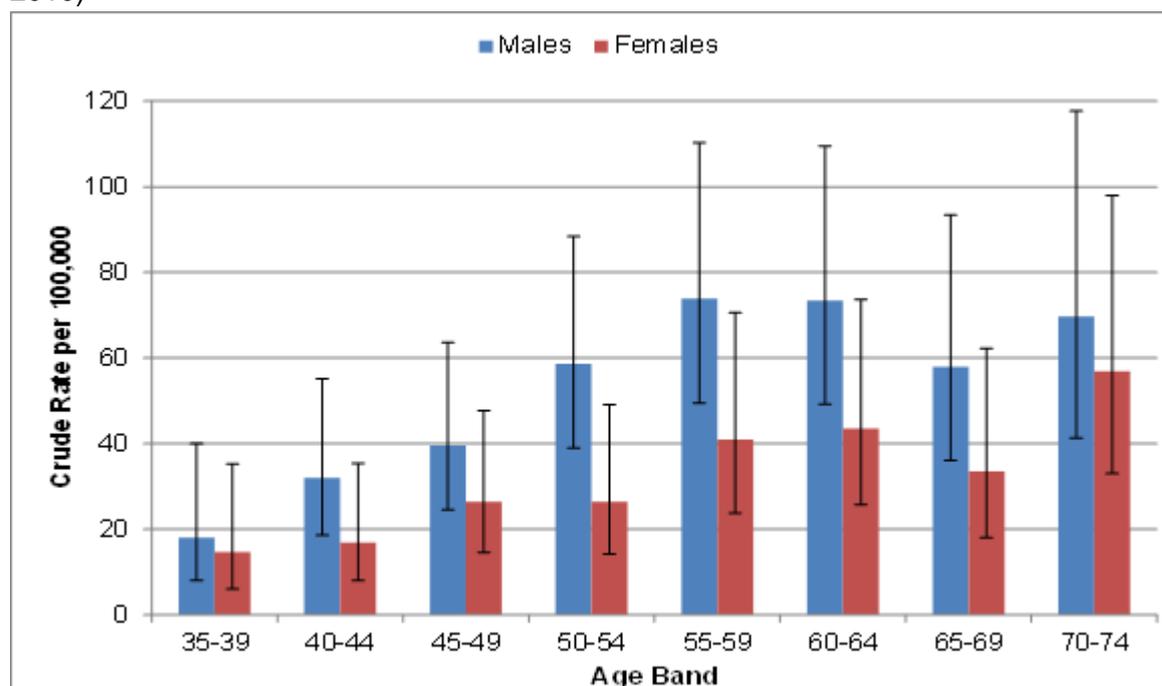
Source: North West Knowledge and Information Team, 2014

Admission episodes for alcohol attributable conditions all ages DSR/100,000 population, 2011/12, by Greater Manchester Local Authorities and Tameside's CIPFA nearest neighbours



Source: North West Knowledge and Information Team, 2014

Mortality rate from liver disease for persons under 75 per 100,000 by age and sex (2008-2010)



Source: Public Health Mortality File, 2013

Policy context:

[The Government's Alcohol Strategy](#), March 2012.

The Home Office launched its Alcohol Strategy in March 2012. The Government summarises its approach as containing proposals to crackdown on 'binge drinking' culture, cut the alcohol fuelled violence and disorder that blights communities, and slash the number of people drinking to damaging levels. The Government strategy includes commitments to:

- Introduce a minimum unit price (MUP) for alcohol
- Introduce stronger powers for local areas to control the density of licensed premises including making the impact on health a consideration for this
- Pilot innovative sobriety schemes to challenge alcohol-related offending
- Reduce young people's exposure to alcohol advertising
- Conduct a review of adult drinking guidelines
- Launch a review of current commitments within the Mandatory Code

Burden of Liver Disease and Inequalities in the North West of England was published in September 2012 and highlights the fact that deaths from liver disease are 42% higher in the North West compared to England.

NICE Guidance PH24 Alcohol-use disorders – preventing the development of hazardous and harmful drinking acknowledges that alcohol-related harm is a major health problem. It is one of 3 pieces of NICE guidance addressing alcohol related problems among people 10 years and older.

[Alcohol Harm Reduction Strategy](#). The Tameside Alcohol Harm Reduction Strategy, 2010-2013 (currently being refreshed)

What interventions work?

The Department of Health in 2010 identified a number of High Impact Changes, which are calculated to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level and which are calculated to have the greatest impact on health commissioned outcomes:

- Work in Partnership – Developing and implementing the local Alcohol Strategy to improve services and address wider community issues associated with alcohol for example minimum unit pricing, the night time economy and violent crime
- Develop activities to control the impact of alcohol misuse in the community for example tackling binge drinking, under age sales, peer education programmes
- Influence change through advocacy
- Improve the effectiveness and capacity of specialist treatment
- Alcohol Specialist Teams in the acute sector and improving links to community services and identification and brief interventions are all key elements of good practice with the hospital setting
- Identification and Brief Advice (IBA) – provide more help to encourage people to drink less. Delivery of IBA a variety of settings for example, primary care, housing, probation service, ambulance services and social services
- Amplify national social marketing priorities aimed at both children and young people and adults

What are we doing now?

Tameside Strategic Alcohol Group and Life Course Action Plan Working Groups

Development, implementation and evaluation of the Tameside Alcohol Programme including the Alcohol Partnership Offer, the Alcohol Needs Assessment and Life Course Action plans.

The Children's Service Partnership Forum

The forum represents a range of agencies that share responsibility for the successful delivery of children and family services. It is an important forum to enable partners to influence policy, strategy and planning, develop pathways, to give and share information, discuss progress and developments, and evaluate the impact of the plan on the outcomes and opportunities for our children, young people and families.

The forum has adopted the Life Course approach, which covers:

- **Starting well** - ensuring the best start in life for children
- **Developing well** - Enabling all children and young people to maximise their capabilities and have control over their lives.

The forum is responsible for the Alcohol Action plans for starting and developing well

Commissioned Services

The responsibility for Commissioning Alcohol Services transferred to Tameside Council in April 2013. There is a range of services available in Tameside to meet local needs from early intervention and prevention, specialist services and inpatient detoxification and residential rehabilitation.

Tier 1/Tier 2 Service –

Identification and Brief Advice/Brief intervention (IBA/BI) Training Programme

- Information about the effects of alcohol to individuals and society, including the local picture of alcohol related harm.
- Information and updates on alcohol units and levels of risk associated with consumption.
- Information and updates on alcohol units and levels of risk associated with consumption.
- The skills to raise the issue of alcohol and how to determine risk using the AUDIT assessment tool.
- Resources, leaflets, prompt cards, posters unit wheels etc. to facilitate IBA/ BI within their role.
- Motivational approaches and techniques to deliver effective Brief Interventions.

A range of partners and organisations delivers IBA/BI across Tameside including Primary Care, Tameside Hospital, New Charter Housing, TMBC, Community Health Services, GMP and GMFRS.

Tier 2 and 3 Services –

- Early Intervention and Prevention Service commissioned from Lifeline, Branching out (CYP Specialist Substance Misuse Service), Nationally and Locally Enhanced Services in Primary Care, Pennine Care Specialist Substance Misuse Services, ADS Alcohol Services, Community based Tier 3 Drugs Service plus the Drug Intervention Programme for Criminal Justice Clients deals with Alcohol use by clients, Recovery and Reintegration Service commissioned from Acorn, Alcohol Treatment Requirement (Court ordered treatment) commissioned from ADS, Peer Mentoring Programme, Integrated Offender Management and Multi-agency Reduction Reoffending Group dealing with the impact of alcohol use by Offenders and the Bridges Domestic Abuse Service

Tier 4 Services

Preferred Provider list for Inpatient Detoxification and Residential Rehabilitation

Hospital Alcohol Liaison Service (HALS) and CYP Specialist Alcohol Nurse

The HALS service aims to work with patients attending THFT for urgent and planned care that have been identified as harmful or dependent drinkers or who attend because of alcohol related harm, the aim being to reduce the level of alcohol harm suffered by those patients.

The HALS team will provide BI to patients identified in A&E, on wards or at preoperative assessments as drinking at harmful levels. Patients admitted for alcohol related harm or who are identified, as dependent drinkers will be supported by the team to move into community based alcohol treatment services. When appropriate discussions will be

undertaken to maximise the opportunities for planned Quick Start detoxification with patients who are admitted for more than 3 days and the opportunity for them to progress into the Ambulatory Detox clinic where appropriate.

The CYP Specialist Alcohol nurse will provides the opportunity to bridge the gap between hospital, community and voluntary services.

The key objectives for this service are as follows:

- Reduce A and E attendances and re presentations
- Increase referrals into appropriate services within the hospital and community.
- To increase partnership working between Tameside Foundation Trust, specialist community and voluntary services.
- To critically evaluate at the end of year one making recommendations to inform future provision.
- Establish close working practices with HALS team including management, performance and governance arrangements.

Health Improvement Team's alcohol work

The Health Improvement Team promotes lower risk drinking in its interactions with clients and actively signpost into specialist services where appropriate. For example, Health Trainers routinely ask about alcohol consumption as part of a lifestyle assessment and may support clients to set goals around reducing consumption. The NHS Health Checks for 40-74 year olds being carried out in community and workplace settings include the Alcohol Audit and participants are given both verbal and written information about the effects of alcohol on health. Weight Matters Advisors have been piloting the Audit C as part of the client's individual Personal Health Plan as well as highlighting the calories in alcohol. This is now being extended to include the full Audit. Smoking Advisors highlight the interplay between alcohol and some non-nicotine treatments, as well as the risk of alcohol lowering inhibitions and increasing the risk of a quitter smoking a cigarette.

The Family Health Mentors Programme (SFT) supports young people in school and other settings to reduce alcohol consumption to less risky levels.

Licensing

Health bodies can now have a say in local decisions about licensing. This means health bodies can present evidence in relation to the licensing objectives, which may include data on alcohol related ambulance call outs and hospital admissions, to licensing.

The new role of Public Health as a responsible authority would be given more weight if a health related objective was introduced for alcohol licensing. Currently the Government's strategy only sets out an intention around a health objective in relation to Cumulative Impact Policies. Consideration should be given as to how health intelligence in relation to individual premises can be utilised in collaboration with partners, regardless of whether a CIP is in place.

Public Health is represented on the new Joint Licensing and Enforcement Group in Tameside.

What needs to happen next?

- Tameside Strategic Alcohol Group to continue to take the strategic lead for all aspects of the Tameside Alcohol Programme and report to the Health and Wellbeing Board
- Alcohol Partnership Offer completed during 2014

- Align Alcohol Programme with the Neighbourhood Offer, Troubled Families, Work Programme and Sexual Health Agenda
- Active participation of partners in the Substance Misuse and Service Transformation Programme
- Social Marketing Campaign for the 50+
- Alcohol Pathway for Young People finalised and disseminated
- Redesign of the Adults Alcohol Pathway
- Alcohol training, education and prevention as part of the Healthy Schools Programme
- Development of Workplace Health Improvement Programme to include Alcohol
- Further development of IBA/BI in primary care with a focus on training across all GP Practices
- Programme Management for the Adults and Children's CCG funding Programmes
- Hidden Harm proposal for Young Carers of Substance Misusing parents developed
- Participation in the GM Alcohol Strategy and Home Office LAAA scheme
- Better access to treatment for certain groups – Black and Minority Ethnic (BME), Women, LGTB and Young People

Who needs to do this?

The Tameside Strategic Alcohol Group and Working Groups, The Children's Partnership Forum, The Tameside Drug and Alcohol Steering Group, The Health and Wellbeing Board Implementation Group, LARA Committee, NES Forum and the Alcohol Service Development Group

Successful completion of drug treatment

- People (adults) who complete drug treatment successfully as a percentage of the total number in treatment;
- Proportion of people who successfully complete who then re-present within 6 months.

Outcomes Framework: Public Health 2.15

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

- Effective drug treatment reduces crime, health and social care costs and increases the quality of life of people who use drugs.
- Drug treatment underpinned by the Recovery Model aims to see service users holistically, as complete people who have the capacity to cope with their distress in such a way that they are able to participate in a full life, developing self-esteem and self-determination.
- The [NHS National Treatment Agency](#) has a presentation on the benefits of investing in local recovery services.

At risk or vulnerable groups:

Our vision is to make recovery a reality for all people who want or need to address their problematic drug use by developing a whole system response that will support people to take responsibility in maintaining their health and wellbeing. However, there continues to be access concerns for (and demand from) women, Black and Minority Ethnic (BME) groups, under 25s and Lesbian, Gay, Bisexual and Transgender (LGBT) communities.

Benchmarking:

The DOMEs report is produced on a quarterly basis and is used locally to monitor performance and compare this to national and cluster trends. At present there is only a Benchmark for Successful Completions and Representations in respect of Opiate and Non Opiate clients and broken down and reported separately for all clients in treatment and criminal justice clients. The latest DOMEs provide data for Quarter 2 and reports the following:-

Successful Completions (All in Treatment)

Opiate = 8.6% (Quartile Range 11% to 12%)

Non Opiate = 47.9% (Quartile Range 49% to 63%)

Successful Completions (Criminal Justice)

Opiate = 11.1% (Quartile Range 11% - 14%)

Non Opiate = 60.9% (Quartile Range 49% to 78%)

Representations (All in Treatment)

Opiate = 37% (Quartile Range: 13% to 5%)

Non Opiate = 3.0% (Quartile Range: 3% to 0%)

Representations (Criminal Justice)

Opiate = 11.1% (0% to 0%)
Non Opiate = 9.1% (0% to 0%)

Overall successful completion rates have fallen slightly in Quarter 2, from 9.5% to 8.6% for opiates, from 43.9% to 47.9% for non-opiates and representation rates have increased from 31.3% to 37% for opiates and from 2% to 3% for non-opiates. Successful completion rates for criminal justice clients for both opiates (11.1%) and non-opiates (60.9%) remain in the top quartile nationally.

Policy context:

The Government's ['Drug Strategy 2010 Reducing Demand; Restricting Supply; Building Recovery 2010: Supporting people to live a drug free life'](#) places a strong emphasis on supporting treatment and recovery, taking a holistic view by putting individuals at the heart of recovery and working with a range of services, such as training, housing and wider health and social care services.

What are we doing now?

Public Health has undertaken a major review of all public health services, including drug and alcohol services, with the view to have a service model around Vulnerable People and Health Inequalities across the Life course as they relate to Domestic Violence, Mental Health, Drugs and Alcohol, Homelessness and Blood Borne Viruses.

The intention is that the model will:

- accommodate appropriate interventions for both drugs and alcohol
- maintain high quality clinical services
- provide support that is 'sequential', that is, the right support at the right time, provided by the right people
- reflect the Life course approach to include prevention and ageing well
- address the issue of re-presentations

In addition the service model will reflect 'whole system integration' underlying the health and social care integrated delivery model:

- Collective resources meeting health & wellbeing outcomes
- Better management of demand
- Streamlining pathways and reducing duplication
- Reducing high-tier acute activity

Service user or public engagement or consultation

Service user engagement and consultation will be a central feature in the redesign of services over the coming months.

What needs to happen next, and by whom?

- Gather knowledge about the current system
- Identify what is of value and what is not

- Identify how best to utilise existing assets, including Primary Care
- Design the system

This programme of work will be influenced, delivered and implemented by the stakeholder members of the Drug and Alcohol Strategic Steering Group, following a period of consultative input. Stakeholders include:

- Service User Advocacy lead
- Clinical lead
- Public Health leads in drugs, alcohol and sexual health
- Children and troubled families lead
- Housing support and homelessness lead
- Adult social care lead
- Commissioning leads

Recorded diabetes

Outcomes Framework: Public Health 2.17

Implication for the population's health & well being:

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

Benchmarking:

The report compared PCTs in England and it indicated that NHS Tameside and Glossop has a higher than average mortality rate. The role of NHS Diabetes is to work to transform diabetes care across the NHS.

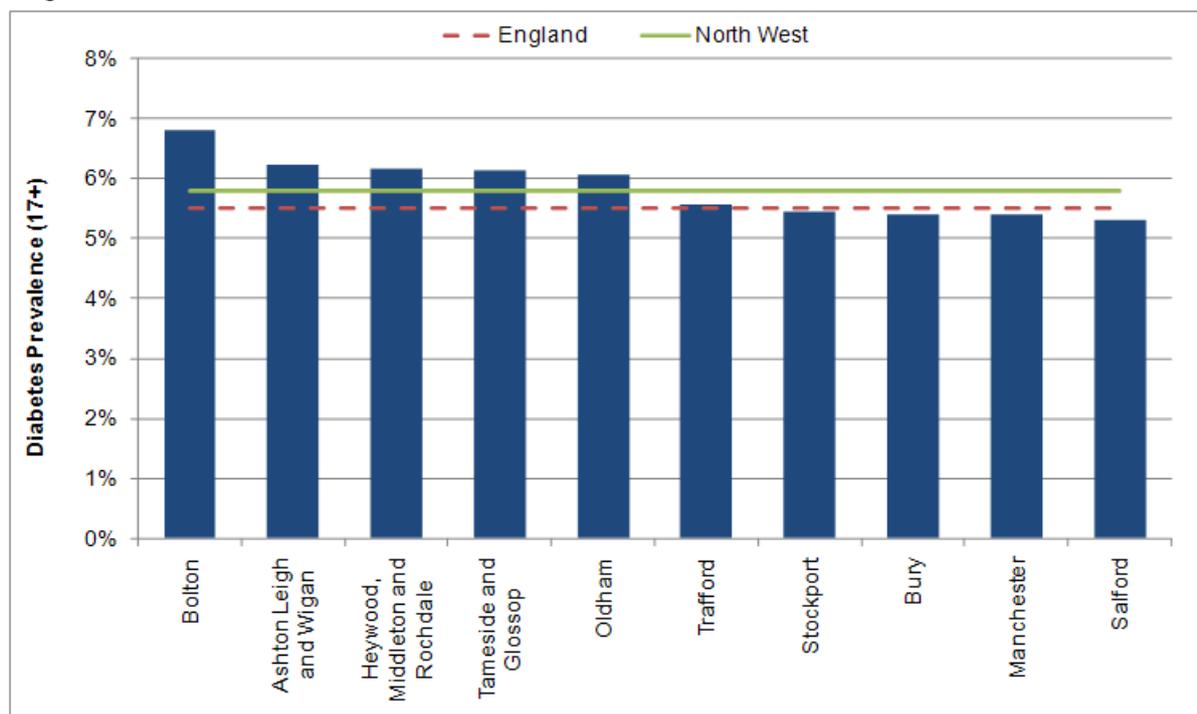
The number of patients on GP diabetes registers has been on the increase – figures for the past 3 years are as follows:

Number of patients on GP diabetes registers

Mar-10	Mar-11	Mar-12
10,481	11,768	12,326

Source: NHS Comparators 2012

Registered Prevalence of Diabetes in Adults 2010/11



Source: NHS Information Centre 2012

Policy context:

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

What did we do in 2011-12?

A clinical lead for the NHS Clinical Commissioning Group (CCG) will be identified by the end of April 2012, and will lead the redesign and improvement of local services for patients with diabetes, and will ensure the offer of support from NHS Diabetes is taken up and that the issues raised in the national report are addressed.

Diabetes care is included in the Quality, Innovation, Productivity and Prevention (QIPP) plans for 2012-13, with plans to deliver improved and increased care in the community and further develop the “self-care” model for patients with diabetes.

What were our plans for 2012-13?

With leadership from the CCG, the Commissioning lead for diabetes/long term conditions will support the clinical lead, once identified, to take forward the improvements needed.

Work across commissioning and public health to increase the number of patients on disease registers and improve the clinical management of patients on those registers. The commissioning team is leading a piece of work via the Quality and Outcomes Framework (QOF) team to support Practices to improve recording and management of patients with long term conditions, including diabetes.

What were our plans for 2013-14?

We have made good progress in our support for patients having achieved the following in 12-13:

- Telehealth service fully implemented and achieving objectives
- Additional courses commissioned from the Expert Patient Programme
- Improvements in recent Peer Review of local stroke rehabilitation services, and recommendations made for further improvements
- Support to practices to increase the number of patients on disease register- encourage early identification and appropriate management of Long Term Conditions (LTCs)
- GP review of cardiology patients with over 25% of patients being transferred back to the care of their GP
- Targets achieved for uptake and offers of NHS health checks
- Clinical Dashboard: giving all GPs access to up to date information on patient A&E attendances, admissions, and discharges from THFT
- Model of care developed for procurement in 2013-14 for patients with diabetes
- Model of care agreed for community respiratory team

Building on this in 2013-14 we improve early identification and management in primary care, appropriate referral and management in secondary care, and work to refine pathways between primary, community and secondary services, including specialist care.

Through our integration work, we will work with our LAs to develop integrated support for people with LTCs, and will include in this the further development of plans for delivery of personalised care plans and budgets.

We are re-commissioning all diabetes services for adults in 2013-14 going out to tender for a fully integrated community based diabetes service. We will ensure that the specification meets national guidance for the management of diabetes, including diabetes management against the nine care processes and with self-care and education a key element. We are also working with our GPs and Practice Nurses to ensure education and support is available for diabetes management in a primary care setting, and will use the primary care balanced scorecard to identify areas for improvement.

Our current pulmonary rehabilitation within the community does not meet the new minimum standard as outlined in the NHS Outcomes Strategy for COPD and Asthma. We will look to address this and have secured additional funding to enhance services locally by means of an integrated respiratory service, which includes pulmonary rehabilitation. This will seek to increase referrals into the service in addition to the service providing in reach to secondary

care to ensure patients post exacerbation are offered pulmonary rehabilitation in accordance with NICE Quality Standards.

Within the prescribing Local Enhanced Service our Medicines Management Team have set targets which encourage GPs to review prescribing in key therapeutic areas in line with NICE guidance. Examples of this have been reviews of prescribing of newer oral agents in type 2 diabetes, identification and effective anticoagulation treatment of Atrial Fibrillation (AF) patients, Inhaled Corticosteroid (ICS) in asthma & COPD patients and prescribing decisions in stable, angina.

We recognise that early identification supports effective management and improved health outcomes so we will work with our member practices to increase the recorded prevalence of long term conditions.

We will increase the number of registers that are above the GM average prevalence by 5% from the 2012-13 baselines i.e. Atrial Fibrillation (GM Prevalence 1.3%), Diabetes (GM Prevalence 6.1%) and COPD (GM prevalence 2.1%).

Emergency admissions/readmissions and unplanned hospitalisation for chronic ambulatory care sensitive conditions

Outcome frameworks:

Public Health 4.11: Emergency readmissions within 30 days of discharge from hospital

- NHS 3b: Emergency readmissions within 30 days of discharge from hospital
- NHS 3a: Emergency admissions for acute conditions that should not usually require hospital admission
- NHS Operating Framework PHQ17: Emergency admissions for acute conditions that should not usually require hospital admission
- NHS 2.3i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- NHS Operating Framework PHQ15: Unplanned hospitalisation for chronic ambulatory care sensitive conditions

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

- Maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes.
- Emergency admissions to hospital are distressing, so better management that keeps people well and out of hospital should lead to a better patient experience.
- Reducing variations in ambulatory care sensitive (ACS) admissions by spreading existing good practice could produce cost savings of £170 to £250 million across England (NHS Institute 2011). This variation-based calculation may significantly underestimate potential savings from managing ACS more effectively as admission rates in all areas are significantly above what should be achievable.

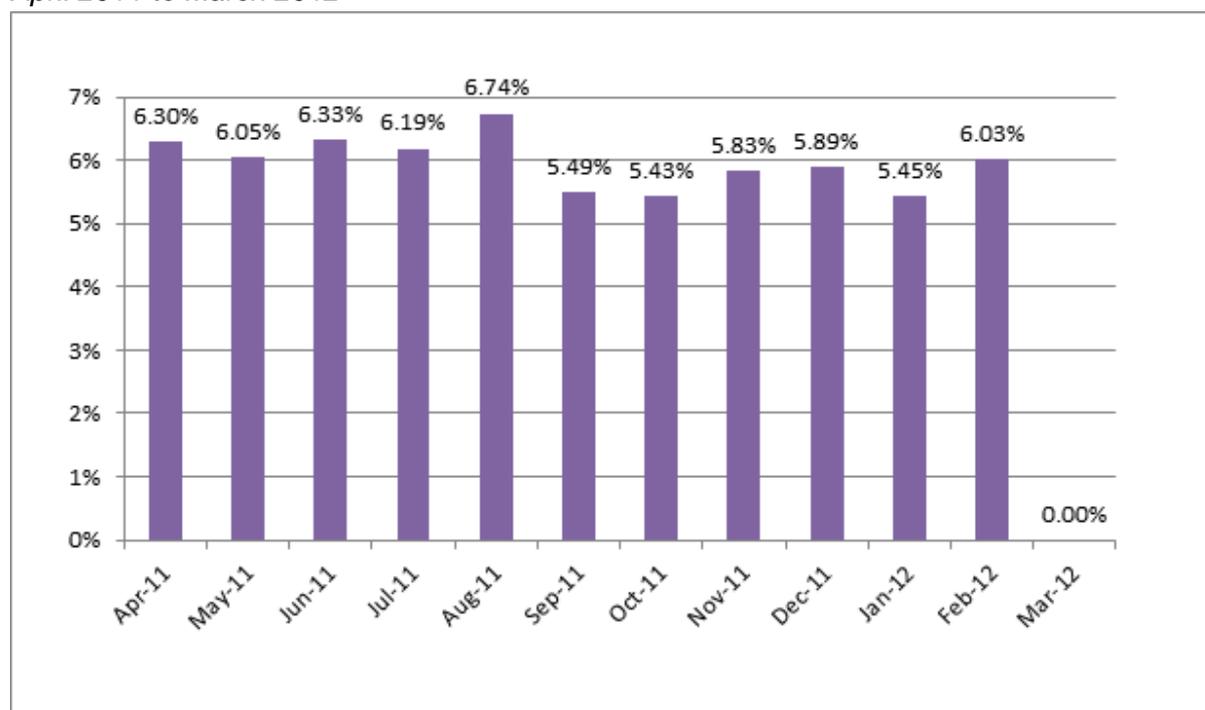
At risk or vulnerable groups:

- Older people; the risk of developing ACS conditions increases with age
- People with mental health conditions; there is a strong association between mental and physical ill health.

Benchmarking:

The aim is to decrease over time the number of emergency re-admissions within 30 days of discharge. Locally, readmission rates for non-elective admissions have increased between 2010/11 and 2011/12 (Month 8 Data) by 17% however 2011/12 year to date is showing a very minimal decreasing trend.

Readmissions that occur within 30 days of any previous discharge, Tameside and Glossop, April 2011 to March 2012



Source: NHS Tameside and Glossop 2012

Policy context:

- The King's Fund 2011: [Transforming our health care system, ten priorities for commissioners](#)
- Department of Health 2009 [Supporting people with long term conditions: commissioning personalised care planning - a guide for commissioners](#)

What interventions work?

Early identification of ACS patients is crucial if their management is to be successful. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices. Some progress can be made through relatively simple measures such as expanding vaccination, where available, to prevent the onset of a condition. For other ACS conditions (chronic and acute aggravated conditions), commissioners will need to encourage active disease management. This can include a number of elements, such as:

- treatment decisions based on explicit proven guidelines
- case management to support people with complex long-term conditions
- disease management and support for self-management for those with less complex long-term conditions
- telephone health coaching, and other behavioural change programmes, to encourage patient lifestyle change
- easy access to urgent care for those with acute aggravated conditions

What did we do in 2011-12?

NHS Tameside and Glossop have a local Emergency Care Network, with membership from both Local Authorities (Social Care), Primary Care, Community services, our local Foundation Trust, North West Ambulance Service (NWAS), and GP Out of Hours. Rates for readmissions are currently under review and subject to new guidance and are due to be released in 2012.

During 2011-12 we have:

- Continued to monitor readmission rates including previous years data for accurate comparison
- Piloted and streamlined discharge processes from acute beds
- Increased in-patient intermediate care capacity
- Implemented local Commissioning for Quality and Innovation (CQUINs) with acute and community providers to support implementation of internal professional standards which includes early consultant specialist review, expected dates of discharge, care and discharge planning
- Introduced 4 ambulatory care pathways (Cellulitis, Community Acquired Pneumonia (CAP), Urinary Tract Infections (UTI's) and Deep Vein Thrombosis (DVT)), which support improved planned pathways of care for urgent presentations and reducing readmissions
- Implemented the Integrated Discharge Team to support early facilitated discharge of older people within 24-48 hours of admission.
- Piloted 15 recuperation beds
- Implemented the care homes pilot delivering additional services to patients in care homes
- Implemented the Short Stay Intervention Unit (SSIU) and Transitional Discharge Ward (TDW)
- Tameside Hospital Foundation Trust (TFT) audit of 50 randomly selected readmission patients, the results of which will feed in to 2012/13 work streams

What were our plans in 2012-13?

In 2012-13, the Emergency Care Network will continue to provide the leadership for this agenda, and plans include:

- Procure 40 intermediate care beds, replacing all current community provision
- Evaluate the SSIU & TDW with a view to continuing with the most successful model
- Evaluate the care homes pilot with a view to refining content and continuing the service should admissions be reduced
- Drive down Length of Stay (LOS) in all areas but particularly where we are an outlier for emergency admission stays and intermediate care stays
- Continue to monitor the outcomes from the existing ambulatory care pathways
- Implement a further 4 ambulatory care pathways

What were our plans in 2013-14?

We have higher emergency admissions for acute conditions that should not usually require hospital admission than both the England and Cluster average.

Emergency readmissions following a non-elective and elective spells at month 7 12/13 have reduced however more work needs to be done to understand the reasons for re-admission.

We know too many people attend A&E and are admitted to hospital because there are not sufficient alternatives services in the community. We have seized the opportunity to lead a partnership approach to this work and have a programme of work focusing on admission avoidance and more proactive diagnosis and management across primary and community care as part of our integration work. Our programme will focus on an integrated step up service, including falls, respiratory, end of life and telehealth/care. We will ensure that education and training runs alongside the service improvement/delivery, so that all stakeholders better understand the impact that their decisions make on the rest of the system.

We will work with care homes (nursing and residential) and NWS to ensure that patients stay in their own 'homes' longer and are only conveyed to an acute hospital setting when really necessary. We will commission additional ambulatory care pathways, IV services, and integrated care with our partners. We will test our commitment to the integration agenda by using aligned budgets to fund alternative community health and social care services, which will prevent more expensive acute health service, spend.

We will also work with member practices to ensure that primary care is able to offer access and alternative support for our patients.

We will continue to monitor re-admissions closely and embed discharge planning into patients' journeys to ensure patients are discharged at the right time and given the right level of care once discharged.

A children's urgent care CQUIN has been developed with the aim of reducing the numbers of children admitted to the Observation and Assessment Unit for under four hours

Quality of Life for People with Long Term Conditions

Outcomes Framework:

- NHS 2: Health related quality of life for people with long term conditions
- NHS 2.1: Proportion of people feeling supported to manage their long term condition
- Operating Framework PHQ14: People with long term conditions feeling independent and in control of their condition

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

Long-term conditions (LTC) are chronic illnesses that can limit lifestyle, such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD) and those living with HIV. There are 15.4 million people living with a long-term condition in England. Numbers are expected to rise due to an ageing population and unhealthy lifestyle choices.

People with LTC are significant users of NHS and social care services. NHS services are measured by:

- the proportion of people feeling supported to manage their condition;
- Early and appropriate diagnoses of the LTC.
- unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (see the corresponding indicator review regarding this issue)
- Unplanned hospitalisation for asthma, diabetes and epilepsy (in under 19s) (see the corresponding indicator review regarding this issue)

At risk or vulnerable groups:

Patients with a diagnosed long term condition

Policy context:

- [Long term conditions NSF](#)
- [Managing people with long term conditions](#)
- [Managing and treating people with HIV](#)

What interventions work?

People with LTC want greater control of their lives, to be treated sooner before their condition causes more serious problems and to enjoy a good quality of life. This means transforming the lives of people with long-term conditions to move away from the reactive care based in acute settings toward a more systematic patient-centred approach, where care is rooted in primary and community settings and underpinned by early diagnosis, strong partnerships across the whole health and social care spectrum. This also includes delivering appropriate and targeted interventions to increase early diagnosis within high prevalence groups.

What are we doing now?

NHS Tameside and Glossop are participating in the Department of Health's LTC Quality, Innovation, Productivity and Prevention (QIPP) programme. We have a local LTC commissioning network, with membership from the Local Authority (Social Care), Primary Care, Community services, our local Foundation Trust, and patient representatives. This is under the leadership of the nominated NHS Clinical Commissioning Group (CCG) lead for LTC. During 2011-12 we have:

- Delivered PCT wide telemedicine service for ECGs
- Redesigned our anti-coagulation pathways to deliver more care in General Practice
- Commissioned GP direct access B-type Natriuretic Peptide testing (BNP and NT-proBNP) in line with NICE guidance on chronic heart failure
- Worked with our GPs and main secondary care provider trust to identify patients who are appropriate for management and care in the community and primary care, and facilitated this transfer of care (for diabetes and cardiology/heart failure)
- Developed local pathways and services for pulmonary rehabilitation
- Expanded provision of self care programmes for patients with long term conditions by increased investment in the "Expert Patient Programme"
- Successfully implemented Telehealth for patients with COPD and Heart Failure.
- Redesigned our community based "Long Term Conditions" team, to focus on the provision of specialist clinical management and care co-ordination for patients with LTC.

What needs to happen next and by whom?

The NHS Clinical Commissioning Group (CCG) plans for 2012-13 centre on the Department of Health's key drivers for the management of long term conditions:

- Risk profiling
- Integrated care teams
- Self care and self management
- Ensure people are on disease registers to target effective disease management

Specific projects for 12-13 include:

- Development of local risk profiling tools and clinical dashboard
- Primary care management of long term conditions and work with primary care to increase the number of patients on disease registers, increasing confidence within primary care to offer HIV testing where appropriate, continue the delivery of the NHS Health Checks, and ensure delivery of LTC related QOF indicators for 12-13
- Cardiology: Implementation of primary care referral pathways, further development of primary care based diagnostics, and potentially GPwSI role
- Development of local primary care based service / expertise (GPwSI) for neurological conditions
- Redesign of local diabetes services – with support from NHS Diabetes – to deliver care in line with the principles outlined in "Diabetes without Walls" (2009)
- Further development and uptake of formal self care / management programmes
- Redesign of local COPD and respiratory pathways in line with the national strategy and the NW Respiratory QIPP

- Ongoing improvement of the management and prevention of AF, delivery of TIA services, and acute stroke care (in line with Greater Manchester & Cheshire Cardiac & Stroke Network guidance)
- Evaluation and potential expansion of telehealth

Quality of life for Carers

Outcomes Framework:

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

Implications for the population's health and well-being

There are nearly six million carers in the UK, with one in 10 people taking on the role of Carer. According to the 2011 census there are 24,059 Carers in Tameside out of a population of 219,324, meaning that 11% of the population of Tameside takes on the role of unpaid Carer. 6.4% of those Carers provide between 1 and 19 hours of care per week, 1.6% provide between 20 and 49 hours, and 2.9% provide over 50 hours of care per week.

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

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

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

At risk or vulnerable groups:

- Young carers
- Black and Minority Ethnic (BME) Carers
- Hidden carers (these are Carers that are not known as Carers to any agencies, services or to local authorities)

- Carers not registered with GPs
- Carers in employment
- Carers who look after people with long term conditions
- Lesbian, Gay, Bisexual & Transgender Carers
- Lone Parents that are Carers
- Carers that are in poverty
- Carers with learning disabilities

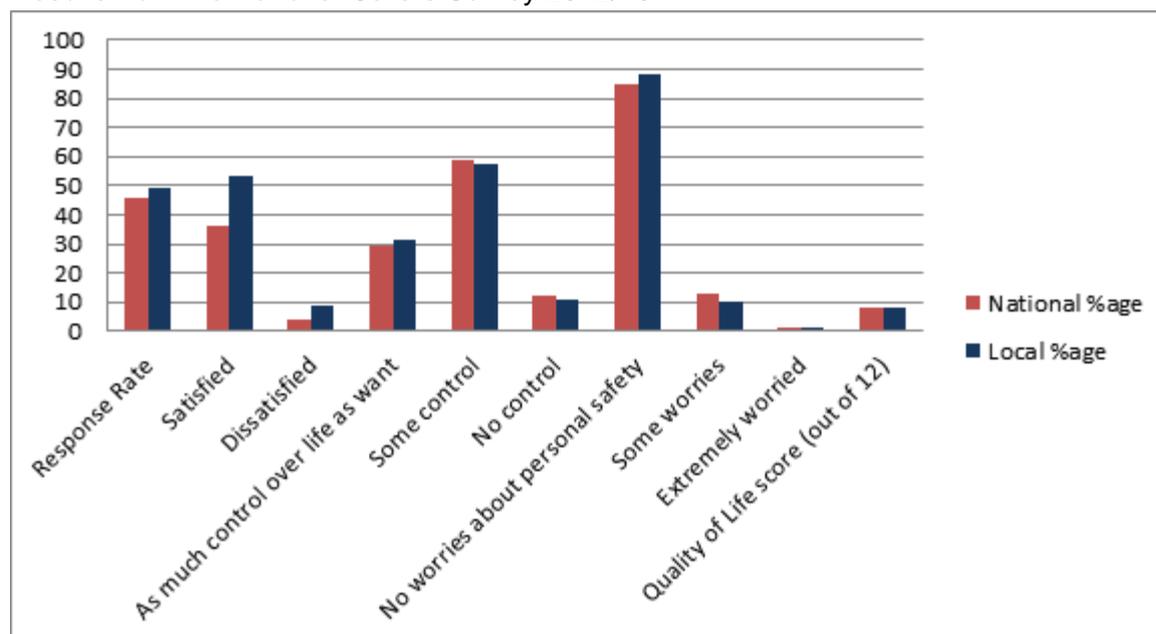
Benchmarking:

The Carers survey carried out in 2012 on behalf of the Health and Social Care Information Centre is a biennial survey, sought out the thoughts and opinions of Carers aged 18+ on a number of topics that are considered to be indicative of a balanced life alongside their caring role.

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

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

Results from the National Carers Survey 2012/13



Source: Health and Social Care Information Centre Personal Social Services Survey of Adult Carers in England - 2012-13

Policy context:

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

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

What interventions work?

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

- Provision of timely and accessible information, advice and support for Carers Adopting an 'early intervention and prevention' approach to help Carers stay healthy and independent
- Access to education, training, work and leisure for Carers
- Appropriate and improved support from a lead health professional to be offered to ensure early intervention when circumstances for Carers change
- Support from GPs, by providing appointments that are tailored around their caring responsibilities
- Health checks for Carers

- Improving emotional support offered by 3rd sector organisations, particularly access to bereavement counselling
- Considering Carers when developing and implementing pathways such as hospital discharge, falls, dementia, stroke and end of life.

What are we doing now?

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

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

Some of the actions currently delivered include:

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

What needs to happen next, and by whom?

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

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

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

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

Some of the key actions will include continued activity on:

- Organisation of more Carer awareness sessions for health and social care staff, community groups, faith groups, voluntary organisations and local employers, and work with schools to identify, recognise and signpost Young Carers
- Identification of more Carers within primary care settings, acute trust and community settings including staffs that are Carers. This also includes Carers within military families
- Promotion of information, advice and support for Carers
- Involving Carers, including Young Carers, in service planning, development and changes
- Ensuring Carers are not financially disadvantaged through access to appropriate Benefit advice
- Reducing the waiting time for assessments both for Carers and the people they support
- Continued development of flexible support services and emergency short term situations
- Continued work with relevant professionals/organisations to identify Young Carers, protecting them from inappropriate caring and giving them the right to be children
- Ensuring that the link between the Carers' Strategy and Dementia Strategy is supported in practical terms
- Reviewing the Carers Individual Grant scheme
- Implementing the Support Bill.

Sickness Absence Rate

Outcomes Framework: Public Health 1.9

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

It is well recognised that a healthy workforce is a productive workforce. This has wider benefits for the community and the local and national economy. As good health is good business, it is vital for employers to embrace this during the current economically uncertain environment.

Every year 140 million working days are lost to sickness absence, much of which ends in a swift return to work. However, a significant number of absences last longer than they need to and each year over 300,000 people fall out of work onto health-related state benefits. Before reaching this point, many have been long-term sick off work. They have become increasingly distanced from the labour market and suffer from the reduced economic, social and health status that come with being out of work. We know that the longer someone is off sick or out of work, the harder it is to get back to work, and worklessness comes at great personal and financial cost. Much absence and inactivity is due to comparatively mild illness which is compatible with work – and may indeed be improved by work. Work sickness absence is a significant cost to the UK economy in terms of working days lost.

The most common reason given for sickness in 2011 was minor illnesses such as coughs, colds and flu. This type of illness tends to have short durations and the greatest number of days lost were actually due to musculoskeletal problems. This accounted for just over a quarter of all days lost or 35 million days. Around 27.4 million days were lost due to minor illnesses and 13.3 million days were lost to stress, depression and anxiety.

At risk or vulnerable groups:

- Routine and manual workers
- Health and social care workers
- Public sector workers
- Workers with long term conditions
- Women and older workers
- Largest workforces (500+) report highest sickness levels

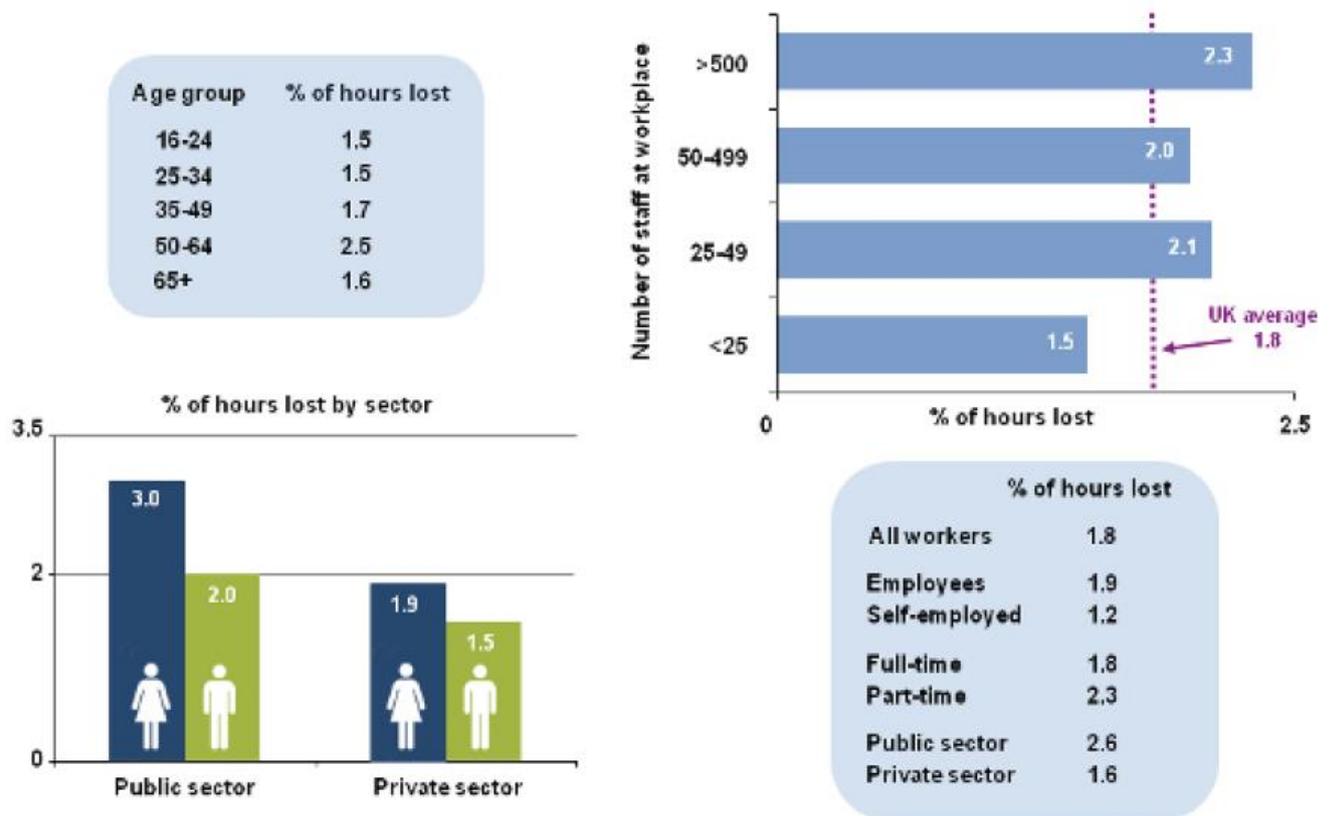
Benchmarking:

There is no local data for this indicator. The number of days lost through national sickness absences remained constant through the 1990's until 2003 and has fallen since then. Over the same period, the percentage of people having a spell of sickness and hence the percentage of working hours lost has been falling. The reason the number of days lost remained constant between 1993 and 2003, when the percentage of hours lost were falling over this period, was because there were more people entering employment during this time.

Looking at the number of days lost per worker, in 1993, around 7.2 days were lost (or around a week and a half based on a 5 day week). By 2011 this had fallen to less than a week (or 4.5 days). Women have consistently higher sickness absence rates than men but both sexes have seen a fall over the past 20 years. People are generally more likely to develop health problems at older ages and sickness absence rates also increase with age.

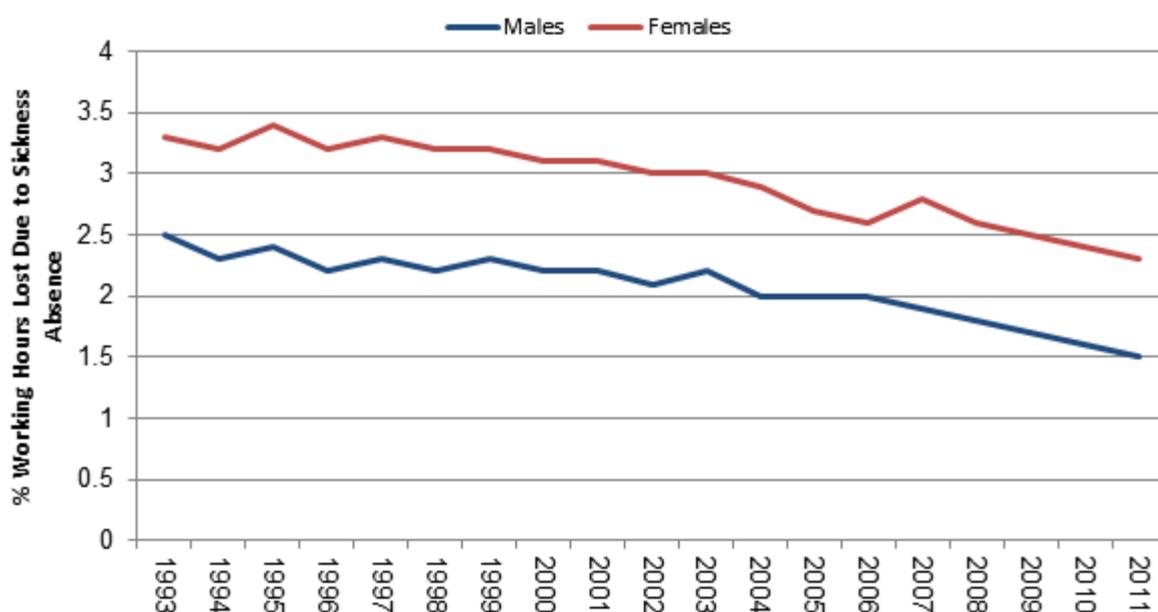
The percentage of hours lost to sickness in the private sector is lower than in the public sector, 1.6 per cent and 2.6 per cent respectively. According to data produced by the Health and Safety Executive, the risk of work-related stress, depression and anxiety is highest in the public sector, with those working in health and social work are almost twice as likely as the average worker to suffer.

Sickness absence rates, annual averages 2011, UK.



Source: Labour Force Survey - Office for National Statistics

Percentage working hours lost to sickness absence



Source: Labour Force Survey - Office for National Statistics

Policy context:

- Dame Carol Black, 2008: [Working for a Healthier Tomorrow](#).
- NICE, 2009: [Promoting well-being at work](#)
- NICE, 2009: [Managing Long-term Sickness Absence and Incapacity for Work](#)
- Health and Safety Executive: [Management Standards for Work-related Stress](#).
- Department of Health, 2009: [The Boorman Review](#)

What interventions work?

- Healthy workforce policies and standards
- Training for employers on the importance of workplace health
- Mental health/preventative stress management interventions e.g. massage, reflexology, yoga, or stress management groups
- Supportive interventions focusing on personal support, training in individual coping skills on health and work outcomes
- Alcohol/smoking - employee assistance programmes, referral to cessation services, and smoke-free workplaces
- Diet - programmes aimed at improving nutrition behaviour e.g. in-house weight watchers/ healthy eating programmes
- Physical activity e.g. lunch time/ after work exercise classes and shower facilities or having a bike rack to encourage cycling to the place of work
- Screening - providing in-house screening services or signposting staff to NHS Health Checks, Chlamydia Screening, as well as raising awareness of screening

programmes (e.g. cervical screening, breast screening etc.) will encourage the uptake of screening

- Promotion of social marketing campaigns including national campaigns such as National No Smoking day, World Health Day, World Asthma Day, World Mental Health Day etc
- Access to local high quality accredited occupational health services

What are we doing now?

- The Health and Well-being Board, through the Joint Strategic Needs Assessment (JSNA) and emerging Health and Well-being Strategy stress the importance of the wider determinants of health as a key priority and that 'work is good for your health'.
- Working with Manchester New Economy to implement the 'Good Work: Good Health' Charter in Tameside
- Developing training 'Well-being Champions' in the workplace
- The Council and NHS have jointly appointed a dedicated Workplace Health Lead for the Borough to promote health improvement
- The Mindful Employer initiative has been commissioned for employers and employees of Tameside workplaces
- The Five Ways 2 Well-being campaign
- Community model for delivering NHS Health Checks developed to support the ongoing GP led service, targeting people in full time work particularly those in routine and manual occupations
- Health Improvement Services deliver interventions in the workplace setting and link into the Work Programme
- Targeted campaigns for smoking cessation

What needs to happen next, and by whom?

- Continue to prioritise and deliver the actions above, driving the work through the Tameside Economic Strategy and Prosperous Tameside Board.
- Local organisations, whether public or private sector, must put staff health and well-being at the heart of their work.
- Workplace health and well-being initiatives need to be backed with strong leadership and visible support at a senior level.
- Continue to promote training and awareness in health and well-being as an integral part of management training and leadership development.
- Build the capacity and capability of management and support at all levels to improve the health and well-being of staff.
- People should be encouraged to improve their own health through education, encouragement and support from local Health Improvement Services.

Take up of the NHS Health Checks Programme

Outcomes Framework: Public Health 2.22

Implications for the population's health & well being:

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

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

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

At risk or vulnerable groups:

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

Benchmarking:

NHS Health Checks – Local target and performance

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

Source: NHS Tameside and Glossop

Due to low uptake of the NHS Health Checks Local Enhanced Service (LES) in 2010/11, the LES was redesigned and has been operational since 1st September 2011. 41 Practices signed up to the revised LES. A Community Health Checks programme during 2012/13 contributed to better uptake, and a detailed Health Equity Audit confirmed the impact of this approach on broadening engagement.

Policy context:

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

- [NHS Health Checks](#)
- [Putting prevention first - vascular checks: risk assessment and management](#)

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

What are we doing now?

The LES continues to support the sending of invitations and completion of health checks.

During 2011/12 a programme of Community Health Checks was available to support the ongoing GP led work. The main aim of the community model is to target the harder to reach and those less likely to attend GP practice for a full NHS Health Check. These hard to reach groups include men, people from disadvantaged communities, Black and Minority Ethnic (BME) groups, carers and people in full time work, particularly those in routine and manual occupations. This will be reinstated in 2014.

Both areas of the Health Check project have been supported by a communications campaign aimed to increase the awareness of the Health Check and the services available across Tameside and Glossop.

Service user or public engagement or consultation:

During 2013/14 a review of NHS Health Checks was undertaken by the Tameside Personal and Health Scrutiny Panel. This included a stakeholder event involving providers, service users and commissioners. There was significant support for the programme, particularly the reintroduction of the Community Health Checks programme.

What needs to happen next and by whom?

- Continue with GP LES in 2013-14
- Work across commissioning and public health to ensure:
 - uptake of health checks is optimised
 - health trainer capacity sufficient to support general practice
 - general practice capacity is sufficient to meet demand for health checks
- Community programme to target group with lower uptake through GP practices

Access to non-cancer screening

Outcomes Framework: Public Health 2.21

Antenatal and Newborn:

- Infectious Diseases in Pregnancy
 - HIV
 - Syphilis, hepatitis B and rubella
- Antenatal sickle cell and Thalassaemia
- Newborn bloodspot
- Newborn hearing
- Newborn physical examination

Adult:

- Diabetic retinopathy

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

Antenatal and Newborn screening programmes all make important contributions to the early identification of conditions that can be treated or require further support and follow up. Diabetic retinopathy is the commonest cause of blindness in people of working age in the UK, and early detection and treatment can preserve sight.

At risk or vulnerable groups:

Antenatal and newborn screening is offered to all pregnant women and new mothers. Retinopathy screening is offered to all newly identified patients with diabetes, and then annually.

Benchmarking:

The measures for the antenatal and newborn screening programmes detailed in the Public Health Outcomes Framework are currently under development, but some indicative information about local activity is available.

Table 1: Local performance of antenatal and newborn, and adult non-cancer screening

Programme	Local information	Local Performance
Antenatal and Newborn		
Infectious Diseases in Pregnancy:	HIV: 99.3% tested 2009/10	HIV: well over national target of 90%
HIV	Syphilis, hepatitis B and rubella: 99.6% tested 2009/10	Syphilis, hepatitis B and rubella: well over national target of 90%
Syphilis, hepatitis B and rubella		
Antenatal sickle cell and thalassaemia	99.9% tested 2009/10	Well over national core target of 85% and developmental target of 95%
Newborn bloodspot	National quality programme under development	Pilot data currently suggests average uptake
Newborn hearing	National quality programme under development	Quality assurance data currently suggests good uptake
Newborn physical examination	National quality programme under development	No data currently available
Adult		
Diabetic retinopathy	Uptake 77.8% for Quarter 3 2011/12	Achieved national 70% minimum standard

Source: NHS Tameside and Glossop, 2012

Policy context:

NHS screening programmes are developed, adopted and overseen by the [National Screening Committee](#), and there are operating and quality assurance standards in place or under development for all programmes. A [national set of KPIs](#) are currently being piloted, and some of these are included in the Public Health Outcomes Framework.

What interventions work?

The National Screening Committee will not approve a screening programme for use in the NHS unless there are associated interventions that can improve outcomes for anyone found to have the condition screened for. There is detailed [guidance for all national screening programmes](#).

What we did in 2010/11

All maternity units employ a Screening Midwife who takes a lead in ensuring that the antenatal and newborn screening programmes are running in line with national guidance and screen-positive cases are followed up. Newborn hearing screening for local babies is provided by Tameside Hospital. Health Visitors and local GPs also have significant roles particularly in the newborn bloodspot and physical examination programmes.

Diabetic retinopathy screening is provided by high street optometrists and Tameside and Glossop Community Health Care as part the [South Manchester Programme](#).

What we did in 2011/12

Tameside Hospital took part in a pilot of a new national quality assurance programme for antenatal and newborn screening. Recommendations included the formation of a local coordinating group to oversee this activity. Emerging guidance as part of the transfer of Public Health to local councils suggests a continuing role for the local Director of Public Health in this work. This will focus on ensuring quality standards are in place plus equitable access and outcomes for different populations groups.

Cancer screening coverage

Breast screening and cervical screening

Outcomes framework: Public Health 2.20 (i) and (ii)

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

Breast cancer is the commonest cancer in women in Tameside, and a significant cause of long term illness and death, but early detection and effective treatment have improved the outlook over the past 20 years. Cervical screening enables the early detection and treatment to prevent the development of, and progression of, cervical cancer and the national programme is estimated to prevent about 4,000 cases of cancer and save about 4,500 lives each year.

The likelihood of developing breast or cervical cancer increases with age, which means that as the number of older people in Tameside increases there will be more cases of breast and cervical cancer. Obesity increases the risk of breast cancer, so the increasing obesity in Tameside will also result in an increase the number of women with breast cancer.

At risk or vulnerable groups:

Whilst breast cancer occurs in both men and women, the risk is much greater in women, so the breast screening programme is only offered to women. Women who have a family history of breast cancer are at greater risk, and those at highest risk are screened more often in line with [NICE guidance](#). There is evidence that Lesbian, Gay, Bisexual and Transgender (LGBT) women do not access breast or cervical screening services as readily as most women ([NHS Cervical Screening Programme, 2009](#)).

Women with learning difficulties generally require additional support when accessing screening services, and this has been recognised in guidance developed by the breast and cervical screening programmes ([NHS Cancer Screening Programme, 2006](#)).

Invitations for breast and cervical screening are restricted to specific age groups at greatest risk (47 to 73 years for breast, and 25 to 64 years for cervical). Women over the target age groups may choose to be screened, but younger women may not.

Benchmarking:

Local uptake of breast screening is consistently above the national standard. Uptake of cervical screening has been reducing in recent years in line with a national trend of fewer young women being screened.

Breast screening coverage (2007/08 to 2009/10)

Indicator definition	% of eligible women who have had a mammogram with a recorded result at least once in the previous 3 years		Performance threshold/acceptable standard		70%
	2007/8	2008/9	2009/10	2010/11	2011/12
NHS Tameside and Glossop	74.7	76.3	76.4	75.1	74.8
North West	72.3	73.2	73.0	72.0	71.5
England	73.2	73.6	73.2	73.4	73.1

Source: [Breast Screening Programme, England 2011-12](#)

Cervical Cancer Screening Uptake (2007/08 to 2011/12)

Indicator definition	% of eligible women who have a recorded adequate test result within the last 5 years		Performance threshold/acceptable standard		80%
	2007/8	2008/9	2009/10	2010/11	2011/12
NHS Tameside and Glossop	79.3	79.6	79.2	78.8	78.8
North West	78.2	78.5	78.4	78.0	78.1
England	78.6	78.9	78.9	78.6	78.6

Source: [Cervical Screening Programme, England 2011-12](#)

Policy context:

Breast and cervical screening are national programmes provided in line with national guidance from the National Screening Committee which is regularly reviewed and updated.

The age range of the breast screening programme is currently being extended beyond 50-70 years to 47 to 73 years.

In 2013 responsibility for screening programmes transferred from PCTs to NHS England, with Public Health England providing advice on the specification of programmes and quality assurance. Directors of Public Health in Local Authorities are responsible for providing challenge and advice to NHS England on the performance of screening programmes.

What interventions work?

It is important to provide good information to women about the benefits of screening, and what examinations involve. The most effective approach to good uptake of breast and cervical screening programmes is the sending of invitation and reminder letters when screening is due. Further reminders of appointments once booked, and reminders for those who do not attend to re-book are also very effective. Social marketing programmes can have an impact on specific groups, but are less cost-effective than reminders ([Greater Manchester Public Health Practice Unit, 2009](#)).

The national programmes provide guidance on promotion of breast and cervical screening to minority ethnic groups ([NHS Breast Screening Programme](#) and [NHS Cervical Screening Programme](#))

What are we doing now?

- Routine invitations and reminders are sent to eligible women.
- Pilots of new approaches using additional targeted written reminders and text messages are in progress within Greater Manchester.
- .
- Tameside and Glossop is part of the three year Macmillan funded pilot Community Cancer Awareness Project in Greater Manchester.

What needs to happen next, and by whom?

Current priorities are:

- the Community Cancer Awareness Project
- local response to national Be Clear on Cancer social marketing campaigns

Preventable sight loss

Outcomes Framework: Public Health 4.12

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

People with sight loss face huge challenges in undertaking everyday tasks that sighted people take for granted. Access to public services, leisure and employment opportunities can be seriously limited by inaccessible public transport and the lack of recognition in the benefits system of blind people's real transport costs. A visit to the local shops can be made hazardous by busy roads, street clutter and poor highway design.

At risk or vulnerable groups:

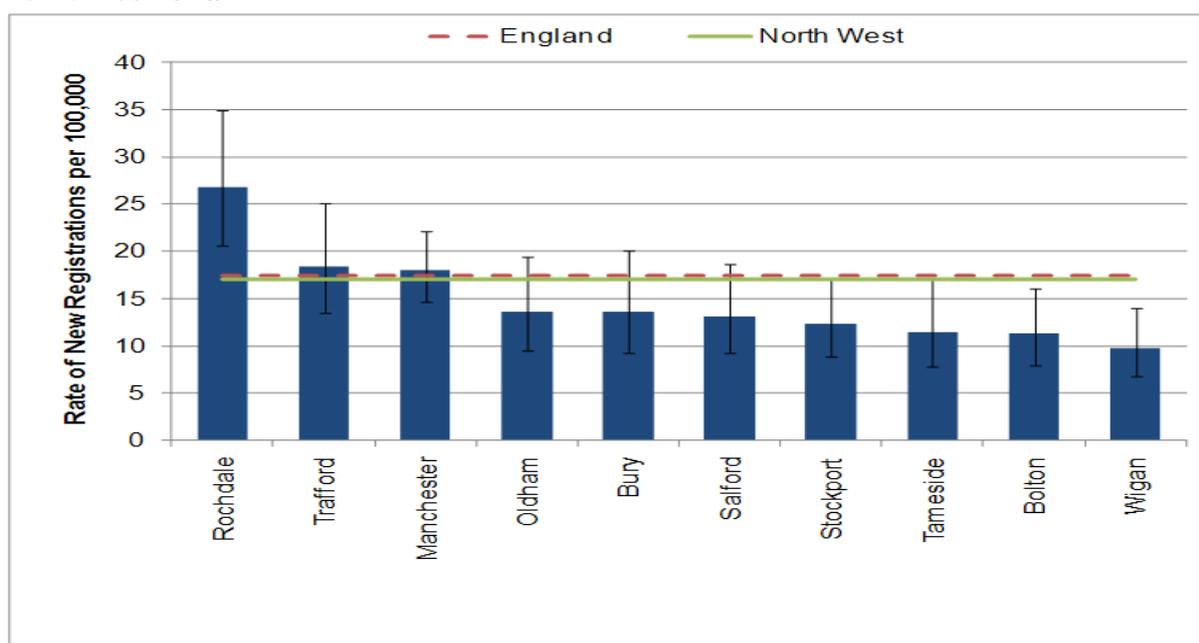
The [Royal National Institute for the Blind](#) (RNIB) has identified the following at risk or vulnerable groups:

- Ethnic Minority Groups;
- Age (Older People more prevalent of sight loss);
- Diabetics;
- Genetic links to Glaucoma;
- Smokers

Benchmarking:

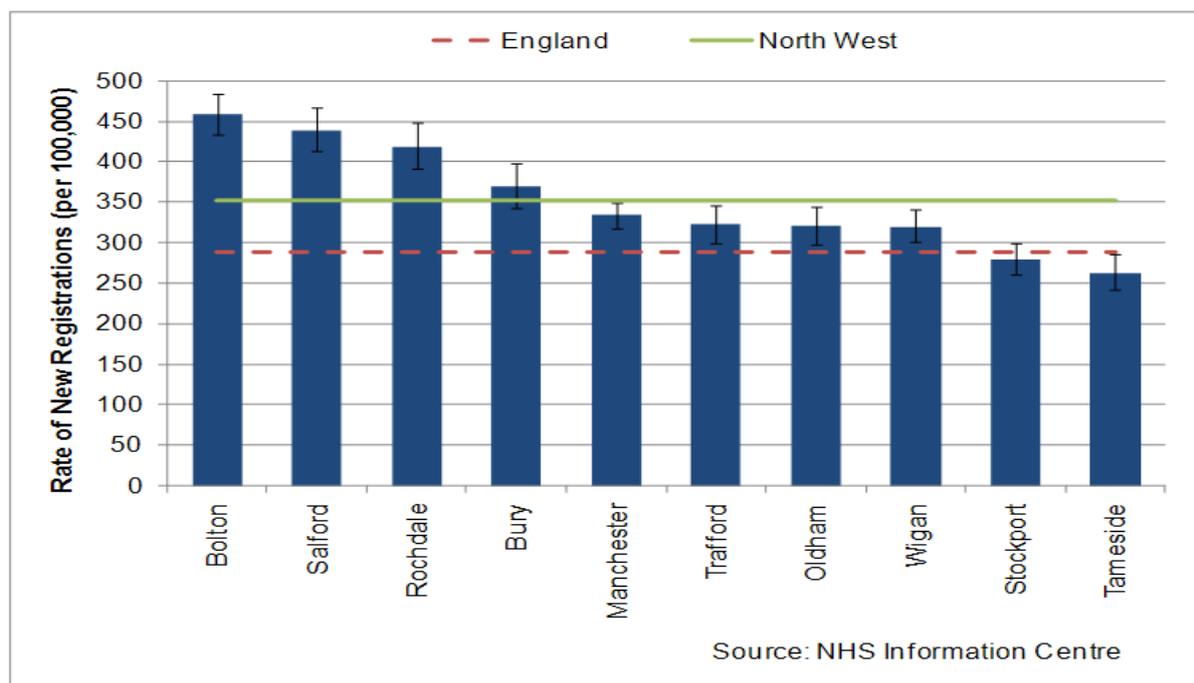
Data is not readily available for the incidence of preventable sight loss. The NHS information centre publish data detailing new registrations of blind and partially sighted persons, although it should be noted that this includes cases that are not considered preventable.

Rate of New Registrations of Blind Persons in Tameside and Greater Manchester Local Authorities 2010/11



Source: NHS Information Centre 2012

Rate of New Registrations of Partially Sighted People in Tameside and Greater Manchester Local Authorities 2010/11



Source: NHS Information Centre 2012

Policy context:

[NICE guidance](#)

What interventions work?

- Earlier detection through screening and accurate diagnosis. [Research by RNIB](#) suggests that 50% of cases of blindness and serious sight loss could be prevented if detected and treated in time
- Encouraging those at particular risk of eye disease to seek an eye examination is seen as a public health imperative fundamental to early detection of preventable eye disease
- On-going monitoring and surveillance of at risk/vulnerable groups

What we did in 2010/11

We have an established diabetic retinopathy screening service, delivered from several community locations (see indicator Access to non-cancer screening programmes), which increases access and choice for patients. Similarly, we have developed a community service for ocular hypertension, which is provided by community optometrists therefore increasing choice and accessibility for patients. We are in the process of reviewing ophthalmology pathways to ensure optimum care closer to home in order to improve access for patients and earlier intervention.

What we did in 2011/12

As part of the review of ophthalmology, we need to raise awareness amongst the population, to educate of the risk factors and promote earlier detection of potential sight loss. We need to develop and implement clear, local pathways for Age-related Macular Degeneration (AMD) and Glaucoma.

Treatment completion for tuberculosis (TB)

Outcome Framework: Public Health 3.5

Implications for Population Health:

Tuberculosis (TB) has re-emerged nationally as a serious public health threat. Incidence in the UK has risen over the past 2 decades, rising above the European average. TB usually causes disease in the lungs (pulmonary), but can also affect other parts of the body (extra-pulmonary). Only the pulmonary form of TB disease is infectious through coughing of infectious droplets, and usually requires prolonged close contact with an infectious case. TB is curable with a combination of specific antibiotics, but treatment must be continued for at least six months. In the UK there are around 9,000 cases of TB reported each year and there are approximately 350 deaths. Most cases occur in major cities. TB incidence in the North West Region is strongly linked to deprivation.

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

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

Programme spend:

The Department of Health estimates that it costs £5,000 to treat a case of “ordinary” TB, compared to £50,000–70,000 for drug resistant TB.

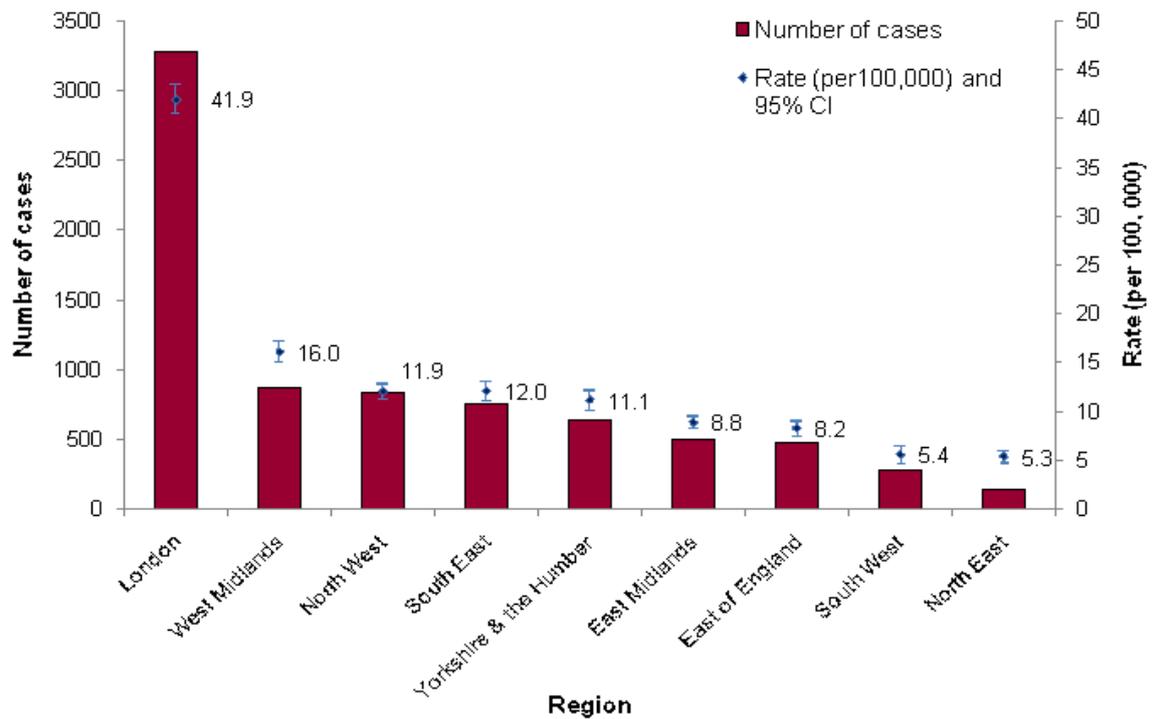
At risk groups or vulnerable groups:

- People from ethnic minority groups, immigrants from high-prevalence countries, particularly South Asia and Sub-Saharan Africa;
- People with HIV
- Prisoners
- Homeless people
- People dependent on drugs and alcohol

Benchmarking:

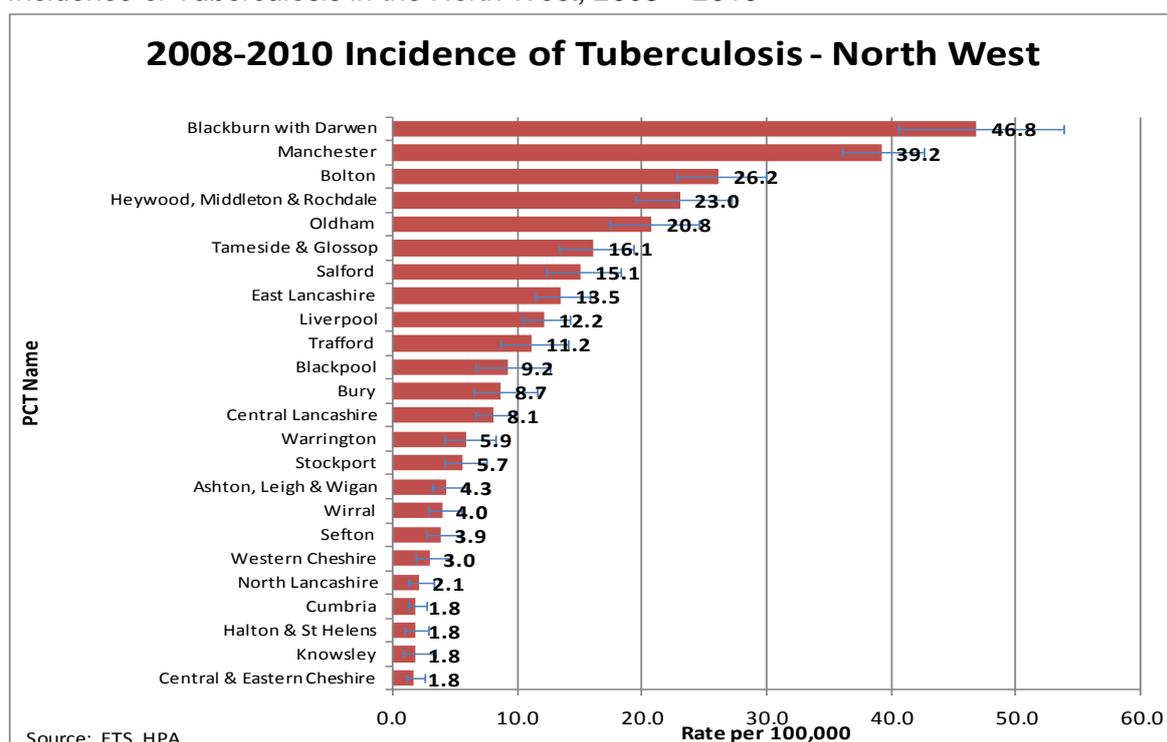
In 2010 TB in the North West increased by 1% whereas nationally it declined by 7%. The NW was the only region to see an increase in the disease. Within the NW there is significant variation in numbers, with the Greater Manchester cluster having the highest rates. For TB control to be effective it is important that each locality offers standardised care.

Tuberculosis case reports and rates by region, England, 2010



Sources: Enhanced Tuberculosis Surveillance, Office for National Statistics mid-year populations estimates; TB Section - Health Protection Services, Colindale

Incidence of Tuberculosis in the North West, 2008 – 2010



Sources: Enhanced Tuberculosis Surveillance, Office for National Statistics mid-year populations estimates; TB Section - Health Protection Services, Colindale

Policy context:

- [TB action plan and toolkit](#) published by the Chief Medical Officer (CMO)
- NICE Guidance includes a TB Pathway; TB Clinical Guideline (CG117); and Guidance on Hard to Reach Groups (PH 37).

What interventions work?

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

What are we doing now?

- The Health Protection Agency (HPA) coordinates TB control by local and national surveillance and the laboratory diagnostic services.
- Last year NHS North West established a TB Summit to direct TB prevention and control activities across the region.
- NHS North West works with local Directors of Public Health to ensure the various aspects of the TB summit are implemented with partners in the Local authorities and local health providers.
- Tameside Foundation Trust manages the TB Specialist Service which is commissioned on a GM level. A GM level specification has been introduced into GM acute trust contracts for 12/13.
- The Local Authority has undertaken research on acceptability of TB communications in an area of Tameside.

What needs to happen next, and by whom?

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

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

Population vaccination coverage

Outcomes framework: Public Health 3.3

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

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

At risk and vulnerable groups:

People who are at risk of, or particularly vulnerable to, vaccine preventable diseases include:

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

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

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

Annual flu vaccination is offered to all those over age 65, children (currently those aged 2 and 3 years) and to adults and children who are particularly at risk of experiencing complications if they get flu. These at risk groups include pregnant women and those with other underlying health conditions. Carers and health and social care workers are also recommended to have the flu vaccination every year.

Policy context:

On 1st April 2013 NHS England Local Area Teams became responsible for commissioning immunisations programmes. In Greater Manchester this function is delivered by Greater Manchester Screening and Immunisation Team, whose staff is employed through Public Health England. Local Authorities have a role in scrutinising and challenging the arrangements for commissioning and providing immunisation programmes.

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

- Public Health England (2013) [The Complete Routine Immunisation Schedule 2013/14](#)
- Public Health England (2013) [Immunisation against infectious disease \(the Green Book\)](#)

Benchmarking:

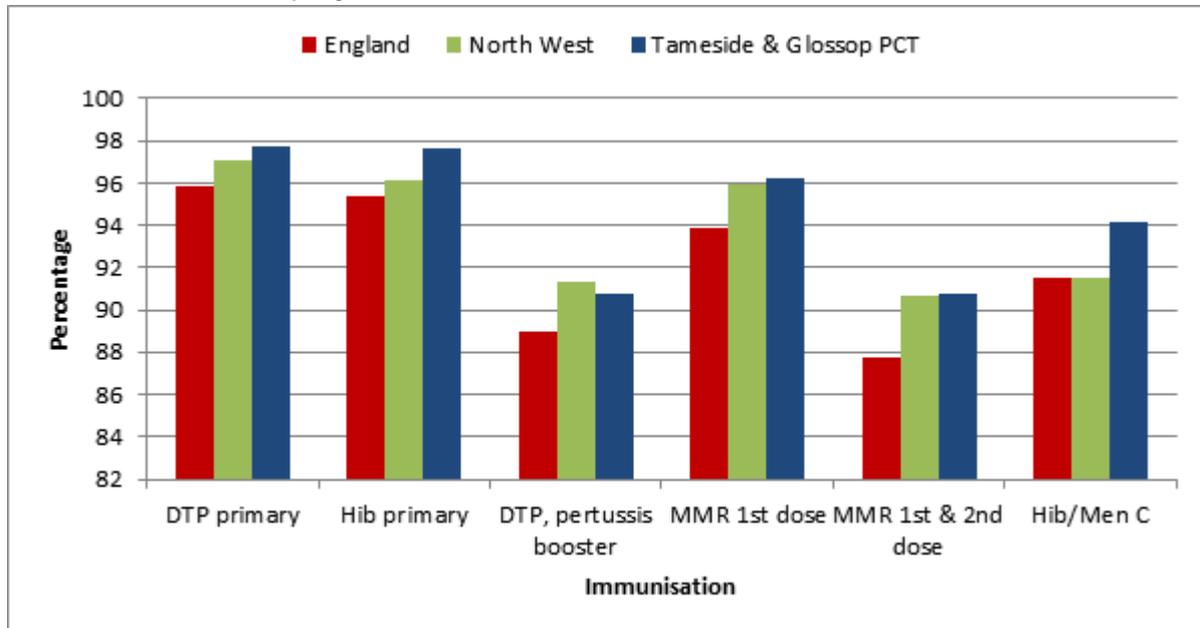
A range of performance and monitoring data is available for screening and immunisation programmes, as described in the table below:

		Frequency	Level	Source
Vaccination and Immunisation	At 12 months DTaP/IPV/Hib MenC PCV	Quarterly	National, Regional, Tameside Glossop	& COVER data
	At 24 months DTaP/IPV/Hib PCV Booster Hib/MenC MMR 1 Hepatitis B			
	At 5 years DTaP/IPV/Hib DTaP/IPV booster MMR 1 MMR 2 Hib/MenC Booster			
	Other vaccinations			
	HPV - 3 doses (12/13 year olds)	Annual	National, Regional, Tameside Glossop	& PHE
	PPV	Annual	National, Regional, Tameside Glossop	& PHE
	Flu (aged 65+) Flu (at risk individuals) Flu (aged 2&3 years)	Seasonal (Nov - Feb)	National, Regional, Tameside Glossop	& PHE

Source T&G PCT

In 2012/13 Tameside and Glossop achieved higher immunisation rates for routine childhood immunisation than the average rates achieved for England. Uptake rates for the majority of immunisations were also higher than the North West average.

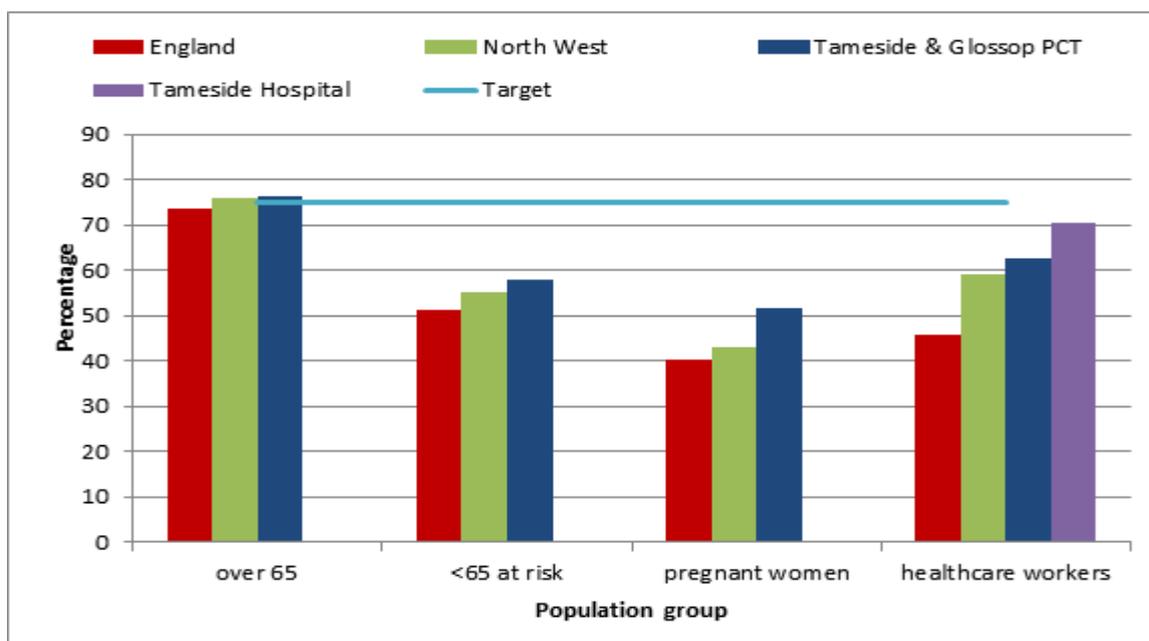
Children immunised by age 5 2012/13



Source: NHS Information Centre 2013

Tameside and Glossop also achieved higher uptake rates for seasonal influenza than the regional and national average. However for several groups uptake rates were still below the target rate of 75%.

Season influenza vaccination uptake 2012/13



Source: [Public Health England 2013](#)

What interventions work?

- [NICE 2009](#) Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people under 19 years

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

Effective and cost effective interventions for maximising uptake include:

- tailored invitations and reminders for 'Did Not Attends' by text or telephone
- improved access to clinics e.g. extended times, weekends
- school based programmes and venues for vaccination
- access to health professional to discuss concerns
- dissemination of good practice
- domiciliary and outreach services
- brief advice and referral
- opportunistic vaccination
- appropriately trained and up to date staff
- ensure staff in place to monitor uptake
- tailored information and support
- immunisation status checks at first health assessment for Looked After Children
- targeted promotional campaigns (social marketing techniques) including benefits/risks
- immunisation checks at entry to school, nursery, play groups; Sure Start Centres, school transfer

What are we doing now?

- Tameside Council and Tameside and Glossop CCG have used local media to highlight the importance of flu vaccination for the over 65s, 2-3 year olds and at risk groups
- Flu vaccination has been made available to at risk groups via pharmacies in Greater Manchester as part of a local pilot.
- Guidance on provision of flu vaccination for social care staff and people living in residential care has been included in care home contracts
- In 2013 3 new programmes were added to the national immunisation schedule: rotavirus and influenza for children, and shingles for people aged over 70. These programmes have been implemented locally.

What needs to happen next, and by whom?

- Greater Manchester Screening and Immunisation Team, Tameside and Glossop CCG and Public Health will work together to improve understanding of vaccination access and uptake across the population across the life course. A comprehensive approach to increasing uptake rates in Tameside will be implemented.
- Partners will work with GMSIT to implement national vaccination programme changes e.g. seasonal flu programme in 2014/15.

People with mental illness and/ or learning disability in settled accommodation

Outcomes Framework:

- Public Health 1.6i: Percentage of adults with learning disabilities known to social services who were in settled accommodation at the time of their latest assessment.
- Adult Social Care 1G: Proportion of adults with learning disabilities who live in their own home or with their family
- Public Health 1.6ii: Percentage of adults receiving secondary mental health services known to be in settled accommodation.
- Adult Social Care 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support

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

The measure is intended to enhance the quality of life for people with care and support needs, by ensuring people are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation. The aim is to improve outcomes for adults with mental illness/ learning disabilities by demonstrating the proportion in stable and appropriate accommodation. The nature of accommodation for people with mental illness/learning disabilities has a strong impact on their safety and overall quality of life and the risk of social exclusion.

Settled accommodation refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium to long-term, or is part of a household with tenure/residency. The accommodation types that represent settled accommodation for the purpose of this indicator are:

- Owner occupier/shared ownership scheme (where tenant purchases percentage of home value from landlord).
- Tenant – Local Authority/Arm's Length Management Organisation/Registered Social Landlord/Housing Association.
- Tenant – private landlord.
- Settled mainstream housing with family/friends (including flat-sharing).
- Supported accommodation/Supported lodgings/Supported group home (accommodation supported by staff or resident caretaker).
- Approved premises for offenders released from prison or under probation supervision (e.g. Probation Hostel).
- Sheltered Housing/Extra care sheltered housing/other sheltered housing.
- Mobile accommodation for Gypsy/Roma and Traveller community.
- Adult placement scheme.

Non-settled accommodation refers to accommodation arrangements that are precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice. The accommodation types that represent non-settled accommodation for the purpose of this indicator are:

- Rough sleeper/squatting.
- Night shelter/emergency hostel/direct access hostel (temporary accommodation accepting self referrals).
- Refuge.
- Placed in temporary accommodation by Local Authority (including Homelessness resettlement) – e.g. Bed and Breakfast.
- Staying with family/friends as a short term guest.
- Acute/long stay healthcare residential facility or hospital (e.g. NHS or Independent general hospitals/clinics, Long stay hospitals, specialist rehabilitation/recovery hospitals).
- Registered Care Home.
- Registered Nursing Home.
- Prison/Young Offenders Institution/Detention Centre.
- Other temporary accommodation.

At risk or vulnerable groups:

Those with mental health problems: Adults aged 18 – 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).

Adults with a primary client group of Learning Disability who have been assessed or reviewed by the council during the year, irrespective of whether or not they receive a service, or who should have been reviewed but were not.

It is also important to recognise that there will be a proportion of adults with mental illness / learning disability who are not accessing mainstream support services.

Benchmarking:

In Tameside, the proportion of people with learning disabilities living in settled accommodation is higher than the North West (60%) and England (59%) average.

Amongst people with mental health problems, there has been a recent increase in those in settled accommodation. Local figures are now much higher than the average across the North West (75%) and England (67%).

The Proportion of adults with learning disabilities and mental health problems, in settled accommodation, (with or without support), 2009/10 to 2010/11.

People with:	Learning Disabilities	Mental Health Problems
2009/10	74.9%	63.4%
2010/11	65.2%	91.8%
2011/12	93.8%	69.4%
2012/13	93.7%	77.2%

Source: Pennine Mental Health Trust and Tameside MBC

Policy context:

[Supported Living – Making the Move](#) : Developing Supported Living options for people with learning disabilities

What interventions work?

- Re-ablement
- Routes to Work for pre-employment training
- Housing Strategy for appropriate housing
- Telecare systems to promote independent living.
- A mixed economy of housing options including Extra Care Housing
- Shared Lives scheme
- Aids, Adaptations and equipment.

What are we doing now?

- We are refreshing the Learning Disabilities (LD) and Mental Health (MH) housing strategy to ensure that future housing is accessible for the MH and LD population.
- All new builds are being designed with future planning in mind.
- Promotion of personal budgets to offer increased choice and control.
- Expansion of Re-ablement services, including the use of technology to promote independent living skills and ensure people are safe.
- Development of Extra Care Housing schemes for people with LD and MH problems.
- Applying for accreditation by National Autistic Society to enable us to provide better support for people with Autism within their own homes.
- Programme of resettlement for people living out of borough.

What needs to happen next, and by whom?

- Continue to prioritise and expand the programmes above to meet the increasing demographics within these client groups.
- Continue to engage and involve clients groups in the commissioning and delivery of services.
- The Health and Well-being Board should drive and govern programmes of joint commissioning and integrated service delivery for Health and Social care Services.

Proportion of adults with learning disabilities, mental ill health or long term conditions in employment

Outcomes Framework:

- Adult Social Care 1F: Proportion of adults in contact with secondary mental health services in paid employment.
- NHS 2.5: Employment of people with mental illness
- Adult Social Care 1E: Proportion of adults with learning disabilities in paid employment
- Public Health 1.8: Employment for those with a long term condition (LTC) including those with a learning difficulty/disability or mental illness
- NHS 2.2 Employment of people with LTC

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

The measure is intended to enhance the quality of life for people with care and support needs, by ensuring people are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness, isolation, and risk of social exclusion and discrimination. Employment outcomes demonstrate quality of life and are indicative that social care support is personalised. Employment is a wider determinant of health and social inequalities.

There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits.

The measure is focussed on "paid" employment, voluntary work is excluded.

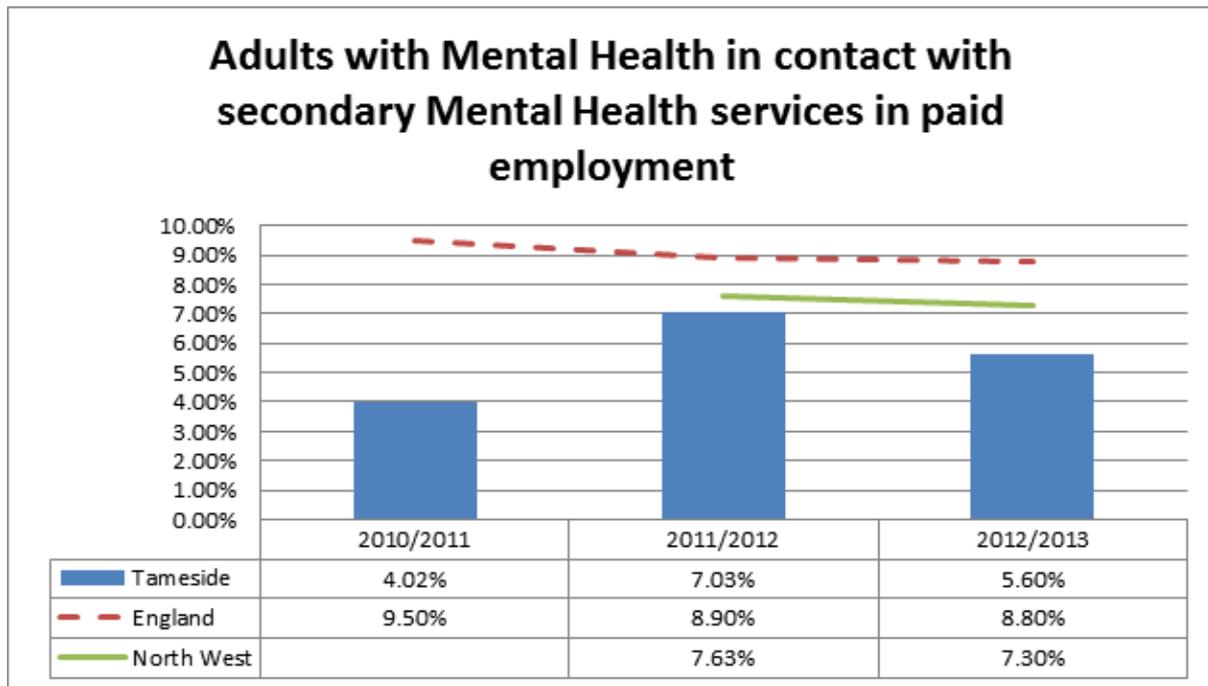
At risk or vulnerable groups:

- Adults aged 18 – 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).
- Adults with a primary client group of Learning Disability who have been assessed or reviewed by the council during the year, irrespective of whether or not they receive a service, or who should have been reviewed but were not.
- Those with long term conditions (LTC) (see more information about LTC in LTC indicator reviews).

Benchmarking:

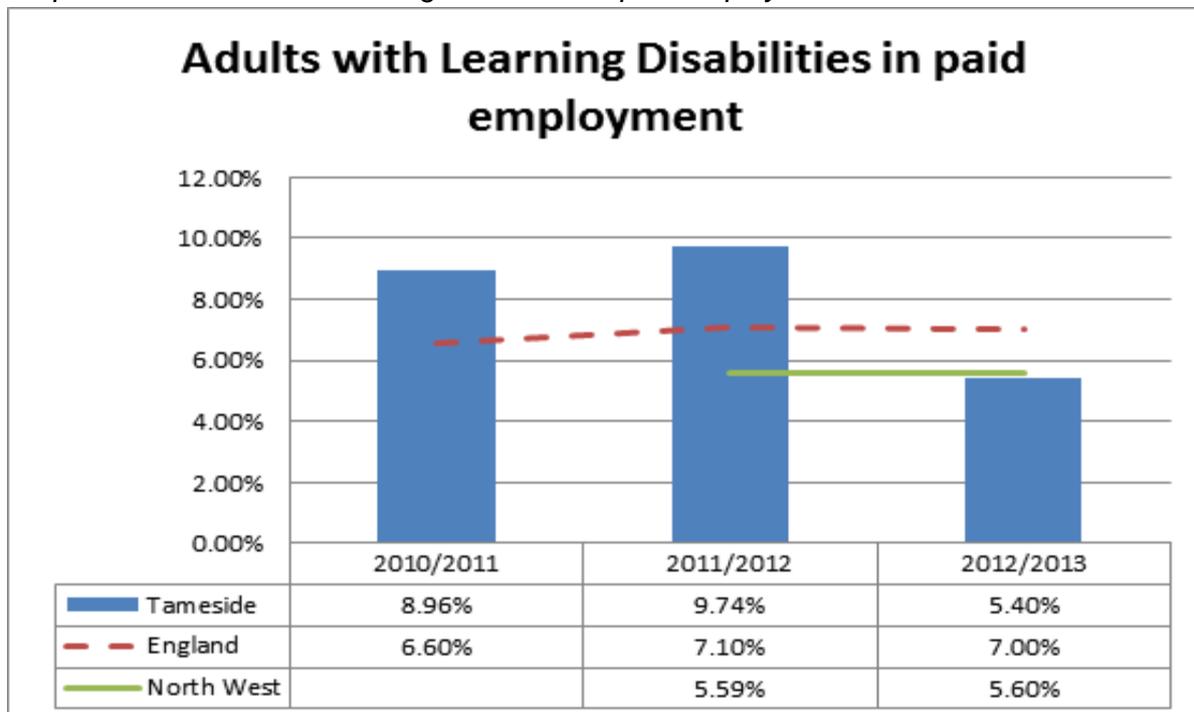
In Tameside, the proportion of local people in employment has fallen for those with mental ill-health with performance lower than the regional and national averages. This is a similar picture for those with learning disabilities.

Proportion of adults in contact with secondary mental health services in paid employment.



Source: Pennine Mental Health Trust, 2014

Proportion of adults with learning disabilities in paid employment



Source: Tameside MBC 2014

Policy context:

- [Work, Recovery & Inclusion: Employment support for people in contact with secondary mental health services](#)
- [Improving the Employment Rates of People Using Secondary Mental Health Services: A Regional Strategy for the North West](#)
- The mental health outcomes strategy, [No Health without Mental Health](#), sets out that mental health should have parity of esteem with physical health and lists six objectives for improvement.
- [Valuing Employment Now: real jobs for people with learning disabilities](#)

What interventions work?

- Routes to Work pre-employment training
- Strong links with local employers and job centres
- Considerable investment in supporting individuals into employment

What are we doing now?

The Mental Health Local Implementation group have met and produced an action plan in relation to “No Health without Mental Health” to inform future commissioning decisions. Progress to date includes:

- Joint pilot with probation services to increase the access to psychological therapies for offenders and promote joint working.
- Increasing Access to Psychological Therapy (IAPT) - for the last 3 quarters the recovery rate has been over 50%. Targets include getting people back into work.
- Plans in place to increase the uptake of primary care mental health services for older people and people from Black and Minority Ethnic (BME) groups. The range of referrers has been increased from GP’s to a wider number of professionals, e.g. health visitors/district nurses, and the range of therapies has increased to include Interpersonal Psychotherapy (IPT), Eye Movement Desensitization and Reprocessing (EMDR) and mindfulness.
- Everyone on the Care Programme Approach (CPA) has an annual health check.
- Access to psychological services: The NHS Clinical Commissioning Group (CCG) supported Pennine Care MH Trust to submit a successful bid to join the Children and Young People’s IAPT. A number of local staff are being trained and service redesign will follow.
- Development of an employment pathway for all client groups which includes a qualification framework for students to assist in securing paid/unpaid employment.
- Working towards the key objectives in “Valuing Employment Now” for people with learning disabilities.
- Link with the Work Programme to support long term unemployment into work.

What needs to happen next, and by whom?

- Development of an older people’s pathway
- Development of an offender health pathway

- A single point of entry will be developed from April 2012 which encompasses primary and secondary care and will streamline access to services
- Develop further links with the Health Improvement team in relation to the BME networks to increase the uptake of psychological services for this minority group.
- Increase the range of therapies on offer to include Cognitive Analytical Therapy (CAT) therapy.
- A general psychological therapy pathway will be developed.
- The Local Enhanced Service (LES) component of the Primary care Mental Health service will be refreshed and re-launched.
- Continue with the pilot to increase access to psychological therapies for offenders.
- Evaluate effectiveness of pathways into early intervention for Looked After Children
- Implementation of the employment project plan which includes good practice interventions that work and is led by Adults Service Management Team.
- The Local Authority will redesign the employment pathway for people with mental health, learning disabilities, autism and physical disabilities to ensure that they have access to pre-employment training/support/qualifications to help access employment. This will be overseen by Routes to Work support in employment scheme.

Adults and children with autism

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

The Autism Act 2009 and subsequent statutory guidance was created in response to increasing evidence that a significant proportion of adults with autism, across the whole spectrum are being excluded from society both socially and economically.

Prevalence within Tameside is difficult to establish as there is a gap in provision in relation to a clear diagnostic pathway. Based on a national formula of 1:100 having an Autistic Spectrum Disorder (ASD), we estimate at this time 2190 people have ASD in Tameside, this increases to 2220 when including Glossop.

Outcomes Framework

Adult Social Care Outcomes Framework 2013 to 2014 all four domains are relevant to this agenda.

At risk or vulnerable groups:

Adults and children who have an Autistic Spectrum Disorder. (ASD).

It is estimated that 50% of people with ASD also have a learning disability, and are vulnerable in terms of being socially and economically excluded.

Benchmarking:

There is currently very little comparative data available to benchmark against in terms of national and regional performance. Tameside are members of the Greater Manchester Autism Consortium which includes facilitation from the National Autistic Society. Good practice and development opportunities such as training are shared across the consortium organisations.

Policy Context:

This area is fundamentally driven by the [Autism Act 2009](#) and subsequent statutory guidance '[Fulfilling and Rewarding Lives](#)' Statutory Guidance for Local Authorities and NHS Organisations to Support the Implementation of the Autism Strategy (2010).

[The Autism Act \(2009\)](#) was created in response to increasing evidence that a significant proportion of adults with autism, across the whole spectrum, are excluded both socially and economically. The Autism Act 2009 was the first ever piece of legislation designed to address the needs of one specific impairment group: adults with autism. The Autism Act 2009 Section 1 (1) required the Secretary of State to prepare and publish a document setting out a strategy for meeting the needs of adults in England with Autistic Spectrum conditions by improving the provision of relevant services to such adults by Local Authorities, NHS bodies and NHS Foundation Trusts. This guidance '[Fulfilling and Rewarding Lives: The Strategy for Adults with Autism in England](#)' was published on the 3rd March 2010.

The Department of Health has released statutory guidance to provide guidance on the Act and subsequent strategy. The guidance is required by law and is "Statutory" guidance. It is

to be treated as if it were guidance issued under Section 7 of the Local Authority Social Services Act 1970.

Progress within Tameside is monitored by Public Health England through the Autism Self-Evaluation process and also by the Autism Strategy Development Group (ASDG) who are responsible for Tameside's Strategy and implementation.

[Fulfilling and Rewarding Lives \(2010\)](#) does include a list of policies that apply to adults with autism. These provide a useful context for how the strategy was developed. Some key policies such as Valuing People Now the Government's Strategy for people with learning disabilities, recognised that adults with autism are some of the most excluded and least heard people in society and that service providers, commissioners and policy makers were not specifically addressing their needs.

The Autism Act 2009 states that local arrangements for leadership in relation to the provision of relevant services to adults with such conditions. This strategy document addresses the local priorities in relation to services to people with autism and in Tameside and offers a local framework.

As around 50% of people with ASD are also thought to have a learning disability, the objectives set out in the statutory guidance closely link to objectives set out in [Valuing People Now: A new three year strategy for people with learning disabilities](#) (2009).

What interventions work?

Key interventions as identified in the statutory guidance, North West Action Plan and Tameside strategy PATH include:

- Increase awareness of autism with front line professionals
- Development of a clear and consistent diagnostic pathway
- Improving access to services and assistance with living independently in the community
- Assistance with access to employment
- To work with key partners to develop and improve access to services
- To improve housing options

Service user and public engagement or consultation

The Autism Strategy Development Group (ASDG) has carer's and carer group representation have informed and contributed to the strategic direction of travel. The Strategy has also involved consultation and engagement from carers, and key professionals across all key organisations. Where we have been poor is in engaging and consulting with people who have ASD.

Further consultation is required with carers and people with ASD on implementation of strategic objectives and this will be facilitated through the Carers Forum and through engagement with user groups.

What are we doing now?

The North West Joint Investment Partnership (JIP) produced a regional action plan to address issues across the region in terms of meeting the statutory guidance. Following this work the Greater Manchester Autism Consortium has been formed to provide a strategically co-ordinated approach to achieving better outcomes for Adults with Autism through supported integrated working across the Greater Manchester. The focus is to develop 5 Autism Networks across the North West which will be aligned to the 5 PCT Clusters. One of the key four stages identified is the identification of key priorities within each network and action planning to achieve identified priorities. This arrangement will allow greater comparative information sharing upon which benchmarking and performance management can be monitored against.

- We are currently working with the National Autistic Society, Autism Specialist Nurse, NHS, Local Authority(LA), Parents / Carers, Education and Children's Services to develop a Joint Autism Strategy for Tameside
- We are working with Pennine Care NHS Trust in progressing a CQUIN to develop a diagnostic pathway for people with autism
- We have established user and carer peer support groups
- We have identified a local GP who represents the autism agenda on the NHS Clinical Commissioning Group (CCG)
- We have identified Senior Managers within the LA and NHS Tameside and Glossop, and local politicians who are responsible for ensuring the Autism Strategy objectives are achieved
- We have an Autism Network website to assist in providing good quality information and advice. www.tameside.gov.uk/autismnetwork
- We are redesigning pre employment services to include access to services by people who have autism
- We have a multi-agency assessment team for children.
- Applying for accreditation by National Autistic Society to enable us to provide better support for people with Autism within their own homes.

What needs to happen next, and by whom?

- The Autism Strategy needs to be finalised and agreed and progress needs to be made with key objectives set out in the strategy (Autism Strategy Development Group)
- A performance management framework needs putting in place to aid performance management of progress to achieve the Autism Strategy objectives (Autism Strategy Development Group)
- The learning Disability Commissioning Strategy is being finalised and will also incorporate commissioning intentions for Autism
- The NHS Clinical Commissioning Group (CCG), Health and Well-being Board and the Local Authority Public Health need to be engaged in driving forward the objectives of the Autism Strategy and ensure that good quality information, advice and support is available (LA & NHS Tameside and Glossop Autism Leads)
- The CQUIN needs to be progressed to develop a diagnostic pathway (NHS Tameside and Glossop Lead)

- Better information systems need to be developed to enable evidence based prevalence rates and forecasting to inform future service planning (Autism Strategy Development Group)
- A link needs to be made to the Mentally Disordered Pathway (Bradley Report) that includes individuals with ASD (LA Autism Lead)
- The Special Educational Needs (SEND) requirements needs progressing and implementing (LA Autism Lead, Education and Children's Service's)

Social care related quality of life

Outcomes Framework: Adult Social Care 1A

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

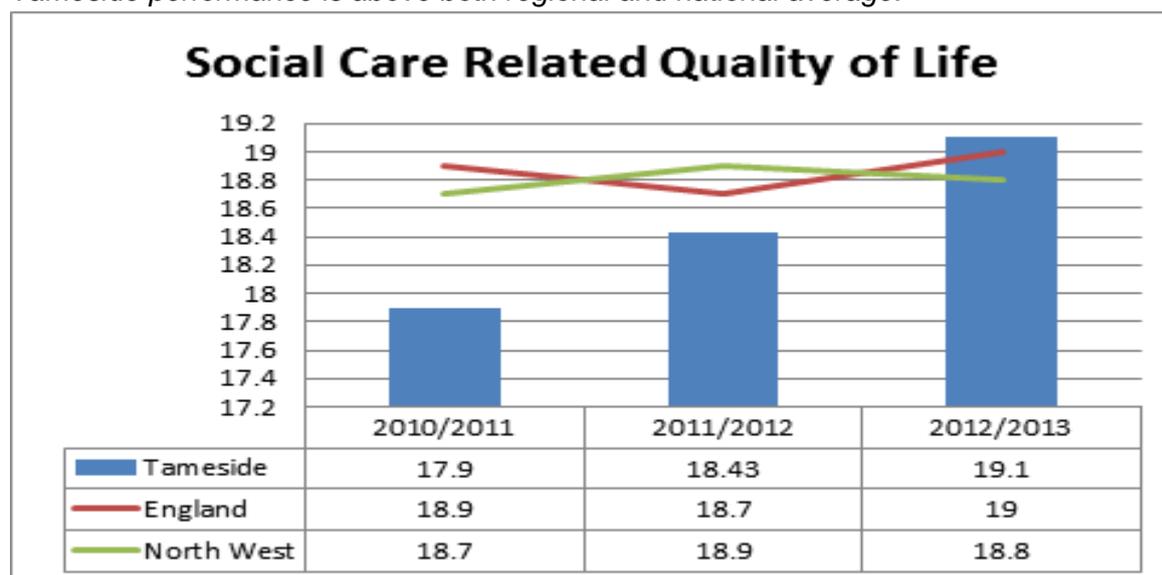
Enhancing the quality of life for people with care and support needs. This indicator gives an overarching view of the quality of life of users of social care. The overall quality of life measure brings together peoples experiences of eight outcomes related to social care, into a single measure: control, personal care, food and nutrition, accommodation, safety, social participation, occupation and dignity.

At risk or vulnerable groups:

All adult social care users

Benchmarking:

Social care related quality of life for Tameside, England and North West Averages 2010/11 – Tameside performance is above both regional and national average.



Source: Tameside MBC 2014

Policy context:

Social Care related quality of life is an overarching measure within the “Enhancing quality of life for people with care and support needs” outcome domain in the [2012 - 2013 Adult Social Care Outcomes Framework](#).

[Our health, our care, our say: a new direction for community services](#)

What interventions work?

- Contract Monitoring to improve quality and outcomes within commissioned services
- Regulated Services that meet national minimum standards
- Inspections by regulators to ensure compliance and quality standards
- Assessments / Reassessments and Support Planning
- Care Management
- Personal Budgets to promote choice, control and independence
- Person Centred Planning
- Re-ablement – support to optimise capabilities
- Assistive Technology
- Tele Health
- Safeguarding
- Well being, Early Intervention and Prevention Services to improve quality of life Service User engagement and consultation.

What are we doing now?

- Drive and monitor improvements via the Tameside Adults Transformation Programme Board.
- Continue to restructure and transform services to ensure alignment with policy drivers.
- Produce an annual Local Account for citizens to demonstrate accountability and transparency.
- Engage in the national Sector Led Improvement Programme.
- Continue to engage and involve service users and carers in the commissioning and development of local services.
- Continue to engage with and promote shared learning with partners with regards to Dignity in Care.

Self-reported well-being

Outcomes framework: Public Health 2.23

The final Indicator for Well Being will be developed in line with ONS's measuring National Well-being Programme and is expected to be ready soon. The current measure of well-being is the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) and is used on adults (16+), designed specifically to measure positive mental health, rather than mental illness.

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

Well-being can be defined simply as, "feeling good and functioning well". The term 'well-being' moves individuals into a more 'personal' space of positive feelings of happiness, comfort and lack of stress. This includes having sufficient material resources, feeling in control and having the capability to manage problems, and experiencing a sense of belonging and meaning with people and place. There is a strong correlation between physical and mental well-being.

People with higher well-being have lower rates of illness, recover more quickly and for longer and generally have better physical and mental health. Improving well-being can lead to better outcomes in employment and productivity, educational attainment, healthy lifestyle behaviours and life expectancy, and better quality of life for the individual, their family and the wider communities by broadening and strengthening networks. Therefore a range of partnership strategies support this objective and the outcome of this indicator is integral to most of the indicators across the JSNA.

At risk or vulnerable groups:

Certain groups experience poorer mental health and well-being particularly those people experiencing socio-economic deprivation. Particular groups at risk of poorer mental health and well-being include people with:

- long-term physical illness,
- low incomes and unemployed,
- low or no qualifications

Benchmarking:

Comparing the North West WEMWBS 2012/13 Survey Results with 2009

- There was no significant change in average mental wellbeing (as measured by mean WEMWBS score) across the North West between 2009 (27.70) and 2012/13 (27.66). The proportion of respondents in the 'low' and 'high' mental wellbeing categories fell slightly in the current survey, with more people shifting into the 'moderate' wellbeing group (2009, 62.8%; 2012/13, 64.3%). Life satisfaction has improved, with 10.5% more people reporting that they were satisfied with their lives than in 2009, a significant difference. More people reported being in very good health in 2012/13 (18.2% more than 2009) and

there was an improvement in overall health and social care needs, with the EQ-5D mean score increasing from 0.84 in 2009 to 0.87 in 2012/13 (a 3.8% increase) with many elements that make up EQ-5D seeing improvements.

The proportion of people 'definitely' agreeing they have time to do the things they really enjoy fell by 9.1% (from 35.7% in 2009 to 32.5% in 2012/13).

Neighbourhood belonging reduced significantly, with 12.7% fewer respondents saying they felt 'very strongly' that they belong to their immediate neighbourhood.

The proportion of respondents who were current smokers has fallen from 29.8% in 2009 to 27.7% in 2012/13.

The number of respondents who are meeting the physical activity standard has reduced from 30.4% in 2009 to 27.1% in 2012/13.

There was an improvement in level of financial worry, with 16.4% fewer respondents feeling worried about money 'almost all of the time' during the last few weeks.

However, 5.2% fewer respondents felt that they were living comfortably on their present income.

The number of people reporting that they talk to neighbours on most days has fallen by 35.2%. Approximately 1 in 20 of those surveyed never talk to their neighbours.

The proportion of people who meet friends and family on most days has also declined from 53.9% in 2009 to 41.2% in 2012/13.

2012/13 additional results

People with long-term conditions had a significantly lower level of mental wellbeing than average. Conditions most strongly associated with lower mental wellbeing include depression and anxiety, liver disease and stroke.

In total 11.7% of respondents reported being financially better off than a year ago, while 29.8% stated that they were worse off

Social capital is linked to a range of outcomes, including mental health and wellbeing. Across the North West, 24.3% of respondents were classified as having high social capital while 28.4% had low levels of social capital. Those with high social capital have significantly higher mental wellbeing than those with low or moderate levels of social capital.

Further analysis of the 2012/13 survey data relating to Tameside and Glossop revealed that:

- 14.4% of the population had low mental well-being
- 55.2% of the population of Tameside and Glossop had moderate mental well-being
- 30.4% of the population had high mental well-being

Tameside and Glossop average WEMWEBS score was 26.5 in 2009. In 2012/13 the result was 28.3 therefore there has been an improvement locally. The North West average was unchanged.

Policy context:

The Tameside and Glossop Mental Health and Well-being Strategy was published in March 2011. This has now drawn to a conclusion and going forward we need to agree a coordinated strategic approach using initiatives such as the wellness offer and the neighbourhood offer.

The approach adopted has been in line with the government mental health strategy "[No health without mental health – a cross-government mental health outcomes strategy for people of all age](#)".

Other useful documents include:

Wellbeing: Why it matters to health policy. Evidence on why wellbeing matters to health throughout someone's life, and what policy makers can do about it. Department of Health, February 2014. <https://www.gov.uk/government/publications/wellbeing-and-health-policy>

Closing the Gap Department of Health. January 2014

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273649/Closing_the_gap.pdf

Better Mental Health for All, Faculty of Public Health. 2014

http://www.fph.org.uk/better_mental_health_for_all

NICE Guidance includes:

- Mental health and wellbeing at work (PH22) 2009
- Social and emotional wellbeing in early years (PH40) 2012
- Mental wellbeing of older people in care homes (QS50) 2013
- Occupational health and Public Health to promote mental health and wellbeing of older people in primary and residential care (PH16) 2008
- Social and emotional wellbeing in secondary education (PH20) 2009 (update for primary and secondary education is in development)
- Older people and independence and Mental Health and Wellbeing are in development.

North West Mental Health and Wellbeing Survey; Public Health England, Centre for Public Health. Liverpool John Moores University

http://www.nwph.net/nwpho/Publications/NW%20MWB_PHE_Final_28.11.13.pdf

Five Ways to Wellbeing: New Economics Foundation.

<http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

The Role of Local Government in promoting Wellbeing

http://www.local.gov.uk/c/document_library/get_file?uuid=bcd27d1b-8feb-41e5-a1ce-48f9e70ccc3b&groupId=10180

These documents encapsulate the evidence and the practical application of the five ways to wellbeing. It is a population approach across the life course. This approach sees mental health as being central to improving health outcomes for the whole population and highlights the importance of addressing the social determinants of health as key to improving mental well-being. There is also recognition of the important link between mental health and physical health.

What interventions work?

Public services can make a significant contribution to improving well-being by tackling poverty and reducing inequalities so that local people can access:

- Affordable, quality and warm housing
- Secure and meaningful employment
- Education, training and learning
- Sports, leisure, culture and arts access to services
- Green space and nature
- Safe and pleasant built environment
- Maximising household income

The New Economics Foundation produced a report providing the evidence base for improving the mental health and well-being of the whole population. From the available evidence the approaches were summarised into [“Five ways to well-being”](#):

- Take Notice
- Give
- Connect
- Be active
- Keep learning

More specific examples of targeted approaches for targeted groups are:

- Health visiting and reducing post natal depression
- parenting skills and support
- healthy schools, and social and emotional learning (SEL) and reducing bullying
- debt advice
- promoting well-being in the workplace
- befriending older people
- time-banking
- community navigators to improve service access and reduce vulnerability
- alcohol brief interventions

What are we doing now?

An important element of the approach began with raising awareness during the 2012 launch for Tameside and Glossop's Year of Health and Well-being. This was reinforced and continues to be so with investment in many areas across the life course that promotes wellbeing. Further investment is planned for 2014/15 and the DPH annual report for 2014 is focused the 5 ways.

What needs to happen next, and by whom?

The North West Mental Wellbeing Survey cites 10 recommendations.

1. To continue to measure improvements in population mental wellbeing through routine monitoring of the average WEMWBS score across localities.

The Council has introduced questions about mental health and wellbeing in the Citizen's Panel. We will look to how we can introduce WEMWEBS to provide longitudinal data on population wellbeing.

2. To ensure that all public policy enhances mental wellbeing and mitigates against any adverse impacts, through using Health In All Policies Approaches (HiAP), Mental Wellbeing Impact Assessment and mental wellbeing outcome measurement.

Health Impact Assessment needs to be introduced systematically across health and council policy makers to ensure the impact on wellbeing is assessed.

3. For the local Health and Wellbeing board to lead strategic direction on improving population mental wellbeing and overseeing the implementation of evidence based interventions and integrated approaches across sectors and the life course.

4. To focus attention on the significant impact that relationships and social support have on health and wellbeing, through furthering our understanding of its contribution to healthy life expectancy and implementing evidence based approaches with families and communities.

5. To integrate mental wellbeing into all physical health pathways, considering interventions during prevention, treatment, recovery and condition management, including the measurement of mental wellbeing outcomes using WEMWBS.

Tameside Health and Wellbeing Implementation Group will receive an overview of the evidence for different interventions that promote mental health and wellbeing with recommendations for action. This will be structured using the lifecourse approach.

6. To value social capital as an asset within communities and invest in community development to build social capital, especially within the most deprived communities and using intergenerational approaches.

7. To further investigate the inequalities related to money worries, living comfortably and being better and worse off and people's mental wellbeing, especially as part of efforts to monitor and mitigate the impact of the economic downturn.

Mental health and wellbeing needs to be an integral component of the Tameside Wellness and Neighbourhood Offer.

8. To continue to engage front-line workers and the public in increasing understanding of wellbeing and taking action to improve it, using tools such as the Five Ways to Wellbeing and the Fair Deal for Wellbeing Discussion Kit.

Health and Social Care Commissioners and providers should incorporate promotion of mental health and wellbeing into contracts.

9. To continue to collaborate on surveys of mental wellbeing, and implementation of recommendations and interventions, across local authorities, thus promoting sharing of expertise and resources which makes the exercise more cost-effective. Conducting the survey on a larger geographical scale also enables consistency and comparability of results.

10. To continue to develop our understanding of the determinants of mental wellbeing and how mental wellbeing is linked to other social outcomes.

The Council will work with Public Health England on implementing the most cost-effective approaches for further research and audit. Greater Manchester DsPH is a pivotal group for coordinating approaches across the GM footprint.

The final evaluation report on the 5 ways to Wellbeing grant will be issued in March 2014.

Access to GP services

Outcomes Framework: NHS Framework (4.4i)

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

General practice undertakes approximately a million consultations each working day and is the main point of entry to other NHS services. There is over £7.7 billion invested in General Practice every year.

Easy, timely and convenient access to GP services and appropriate onward referral to specialist services, with good patient experience are essential to ensure that all patients are offered high quality patient care and value for money.

At risk or vulnerable groups:

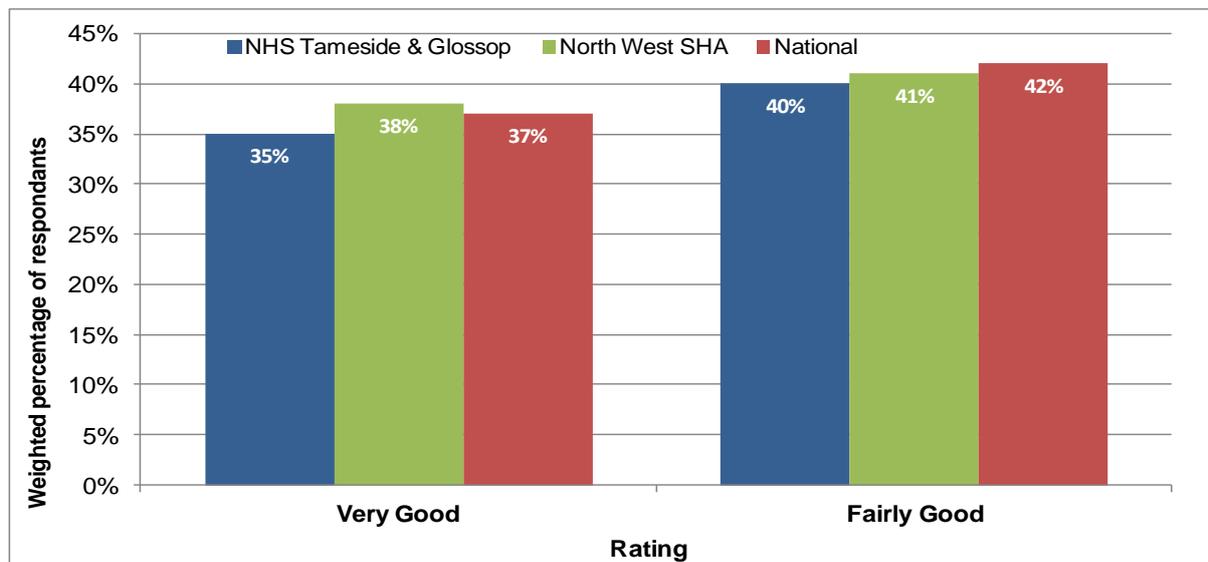
- People with learning disabilities
- Older people
- Children and families living in deprivation
- People with disabilities
- People not registered with GP practices

Policy context:

High Quality Care for All – Primary Care and Community Care Services: [Improving GP access and responsiveness](#), highlights what NHS commissioning organisations and GP practices can do to improve access to GP services.

Benchmarking:

Overall experience of making appointment, Quarter 2, NHS Tameside and Glossop, North West SHA and National 2011



Source: GP patient Survey- July to September 2011; [data](#); [survey results](#)

What interventions works?

- providing transparent information
- ensuring minimum standards
- providing regular insights into practice performance
- undertaking research focused on understanding the needs of the local population to address their needs
- supporting quality improvement
- engaging key stakeholders
- sharing views of the general public
- understanding the demand for services and how it can be met
- putting systems in place to manage this demand
- ensuring that practice environment supports access to information in the waiting area
- providing a patient-friendly service
- setting up patient participation groups and methods of obtaining reliable feedback

What did we do in 2011-12?

NHS Clinical Commissioning Groups (CCGs) are currently scoping out the use of quantitative and qualitative information across primary and secondary care that would form a part of their regular flow of intelligence needed to inform their decision making.

What were our plans for 2012-13?

There is a need for the local NHS trust to record complaints, compliments and issues around access from patients, commissioners and providers in order to capture the right information at the right time so that it can have a positive impact on future planning and delivery.

What were our plans for 2013-14?

As a CCG we were committed to supporting our member practices in their roles as providers and commissioners of healthcare locally, and work closely with the Local Area Team of NHS England on primary care provision. The development of a local primary care strategy is a priority.

Improving access to NHS dental services

Outcomes framework: NHS outcomes framework (4.4ii)

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

- Dental disease can cause pain, sepsis, loss of appearance and confidence, loss nights' sleep, missed work, and required avoidable and unpleasant dental treatment including extractions under general anaesthetic which represent an avoidable risk to life.
- The latest [Adult Dental Health Survey](#) found that, in the North West of England, problems with teeth or gums cause problems to a third of the population, including eating for one fifth of the adult population and reluctance to smile to a further one fifth.
- Good oral health is highly prized by the population, largely due to its link to good appearance and attractiveness.
- The importance of access to dental care to citizens and communities has been recognised nationally by successive governments and has been the subject of campaigns locally by communities, elected members and members of parliament which have driven improvements in dental access across Tameside and Glossop.

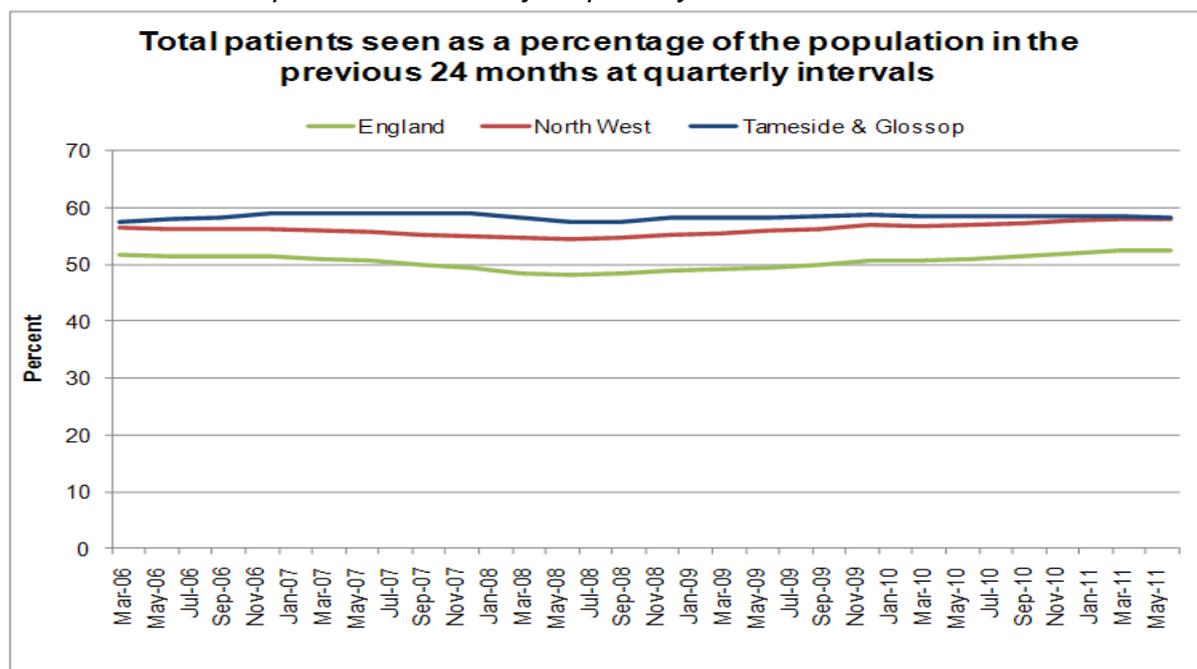
At risk or vulnerable groups:

The adult dental health survey showed that social class of head of household or educational attainment or both are independently related to all the measures of oral health used – with higher levels of dental need and lower levels of dental attendance in those from less privileged backgrounds.

In addition particular groups of the Tameside and Glossop population have reported problems in gaining access to general dental services. These include those with mental health issues, learning disabilities, substance misuse issues, or those who have problems in attending a dental surgery due to physical, mental or social causes. Hospital in-patients have traditionally had problems in gaining access to dental services.

Benchmarking:

Patients seen in the previous 24 monthly at quarterly intervals



Source: NHS information centre March 2011

The Department of Health General Practice survey dental data (2010-11) showed that 96% of Tameside and Glossop residents who had tried to find a dentist in the previous 3 months were successful compared to 94% in England and the North West.

Policy context:

[Pilot of new dental contract](#) intended to improve oral health, access to dental services and quality of care.

What works?

- Affordable dental services
- Access to NHS dentistry
- Focus of good dental health that goes beyond only treatment

What are we doing now?

The following services have been commissioned for the population of Tameside and Glossop:

- A dental access helpline giving:
 - Access to urgent dental care, in hours and out of hours
 - Access to routine dental treatment guaranteeing access to all residents.
 - Domiciliary care for those unable to leave the house.
- Specialist paediatric dental services including sedation, general anaesthetic and special needs treatment.

Non-recurrent Department of Health funding in 2011-12 was used to fund additional dental capacity and a communications campaign to stimulate dental attendance.

In addition the dental health promotion team promote the uptake of NHS dental services across the community and also use a targeted approach to ensure equity among groups most at risk. These include users of substance misuse services, people in residential care, children and adults with physical disabilities, children and adults with mental health issues, families living in areas of social-economic deprivation and Black and Minority Ethnic (BME) communities.

Resources on how to access dental services are produced and distributed to health visiting teams, community mental health teams, GPs, pharmacists, housing associations, schools, Connexions and through the Tameside MBC website.

What needs to happen next, and by whom?

Responsibility for commissioning dental services has transferred to NHS Greater Manchester and will transfer to the NHS Commissioning Board from 2013. Locally there is a need to:

- Maintain universal and targeted support for uptake of access to dental care.
- Work through the Health and Well-being Board and the NHS National Commissioning Board to ensure that that clear pathways into appropriate dental care meet the needs of all communities within Tameside and Glossop.

Social Connectedness

Outcomes framework: Public Health 1.18

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

Social connectedness refers to the relationships people have with others and the benefits these relationships can bring to the individual as well as to society. Social connectedness is vital for health and well-being.

Recently, several studies have demonstrated links between social connectedness and positive outcomes for individual health and well-being. People with a wider circle of friends are generally happier, healthier and better off than those that have limited interaction with others. Evidence has also proven that a strong sense of well-being and happiness spreads through social networks. However, as well as having a positive influence on health and well-being, social networks can also have a negative influence on health behaviours depending on the 'culture' of the group; for example, starting and stopping smoking.

Membership in groups is essential to our mental and physical health and well-being. As individuals, a large part of our sense of self is driven by group membership and social identity. Membership of groups gives us a sense of social identity whether it is sporting clubs, volunteering groups or local common-interest community groups. Our ability to access and be part of local groups is part of who we are as individuals and communities.

Linked to social connectedness is a strong sense of community cohesion and good community relations. Feelings of difference can influence individual choices around which services people feel comfortable accessing. For example, perceptions that a service is specifically targeted at one group over another can leave people feeling isolated and unwilling to seek support.

At risk or vulnerable groups:

A lack of social connectedness is most prevalent amongst groups that are at risk of social exclusion e.g. Black and minority Ethnic (BME) communities; ex-offenders; Lesbian, Gay, Bisexual and Transgender (LGBT) communities; migrant communities; refugees and asylum seekers, people with learning disabilities and mental health needs.

Benchmarking:

All questions are asked annually in the Tameside Citizens Panel, and therefore no comparison data is available.

The most comparable indicators are as follows

Indicator	Latest available data (2011)
% of residents who volunteer	40.6% of respondents had given either 'unpaid help to any group, club or organisation' or 'unpaid help as an individual only and not through groups, clubs or organisations'
% of resident who are satisfied with their area as a place to live	69.8% of people are satisfied with their local area as a place to live (unchanged since 2009)
% of residents who feel they belong to their local area	66.6% agree (performance is down two-thirds based on trend data from 2009 which shows 73.8% of people agreed with the statement)
% of residents who feel people from different backgrounds get on well together	55.5% agree (with the lowest performing area being Hyde with just 43.9% of people agreeing with the statement – Hyde is the only area to score below 50%)
% of residents who regularly meet and talk with people from different backgrounds	(Hyde has the highest % of people who never meet and talk with people from different backgrounds, 18.6%)

Source: Tameside MBC 2012

Policy context:

- [Creating the conditions for Integration](#) – UK National Integration Strategy (February 2012)
- [Tameside Community Cohesion Strategy](#)
- [Tameside Volunteering Strategy](#)

What interventions work?

Social connectedness is fostered when family relationships are positive, and when people have the skills and opportunities to make friends and to interact constructively with others. Good health, employment, and feeling safe and secure all increase people's chances of developing positive social networks that help improve their lives.

What are we doing now?

Delivering cultural activity to bring people together and increase their sense of belonging.

- Providing access to networks and groups that create social connectedness (through the faith, community and voluntary sectors)
- Targeted work to build community cohesion in Hyde.
- Implementing Tameside Race Equality Framework.
- Awareness raising campaign around hate crime.
- Strengthening Communities work to reduce vulnerabilities around violent extremism.
- 5 ways to well-being promotion and community grants

What needs to happen next, and by whom?

- Benchmarking with an agreed measure of social connectedness to begin analysing gaps and planning future work streams

- Develop understanding locally of the link between social connectedness and health and well-being
- Awareness raising campaign to encourage people to get involved in their community (either through volunteering or through membership in a group/network) led by T3SC and the Volunteer Centre

Statutory homelessness

Outcomes framework: Public Health 1.15

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

Homelessness is the most extreme form of social exclusion and is a strong indicator of social injustice in any society.

The prevention of homeless in Tameside continues to be a key priority for the Council and its partners. Households experiencing homelessness or who are threatened with homelessness are trapped in cycles of deprivation that impact on their health, emotional wellbeing and life chances. The effects on children within households experiencing or threatening homelessness can be life long.

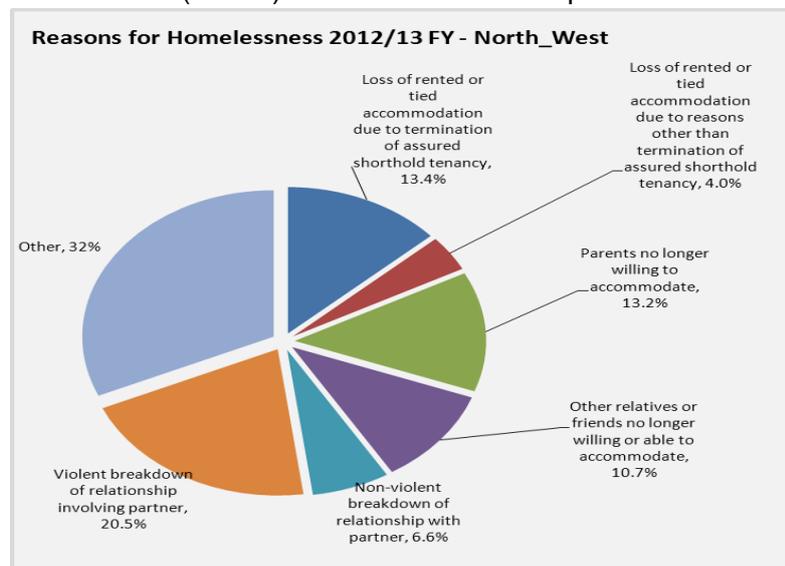
At risk or vulnerable groups:

The links between homelessness and health inequality are now well established by research and include a range of both physical and mental health conditions including respiratory issues, poor dental health, skin diseases, depression, and schizophrenia and substance dependency. Research collated by Homeless Link illustrated that:

- 80% of homeless people have more than one health condition
- 70% of homeless people have at least one mental health condition
- People who sleep rough are 200 times more likely to contract tuberculosis than the general population.
- A third of rough sleepers have attempted to commit suicide

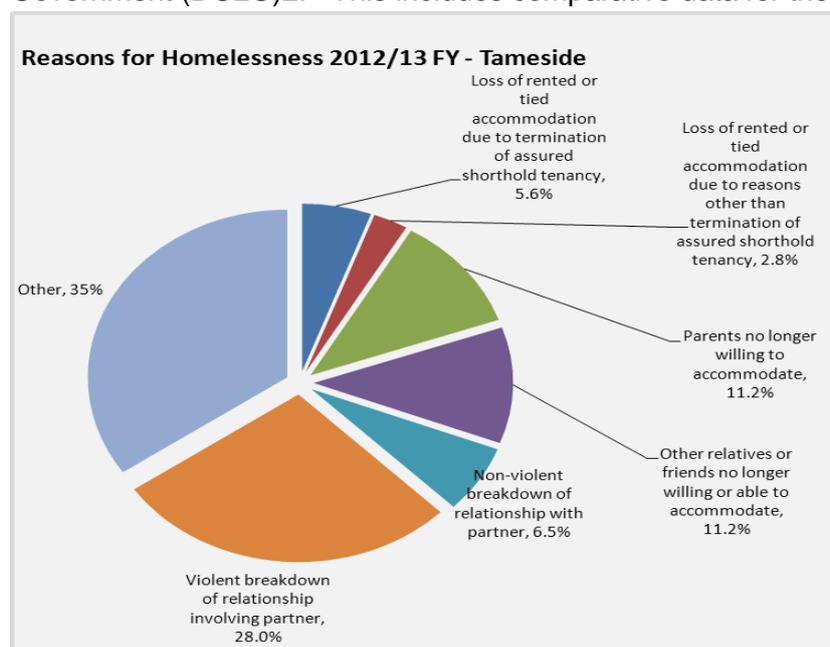
Benchmarking:

Homelessness statistics provided by the Department for Communities and Local Government (DCLG)¹. This includes comparative data for the North West.



Source: Tameside MBC 2014

Homelessness statistics provided by the Department for Communities and Local Government (DCLG)². This includes comparative data for the North West.



Source: Tameside MBC 2014

Policy Context

- Health and Wellbeing Strategy 2013-16
- Troubled Families
- Sustainable Communities Strategy
- [The Localism Act 2011](#)
- [Welfare Reform Act 2012](#)
- [Tameside Housing Strategy 2010-16](#)
- [Tameside Homelessness Strategy 2008-13](#)

What interventions work?

The Homelessness Prevention Strategy has identified the following 4 key strategic themes.

- Early Intervention and Prevention
- Accommodation and Access
- Positive Move-On and Sustainability
- Improving Health and Wellbeing

What are we doing now?

Early Intervention and prevention

Our record of preventing homelessness over the past 5 years has been very positive with a 70% increase since 2008 in the number of households who have either been able to stay in

their own home or have been provided with alternative accommodation. Much of this success has been built on robust partnerships that have enabled early intervention in cases where a risk of homelessness has been identified.

Mitigating the impact of Welfare Reform

The Council has given a clear message that tackling poverty and addressing the negative impact of welfare reform remains a key strategic priority. Our network of advice agencies in Tameside is strong, and includes the Council's Welfare Rights Team, Citizens Advice Bureau, MINT and Cashbox (Credit Union). Our Registered Providers also provide specialist advice to their tenants many of whom will be under increased financial pressure with the impact of Council Tax and the under occupation levy.

Improving Health and Wellbeing

There is a direct correlation between homelessness and a range of other health and social issues that serve to increase a person's vulnerability. Notable among the key issues that frequently combine with homelessness are substance misuse, offending behaviour, mental health issues, low educational attainment and domestic violence.

Hospital Discharge Protocol

The protocol aims to promote a joint understanding across all sectors of the importance of sharing information as early as possible in cases where there is a likelihood of a patient being discharged from hospital with nowhere to live. New Charter has been successful in a bid to the Transitional Homelessness Fund that has enabled them to create a post dedicated to improving outcomes for customers who are at risk of homelessness when being discharged from hospital.

What needs to happen next, and by whom?

Tameside Council

As part of the Gold Standard Challenge that has been developed by the National Practitioner Support Service (NPSS) the local authority will be expected to adopt a corporate commitment to preventing homelessness which has full support across all local authority services.

Housing Options

In co-operation with neighbouring local authorities we shall take part in a peer review process that benchmarks our approach to housing options and homelessness in comparison to services in other areas. This is part of the Gold Standard challenge developed by NPSS designed to promote best practice and help the process of delivering more efficient and cost effective homelessness prevention services.

Strengthening Partnerships

To maximise the effectiveness of homelessness prevention we will build upon our existing partnerships and to identify opportunities to broaden the network of agencies identifying this

as their strategic priority. We will be ensuring that homelessness prevention work across the wider partnerships is captured in the data collected for the local authority statistical returns.

Making Every Contact Count

The new structures and ways of commissioning provide opportunities to maximise our partnerships and we will be looking to identify ways of working together and sharing our outcomes. The Making Every Contact agenda has indicated that sharing outcomes between sectors is an effective means of making best use of resources.

People entering prison with substance dependence issues who are previously not known to community treatment

Outcomes Framework: Public Health 2.16

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

Offenders who use heroin, cocaine or crack cocaine commit between a third and a half of all acquisitive crimes ([NTA](#)).

Effective recovery from drug dependence will reduce crime, cut the cost of drug-related harm to society, and make communities safer for everyone. Therefore, access to and choice of treatment for drug misuse should be the same whether people participate voluntarily or are legally obliged to do so. The aim is to break the link between drug use and criminal behaviour, so that individuals do not reoffend on release and have the opportunity to recover and reintegrate with society. In this way, effective treatment can liberate them, their families, and their communities from the harms they suffer as a result of drug-related crime.

A [report](#) published by the National Treatment Agency (NTA) estimates that current drug treatment provision prevents 4.9 million crimes in England a year, with an estimated saving to society of £960 million in costs to the public, business, the criminal justice system and the NHS.

At risk or vulnerable groups:

- Remand Prisoners
- Sentenced Prisoners
- Prisoners Friends and Families
- Women prisoners. Estimates suggest 60-70% of women who enter prison have drug problems. They are more likely to self-harm than men, have higher rates of attempted suicide, and are more likely to suffer drug-related deaths in prison and soon after release. Many women arrive in prison pregnant or have dependent children. They may be held in establishments far away from their families.

Benchmarking:

The data source for this indicator in the Public Health Outcomes Framework is still in development; therefore performance data for this indicator is not currently available.

National and Local Policy context:

The [Drug Strategy for England](#) aims to engage and work with offenders at every stage of the criminal justice system, creating an end-to-end support structure. The strategy also sets out an intention to develop and deliver liaison and diversion services at police stations and courts to divert offenders with health problems away from custody at the earliest opportunity – referring them into the treatment services that they need.

In April 2013 local authorities became responsible for commissioning community drug and alcohol treatment for their local population. This work will be supported by Public Health England (PHE) which now has responsibility for the functions previously delivered by the NTA.

Tameside Metropolitan Borough Council (TMBC) is not responsible for commissioning services in prisons, as there is no prison within the borough.

What interventions work?

The Government accepts that treatment in the criminal justice system, whether in the community or in prison, can be highly effective. The Government's vision is a locally commissioned, recovery-focused prison based treatment system, described in the Green Paper "[Breaking the Cycle](#)".

TMBC are responsible for commissioning the Drug Interventions Programme (DIP). The government introduced DIP in 2003 and it brings together a range of agencies including the police, courts, prison and probation services, treatment providers and local authorities. A number of other initiatives operate under DIP, including Test on Arrest, Required Assessment and Restrictions on Bail.

Integrated Drug Treatment System (IDTS) is the primary drug treatment system in many prisons. The prison system should work closely with DIP to ensure that offenders receive seamless support and are kept in treatment even after release, when relapse becomes more of a threat. It is envisaged that substance misuse services are commissioned to offer seamless case management across both community and prisons.

What are we doing now?

- Tameside Public Health Team commissions community based drug and alcohol services and a significant priority is meeting the needs of offenders.
- Public Health works alongside the Integrated Offender Management Programme to offer a multi-agency approach to reducing re-offending linked to substance misuse.
- Public Health commissions a Criminal Justice treatment service providing Drug workers who undertake assessment and encourage engagement with treatment providers. They operate within the DIP and undertake in-reach or outreach with service users in prison.
- Community-Lead Initiatives (CLI) programme is a successful initiative using volunteers to support offenders with substance misuse issues.
- Criminal Justice System (CJS) workers undertake prison in-reach including protocols with local prisons to facilitate IDTS. Additionally this will also include continuity of through care and aftercare, (ensuring that clients can access treatment on entry and release from prison)
- There is a Complex Needs Panel for adults with multiple problems. This multi-agency process seeks to limit the anti-social behaviour caused by adults who frequently drink and take drugs in public. In addition to looking at enforcement options, the group co-operates to offer support and protection to these adults – many of whom are responsible for committing many low level crimes, rough sleeping and will spend short periods in prison.

- Women and families centre is a probation initiative supporting women to connect with services, including health and substance misuse services.
- Ramp programme is a motivational programme providing a link to recovery and re-integration.

Service user or public engagement / consultation:

Service user consultation will be undertaken to inform the re-commissioning of services in 2014/15.

What needs to happen next?

A refresh of the local needs assessment will be undertaken to inform the re-commissioning of services, including DIP provision. Re-commissioned services will be in place by April 2015.

Reducing Reoffending

We have considered the indicators in relation to both the National Offender Management Targets of reducing reoffending, GMPT 3 year Plan and the transforming rehabilitation Agenda and also within the Tameside 'Joint Health and Well-Being Strategy 2013 - 2016', the aims of which complement each other inextricably. We have assessed the criminogenic needs of our cohort against the aims of the wellbeing strategy and will highlight areas of current successful delivery within these key areas. We will then further draw on where we might increase, expand or create services aimed at reducing reoffending and encouraging wellbeing and health among the cohort and larger community within Tameside.

Implications for Population's health and well being

We know that 90% of prisoners have a diagnosable mental health or substance misuse problem or both and more than 80% of offenders smoke –and these patterns are reflected amongst those on Probation Community caseloads. There are many advantages to Health Service and Criminal Justice organisations working in partnership, particularly when financial resources are limited and the need for value for money to intervene before these situations become even more acute. Supporting offenders to choose and maintain healthier lifestyles can have a significant impact on the Health Service. These include reducing alcohol related crime which directly impacts upon medical services such as A&E departments. Likewise

obesity, poor nutrition, smoking, sedentary lifestyles, feelings of wellbeing and excessive drinking are all life style issues that are resulting in high health care costs through emergency admissions, hospitalisation, community services, prescribing costs, disease and infirmity as well as related costs of incapacity benefits.

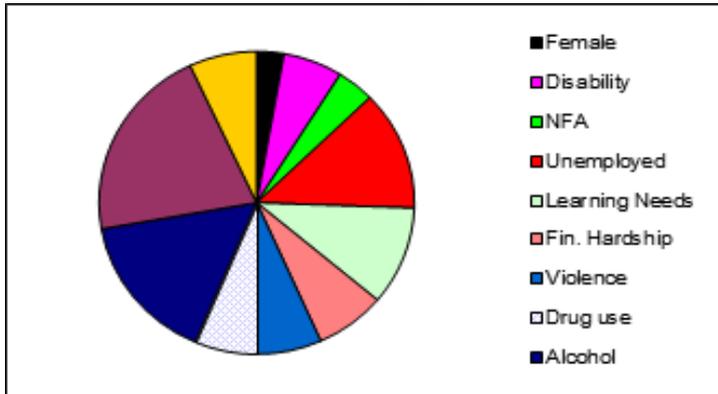
At Risk or Vulnerable Groups

In order to holistically manage our offenders we carry out an assessment utilising the Oasys management system. This tool allows practice staff to plot key indicators regarding an individual's needs and any vulnerability that will impact on the likelihood of them reoffending. The indicators that are most relevant to Tameside's JSNA data capture are: Sex, Age, Disability, Ethnic Origin, Parental Responsibility, Education, Finances, Housing, Employment, Mental Health, Drug Use, Alcohol Use, and Violence Relating to Domestic Abuse, Emotional Issues, and Well Being. The below demonstrates the averages for the above through the most recent 3 month period which we believe to be within the norm for our cohort

- 87% of offenders are White Caucasian
- 10% of offenders are female
- 22% of offenders have a disability
- 14% of offenders are of no fixed abode
- 46% of offenders are unemployed
- 38% of offenders have learning difficulties
- 26% are in financial hardship
- 23% have a problem with using drugs
- 57% have problems with alcohol
- 75% have mental health and coping issues

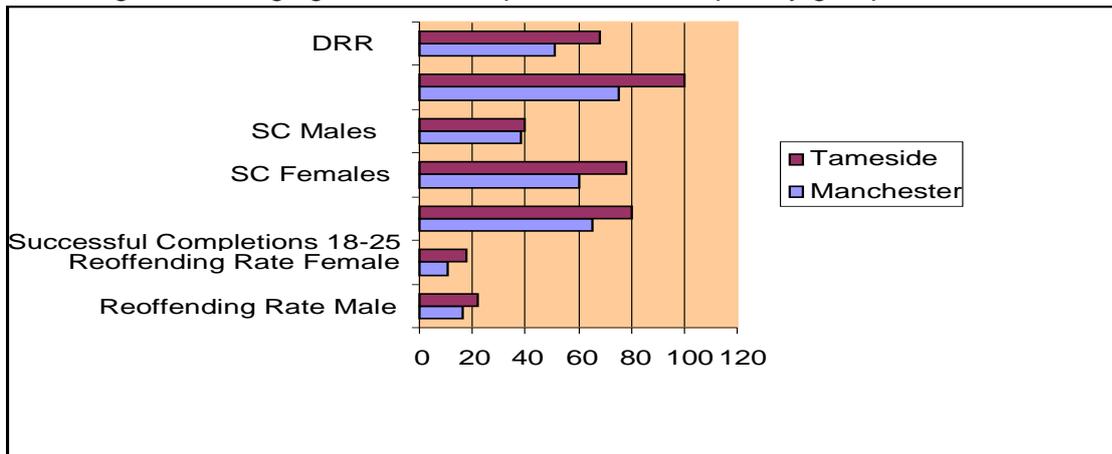
- 25% are in poor health
- 24% are DV offenders

Relevant JSNA Indicator Average for most recent 3 month



Source: Tameside MBC 2014

Reducing reoffending figures and completion rates for priority groups, Tameside, 2013



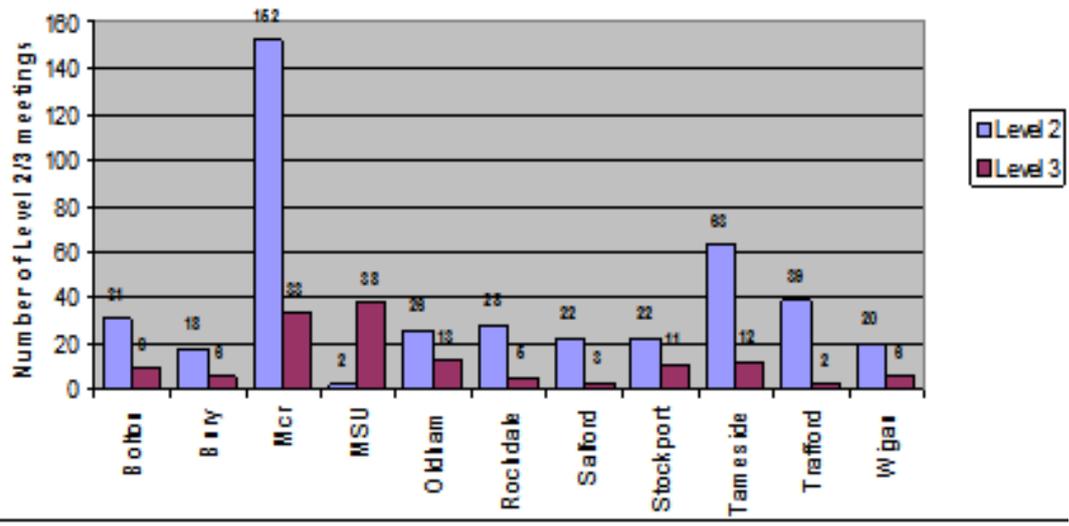
Source: Tameside MBC 2014

The headlines are whilst our male reoffending rates are still higher than GM , they are considerably reduced compared to 2 years ago .This needs to be considered too within our rates of serious harm offenders as outlined in table 3 . Despite a considerable rise in numbers of women offenders up by 42% on 2 years ago, the reoffending rates are lower than the GM level. Anecdotally we attribute the former to the economic downturn and changes in welfare reform. We would hope that the latter is as a result of improved women offender services. We would also draw attention to our very high rates of successful alcohol treatment requirements and completions of young male supervision orders. Our Drug Treatment Order completions too are an improving picture.

The graph below illustrates that Tameside has a much higher rate of serious harm offences that reach the threshold for MAPPA interventions than would be expected for size of the

Borough. This is contributed to by serious Domestic Abuse and serious Organised Crime Offenders.

Number of MAPP level 2/3 meeting, 2013 to 31st March 2014



Source: Tameside MBC 2014

What Interventions Work?

The Women and Their Families Support Centre: This provides supervision to all our women offenders who are being managed in the community and those being supervised on licence post a custodial sentence. In addition the Centre provides holistic wrap around support for victims of domestic abuse, substance misuse service users and other hard to reach vulnerable groups such as BME women and LGBT groups. The Centre has been developed on a one stop shop model to enable easy access to services which seek to provide Recovery pathways including education and training, parenting programmes, healthy eating and budget management. The centre has contributed to a 6% drop in expected re-offending.

IOM: Integrated Offender Management in Tameside has contributed year on year since 2009 to contribute in reductions in reoffending of between 35 %and 37%per annum for our most serious and prolific offender rates. This Partnership led intervention provides a rapid information and response approach combined with prison in reach and full package of rehabilitative support to offenders who wish to turn their lives around. The Programme relies extensively in the use of peer mentoring and ex offender interventions who are able to champion the Recovery approach. The Tameside model was highly acclaimed in a Joint Thematic Inspection by HMIC and HMIP in June 2013

Troubled Families: Intensive working with families: where one individual is being supervised within the CJS, but families are deemed to be at risk of further criminality. The project aims to do this by addressing issues surrounding unemployment, anti-social and criminal behaviour and poor school attendance. These families frequently display problems with substance misuse and domestic violence. The Criminal Justice results for the initiative are currently attracting 65% success rate using PBR indicators.

Forensics Psychology: Complex case discussion service offered on a monthly basis through Probation led initiative with Calderstones Hospital. This is facilitated by a forensic psychologist who supports Offenders Managers with working with difficult cases where personality disorder, Autism and Asperger's and learning disability are a feature.

Young Adults Specialism : Establishment of a co-located Probation and YOT to bridge the gaps between youth and adult criminal justice services for the most vulnerable and immature young adults. Research by the T2A alliance demonstrates that a change to adult CJ services around age 18 can hinder a young person's pathway out of offending and their transition to adulthood (given that probation services are most often geared up to manage adults). Successful completion rates for YAs in Tameside are among the highest in GMPT; usually around 80%, indicating positive engagement and therefore a greater likelihood of successful outcomes.

Service User Questionnaire: A recent mixed male and female consultation of service users in Tameside carried out by CLI our peer led Recovery group, highlighted an alarming concern around a wide variety of health issues including having no GP, no access to a dentist, concerns around inter-generational cardio vascular disease, poor diet and sleeping patterns and fuel and food poverty. The overwhelming view that their situation was five times worse than five years ago. This largely concurred with what we know are the disadvantages that offenders and indeed their families often experience within our society generally when compared to the general population.

The Social Exclusion Unit Report 'Reducing Re-offending by Ex-prisoners' identified Physical and Mental Health, and Drugs and Alcohol as two of the 7 Pathways to reducing re-offending. The recently published [Bradley Report](#) concerning people with mental health problems or learning disabilities in the CJS further highlights the need for criminal justice and health care systems to work in partnership.

Next steps:

Health Trainers – Tameside council are looking to work with us to develop a health volunteering service for offenders- Public Health and Offender Management Services

It is evident that we have significant issues with both serious organised crime and domestic abuse which are disproportionate to the size of the Borough and numbers of offenders that are supervised. This requires intensive intervention and improved integration of Services if further intergenerational harm is to be avoided – Public Service Reform Team

Offender Management Services to be represented on Health and Well Being Board to ensure that offender health is ensured within CCG and Public Health commissioning – Health and Wellbeing Board

PCC funding to be made available to ensure that IOM and Peer Mentoring activity continues to ensure a safe and secure Borough and provision of wrap around Recovery Services for offenders who chose rehabilitation – Public Health

Expansion of Women and Their Families Centre to hard to reach groups in Ridge Hill and Hattersley –Offender Management Services and New Charter commissioned services

Further development of Offender Mental Health and Diversionary Systems to reduce numbers of offenders with mental health issues being sentenced inappropriately to custody-Health and Wellbeing Board, Public Health and CCG

Given the very high levels of alcohol misuse in the offender population in Tameside high priority should be given to Alcohol Treatment Requirement provision – Public Health and Offender Management Services

Greater Manchester Probation Trust has been a strong partner within the Tameside Partnership arrangements and consideration needs to be given to development of new working arrangements with the newly formed NPS and Community Rehabilitation Companies post May 2014 to ensure offender health needs are met – Tameside Neighbourhood Board

Violent Crime, including domestic violence and sexual violence

Outcomes Framework: Public Health 1.11 and 1.12

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

Domestic Abuse is linked to:

- alcohol and increased risk due to alcohol use
- A&E attendances
- Maternity Services due to increased risk of domestic violence during pregnancy
- Increased risk due to substance misuse (e.g. steroid rage)

Violence is linked to:

- Night Time Economy and alcohol related crime
- Forced Marriage
- Honour Based Violence
- Female Genital Mutilation –a clear health risk for women and girls and also a crime

Programme spend:

£100,000 per annum for IDAAS (adult drugs & crime and disorder funding)

At risk or vulnerable groups:

Women, young males and females, same sex relationships

Benchmarking:

There are no local statistics around Domestic Abuse (DA) on iQuanta (Home office database for police performance) other than the number of incidents for the Force as a whole. Comparison to other areas is not possible.

Violent Crime: To fall in line with HMIC rationale there are two indicators 'Violence with Injury' and 'Violence without Injury'.

Violent Crime for Tameside, Pooled 3 years 2010-2013

Type of Crime	GM Rank	MSG Rank	Tameside Rate	GM Average	MSG Average	Source:
Violence Against the Person	8/10	13/15	40.51 / 1,000 residents	34.73 / 1,000 residents	33.93 / 1,000 residents	iQuanta
Violent Crime with Injury	8/10	13/15	21.52 / 1,000 residents	18.72 / 1,000 residents	18.77 / 1,000 residents	iQuanta
Violent Crime without Injury	9/10	15/15	18.98 / 1,000 residents	16.01 / 1,000 residents	15.16 / 1,000 residents	iQuanta

Sexual Crime for Tameside, Pooled 3 years 2010-2013

Type of Crime	GM Rank	MSG Rank	Tameside Rate	GM Average	MSG Average	Source:
Sexual Offences	4/10	9/15	2.88 / 1,000 residents	3.06 / 1,000 residents	2.88 / 1,000 residents	iQuanta
Rape	8/10	11/15	0.97 / 1,000 residents	0.87 / 1,000 residents	0.88 / 1,000 residents	iQuanta
Other Sexual Offences	3/10	8/15	1.90 / 1,000 residents	2.1 / 1,000 residents	2 / 1,000 residents	iQuanta

Domestic Violence (Repeat MARAC) for Tameside, Pooled 2 years 2011-2013

Type of Crime	GM Rank	Tameside Rate	GM Average	Source:
Domestic Violence Number of Repeat Incidents	5/10	0.76 / 1,000 residents	0.82 / 1,000 residents	GMP, Specialist Protective Services

*Ranking system with 1 being the best ranked position and 10 being the worst ranked position

Policy context:

- Government launch of '[Ending gangs/violence report](#)'- key themes are support, prevention, punishment, complex families
- Development of a local violent crime strategy- delivery plan with 4 themes; domestic abuse, sexual violence, night time economy and young people
- [Greater Manchester Policing Priority for 2012-2013](#) includes 'Help keep people safe: We will work with our partners to reduce and prevent crime, pursue the most persistent offenders and reduce the harm they cause.'

What are we doing now?

- Greater Manchester Police (GMP) currently piloting domestic violence protection orders
- Current interventions- IDVA (Independent Domestic Violence Advisors) service, Sanctuary housing
- New Statutory duty of domestic homicide reviews
- GMP centralised rape unit in 2012
- Development of a local top ten premises scheme
- New strategy- look at what are the gaps locally and what can be planned for the next 12 months that is cost free?
- New service that incorporates refuge, sanctuary, IDAAS, SUFS - 'Bridges'.
- Non criminal justice perpetrator programme introduced - 'New Paths'
- Workforce development programme relating to Domestic Abuse

What needs to happen next, and by whom?

- Investigate potential to commission Independent Sexual Violence Advocacy Service (ISVA) locally.
- Realignment of counselling services for both domestic violence and sexual violence victims.
- Support available for male domestic abuse victims.
- Holistic approach to identify and manage victims across all organisations with access to support services
- Improve data collection particularly in A&E
- Support and intervention for medium risk victims
- Embed workforce development

Utilisation of green space for exercise/health reasons

Outcome Framework: Public Health 1.16

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

For the purposes of this paper, green space is defined as the green open spaces in and around towns, including parks and the wider countryside. Access to good-quality and well maintained green spaces promote physical activity, positive mental well-being and healthy childhood development. Ninety one per cent of people report using parks and countryside to some extent. In England, 42 per cent of people use these spaces at least once a week.

The value of green space for exercise is unquestionable. Good quality spaces will encourage people to make short journeys on foot or by bike. Regular physical activity contributes to the prevention and management of over 20 conditions including coronary heart disease, diabetes, certain types of cancer and obesity. For example, strokes cost the NHS £2.8 billion a year and physical activity reduces the risk of having a stroke by a third.

Access to green space positively impacts on mental health. Responses to nature have a calming and restorative effect helping to improve mental well-being. Moderate activity in a green environment can be as successful at treating depression as medication.

Children with access to safe green space are more likely to be physically active and less likely to be overweight. Outdoor play encourages healthy brain development and promotion of healthy well being through adulthood.

At risk or vulnerable groups:

People from the most deprived areas are much more likely to visit urban destinations and places closer to home with 46% of visits (DE social grades) being within one mile of their starting point. This is a significantly larger proportion than recorded amongst the more affluent AB social grades (38 %).

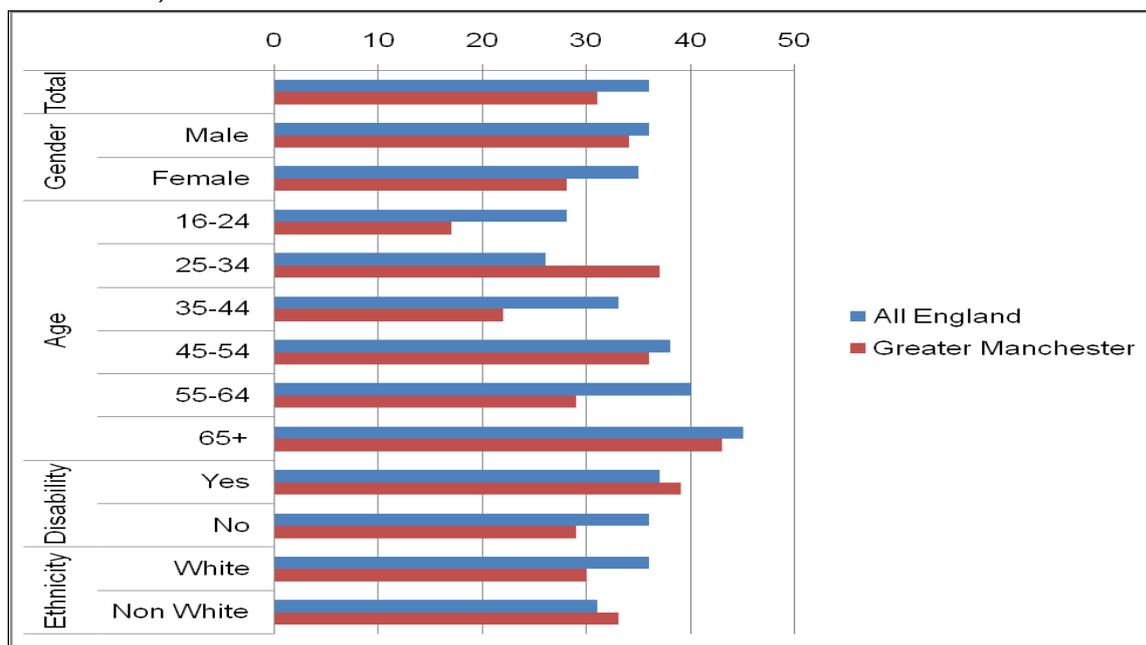
Respondents from Black and Minority Ethnic (BME) communities were twice as likely to visit green space within two miles of their starting point compared to respondents from white communities.

Benchmarking:

It is estimated that between March 2010 and February 2011, the 41.7 million adult residents in England took a total of 2.49 billion visits to the natural environment. Just over half of these visits (53 per cent or 1.31 billion) were to places in the countryside and just over a third (37 per cent or 0.92 billion) were taken to green spaces within a town or city.

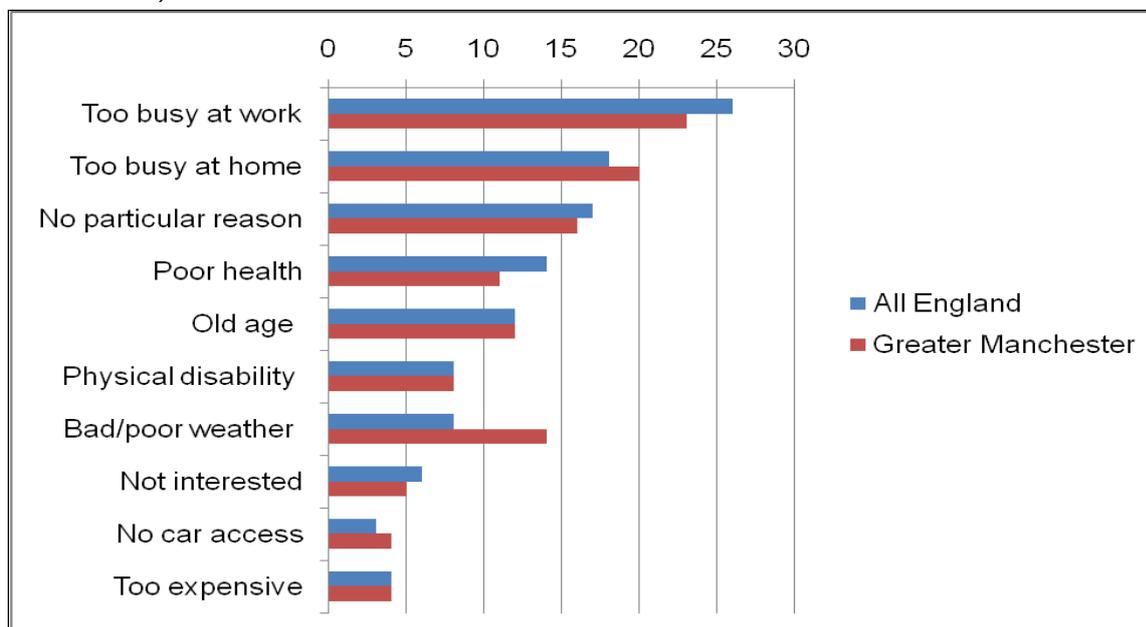
Across England, the use of green spaces for exercise or health reasons was given as the main reason for the visit by 36% of people surveyed, while in Greater Manchester the figure was 31%.

Percentage of people using green space for exercise/health reasons (England and Greater Manchester)



Source: Tameside MBC, 2012

Percentage of people's reasons for not using green space (England and Greater Manchester)



Source: Tameside MBC, 2012

Policy context:

- [Our Natural Health Service](#) published by Natural England
- [Community green: using local spaces to tackle inequality and improve health](#) published by Cobe space

- [Tameside Council PPG17 Open Space Study](#) final assessment report August 2010
- [Tameside Countryside Strategy 2009 – 2019](#)
- <http://www.green-space.org.uk/resources/aboutparks/health.php>

What interventions work?

- Accessibility to good, well managed green space close to where people live.
- British Trust for Conservation Volunteers (BTCV) Green Gym
- Activities led by volunteers/local community as part of locally led initiatives.
- Walking for Health initiative
- Initiatives and activities that involve whole intergenerational family groups.

What are we doing now?

- Provision of network of freely accessible parks, countryside and green spaces for informal grass root sports/fitness/well-being activities.
- Annual greenspace events and activities programme.
- Opportunities for active volunteering within greenspace.
- Supporting groups/volunteers wishing to use parks and countryside sites.
- Promotion of parks and countryside to targeted underrepresented groups.
- Provision of opportunities for exercise such as allotments, play areas, football pitches, bowling greens, outdoor adult gyms.

What do we need to do now?

- Development of an effective mechanism to link GP referrals to existing Greenspace health improvement opportunities such as Wild Work Outs, events and activities programme, volunteering opportunities and park activities.
- Identify and secure further investment in the Parks, Countryside and Green spaces close to where people live.
- Development of the 'Green pathways' project, linking Parks and Countryside sites through investment in footpaths, bridleways and cycle paths.
- Work more closely with planning to deliver health and well-being benefits from every development.
- Ensure that the value of green space is represented on health and well being boards.
- Further promotion of parks and countryside to targeted groups such as those with heart conditions, older people and Black and Minority Ethnic (BME) groups.

Air Pollution

Outcome Framework: Public Health 3.1

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

Air pollution is currently estimated to reduce the life expectancy of every person in the UK by an average of 7-8 months with estimated equivalent health costs of up to £20 billion each year. Very high concentrations of some pollutants are associated with the development of cancer, in particular leukaemia.

At risk or vulnerable groups:

Older and younger people may be more susceptible to poor air quality episodes. Individuals with pre-existing medical conditions such as heart disease, bronchitis, asthma and other types of lung disease are most at risk of suffering adverse health effects from poor air quality.

Policy context:

Under the requirements of Part IV of the [Environment Act 1995](#), all local authorities are required to periodically review and assess air quality in their areas against health based objectives prescribed by the Government.

Where it is found that the objective levels are unlikely to be met, local authorities must declare Air Quality Management Areas (AQMAs) and draw up an Air Quality Action Plans (AQAPs) for improving air quality in those areas.

Benchmarking:

In GM, a regional approach to dealing with air pollution has been adopted, recognising that the sources of pollution do not respect political boundaries. A GM Air Quality Strategy, 'Clearing the Air', was produced in 1997 setting out the framework for improving air quality in the region. It links air quality to planning, transport, sustainability and environmental health functions.

Tameside MBC and the other Association of Greater Manchester Authorities (AGMA) authorities contribute to a GM wide air quality monitoring and modelling programme. The authorities have also worked with Transport for Greater Manchester (TfGM) and update the Emissions Inventory for Greater Manchester (EMIGMA). This database records all emissions from stationary point sources (industry), mobile line sources (road and rail links) and area sources (domestic emissions), across 1272km² of GM.

This database allows the magnitude and spatial distribution of emissions across the City region to be investigated.

What interventions work?

Currently the health based objectives are being met for all pollutants of concern with the exception of nitrogen dioxide and particulates. There are still significant areas across GM, predominantly associated with the road network where these two pollutants may exceed the objectives.

What are we doing now?

Tameside MBC and the other authorities in the Greater Manchester (GM) city region identified these areas of poor air quality, designated them as AQMA and introduced a joint AQAP. Given that the predominant source of this pollution is from road traffic, the air quality action plan was absorbed into the Greater Manchester Local Transport Plan.

The links between improving air quality and reducing our carbon footprint continue to be strengthened and developed.

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

We need to continue to proceed with the implementation of the GM AQAP. It is imperative that a joint approach to improving air quality across GM is maintained and strengthened. A closer working relationship with public health experts needs to be developed to encourage an exchange of information and expertise.

The Percentage of the population affected by noise

Outcome Framework: Public Health 1.14

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

The significance of noise pollution has been recognised for some time. Noise can disrupt human activities and make the environment unpleasant for large numbers of people. The effect of noise on human health both physically and psychologically is undoubted. Noise damages hearing and is the greatest single cause of preventable sensor neural loss in the world. Noise, unlike other forms of pollution, has prompted members of the public to commit acts of violence against each other, against enforcement officers and has, unfortunately, also led to the suicide of those unwillingly exposed to it.

At risk or vulnerable groups:

No data is available to correlate environmental noise with socio-economic status as we do not have an overlay of socio-economic and noise maps. However, inspection of the noise map for Tameside would suggest that areas of higher noise levels coincide with areas of socio-economic need.

Benchmarking:

The Environmental Noise Directive (END) requires Member States to develop and adopt action plans 'designed to manage noise issues and effects, including noise reduction if necessary'. The action plans will be developed following a consultation process involving Local Authorities, other Government Departments and other interested bodies and members of the general public.

The END has set out requirements for action plans. These include:

- a description of the agglomeration, the major roads, the major railways or major airports and other noise sources being taken into account in the plan
- a summary of the results of the noise mapping
- an evaluation of the estimated number of people exposed to noise, and identification of problems that need to be improved
- any noise reduction measures already in force and any projects in preparation
- actions to be taken in the next five years
- a long term strategy

It is envisaged that action plans will identify relevant measures (both existing and new) to manage environmental noise from the sources mapped. Such measures could range from over-arching national strategies which take noise into account, to local targeted measures designed primarily to address a specific noise issue. The plans will also include some form of cost-benefit assessment of measures, to ensure their sustainability, and estimates of the

reduction of the number of people affected by excessive noise as a result of the proposed measures. The END makes specific reference to paying attention to 'quiet areas' in agglomerations that may be discernible from the noise maps, and requires us to identify and where possible protect quiet areas. The Department for Environment, Food and Rural Affairs (Defra) commissioned a research project to assist in the process of defining quiet areas in urban areas.

Policy context:

The World Health Organisation reports that in the European Union countries about 40 % of the population are exposed to road traffic noise with an equivalent sound pressure level exceeding 55 dB(A) daytime and 20 % are exposed to levels exceeding 65 dB(A). Taking all exposure to transportation noise together about half of the European Union citizens are estimated to live in zones which do not ensure acoustical comfort to residents. More than 30 % are exposed at night to equivalent sound pressure levels exceeding 55 dB (A) which is disturbing to sleep.

Additionally the [Environmental Noise \(England\) Regulations 2006](#), and are intended to inform the production of noise action plans for large urban areas, major transport sources, and significant industrial sites in England. The aims of the regulations are:

- the determination of exposure to environmental noise, through noise mapping;
- provision of information on environmental noise and its effects on the public;
- adoption of action plans, based upon noise mapping results, which should be designed to manage noise issues and effects, including noise reduction if necessary;
- Preservation by the member states of environmental noise quality where it is good.

Population exposure figures are calculated by firstly statistically assigning census output area data to buildings in the mapped area (rather than precisely determining the number of people living in each building). A count is then made of number of people falling in each noise band calculated. All population exposure figures are rounded to the nearest 100 people, in accordance with the requirements of the END.

What interventions work?

The Association of Greater Manchester Authorities (AGMA) local authorities have agreed joint policies with respect to dealing with neighbourhood noise including response times and standardised responses. Analysis of the response time data and the number of repeat complaints shows that neighbourhood noise complaints are being resolved more quickly with fewer repeat requests for service.

What we are doing now?

Tameside has adopted the AGMA standardised approach to dealing with neighbourhood noise.

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

Noise action plans need to be completed and be built into planning guidance regarding areas for development. Action plans will cover the Greater Manchester conurbation. Local Authorities are to continue to liaise with Defra in respect of local data and in particular quiet area.

Comprehensive, agreed inter-agency plans for responding to public health incidents

Outcomes framework: Public Health 3.7

Implications for population's health and well-being:

Emergency preparedness encompasses emergency planning and business resilience. It is essential to protect the safety of the population from serious adverse incidents e.g. severe weather disruption of services, pandemic flu or even a Chemical, Biological, Radiological, Nuclear (CBRN) event. Organisations need to understand their capacity and capability to respond to a range of incidents affecting their workforce, estates and communications functions; and therefore their ability to deliver services to the affected population and their normal daily business. The focus in planning is risk mitigation and articulating contingencies. Whilst each organisation needs to have a robust and comprehensive set of plans many can only be effective if done in conjunction with partners as a change in service in one sector is likely to affect others. Therefore emergency preparedness is a multi-agency activity that proactively plans, trains staff and tests resilience.

At risk groups:

This will depend on the nature of the incident but it is important to identify mechanisms for contacting a range of organisations that provide for vulnerable groups/populations either by characteristic or geography.

Benchmarking:

To be determined when indicator available

Policy context:

[The Civil Contingencies Act 2004](#) requires Category 1 responders (NHS acute trusts, local authorities, blue light services) to discharge specific functions in order to ensure resilience in any emergency response to an incident. Public Health England (PHE) and the NHS Commissioning Board will be Category 1 responders.

Category 1 responders are subject to the full set of civil protection duties. They will be required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency; and
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

The NHS England Emergency Preparedness Framework 2013 is a strategic national framework containing principles for health emergency planning for all NHS England at all levels including NHS provider organisations, providers of NHS funded care, clinical commissioning groups (CCGs), GPs and other primary and community care organisations. They need to meet the requirements of the CCA (2004), the Health and Social Care Act (2012), the NHS Standards contracts, the NHS England EPRR core standards, the NHS England command and control framework (2013) and NHS business continuity management framework (2013). This framework supersedes both the "The NHS Emergency Planning Guidance 2005" and the "Arrangements for Health Emergency Preparedness, Resilience and Response". The Greater Manchester Local Health Resilience Partnerships (LHRP) is the forum for coordination, joint working and planning for EPRR across all relevant health bodies. Each NHS organisation is required to nominate an accountable emergency officer (AEO) to assume executive responsibility and leadership across all relevant health bodies.

Category 2 organisations (e.g. Health and Safety Executive, transport and utility companies) are less likely to be involved in the heart of planning work but will be heavily involved in incidents that affect their sector. Category 2 responders have a responsibility for co-operating and sharing relevant information with other Category 1 and 2 responders.

In relation to infection control providers of regulated activities should be able to demonstrate the need for compliance with Criterion 9 of the Code of Practice for the prevention and control of infection and any related guidance. Local systems are required to report significant outbreaks of infection to the Health Protection Unit/Public Health England (PHE).

Each NHS Trust is responsible for planning its response to incidents which cannot be dealt with as part of the normal, day to day activity of the NHS. This is a statutory duty under both the requirements of the Department of Health and also the [Civil Contingencies Act 2004](#).

Under the Health and Social Care Act 2012, the local authority and the Director of Public Health acting on its behalf, have a pivotal role in protecting the health of its population. This includes planning for and responding to incidents and emergencies involving a risk to public health. A range of threats and hazards can represent a risk to public health. These include but are not limited to:

- Major incidents and emergencies (including Chemical Biological Radiological and Nuclear - CBRN)
- Pandemic influenza
- Outbreaks of infectious and communicable diseases, including all notifiable diseases
- Environmental hazards and contamination
- Severe weather, including flooding, heatwave and cold weather
- Zoonotic disease

Following the introduction of the Health and Social Care Act 2012, local authorities have new responsibilities in relation to health protection. The Civil Contingencies and Resilience Unit (CCRU) have been commissioned by GMDsPH to provide public health specialist emergency planning advice and where appropriate response for public health emergencies.

What interventions work?

Having robust tested emergency plans covering a comprehensive range of potential incidents developed with Category 1 responders. Organisations should be resilient by ensuring they have up to date business continuity plan and a trained workforce capable of responding to emergencies.

What are we doing now?

- Comprehensive emergency plans in place covering a range of potential incidents
- NHS Commons Standards self-assessment completed
- Training and exercise programme in place for key responders.
- Tameside and Glossop Health Resilience Group (HERG) have been established under the chairmanship of the Clinical Commissioning Group. The role of this group is to provide EPRR assurance for the NHS local commissioners and providers. The HERG is accountable to the Local Health Resilience Partnership, which is a Greater Manchester EPRR group for health partners including PHE and the NHSE.

What happens next, and by whom?

- The CCRU will continue to work Council Public Health departments to develop training programme for the public health workforce; develop or refresh relevant emergency plans ensuring there is public health aspect included; develop the wider partnership connection with Category 1 responders and Category 2 where relevant through a Tameside. Resilience Partnership Forum.
- The HERG will continue to review and implement its action plan to provide assurance to the LHRP on EPRR.
- PHE to continue to work with GMDsPH on EPRR preventative strategies and response plans.

Public sector organisations with broad-approved sustainable development management plan (SDMP)

Outcomes framework: Public Health 3.6

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

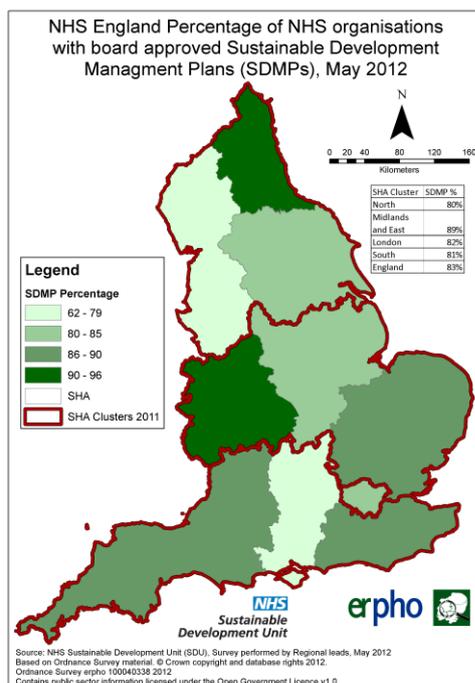
The change in climate will alter the physical geography of the world, leading to major changes in the human geography— where people live and how they live their lives. Even at more moderate levels of warming, studies show that climate change will have serious impacts on world output, on human life and on the environment.

The changes threaten the basic elements of life for people around the world – access to water, food, health, and use of land and the environment. Hundreds of millions of people could suffer hunger, water shortages and coastal flooding as the world warms, and millions of people will potentially be at risk of climate-driven heat stress, flooding, malnutrition, water related disease and vector borne diseases.

Sustainable development plans provide the framework for balancing economic, social and environmental considerations, including climate change, and looks to communities' resilience and adaptation in the years ahead. The first step to monitoring sustainability is a process measure for board approved Sustainable Development Management Plans (SDMP).

Benchmarking:

NHS organisations with Board approved SDMP, 2012.



Source: *East of England Public Health Observatory (ERPHO), 2012*

Policy context:

- [Climate Change Act 2008](#) – which identifies an 80% reduction in carbon emissions by 2050 to reduce the UK impact on climate change?
- [National Sustainability Strategy “ Taking the long term view”](#)
- [National NHS Strategy “ Saving Carbon, Improving Health”](#)
- [The Stern Review](#)

What interventions work?

The local [Tameside strategy](#) highlights the need to:

- Make more efficient use of energy and natural resources, and tackle fuel poverty
- Reduce carbon emissions and develop a strategy for adapting climate change
- Reduce the impact of transport on our highways, reduce reliance on the car and encourage people to make more use of sustainable ways to travel, e.g. cycling and walking
- Raise awareness of our impact on the environment amongst local people and businesses, and encourage a more sustainable approach to everyday life
- Support Tameside’s businesses, organisations, community groups and residents in the transition to a low carbon economy
- Adopt a sustainable approach to procurement and economic growth

What we did in 2011/12?

Locally, a multi agency Tameside Sustainable Use of Resources Group developed [Low Carbon Tameside](#) – Sustainable use of Resources Strategy 2010-2020.

More recently, the Association of Greater Manchester Authorities (AGMA), published a [Climate Change Strategy](#) in 2011. This provides a framework for local authorities and their partners to focus on reducing carbon emissions within local communities and partner organisations.

NHS Tameside and Glossop Board approved the 2010- 2015 Sustainable Development Plan in January 2010 and the underpinning five year plan in May 2010.

The 10% carbon reduction in 2010 was achieved and in 2011/12 and 11% reduction from baseline is anticipated. Specific developments that have contributed to this achievement are:

- Increased insulation,
- Installing hot water at the point of delivery systems,
- Lighting improvements,
- Reduction in vehicle fleet
- Promotion of recycling and waste management

In addition:

- Schemes to increase biodiversity have been implemented at two sites
- Heat wave resilience measures have been implemented at Shire Hill Hospital

- The new GP surgery build is expected to achieve BREEAM excellence
- Standard NHS Contract includes a clause on expectation regarding progress on climate change adaptation, mitigation and sustainable development, including carbon reduction.
- Estate rationalisation has aligned with workforce changes.

What were our plans in 2012/13?

Due to the reorganisation of public sector organisations, there needs to be a refresh and refocus of the Tameside Sustainable Use of Resources Group. They can then review and update the Low Carbon Tameside Strategy and work plan in line with new emerging successor organisations and the recently published Greater Manchester Strategy. Examples of work streams within the work plan are:

- Carbon literacy: improving local peoples' understanding of carbon emissions, their impact, and how actions can help to reduce emissions
- Reduction in water consumption; increase water conservation
- Development of green travel plans

Killed or Seriously Injured Casualties on England's Roads

Outcomes Framework: Public Health 1.10

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

In 2012, 6,058 people were injured in accidents on Greater Manchester's roads, 698 of whom were either killed or seriously injured (KSI), 47 of whom were in Tameside.

Road accidents impose a wide range of human and financial costs on people and organisations, estimated to be £321 million in Greater Manchester in 2012. Therefore, reducing the number and severity of accidents has significant human and financial benefits and Greater Manchester's approach to reducing road casualties is set out within the third Greater Manchester Local Transport Plan (GMLTP3).

At risk or vulnerable groups:

Research has shown that vulnerable groups (in terms of their accident risk) include:

- children and older people (particularly as pedestrians);
- pedestrians;
- cyclists;
- motorcyclists; and
- Young males are also relatively vulnerable as drivers.

There is also a strong link between deprivation and road accidents, children from social class V (unskilled) are five times more likely to be involved in a fatal road accident than those from social class I (professional).

Benchmarking:

As part of GMLTP3, 16 Key Performance Indicators (KPIs) have been developed, grouped into 4 categories based upon the GMLTP3 objectives, including:

- KPI 10 – Total KSI on Roads: Number of people killed or seriously injured on local (non – motorway) roads.

The target is for a 40% reduction in the number of KSIs in Greater Manchester by 2012, as outlined within the Department for Transport (DfT) Strategic Framework for Road Safety.

The following table illustrates the KSI casualty trends and forecast casualty reductions for both Greater Manchester and Tameside for the period up to 2020

KSI Casualty Trend 2000 – September 2013 and Projection to 2020								
Year	KSI Casualty Totals				Index			
	Actual		Projection		Actual		Projection	
	GM	TMBC	GM	TMBC	GM	TMBC	GM	TMBC
2005 – 2009 Baseline	916	64			100	100		
2010	743	58	810	56	81	91	88	88
2011	746	57	777	54	81	89	85	85
2012	698	47	746	52	76	74	81	81
2013	643	52	724	50	70	82	79	79
2014			687	48			75	75
2015			660	46			72	72
2016			634	44			69	69
2017			608	42			66	66
2018			584	41			64	64
2019			560	39			61	61
2020			551	38			60	60

Source: Highways Forecasting and Analytical Services (HFAS), 2013

- KPI 11 – Casualty Rates – Head of Population: Number of people killed or seriously injured on Greater Manchester roads/Greater Manchester resident population.

The target is a 45% reduction in the KSI Casualty Rate expressed as the number of KSIs per 1 million population within Greater Manchester, based on the KSI forecast (KPI 10 above), plus the anticipated changes in resident population.

KSI Casualty Rate Trend 2000 – September 2013 and Projection to 2020								
Year	KSI Casualty Totals				Index			
	Actual		Projection		Actual		Projection	
	GM	TMBC	GM	TMBC	GM	TMBC	GM	TMBC
2005 – 2009 Baseline	357	296			100	100		
2010	283	267	308	256	79	90	86	86
2011	283	263	294	244	79	89	82	82
2012	260	214	280	233	73	72	78	78
2013	239	237	270	225	67	80	76	76
2014			254	211			71	71
2015			242	201			68	68
2016			231	192			65	65
2017			220	183			62	62
2018			210	174			59	59
2019			200	166			56	56
2020			196	163			55	55

Source: Highways Forecasting and Analytical Services (HFAS), 2013

Policy context:

- [National Policy](#) - The Department for Transport's "[Strategic Framework for Road Safety](#)" (May 2011) sets out the overall strategic framework and policies to reduce death and injury on the nation's roads.
- [Greater Manchester Strategy \(2013 - 2020\)](#) - The Greater Manchester Strategy (GMCA 2013) sets out the key priorities to enable the conurbation to achieve its economic potential.
- [Third Greater Manchester Local Transport Plan 2011/12 to 2015/16](#) - The GMLTP3 (April 2011) sets out the transportation plans and spending priorities of Transport for Greater Manchester (TfGM), the ten Greater Manchester Councils and other key partners in the short, medium and long terms.
- [Tameside Community Strategy 2012 – 2022](#) - Tameside's Sustainable Community Strategy 2012-2022, was developed in response to changing local priorities and emerging issues across Greater Manchester.
- [Road Traffic Collisions and Causalities in the North West of England:](#) North West Public Health Observatory, 2011.

What interventions work?

The types of interventions that have been successful to date include:-

- Local safety schemes, including 20 mph zones.
- Road safety training in schools, i.e. cycle training
- Safety camera operation and policing activities
- Education and training
- Publicity information and safety campaigns
- Other highway works such as carriageway maintenance and street lighting works

What are we doing now?

A local safety scheme programme for 2013/14 has been identified for highway locations/junctions with poor accident records. In addition, traffic management, maintenance and, street lighting programmes have been identified which will also contribute to accident reduction.

At the wider Greater Manchester level the Greater Manchester Casualty Reduction Partnership has continued to target casualty reduction activities at high risk behaviours and locations and in support of the most vulnerable people.

Service User or Public Engagement or Consultation

THE GMLTP3 and the Tameside Community Strategy 2012 – 2012 have been the subject of consultation that has shaped their content. Individual local safety schemes are the subject of consultation and consequent amendment as part of the implementation process.

What needs to happen next, and by whom?

The low level of casualties in Greater Manchester makes it harder to achieve further reductions. However, there are still many highway locations where the potential for accidents is still high, and the Council will continue to implement local safety, traffic management schemes, maintenance and, street lighting programmes to help reduce the number of accidents.

In order to continue the recent positive accident trend, the TfGM Joint Road Safety Group proposes to target casualty reduction activities for example introduction of 20mph zones, at high risk behaviours and locations and in support of the most vulnerable people, through the Greater Manchester Casualty Reduction Partnership.



Ageing and Dying Well

Older People's perception of community safety

Outcomes Framework: Public Health 1.19

This indicator is currently not defined in the framework and there is no existing indicator which specifically considers Older People's perception.

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

Feeling and being unsafe or 'at risk' has a significant negative impact on older people's health and can leave them isolated and unable to participate socially and economically in their community.

Home Office Research Study 269 (June 2003) considered the impact of distraction burglary amongst older adults and minority ethnic communities:

- An increased level of trauma above the cut off for PTSD
- Poor mobility is a significant vulnerability factor in older people being targeted
- In some cases a worsening of health status over three months post incident of crime
- Significant impact on quality of life
- Increased concern about crime in general

At risk or vulnerable groups:

Focus on...Fear of Crime, (CARDI, 2010) highlighted that:

- Fear of crime has been shown to be significantly higher amongst older people
- The fear of crime can reduce the level of participation of older people in physical activity and social interaction. This can lead to further isolation and social exclusion.

Benchmarking:

Limited benchmarking data is available, but age categories in the Tameside ROS and Citizen's Panel questionnaires have been considered to develop a proxy indicator for this:

- ROS 2010-11: Question related to level of satisfaction with community safety measures (e.g. CCTV, Patrollers). Baseline – 30% (age 60+) fairly or very satisfied compared to 32% all ages. Next ROS due to be undertaken in 2014.
- Citizens' Panel: Question – how safe do you feel when you are out in your local area during the day? Baseline – 97.4% (60+) very or fairly safe compared to 97.5% all ages. In 2013 this had risen to 98.7% (for 60+) compared with 97.3% overall. A large amount of perception data is held by TMBC.

Policy context:

Older people are a national priority across a range of agendas, however within crime and disorder there is nothing specifically relating to older people. Vulnerability seems to be the overarching category.

What interventions work?

Home Office Research Study 269 suggests that work to raise awareness within communities and amongst older people can impact on reducing the risk of becoming a victim of crime. The Home Office Research Study also suggests that when a crime does occur, appropriate referral and support to health provision should be a protective factor in reducing the risk of the crime being repeated:

“The findings from the study with older adults highlighted the importance of assessing and treating victims of distraction burglary as individuals, rather than developing a standard response to distraction burglary victims. For victims, the assessment and prolonged intervention for physical and mental health problems should concentrate on the relatively small proportion of victims and repellers experiencing serious trauma as a result of the distraction burglary incident.”

What are we doing now?

There is extensive awareness amongst front line staff groups of the importance of reducing the risk of crimes occurring. There is a need to ensure that this is part of ongoing training and induction with appropriate front-line services. We undertake awareness raising work within communities that are at risk and try to build up social awareness and support where possible.

What needs to happen next, and by whom?

- There needs to be a whole system approach to prevention of vulnerability that should be part of an integrated programme rather than only considering crime and fear of crime.
- Programme focussing on prevention needs to be developed which includes health professionals and frontline services.
- Health professionals and frontline services need to be more aware of the impact of crime and fear of crime on Physical and Mental health.
- Joint referral
- Homes for life

On-going Consultation

Tameside Citizens' Panel was set up in 1998 as a corporate resource to investigate resident perception of service delivery and Council priorities. The Panel is made up of around 2,000 residents, with membership being routinely refreshed. There are three questionnaires sent

out each year that are developed in partnership with service areas and external organisations.

Questions relating to community safety and crime are entered in the Panel annually, with results being tracked to highlight changes in perception.

In addition to this the Council use a wider consultation tool known as the Resident Opinion Survey (ROS). The ROS is undertaken every three years and delivers a more widespread questionnaire, with information being sought at a face-to-face level with residents.

Health related quality of life for older people -

Outcomes Framework: Public Health 4.13

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

The population is growing older. In England, the number of people aged over 65 is due to rise by a third by 2025. In the same period the number of people over 80 will double and the number over 100 will increase fourfold. This welcome increase in life expectancy is however associated with an increase in years spent with some disabling illness.

Economic well-being has a direct correlation with the quality of life that older people can experience. Achieving economic wellbeing is not just about ensuring that older people who are retired receive the benefits they are entitled to, but ensuring that as they approach retirement, at whatever age they choose, they are able to be as economically active as possible.

Our ageing society offers great challenges to health and social care providers. Investing in prevention services at a local level can help to meet these challenges. Prevention services for older people are services that offer advice, support or interventions to help:

- Older people who are healthy to continue to live independently for longer
- Older people who are unwell to regain their independence or to prevent or delay the onset of further health problems

At risk or vulnerable groups:

- Frail older people
- Economically inactive
- Older people with long term limiting illnesses
- Older people living in poverty
- Older people living in isolation or on their own

Benchmarking

Over the next 20 years the age profile of Tameside and Glossop will change quite significantly. Currently there are 34,525 people aged 65 and older in Tameside, making up 15.7% of the population. The proportion over the age of 35 is expected to increase to 21.9% by 2035. Similarly, the projections show a doubling in the number of people over the age of 85: from 4,213 to 10,800 by 2035 ([Older People Health and Wellbeing Atlas](#)).

Tameside has a significantly higher proportion of older adults affected by income deprivation compared with England as a whole. In Tameside almost a quarter of adults over the age of 60 (23.4%) live in households receiving pension credit (guarantee), compared with 18.1% of over 60s year olds in England ([Older People Health and Wellbeing Atlas](#)). High levels of income deprivation are likely to have a negative impact on health and wellbeing.

The Public Health Outcomes Framework indicator on health-related quality of life for older people is derived from responses to the GP Patient Survey, which asks respondents to describe their health status in relation to: mobility, self care, usual activities, pain/discomfort, anxiety and depression. Data for this indicator has not yet been published.

Policy context:

- [Department of Health - Building the National Care Service, March 2010](#)
- [Department of Health – Integrated Care: Our Shared Commitment, May 2013](#)
- [Audit Commission - Improving value for money in adult social care, June 2011](#)

What interventions work?

Investing in prevention services at a local level can offer a more efficient use of resource and help deliver better outcomes for older people enabling them to live healthy, happy and independent lives.

The [Prevention package for Older People](#) promotes local provision of prevention services and best practice in the following areas:

- Falls Prevention – an effective falls prevention service can help to save lives and save money.
- Foot care – Providing foot care services can help prevent or delay the need for older people to access more costly acute care services
- Intermediate Care, Telecare and Audiology – Getting people home quickly, and supporting them to stay there longer, can deliver multiple benefits

There is good evidence that exercise programmes for older people can improve strength, aerobic capacity, balance and function.

What we did in 2010/11

The development and implementation of an action plan across Tameside covering the following themes and priorities:

- Creating a positive culture for older people where older people are seen as valued members of society, with intergenerational understanding, with all partners working together to engage with and meet the needs of older people
- Information, communication, choice and control. This includes improving information for older people about what services are available for them; improving information for service providers about the needs of older people, especially those who are most vulnerable; and improving the engagement of older people in the shaping of and delivery of the services they need.
- Feeling safer in the community including increasing the visibility of the uniformed services, reducing the fear of crime amongst older people and increasing security for older people

- Lifelong Housing. In order for older people to remain active in their own homes, an appropriate supply of housing stock is needed which reflects the needs of the population of older people.
- Healthy Lifestyles including creating more opportunities for older people to engage in activities which support healthy lifestyles (healthy nutrition, exercise and social activities). Improving access to preventative health checks, health promoting information, and opportunities to engage in volunteering activities.
- Access to adequate income. Priorities include supporting older people to continue to be economically active for as long as they wish, improving the income of those who are not economically active and the financial literacy of older people.
- Getting around. Access to goods, services , and social activities is needed for older people to maintain and enjoy a good quality of life including easy access to town centres and amenities

Additionally the District Nursing Team across Tameside and Glossop has been reorganised to become a 24hour 7 days a week service since January 2011. The Well-being and Prevention Service in Tameside provides person-centred and integrated support for older people through investment in preventative approaches which promote health, well-being and independence for older people.

Service user/public engagement/consultation

What we did in 2011/12

All public, private and voluntary and community sector organisations must ensure that they are considering the needs and aspirations of older people in the way that they plan and deliver services

- All services should promote the well being of older people by ensuring that universal services are readily engaging them in active community, along with specialised services being available when needed
- Older people to play an active role in the life of their communities as valuable contributors to the economic and social life of the borough
- A focus on older people with long term conditions for example diabetes and cancer to enable them to manage their conditions and maintain the best possible quality of life
- A public information leaflet on existing entitlements including flu vaccination, cancer screening and sight tests

This needs to be carried out by Derbyshire and Tameside Health and Well-Being Boards and the Tameside Strategic Partnership and its thematic sub groups, particularly The Supportive Communities Partnership, which includes:

- Key agencies from all sectors responsible for the planning, commissioning and delivery of services to older people
- Representation from the Tameside Older People's Advisory Group
- Local people who have been elected onto regional or national Better Government for Older People's Group

What are we doing now?

Using the Health and Wellbeing Strategy 2013 – 2016 as our main driver, we have prioritised the following:

- Putting services and interventions in place that prevent unnecessary hospital admissions
- Developing responsive integrated services
- Have a particular focus on frailty, falls prevention and dementia

We aim to achieve these priorities by:

- Increasing access to universal prevention and health and wellbeing services.
- Increase care and support that is either 'at home' or closer to home.
- Increase our community-based services, which will provide diagnostic and preventative interventions.

Falls and injuries in the over 65s

Outcomes Frameworks:

- Public Health 2.24: Falls and injuries in the over 65s
- Public Health 4.14: Hip fractures in over 65s
- NHS 3.5: Improving recovery from fragility fractures

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

Hip fractures account for 25% of fractures from all falls in the community. 10% of people who sustain an osteoporotic hip fractures die within one month and 33% die within 12 months. Fewer than half of older people return home after hip fracture and half of all fallers who fracture their hips are never functional walkers again. Frequent falls are a contributing factor in 40% of admissions to nursing homes.

Falls in the over 65s is a significant cause of admissions, morbidity and mortality, accounting for over 4 million bed days per year in England and costing the NHS over £2 billion. In Tameside and Glossop the cost of inpatient spells alone for fractures, falls and osteoporosis for people over 55 was over £5 million in 2010/11. Falls are the leading cause of accident-related mortality in older people; 35% of people over 65 fall and 45% of people over 80 living in the community fall each year. 10% result in a serious injury requiring admission and 5% result in a fracture.

- Each year, 35% (estimate) of people aged 65 and over falls at least once. In Tameside & Glossop this equates to 13,440 falls per year currently, due to the expanding population we can expect this to increase to 21,000 falls per year in over 65s by 2030
- 10% of all ambulance service calls are to people over 65 who have fallen, about 60% are taken to hospital. In 2010/11 there were 3,900 ambulance call outs for falls in T&G. Based on population projections there could be almost 6000 by 2033
- One in ten falls in over 65s results in injury requiring hospital admission; from 2007 to 2011 there were an average of 1,400 admissions to Tameside Foundation Trust each year for falls.
- One in twenty falls in over 65s results in a fracture; from 2007-2011 Tameside Foundation Trust treated an average of 600 fractures each year in over 55s

At risk or vulnerable groups:

Older people are most at risk from falls, in particular those aged over 85, females, and those from the least advantaged social groups. The ageing population in Tameside and Glossop means that the rate of falls and hip fractures will increase unless preventative measures are put into place.

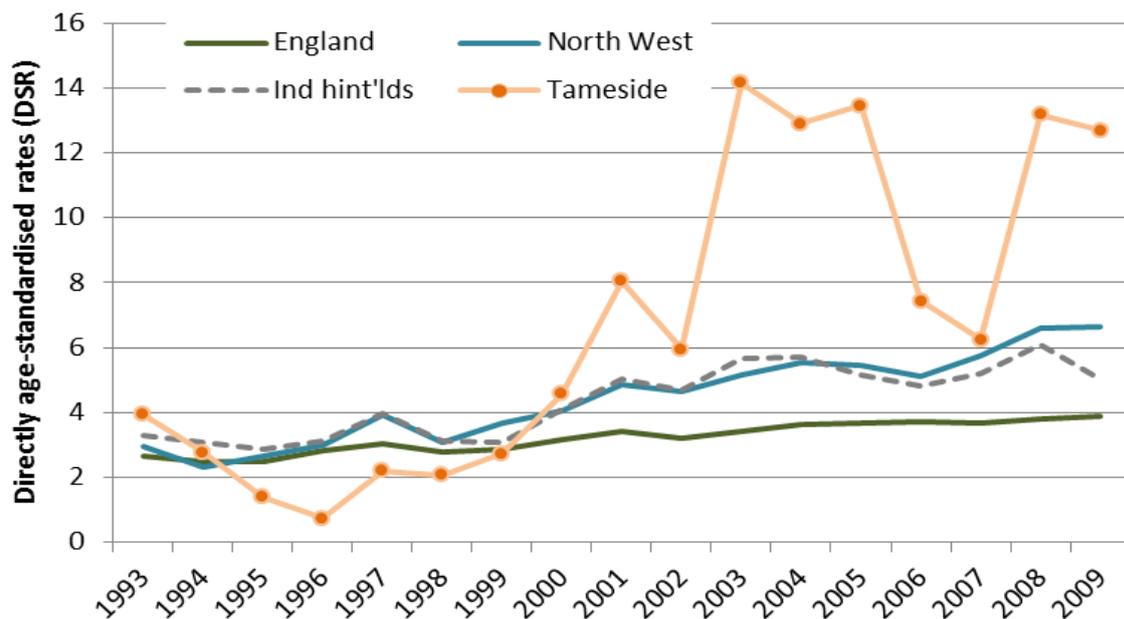
Policy context:

- [RCP 2010 National Audit of Falls and Bone Health for Older People \(RCP\)](#)
- [Department of Health 2009 Prevention Package: Falls and fractures](#)
- [NICE Guidance CG21 Falls: The assessment and prevention of falls in older people](#)
- [NICE Guidance CG124 Hip fracture: The management of hip fracture in adults](#)
- [NICE TA160 Primary prevention of osteoporotic fragility fractures in postmenopausal women](#)
- [NICE TA161 Secondary prevention of osteoporotic fragility fractures in postmenopausal women](#)

Benchmarking:

Although numbers are small in Tameside currently with an average of around 40 deaths per year, the rate of deaths from accidental falls has increased dramatically since 2001 and is now around double that for the North West and Industrial Hinterlands.

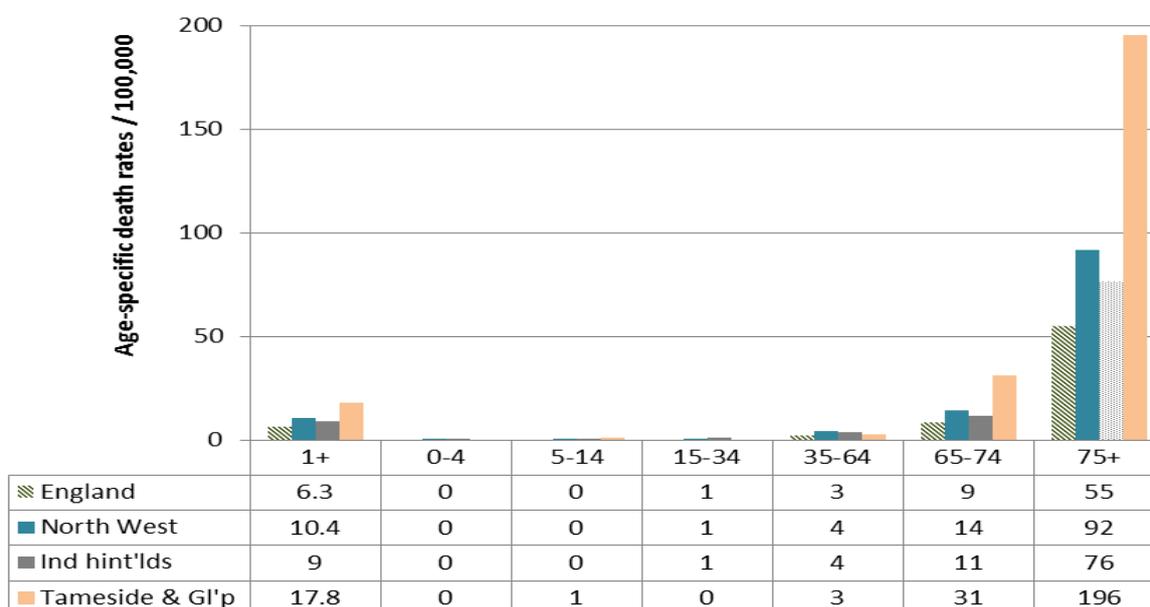
By 2033 there will be around 59 deaths per year due to falls (based on population projections).



Source: *Pubic Health, Tameside MBC 2014*

Mortality from falls

It can be seen from the chart below that the vast majority of these deaths are in people aged over 65.



Source: Tameside MBC 2014

Age-specific death rate after a fall

What interventions works?

Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.

- Rapid admission (within 4 hours) and early surgery (within 48 hours) of hip fracture patients.
- A care bundle approach to the initial management of hip fracture patients (to include, as a minimum, pain relief, pressure sore prevention and intravenous fluids).
- Mobilisation on the day after surgery, and daily thereafter, improves recovery from hip fracture.
- Fracture liaison services following the best-evidenced models either for acute-based services (e.g. Glasgow) or primary care-based services (West Sussex).
- Routine screening for falls of older people presenting to Emergency Departments or minor injury units (MIUs).
- Therapeutic exercise programmes and falls prevention programmes, particularly for those older people who have fallen and fractured or who are at risk of fracture.
- Individualised multi-factorial interventions, for older people with recurrent falls or at risk of falling, including strength and balance training, home hazard assessment, vision assessment and medication review.

- Multidisciplinary assessment following a fall to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function.
- Treatment with bisphosphonates for primary and secondary prevention of fragility fractures in postmenopausal women who have osteoporosis.

What are we doing now?

- The CCG lead continues to test and examine the commissioned clinical offer and falls pathway
- Age UK provide a local falls prevention programme, home assessments and an exercise programme and investment is increasing in 2014
- Tameside council commissions a Handy Person service via Age UK to provide balance & stability aids.
- Tameside Foundation Trust participates in the National Hip Fracture Database and the Best Practice Tariff.
- Participated in a GM falls peer review process, CCG and Public health partnership.

What needs to happen next, and by whom?

- Tameside Foundation Trust to comply with the Department of Health falls and fractures standards and NICE guidance
- Primary care and community services to screen older people for falls and refer those at risk for intervention
- Primary care to identify, and treat according to NICE guidance, people with osteoporosis
- Commissioners to ensure there is a comprehensive falls pathway available to all those at risk in Tameside and Glossop
- Local authority to ensure that community activities are available to all older people to reduce their risk of future falls and to promote active ageing
- A new specification for Age UK is currently in draft for 2014
- Greater Manchester Fire and Rescue may offer a new falls intervention in 2014

Re-ablement/rehabilitation of older people following discharge from

Outcomes framework:

- NHS 3.6: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
 - i. The proportion still at home 91 days after discharge into rehabilitation
 - ii. The proportion offered rehabilitation following discharge from acute or community hospital
- Adult Social Care 2B: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

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

When people develop care needs, it is important that they receive the support they need in the most appropriate setting, and they are supported to regain their independence. This measures the benefits to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – this is the key outcome for many people using reablement services. The outcome measures the success of reablement and rehabilitation services in supporting older people to return home and live independently after discharge from hospital.

At risk or vulnerable groups:

Adults aged 65 + who have been discharged from hospital to their own home, short term residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move back to their own home.

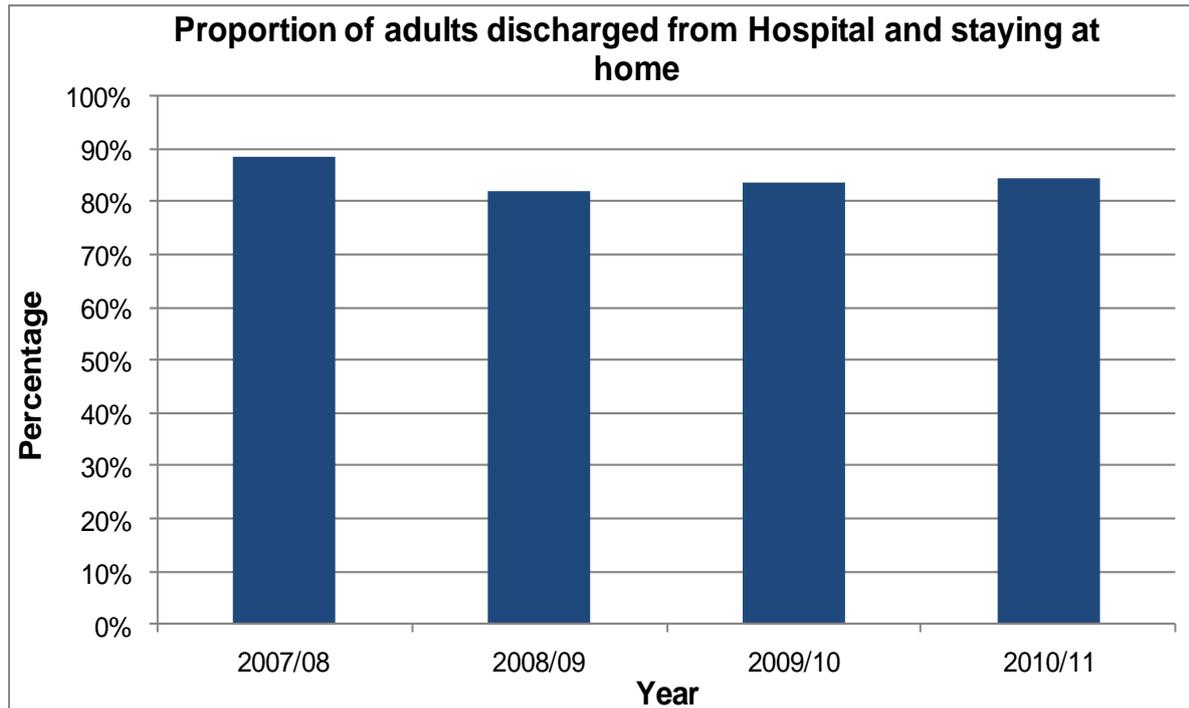
Policy context:

[Intermediate Care – Halfway Home Guidance 2009](#)

Benchmarking:

Local performance is 84.3%, which is higher than both the NW average (78.3%) and the England average (82%). Local performance for patients discharged home from Shire Hill Hospital (which includes a Stroke Rehabilitation unit) is 86.8%.

Proportion of adults discharged from hospital and staying at home



Source: *Tameside MBC 2012*

What interventions work?

- Re-ablement
- Community Assessment and Rapid Access Team (CARA)
- Aids, Equipment and Adaptations
- Assistive Technology (Telecare / Telehealth)
- Carers Services
- Care Management
- Personal Budgets
- Well-being and Prevention
- Well-being, Early Intervention and Prevention Services

What are we doing now?

- Locally, our community inpatient facilities have agreed KPI's to ensure that 70% of patients remain at home after 91 days after discharge. (Threshold of 65%). As indicated above, this target is being delivered.
- Expansion of the Re-ablement service, with increased promotion of Assistive Technology.
- Redesign of Intermediate Care services resulting from the Intermediate Care Strategy action plan.
- Increased delivery of Personal Budgets offering greater choice and control.
- Implementation of the Halfway Homes guidance
- Redesign of the Well being and Prevention Service

- Redesign of the Assessment and Care Management Service

What needs to happen next, and by whom?

- Continue to monitor the performance of the community inpatient units and work with the new provider in 12/13 to stretch and improve this performance.
- Expansion of Reablement by the Adults Management Team
- Community and voluntary sector response
- Continue to develop and expand the programmes above in response to the increasing demographics.
- Driven and governed by the Health and Well-being Board to develop programmes of joint commissioning and integrated service delivery for Health and Social Care Services.

Enhancing quality of life for people with dementia

Outcomes Framework: Public Health 4.16; NHS 2.6.

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

Dementia may result in:

- Premature death, life expectancy is usually between 5 – 10 years post diagnosis
- Loss of independent living (resulting in the need for costly care package)
- Loss of physical ability to keep mobile increases social isolation and increases ill health
- A greater risk of mental health ill health; particularly depression
- Burden on carers that can manifest in decline in the carer's mental and/or physical well-being.

Programme spend:

Care home placement of people with dementia costs the UK £7billion per year with two thirds paid by social services and one third by older people and their families themselves. The National Audit Office has estimated the excess cost to be more than £6 million per year in an average general hospital.

At risk or vulnerable groups:

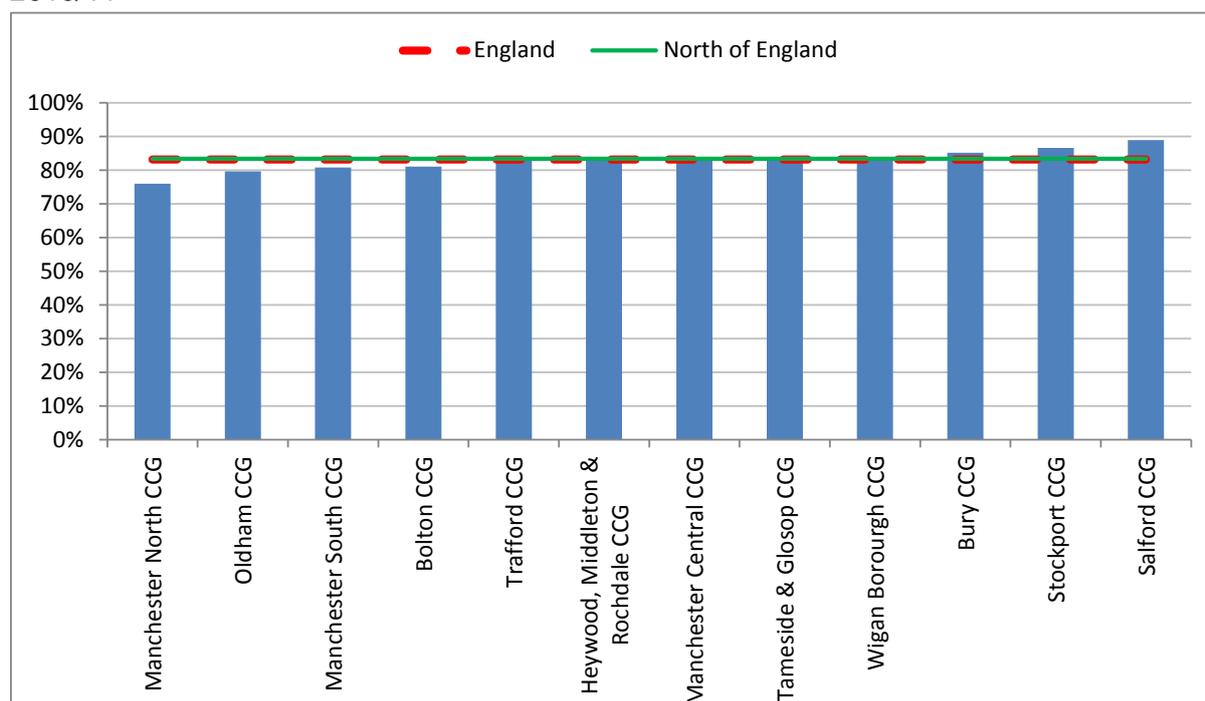
- Older people (65 and over) - The proportion of people with dementia doubles for every 5 year age group, with one third of people over 95 having dementia
- People with learning disabilities
- People with a history of significant alcohol misuse

Benchmarking:

The Office of National Statistics (ONS) estimated that in 2006 the population of Tameside was 214,400 and projected a rise to 230,000 by 2019. It is estimated that in 2014 there are 2,500 people over the age of 65 with dementia in Tameside; this is 6.5% of the 65 and over population. By the year 2025 this total is expected to rise by 40.6% to reach 3,351 people. Males over 65 with dementia are projected to rise by 60.3% to reach 1,223 and females by 31.3% to reach 2,128 in 2025.

The figure below shows the percentage of dementia patients that received a review of their care within the preceding 15 months to March 2013. Within NHS Tameside and Glossop, 83.6% of dementia patients received a care review within this 15 month period, which is marginally higher than that of the North-West and England averages.

Percentage of dementia patients whose care has been reviewed in the previous 15 months, 2010/11



Source: NHS Information Centre 2014

Policy context:

The [National Dementia Strategy](#) was published in 2009 and has been adapted locally to reflect to the needs and priorities for the population of Tameside and Glossop.

The Operating Framework for the NHS in England 2012/13: For the first time to support local accountability in 2011/12, NHS organisations were asked to work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy. That requirement was also applied in 2012/13 with the additional expectation that any local or national CQUIN goals should be included.

In February 2012 David Cameron launched the [PM's Challenge on Dementia](#), a high profile pledge to improve, awareness of dementia, quality of care for patients with dementia and research into the condition over the next three years.

Integrated Care: aims to improve patient experience and achieve greater efficiency and value between health and social care delivery systems.

Everyone Counts planning for patients is a framework that describes the NHS ambition to focus on better outcomes for patients it outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.

What interventions work?

- Raising awareness and understanding of dementia
- Early diagnosis and a range of support mechanisms for patients and their carers to live well with dementia
- Good quality care for people with dementia with acute illness in a dementia friendly environment

What did we do in 2011/12?

NHS Tameside and Glossop are committed to working in partnership with both Tameside Metropolitan Borough Council (TMBC) and Derbyshire County Council (DCC) to raise standards of care for people with dementia, and their carers. A local strategy, reflecting the domains of the National Dementia Strategy, has been developed and a challenging Action Plan agreed with key stakeholders. A multi professional – multi agency Local Implementation Group (LIG) was established in 2011/12 and will oversee the implementation of six key work streams focusing on the following national dementia priorities:

- Good quality early diagnosis and intervention for all and easy access to care, support and advice following diagnosis
- Improved quality of care for people with dementia during episodes of acute illness, including in General Hospitals
- Living well with Dementia in Care Homes
- Good quality End of Life services for people with dementia
- An informed and effective workforce for people with dementia
- Effective use of anti psychotic drugs

Partnership working and engagement is critical to the success of this programme. Constituent members of the group include, Tameside MBC, Derbyshire County Council/High Peak Borough Council, Pennine Care Mental Health Foundation Trust, Tameside Hospitals Foundation Trust (THFT), The Alzheimer's Society, Age UK and Tameside and Glossop Community Healthcare (T&GCH).

In 2011/12 a Commissioning for quality and Innovation (CQUIN) indicator was developed with Pennine Care to develop personal profiles for all patients admitted to Older Peoples' inpatients wards with dementia and to audit anti-psychotic prescribing.

What were our plans for 2012-13?

NHS Tameside and Glossop will continue to engage with partners to pursue the national dementia agenda through its local strategy and the use of existing and emerging national guidance such as the Department of Health Commissioning Pack, NICE Quality Standards, SCIE guidelines, and the Department of Health Quality Outcomes Framework for people with Dementia, outlined in the local action plan which is jointly owned by Tameside MBC, Derbyshire CC and NHS Tameside and Glossop.

Plans for 2012-13 include:

- Response to national audits
- Membership of Greater Manchester (GM) Lead Dementia Commissioners forum
- Demonstrator site within GM in 2012/13 to showcase an innovative approach to End of Life Care (EoL Care) for people with dementia
- Local providers have signed up to participate in the AQuA Dementia Challenge throughout 2012/13 which will focus on improving the care of people with dementia in General Hospitals
- Compliance with the NICE Quality Standard for all provider organisations

Using the leverage of the acute care CQUINs we will:

- Improve diagnosis rates through screening and onward referral ,
- Support Tameside Hospital Foundation Trust (THFT) to improve the experience of patients with dementia and their carers through better identification of their condition and needs on admission,
- Support THFT to reduce Length of Stay (LOS) for patients with dementia and reduce readmission rates for patients with dementia:
- Support THFT to reduce Anti Psychotic prescribing rates in secondary care where appropriate,
- Work with THFT and partners to develop pathways for patients with dementia,
- Support THFT to deliver care in a dementia friendly environment and continue to comply with mixed sexed accommodation mandates.
- Develop proxy measures to monitor our progress against reducing non elective inpatient admissions for patients with dementia
- Ensure we have responsive community alternatives to admission. This will include working with General Practitioners, Care Homes and community based staff to reduce the variation in confidence and competence to deal with patients with dementia through training and awareness raising
- Primary Care will be enrolled to support the drive to improve diagnosis rates against expected prevalence of dementia locally (as per the NHS Atlas of Variation) and we will support patients and their carers by providing good quality information and signposting to support following diagnosis
- We will commit to review Memory Assessment Services in 2012/13 to support better access

NHS Tameside and Glossop have been proactive in working with providers to reduce anti psychotic prescribing and will continue to look to improve with the support of the NHS Institute's 'Call to Action'.

What were our plans for 2013-14?

Dementia is one of our local priorities and a key aspect of our Mental Health and End of Life clinical challenges and we are determined to improve the outcomes for patients with dementia and their carers.

Our joint Dementia Strategy developed with partners across Health and Social Care outlines the desire to:

Encourage help-seeking and help offering (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour;

- Make early diagnosis and treatment the rule rather than the exception;
- Enable people with dementia and their carers to live well with dementia by the provision of good quality care for all with dementia from diagnosis to the end of life, in the community, in hospital and in care homes.

We have a Dementia Advisory Group, which is a multi disciplinary working group, including all local stakeholders which oversee work to review existing services and develop a local pathway for dementia and reports to the Mental Health Local Implementation Group.

We recognise that our diagnosis levels are lower than expected and with an ageing population we need to ensure we identify people with dementia early so we can support them and their carers to live quality lives. We are aiming for a dementia diagnosis rate of 51.9% in 2013-14 and 52.9% in 2014-15.

Dementia was our 'test' pathway for integration work, and we continue with this work, specifically the development of an integrated approach to a local pathway. Earlier detection and diagnosis is an integral element of this pathway so we will work with primary care raising awareness to recognise the early onset of dementia, identify carers and develop their disease registers.

We will continue to pursue the development of a Local Enhanced Service (LES) for the shared care monitoring the dementia medication to relieve some of the pressure for memory services and engage with the GM plans when they are more formalised.

We will work with our member practices to increase the recorded prevalence of people diagnosed with Dementia; to strengthen the focus on prevention, early detection (in primary care), screening (national CQUIN) and alternative interventions (reducing antipsychotic prescribing). This aligns with the national policy to increase public awareness of dementia, and the local integration project objectives.

We will increase the uptake of GP Disease Registers by 5% from the 2012-13 baseline (GM prevalence 0.5%).

Fuel poverty and Excess winter deaths

Outcomes Framework: Public Health 1.17 and 4.15

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

The government's definition of fuel poverty changed during 2013 meaning that it is no longer defined as a household who has to spend more than 10% of their income to adequately heat their home. The definition is now based on households with low incomes and higher than typical energy costs. This does not alter the inherent issue and the solutions to this problem. The key drivers remain, and due to continuing rising energy prices, a high number of households with low energy efficiency and stagnating incomes, an increasing number of households are falling into fuel poverty.

Living in poorly heated housing is associated with increased morbidity and mortality. For example, living in cold housing has shown to be associated with respiratory and cardiovascular diseases and high blood pressure. There is evidence that decreasing household temperatures increase blood pressure; a 1°C lowering of living room temperature is associated with a rise of 1.3mmHg blood pressure (1). These aspects are also the main causes of excess winter deaths. In England and Wales there were over 31,000 excess winter deaths in 2012/13, the majority of these being people aged over 75. In Tameside, there were 12% more deaths in the winter of 2012/13 compared with the non-winter period (2). Excess Winter Deaths (EWD) can be a good indicator of the impact of fuel poverty and a conservative estimate of the number of excess winter deaths directly caused by fuel poverty is 10% which nationally equates to over 2,700 people across the country per year.

Service User Engagement:

One of the most effective methods of tackling fuel poverty is a holistic approach involving a face to face assessment of a household. This has been delivered in recent years as part of the NHS Health Improvement team outreach work. Vulnerable residents are targeted and their circumstances discussed around fuel poverty and appropriate support is explored. Examples of the type of support include referrals into local housing retrofit programmes and financial inclusion work such as applications to the Warm Home Discount or Trust Funds. The focus is on intervention rather than signposting. Throughout this programme, a comprehensive toolkit of fuel poverty interventions has been developed containing all relevant information and guidance for professionals assisting households at risk of being in fuel poverty. The toolkit that has been developed has been shared across other partner organisations, primarily Registered Housing Providers to begin with to allow their front line staff to undertake the same approach in trying to tackle fuel poverty.

At risk and vulnerable groups:

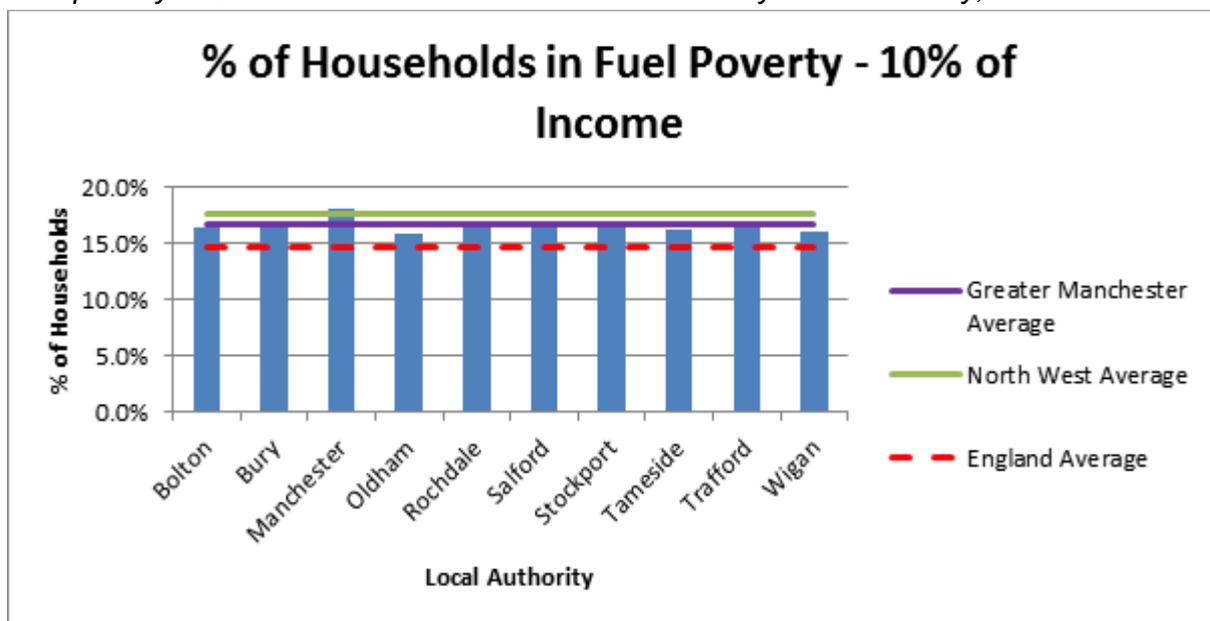
Typical vulnerable groups are disproportionately affected by fuel poverty; over 60s, people with long term disabilities, long term unemployed and low income families (particularly those with young children); as are people with existing conditions such as circulatory or respiratory diseases. Many of these groups spend more time in their homes therefore requiring more heating, have a lower financial capacity to pay for energy and are also more likely to live in

homes with poor energy efficiency ratings. It should be noted that due to the wide roll out of the decent homes programme among the social housing sector, we have seen the rate of fuel poverty in the private housing sector increase above that of the social rented sector for the first time. This is also attributable to particularly poor quality housing in the private rented sector.

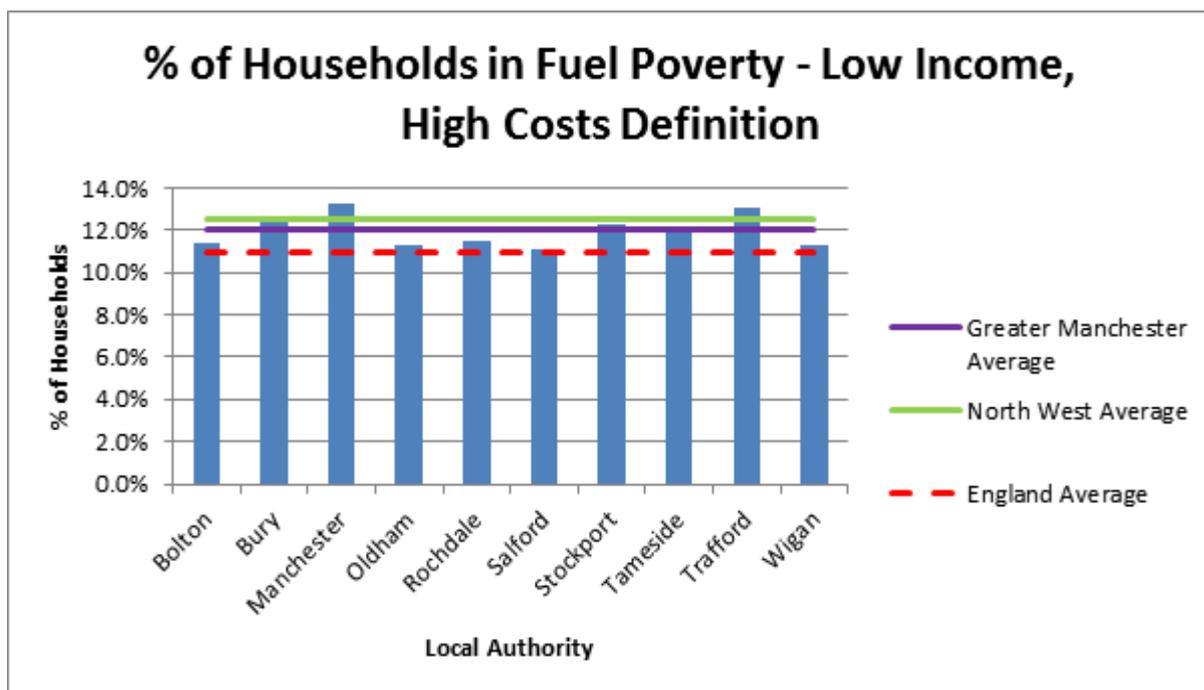
Benchmarking:

While the government has changed the definition of fuel poverty, they have continued to report on the number of households affected by the old definition. This is to allow some continuity in data reporting. Looking at both old and new definitions, the level of fuel poverty in Tameside remains above the national average but below the average for both Greater Manchester and the North West.

Fuel poverty in Greater Manchester and the North West by Local Authority, 2011



Source: Department of Energy and Climate Change 2013



Source: Department of Energy and Climate Change 2013

Policy context:

A new definition of fuel poverty has been implemented by the Government which is based on recommendations made in the [Hills Fuel Poverty Review](#). This is summarised along with interim plans for ongoing targeting and policy support in [Fuel Poverty: A Framework for Future Action](#) published by DECC in July 2013. Key to this new definition is the move away from being based solely on household income and it now takes household energy costs into account. This new definition also includes the 'Fuel Poverty Gap'. This measures the depth of fuel poverty by stating the cost reduction required to bring a household out of fuel poverty. This essentially measures the degree to which a household is in fuel poverty. Much of the proposed policy plans focus on housing retrofit as the most cost effective tool to tackle fuel poverty via vehicles such as the Energy Company Obligation (ECO). This paper acts as a bridge between the Hills Fuel Poverty Review and the upcoming Government strategy on fuel poverty which is now expected at some time in autumn 2014. This framework also makes particular reference the role of the third sector and opportunities to engage with vulnerable residents such as the Smart Meter roll out. There is little direct support for fuel poor households outside of the ECO and Warm Home Discount. There remains a significant amount of concern that these proposed measures will not be adequate in preventing the growth of fuel poverty. Current and future proposed national policy provision to tackle the issue of fuel poverty is far less than it has been in previous years via schemes such as CERT and Warm Front.

The Local Authority is promoting ECO funding for qualifying households via the Greater Manchester (GM) Get Me Toasty scheme which aims to reach as many households as possible. The Public Health team now sits within the Local Authority which will increase collaborative working and pooling of resources with Housing and Environmental

professionals. A number of proposals have been put forward around where best to direct resources locally to tackle fuel poverty.

Key support has been received during the winter of 2011/12 (£83k) and 2012/13 (£105k) from the Department of Health via the Warm Homes Healthy People fund. This helped deliver a range of services and tools to help tackle fuel poverty. There were limitations due to the short amount of notice and short delivery timescales.

There has previously been an active Affordable Warmth Strategy within Tameside, co-ordinated by Tameside Council but this is now out of date. Due to the uncertainty and the delay in the Government publishing their national fuel poverty strategy, Tameside Council is also delaying publishing a new strategy to ensure that an appropriate and long term policy and action plan can be set out in the near future.

What interventions work?

- Maximising uptake to national funding streams such as the Energy Company Obligation to allow energy efficient measures to be fitted in homes which are at risk of being in fuel poverty
- Direct face-to-face advice and support via targeted outreach work in communities
- Collaboration between key local partners such as community agencies, charities, third sector, Local Authority and Public Health
- Direct Local Authority funding (local Boiler Scrappage Scheme)

What are we doing now?

- ECO: Housing retrofit measures via Get Me Toasty scheme
- Boiler Scrappage: Providing over 200 LA funded boilers to vulnerable households
- Priority Outreach: LA working with NHS Health Improvement team to deliver direct interventions for the most vulnerable residents in their own homes. Proposals put forward to roll this out for fuel poor households long term.
- Citizens Advice Bureau Support: Based on previous results and interventions delivered by CAB, funding has been awarded to provide fuel debt assistance, support for Warm Home Discount applications and home visits for the most vulnerable clients.
- Greater Manchester (GM) Fuel Poverty Strategy Group provides a strategic overview of work on fuel poverty in GM.
- Public Health collaborative working: Identifying available resources to tackle fuel poverty within the remit of Tameside Public Health team.

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

Tameside Council intend to rewrite the Tameside Affordable Warmth strategy once the Government release the national fuel poverty strategy. Key actions for the LA will be the continuation of housing retrofit schemes, increase outreach work in most vulnerable communities and build on collaborative work with Public Health team. There is also a

responsibility on other partners to work to tackle fuel poverty such as Registered Housing Providers, community agencies (CAB), charities, third sector and private landlords. A collaborative and partnership approach will be encouraged and much of this will be led by the Local Authority and the local Health & Wellbeing Board.

References

Woodhouse PR, Khaw KT, Plummer M. 'Seasonal variation of blood pressure and its relationship to ambient temperature in an elderly population'. J Hypertens. 1993 Nov;11(11):1267-74

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ONS. Excess Mortality In England and Wales 2011/12. [Online] 2013. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-326925>

Permanent admissions to residential and nursing care homes per 100,000 population

Outcomes Framework: Adult Social Care 2A

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

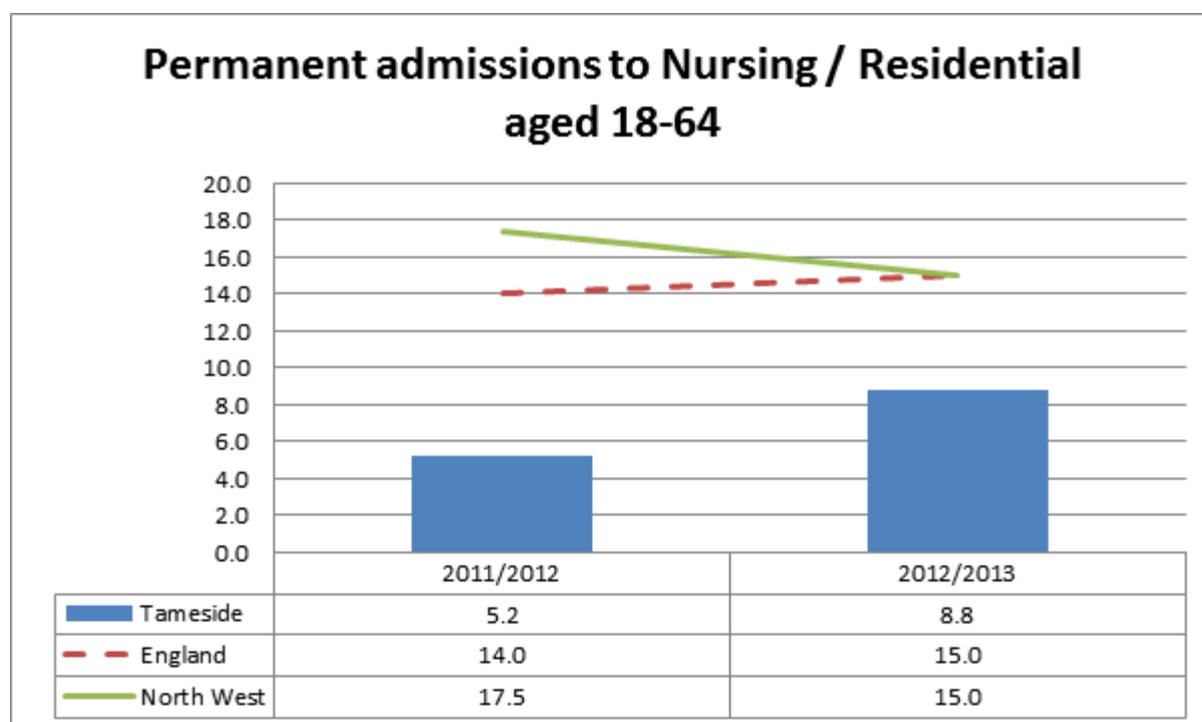
Delaying and reducing the need for care and support. Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency, and local health and social care services will work together to reduce avoidable admissions. Research suggests where possible people prefer to stay in their own home rather than move into residential care. This is a high level indication of the success of social care services in delaying dependency, in particular for older people, and reducing inappropriate permanent admissions to residential and nursing care.

At risk or vulnerable groups:

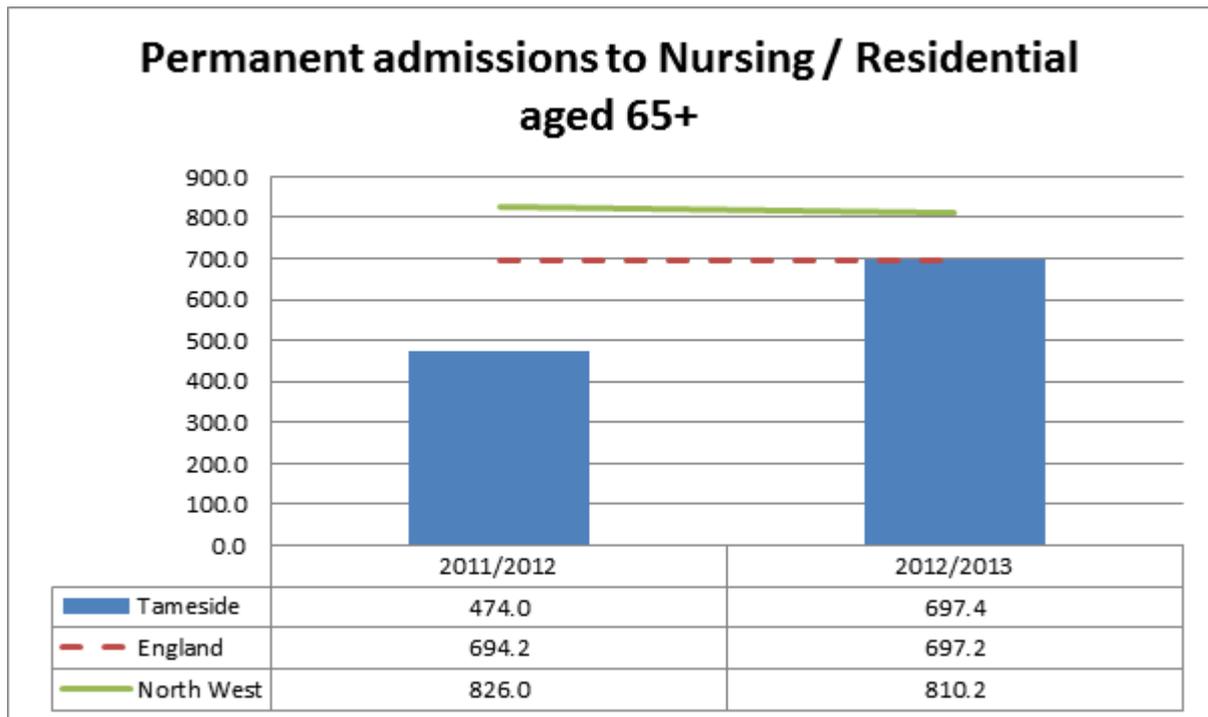
This is a two part measure reflecting the number of admissions of younger adults and older people to residential and nursing care homes relative to the population size of each group. The measure compares council records with ONS population estimates.

Benchmarking:

Admissions for both people aged 18-64 and 65+ are both well below the regional and national average – this is excellent performance and aligns with our reducing placement policy over the years.



Source: Tameside MBC 2014



Source: Tameside MBC 2014

Policy context:

Permanent admissions to residential and nursing care homes per 100,000 population is an overarching measure within the “Delaying and reducing the need for care and support” outcome domain in the 2013 2014 Adult Social Care Outcomes Framework.

Half Way Homes Policy

What interventions work?

- Re-ablement
- Integrated Response and Intervention Service (IRIS)
- Assistive Technology
- Personal Budgets
- Aids, Equipment and Adaptations
- Investment in Wellbeing and Prevention
- Carers services
- Intermediate Care

What are we doing now?

Expansion of the Reablement service, with increased promotion of Assistive Technology.

Redesign of Intermediate Care services resulting from the Intermediate Care Strategy action plan.

Increased delivery of Personal Budgets offering greater choice and control.

Implementation of the Halfway Homes policy.

Redesign of the Well being and Prevention Service

Redesign of the Assessment and Care Management Service

What needs to happen next, and by whom?

All of the above lead by the Adults Management Team

Reducing premature death in people with learning disabilities

Outcomes framework: NHS 1.7

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

People with learning disabilities (LD) have poorer health than their non disabled peers and these differences in health status are, to an extent avoidable.

The health inequalities faced by people with LD start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The inequalities evident in access to health care are likely to place many NHS Trusts in England in contravention of their legal responsibilities defined in the Equality Act 2010, the Mental Capacity Act 1006 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People with LD have a shorter life expectancy and increased risk of early death when compared to the general population. Life expectancy is increasing, in particular for people with Down's syndrome, with some evidence to suggest that for people with mild learning disabilities it may be approaching that of the general population. Nonetheless, all cause mortality rates among people with moderate to severe LD are three time higher than in the general population, with mortality being particular high for young adults, women and people with Down's Syndrome.

[Health Inequalities and People with Learning Disabilities in the UK 2011](#)

At risk or vulnerable groups:

- Those with learning difficulties and disabilities
- Those not known to services
- Those not accessing services
- Young Adults
- Women
- People with Down's Syndrome

Benchmarking:

There is no definitive record of the number of people with LD in England. However it is estimated that in England in 2011 1,191,000 people have learning disabilities.

This includes:

- 286,600 children (180,000 boys,106,000 girls) age 0-17;
- 905,000 adults aged 18+ (530,000 men and 375,000 women), of whom 189,000 (212%) are known to learning disabilities services.

In Tameside there are 929 people with a LD who access learning disability services. The median age at death in Tameside is 5 years higher (60 years) than the England and the North West average (55 years). For more information see Tameside [Learning Disabilities Profile 2012](#)

Policy context:

- [Valuing people](#)
- [Valuing People Now](#)
- [People with Learning Disabilities in England 2011 \(DH\)](#)

What interventions work?

- Specialist teams providing support
- Delivery and access to NHS Health Checks
- Maximising opportunities for Health Screening and Health Promotion
- Maximising work opportunities for people with LD

What did we do in 2011-12?

- The LD self assessment framework has been completed for the last 2 years and there are action plans to respond to the areas which need improvement.
- There is a hospital liaison nurse who provides support for people with LD who attend hospital for either planned or unplanned admissions.
- There is a GP liaison nurse who works with GP surgeries to understand the LD population and increase uptake of annual health checks. We are developing a Local Enhanced Service (LES) to support this increase.
- There is a screening programme in place for early onset of dementia in people with LD
- The LD self assessment identified specific groups of people with LD (older people, carers, Black and Minority Ethnic (BME), people with profound and complex needs, people with autism) that need specific support to enable them to access appropriate and accessible services
- Following a local serious case review Tameside Adult Safeguarding Partnership developed an Action Plan which has now been implemented

What were our plans in 2012-13?

- Increase the number of NHS Health Checks and Screening opportunities delivered to adults with LD
- Implementation of the LES for NHS Health Checks and follow up any issues highlighted
- Further increase in awareness of the health issues experienced by people with learning disabilities
- Further develop strategies to meet the needs of people with LD with profound and complex needs, carers, BME and older people.
- Improved health promotion training and skill development for residential care staff
- Improved access to familial information for staff and carers

What were our plans in 2013-14?

We currently have an uptake of less than 50% of GP practices who carry out the Learning Disability annual health check as part of the Directed Enhanced Service. We have a primary care liaison nurse within the learning disability service who is working with GP practices and

the plan is to increase the number of people with a learning disability who have their annual health check.

We do not currently have a data system which is sophisticated enough to determine how many people with a learning disability have been screened for cancer. So we are working with other CCGs across GM to develop better systems to identify when people with a learning disability have had any screening for cancers.

We have a hospital liaison nurse within the learning disability service who has oversight of all hospital admissions, planned or unplanned and will provide support to hospital staff as necessary. The hospital passport has been refreshed. We plan to increase the number of reasonable adjustments made by the hospital for people with a learning disability accessing their services and have a CQUIN to support this. We will also increase the use of formal end of life tools across health and social care.

We are making the patient experience questionnaire more user-friendly so that improvements can be made to services in light of feedback from people with a learning disability.

Mortality and hospital admissions due to serious mental illness, self harm and suicide

Outcomes Framework:

- Public Health 4.9: Excess under 75s mortality in adults with a serious mental illness
- NHS 1.5: Excess under 75 mortality in adults with serious mental illness
- Public Health 4.10: Suicide
- Public Health 2.10: Hospital admissions as a result of self harm.

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

Poor mental health has both personal and societal costs. People with severe mental illness are estimated to die on average 20 years earlier than the general population largely due to co-existing physical health conditions ([RCPSYCH](#)). Poor mental health is associated with an increased risk of physical illness, due in part to a less healthy lifestyle and more frequent health-risk behaviour while physical illness increases the risk of poor mental health. In addition people who harm themselves can be subject to stigma and hostility ([NICE](#)).

In 2011 there were 6045 suicides in the UK. The rate of suicide was significantly higher than in 2010, and was the highest rate since 2004. However, this apparent increase could be due to changes in the way narrative verdicts by coroners are recorded ([ONS](#)).

A significant number of admissions to medical wards in England are as a result of deliberate self harm. Indeed, there are over 100,000 inpatient admissions in England every year as a result of intentional self harm, and the incidence of self-harm appears to be increasing ([HSCIC](#)).

At risk or vulnerable groups:

People of all ages and from all social and cultural backgrounds may harm themselves but some groups are especially vulnerable because of life experiences, personal or social circumstances, physical factors or a combination of these elements. There is a higher incidence of self-harm among prisoners, asylum seekers, veterans from the armed forces, people bereaved by suicide, some cultural minority groups, people with learning disabilities and lesbian, gay, bisexual and transgender people.

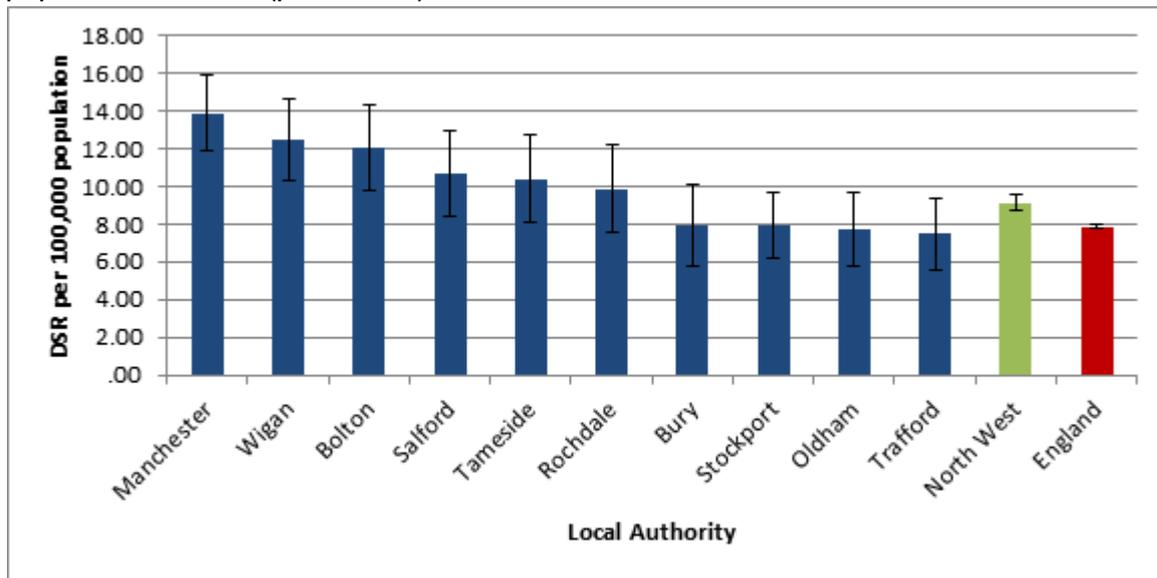
3/5 admissions for self harm are for women, with the highest rates of admission among 15 to 19 year olds ([HSCIC](#)).

2/3 of suicides are among males. In 2011 the highest suicide rate was for men aged 30-44. Female suicide rates were highest in 45-59 year olds ([ONS](#)).

Benchmarking:

The mortality rate for suicide in Tameside is significantly higher than the England average, and is among the highest in Greater Manchester

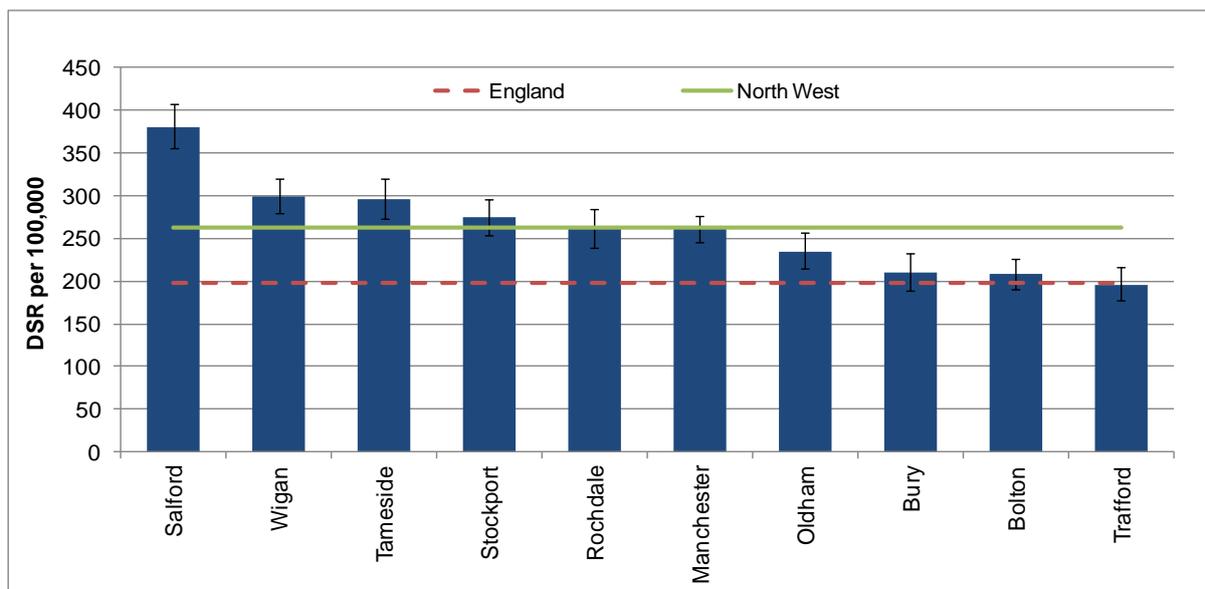
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population 2009-11 (provisional)



Source: [Public Health England 2013](#)

The Public Health Outcomes Framework indicator for self-harm is still in development, however data from 2009/10 suggests the rate of emergency admission for self harm was higher in Tameside and Glossop than then England or North West rates.

Emergency Hospital Admissions for Self-Harm – 2009/10



Source: *Association of Public Health Organisations 2012*

The indicator on excess under-75 mortality in adults with serious mental illness is also not yet available at Local Authority or Clinical Commissioning Group level.

Policy context:

The national mental health strategy '[No health without mental health](#)' was published in 2011. This strategy aims to involve a wide range of partners at national and local level, and the public, in improving mental health of the population and making high quality services available to all.

Improving mental health and wellbeing is a key theme in the Tameside Health and Wellbeing Strategy, and is the focus for the Director of Public Health Annual Report 2013/14.

What interventions work?

- [NICE guidance on Self-harm CG16](#)
- [NICE Guidance on Long-term Self-Harm Management CG133](#)
- [NICE Evidence Briefing on Youth Suicide Prevention](#)
- Raising public awareness regarding mental health issues leads to improvement in attitudes
- Training and education of staff regarding recognition of signs of distress and how to respond
- GP education programmes aiming to increase detection of depression
- Specific psychotherapies to prevent repetition of self-harm
- Responsible approach to reporting suicide and mental health issues by the media

What are we doing now?

- The Greater Manchester Police have produced a report focusing on analysis of initial deaths highlighting trends and identifying hot spots at Greater Manchester as well as locality level
- A Greater Manchester approach is being developed by GM Suicide Prevention Group to address serious mental health issues
- Extensive training is delivered locally within the acute sector to highlight the links between mental health and substance misuse

Service user/patient consultation and engagement**What needs to happen next, and by whom?**

- Ensure improvement in quality of suicide data linking initial death reports with coroner's outcomes
- Improvement in capturing a data related to attempted suicide
- Conduct a comprehensive gap analysis of patient care pathways for suicide prevention
- Develop effective care plans and patient care pathways with support from a multi-disciplinary team to ensure effective and timely support for a person who self harms.

Mortality from Communicable Disease

Outcomes Framework: Public Health 4.8

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

Communicable diseases include a range of conditions, including the seasonal influenza virus, healthcare associated infections (HCAI), sexually transmitted infections (STIs) such as Human immunodeficiency virus (HIV) and gonorrhoea, among many others. They have diverse routes of infection, various associated risk factors, and extreme ranges of related mortality and morbidity. Indeed, while mortality is high in some communicable diseases, time from contraction to death can be relatively long with early detection and high quality care.

At risk or vulnerable groups:

Some populations are more susceptible than others to different communicable diseases.

HCAI: HCAI cover a range of diseases including methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium Difficile* (*C. Difficile*) and *Escherichia coli* (*E. coli*). HCAs while often having low levels of infection in the general population, can be dangerous in environments (such as hospitals) where the infection can be spread quickly across a large number of people who are often already in poor health, e.g. the elderly, those with underlying illnesses, and anyone who is immune-compromised.

Seasonal Influenza: The most at risk from serious complications and mortality are those who already have underlying conditions, such as those with cardiac, respiratory, or immune system problems, as well as the elderly (who often have other conditions), and the young (who have not yet developed immunity).

Vaccine Protected Diseases: Vaccination up-take rates, particularly among children, vary according to a number of factors. There are significant reductions in vaccination rates among children in more deprived areas, those from large families, among travelling communities, and children by parents with chaotic lifestyles.

Policy context:

The Annual Report of the Chief Medical Officer 2011: Volume 2 highlights that while a new infectious disease has been discovered nearly every year over the past 30 years, there has been very few new antibiotics developed leaving our armoury nearly empty as diseases evolve and become resistant to existing drugs. In addition, to the development of new drugs the report highlights that looking after the current supply of antibiotics is equally important. This means using better hygiene measures to prevent infections, prescribing fewer antibiotics and making sure they are only prescribed when needed. The report covers a life course approach. There are 17 recommendations in this report (page 139 – 141) of which 2 relate to HWBB responsibilities. Other recommendations are relevant though the responsibility resides with PHE or NHSE.

www.gov.uk/government/uploads/systems

In support of this there is also the DH and DEFRA “UK 5 year Antimicrobial Resistance Strategy 2013 to 2018” (Sept 2013).

The PHE report, “Our priorities for 2013\14” has 5 high level priorities, one of which is;

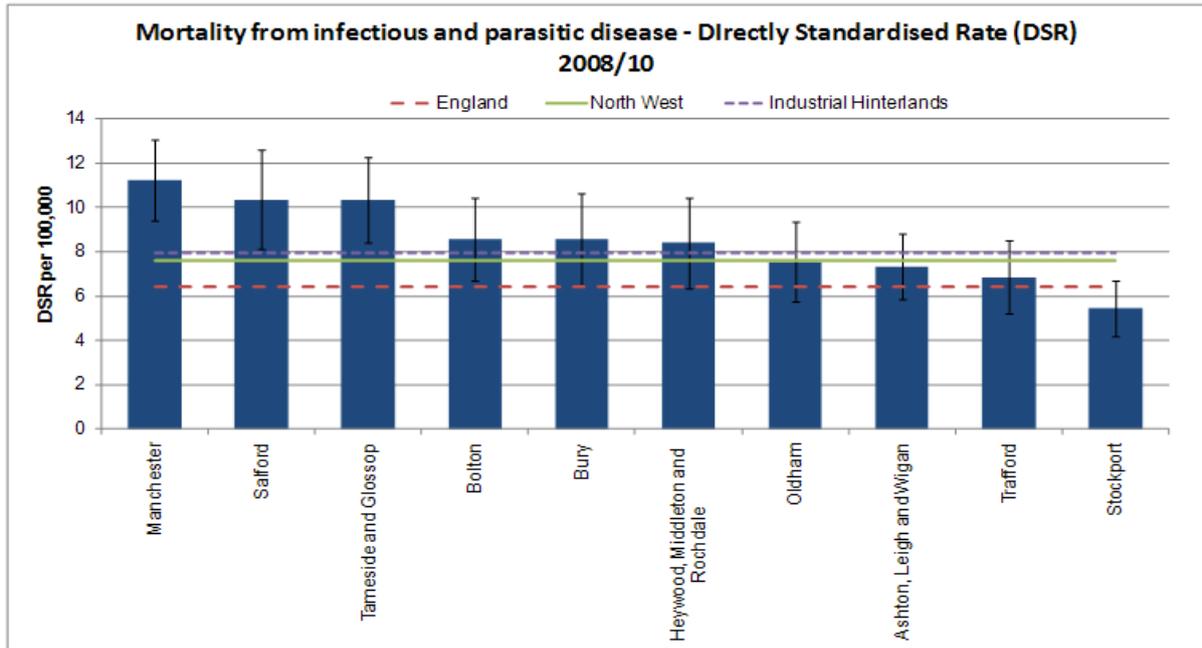
“Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics.”

The key actions identified are:

- Reverse the current trends so that we can reduce the rates of TB infections. We will work with LAs and the NHS in those areas with high levels of TB infections to put into place effective strategies.
- Lead on the gold standards for current vaccinations and screening programmes, reverse the current increase in cases of measles, and support the delivery of the new programmes for Rota Virus, childhood flu, pertussis, pertussis in pregnancy and shingles.
- Tackle antimicrobial resistance (AMR) through surveillance of patterns of resistance to antibiotics, supporting microbial stewardship and other national strategies to address the rise of antimicrobial resistant organisms.
- Develop and implement a national surveillance strategy to ensure the PH system responds rapidly to new and unexpected threats to health of all kinds, bringing together the full range of PHE surveillance and intelligence capabilities.

Healthcare associated infections remain an issue of national importance. The reduction of clostridium difficile and MRSA bacteraemia are nationally set targets for CCGs and Acute Trusts.

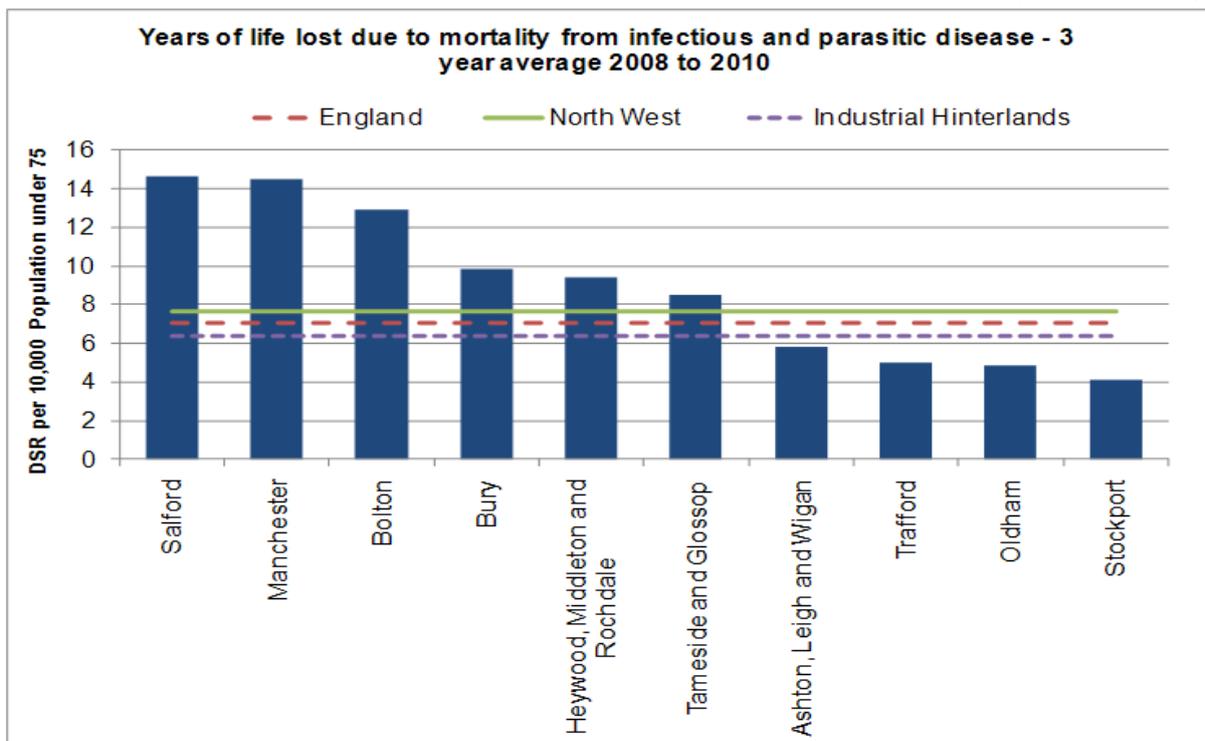
Three Year Pooled Mortality Rate from Infectious and Parasitic Disease (2008 to 2010)



Source: NHS Information Centre, 2010

The following figure shows the directly age- standardised rate (per 10,000 of European standard population) of years of life lost due to infectious and parasitic disease. The local rate is higher than the comparable PCTs, the North West and England, showing that there is opportunity to reduce the impact of infectious and parasitic disease locally.

Three Year Pooled Years of Life Lost due to Infectious and Parasitic Disease (2008 to 2010)



Source: NHS Information Centre, 2011

What works?

Vaccination is key to reducing the spread of communicable disease. When a population has sufficient rates of immunity to prevent spread of a communicable disease, this is known as herd-immunity. The level of vaccination required to achieve herd immunity changes depending on the disease: measles, for example, requires a vaccination rate of between 92 and 95% to effectively block transmission, whereas Diphtheria only requires a rate of 80 to 85%.

HCAI: recruitment of modern matrons to promote improved clinical care standards in infection control; promotion of the use of alcohol hand gel; regular audits to ensure high standards of hand hygiene in healthcare environments; availability of isolation facilities; as well as a culture of continuous quality improvement.

Seasonal Influenza: to protect against the dangerous effects of seasonal influenza, vulnerable groups need to be targeted: those with respiratory conditions; the elderly, and the immune-suppressed. Having comprehensive plans in place to reduce the spread in healthcare settings are very important.

Vaccine Protected Diseases: The key to this approach is making vaccine uptake a priority. Vaccination clinics should be held at times which suit the population being targeted.

Vaccination should be combined with other appointment and clinic visits; ensure that all front line staff in clinics and practices are actively checking for immunisation status; work directly with communities who are under-vaccinated to increase vaccination rates; offer 'domiciliary' vaccination service for non-attendees; and use reminders to help promote attendance.

STIs and HIV: condom provision for high risk groups; condom subsidy schemes; Outreach health promotion and safe sex programmes for high risk groups and hard to reach groups; high quality integrated Sex and Relationships Education; short access times for GUM services.

What are we doing now?

- work with local healthcare providers to reduce their HCAI rate through the development of guidance with support for education around antibiotics prescribing and hand hygiene;
- providing specialist sexual health clinics; young person friendly community based sexual health and contraception services;
- dedicated specialist Tuberculosis service;
- primary care targeting of high-risk groups for vaccination;
- Targeting vulnerable groups for administration of vaccine

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

- Season flu plans are being developed to ensure that the most vulnerable to the effects of seasonal flu are targeted for vaccination

- Clear joined up plans need to be in place to ensure that progress in reducing HCAI is sustained and improved further
- Vaccine uptake rates are high in Tameside and Glossop for vaccine-protected conditions. Long and medium term strategies must be developed to ensure the maintenance of this performance and to target specific groups with low uptake rates.

Under 75 mortality rate from all cardiovascular disease (CVD) and Improving recovery from stroke

Outcome frameworks: Public health 4.4; NHS 1.1 and 3.4

Implication for the population's health & well being:

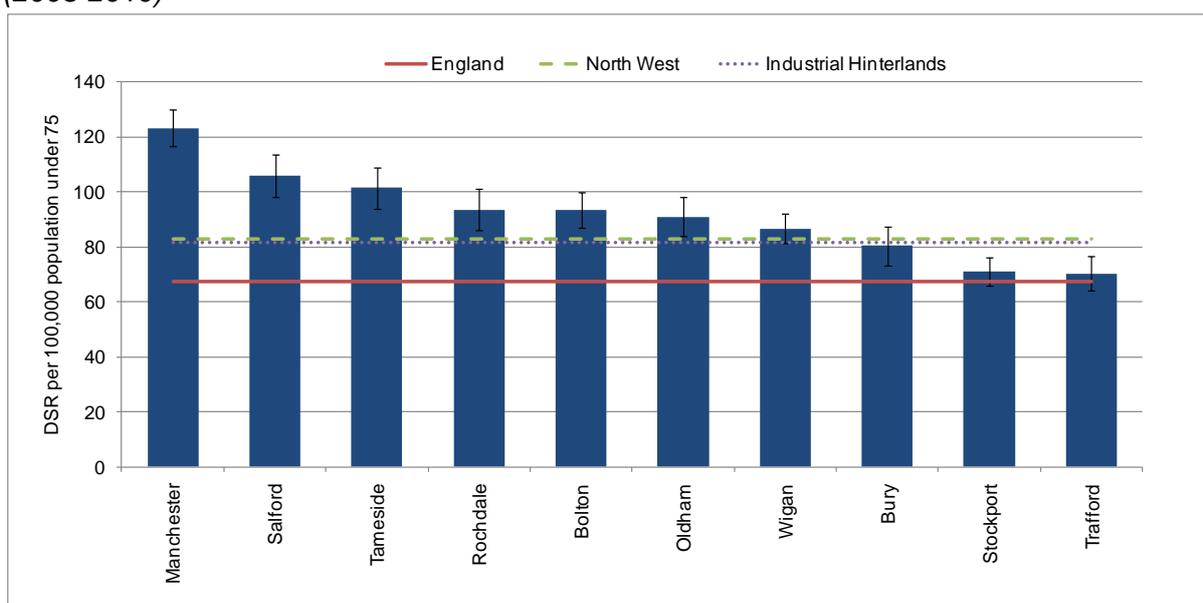
Cardiovascular diseases are the main cause of death in the UK causing around 147,300 deaths in England in 2010 (around a third of all deaths). Around 45% of all deaths from CVD are from coronary heart disease (CHD) and more than a quarter from stroke (27%). CHD is the most common cause of death in England and Wales (15% of all deaths in 2010).

Benchmarking:

The [cardiovascular disease health profile](#), released in 2012, includes the following as key messages for Tameside and Glossop in relation to CVD:

- Early mortality rates from CVD (< 75 years) are significantly higher than the national rate, but have decreased by 55.2% since 1995.
- Emergency admission rates for both CHD and stroke are significantly higher than the national rate.
- The mortality rate within 30 days of a **segment elevation myocardial infarction (STEMI)** is similar to the national rate.
- For people having myocardial infarction reperfusion in 2010, the median time to primary angioplasty treatment from a call for help was 129 minutes in Tameside and Glossop; this is higher than in Industrial Hinterlands and England (95 and 113 respectively).
- Stroke patients under 75 years are less likely to be discharged back to their usual place of residence compared to the national picture

Under 75 mortality from cardiovascular disease by PCT, England and North West averages (2008-2010)



Source: NHS Information Centre 2012

Policy context:

NHS organisations should implement clinical strategies aimed at reducing early mortality from CVD, including CHD, stroke, kidney disease and diabetes. There is strong evidence that early treatment supports better clinical outcomes. There are a number of key areas where commissioners and providers can work together to ensure earlier diagnosis and treatment.

- [NICE Guidance](#)
- [Policy Interventions for Reducing Cardio Vascular Disease](#)
- [National Stroke Strategy](#)

What interventions work?

- Healthy lifestyles and prevention interventions
- Health Checks- Invite 20% of eligible population and deliver health checks to 75% of those invited
- Quality Outcomes Framework (QOF) - Identify missing people from chronic disease registers
- Design and implement a pathway for universal care of all CVD patients:
 - Embed referrals to health trainers into treatment pathway for people with CVD risk factors
 - To include referrals for: physical activity, obesity, affordable warmth
- Quality, Innovation, Productivity and Prevention (QIPP) plans - Use QIPP plans to divert care from secondary to primary care.
- Quality of care in hospital/secondary care -Use Sentinel audit to monitor improvement the quality of local stroke services in secondary care, including stroke and cardiac rehabilitation.

What did we do in 2012-13?

NHS Tameside and Glossop continue to deliver reductions in CVD mortality, but we are not addressing the gap between our population and the national and SHA population. We aim to reduce the incidence of CVD through our prevention work and also improve the management of the disease. Support is being given to primary care to help with disease management, identifying patients at risk and monitoring/preventing hospital admissions.

What were our plans in 2013-14?

We have reduced the number of people under 75 years old who are dying from CVD by 55% since 1995, but we still have significantly higher rates than the national rate. We have more people being admitted as an emergency for heart disease than the national rate. However our mortality rate within 30 days of a heart attack is similar to the national rate.

In 2013-14 we will continue to build on this success. Our Clinical Lead for Cardiology, through his work with the Clinical Network, local service providers, and our GPs, will ensure delivery of high quality cardiology services locally, in line with the GM Cardiac Strategy.

We will optimise early identification and management of cardiovascular disease particularly in general practice and improve the quality and effectiveness of long term conditions disease registers, to include CHD/CVD. We will develop a primary care balanced scorecard to support this work.

Our local plans for cardiology and cardiac services will include a full review of cardiac rehabilitation services (currently delivered via Tameside Hospital Foundation Trust (THFT)) to ensure national standards are met.

We have made good progress in our support for patients having achieved the following in 12-13:

- Telehealth service fully implemented and achieving objectives
- Additional courses commissioned from the Expert Patient Programme
- Improvements in recent Peer Review of local stroke rehabilitation services, and recommendations made for further improvements
- Support to practices to increase the number of patients on disease register- encourage early identification and appropriate management of Long Term Conditions (LTCs)
- GP review of cardiology patients with over 25% of patients being transferred back to the care of their GP
- Targets achieved for uptake and offers of NHS health checks
- Clinical Dashboard: giving all GPs access to up to date information on patient A&E attendances, admissions, and discharges from THFT
- Model of care developed for procurement in 2013-14 for patients with diabetes
- Model of care agreed for community respiratory team

Building on this in 2013-14 we improve early identification and management in primary care, appropriate referral and management in secondary care, and work to refine pathways between primary, community and secondary services, including specialist care.

Through our integration work, we will work with our LAs to develop integrated support for people with LTCs, and will include in this the further development of plans for delivery of personalised care plans and budgets.

We are re-commissioning all diabetes services for adults in 2013-14 going out to tender for a fully integrated community based diabetes service. We will ensure that the specification meets national guidance for the management of diabetes, including diabetes management against the nine care processes and with self-care and education a key element. We are also working with our GPs and Practice Nurses to ensure education and support is available for diabetes management in a primary care setting, and will use the primary care balanced scorecard to identify areas for improvement.

Our current pulmonary rehabilitation within the community does not meet the new minimum standard as outlined in the NHS Outcomes Strategy for COPD and Asthma. We will look to address this and have secured additional funding to enhance services locally by means of an integrated respiratory service, which includes pulmonary rehabilitation. This will seek to increase referrals into the service in addition to the service providing inreach to secondary care to ensure patients post exacerbation are offered pulmonary rehabilitation in accordance with NICE Quality Standards.

Within the prescribing Local Enhanced Service our Medicines Management Team have set targets which encourage GPs to review prescribing in key therapeutic areas in line with NICE guidance. Examples of this have been reviews of prescribing of newer oral agents in type 2 diabetes, identification and effective anticoagulation treatment of Atrial Fibrillation (AF) patients, Inhaled Corticosteroid (ICS) in asthma & COPD patients and prescribing decisions in stable-angina.

In conjunction with our LAs we will continue "Safe Handling & Administration of Medicines" training to both LA and private provider carers which covers a large proportion of carers responsible for patients with multiple LTCs. This helps patients and carers with the use of inhalers so they are more effective in inhaling a therapeutic dose, enhancing management and reducing exacerbations. Nurses working in nursing homes are also supported in this training through the PINK (programme to invest and improve nurses' knowledge).

We have a particular focus on CVD, COPD, diabetes, cancer and urgent care, and through partnership working we will integrate key care pathways to maximise opportunities to support individuals.

Building on our success in 2012-13, in 2013-14 we will continue to commission, via our Local Authority (LA) colleagues, a range of health improvement initiatives focussed on CVD, including the NHS Health Check. We have established a series of workstreams in response to the National Outcomes Strategy for COPD and Asthma and have secured additional funding and approval to redesign respiratory services.

Under 75 mortality rate from respiratory disease

Outcomes Framework: Public health 4.7; NHS 1.2

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

Respiratory disease, in particular Chronic Obstructive Pulmonary Disease (COPD) is a disabling illness. Although it affects people in different ways, those with COPD often have attacks of breathlessness, a bad cough and repeated chest infections. They produce a lot of sputum and can be affected both in the winter, in a cold snap, and in the summer, when air pollution can be high. Quality of life for people with advanced COPD is also affected. There are problems with restricted mobility and these are compounded by social isolation and self-esteem. The majority of COPD cases are caused by smoking, and stopping smoking, even after COPD is diagnosed can slow down the progression of the disease.

At risk or vulnerable groups:

The [National Outcomes Strategy for COPD and Asthma](#) identifies those most at risk as:

Current and ex-smokers are most at risk of contracting COPD

People who have been exposed to inhaled dusts and gases in the workplace

Those who have an inherited genetic problem that leads to the early onset of emphysema

Those who may have had a previous diagnosis of asthma

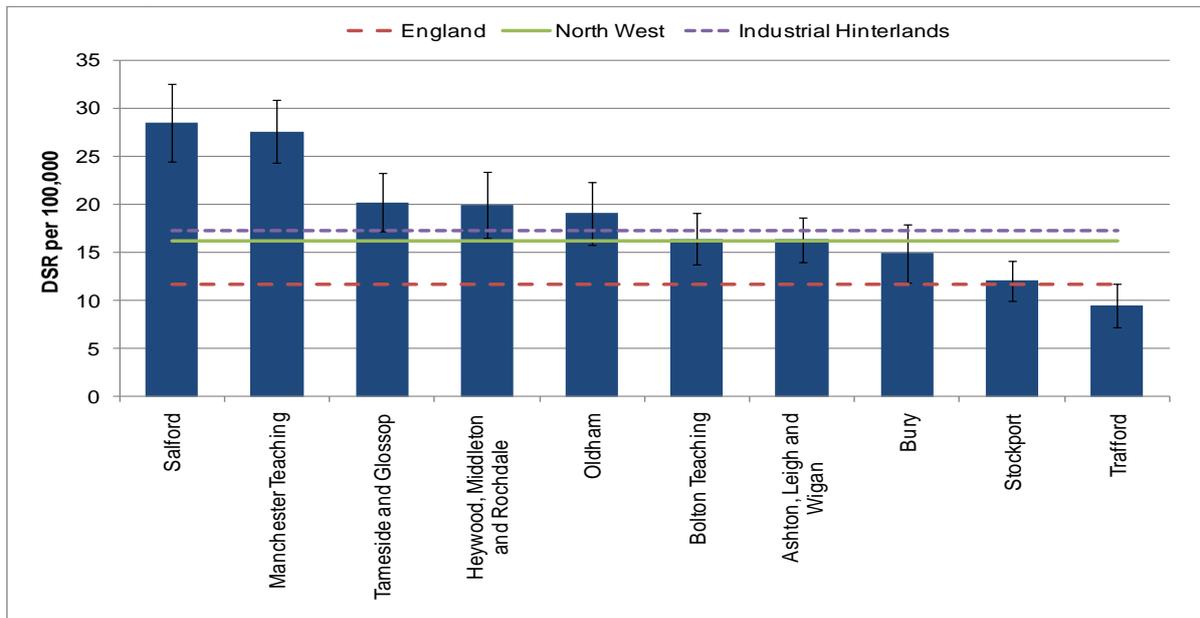
Routine/manual workers

Bangladeshi men and women

Benchmarking:

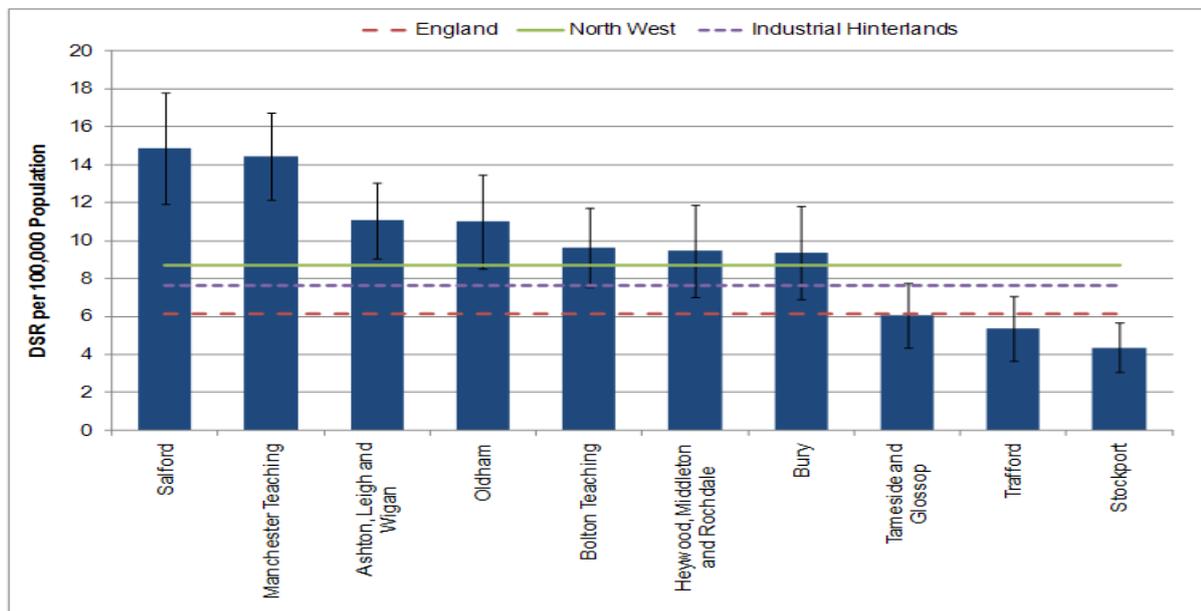
Tameside and Glossop have one of the highest rates of mortality for COPD in Greater Manchester and are slightly above the North West (NW) and England average in respect of asthma mortality. Pneumonia related mortality within Tameside and Glossop is below the England average and slightly below the NW average however pneumonia continues to be a priority locally, as it has been identified as one of the most common causes of death for Tameside Hospitals Foundation Trust in 2010/11 as indicated by the Summary Hospital Mortality Index (SHMI) reports.

Directly Standardised under 75 mortality from bronchitis, emphysema and other COPD (2008-2010)



Source: NHS Information Centre 2012

Directly Standardised under 75 mortality from Pneumonia (2008-2010)



Source: NHS Information Centre 2012

Policy context:

NHS organisations should continue to support the other clinical strategies aimed at reducing early mortality from respiratory disease. There is strong evidence that early treatment supports better clinical outcomes. There are a number of key areas where commissioners and providers can work together to ensure earlier diagnosis and treatment.

[An outcomes strategy for people with chronic obstructive pulmonary disease \(COPD\) and asthma in England.](#)

[An Outcomes Strategy for COPD and Asthma: NHS Companion Document](#)

[Service improvement guide for developing COPD services](#)

[NICE Guidance for Respiratory Disease](#)

What interventions work?

[National Guidance from NICE](#) recommends the following interventions in order to manage respiratory disease, reducing mortality:

Accurate diagnosis;

Stop smoking;

Promote effective inhaled therapy;

Provision of pulmonary rehabilitation;

Use non-invasive ventilation;

Manage exacerbations;

Ensure multidisciplinary working.

What did we do in 2011-12?

COPD: NHS Tameside and Glossop have high incidence of COPD. COPD has been identified as a priority area with support from the NHS Clinical Commissioning Group (CCG) to enhance the identification and management of COPD across Tameside and Glossop.

A COPD Project Group was established in readiness for the release of the [National Outcomes Strategy for COPD and Asthma](#) which has multi-disciplinary membership, comprising of representation from primary, secondary and community care and a local patient group representative. A project plan has been developed which incorporates the 6 objectives of the National Outcomes Strategy.

Considerable work is already underway against the project plan in respect of a training and education programme in primary care as well as the development of a local pathway. Work has already commenced to pilot case finding and screening in the community, the

development of a primary/community pathway for COPD and provision of training across Primary/Community Care.

Asthma: A pilot training programme has commenced across several GP practices in order to appropriately diagnose asthma, develop and agree treatment plans with patients in order to manage their condition effectively.

Pneumonia: An ambulatory care pathway for community acquired pneumonia has been developed for Tameside and Glossop and has been implemented across primary, secondary and community care. The pathway ensures appropriate assessment, diagnosis and management upon presentation and subsequent discharge arrangements for management in the community.

What were our plans for 2012-13?

Smoking cessation needs to be embedded within all stages of COPD care pathway, from prevention through to disease management.

Earlier identification and management of COPD/Asthma: We will continue to work with primary, secondary and community care in order to improve the identification and management of COPD. The release of the [National Outcomes Strategy for COPD and Asthma](#) identifies the early and accurate diagnosis of COPD as a key outcome. We will continue to work with secondary care colleagues in order to establish fully integrated pathways to reduce length of stay and safe transfer of patients to a community setting.

Pneumonia: Continually review the Community Acquired Pneumonia (CAP) pathway and its effectiveness, updating as required and in accordance with national guidance

What were our plans for 2013-14?

We have higher rates of premature mortality from respiratory disease in comparison to the England median however this is prevalent of other CCGs in the same ONS group.

We have established a series of work streams in response to the National Outcomes Strategy for COPD and Asthma and have secured additional funding and approval to redesign respiratory services. This includes the redesign and procurement of an integrated respiratory service, which will encompass:

Pulmonary Rehabilitation;

Community Team to manage exacerbations and support patients in their own home;

Home Oxygen Assessment and Review Service;

Early Supported Discharge Team;

NIV service;

Supporting self care

We have also invested in a training and mentorship program in primary care for Practice Nurses and GPs to enhance the diagnosis and management of respiratory disease to ensure earlier diagnosis and intervention.

We have made good progress in our support for patients having achieved the following in 12-13:

Telehealth service fully implemented and achieving objectives

Additional courses commissioned from the Expert Patient Programme

Improvements in recent Peer Review of local stroke rehabilitation services, and recommendations made for further improvements

Support to practices to increase the number of patients on disease register- encourage early identification and appropriate management of Long Term Conditions (LTCs)

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We have a particular focus on CVD, COPD, diabetes, cancer and urgent care, and through partnership working we will integrate key care pathways to maximise opportunities to support individuals.

Building on our success in 2012-13, in 2013-14 we will continue to commission, via our Local Authority (LA) colleagues, a range of health improvement initiatives focussed on CVD, including the NHS Health Check. We have established a series of work streams in response to the National Outcomes Strategy for COPD and Asthma and have secured additional funding and approval to redesign respiratory services.

Under 75s mortality rate from cancer

Outcomes framework: Public Health 4.5 and NHS 1.4

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

Cancer is the commonest cause of premature death in people under 75 in Tameside and Glossop, and England as a whole. The chance of developing cancer increases with age, so as the number of older people continues to increase, so we can expect there to be more people with cancer. At the same time, death rates from cancer have reduced in the last twenty years, so the chance of dying from cancer is reducing. Stopping smoking, screening and better treatments have all helped to make this change. But if unchecked, current increases in obesity and alcohol consumption will result in increases in cancer in the future.

At risk or vulnerable groups:

Cancer is commoner and mortality generally higher in deprived communities, older people and men. There are significant differences between areas across England and within the North West.

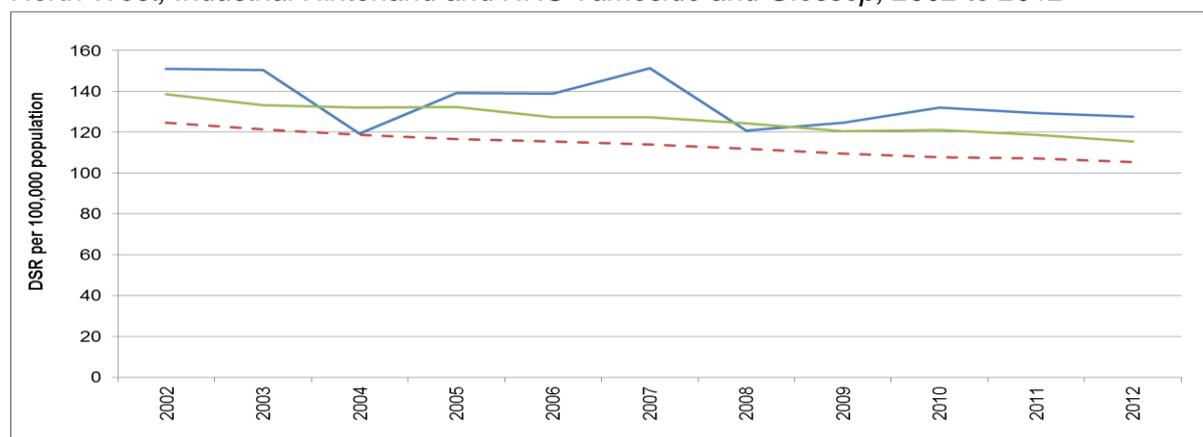
According to the [Reducing Cancer Inequality Report](#), it is also estimated that if survival from cancer in England was as good as the best in Europe about 66 lives would be saved in each PCT area per year.

Benchmarking:

Cancer is the most common cause of death in Tameside for males and females, and there are significantly more deaths than there should be, given the population age and gender profile.

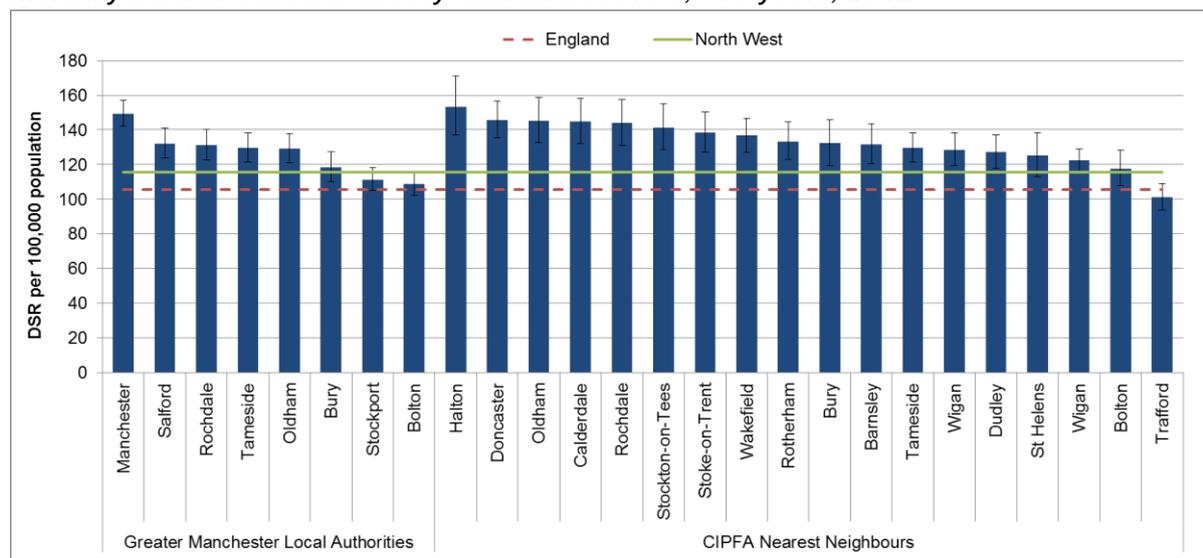
- Cancers are the commonest cause of premature death in Tameside – responsible for 36.5% of all deaths in males under 75 years, and 42.7% of deaths in females under 75 years in 2006.
- Death rates for all cancers as a whole are higher in Tameside and Glossop than the average for the North West and England.

Mortality from all cancers: directly standardised rate, <75 years, Annual Trend for England, North West, Industrial Hinterland and NHS Tameside and Glossop, 2002 to 2012



Source: NHS Information Centre 2013

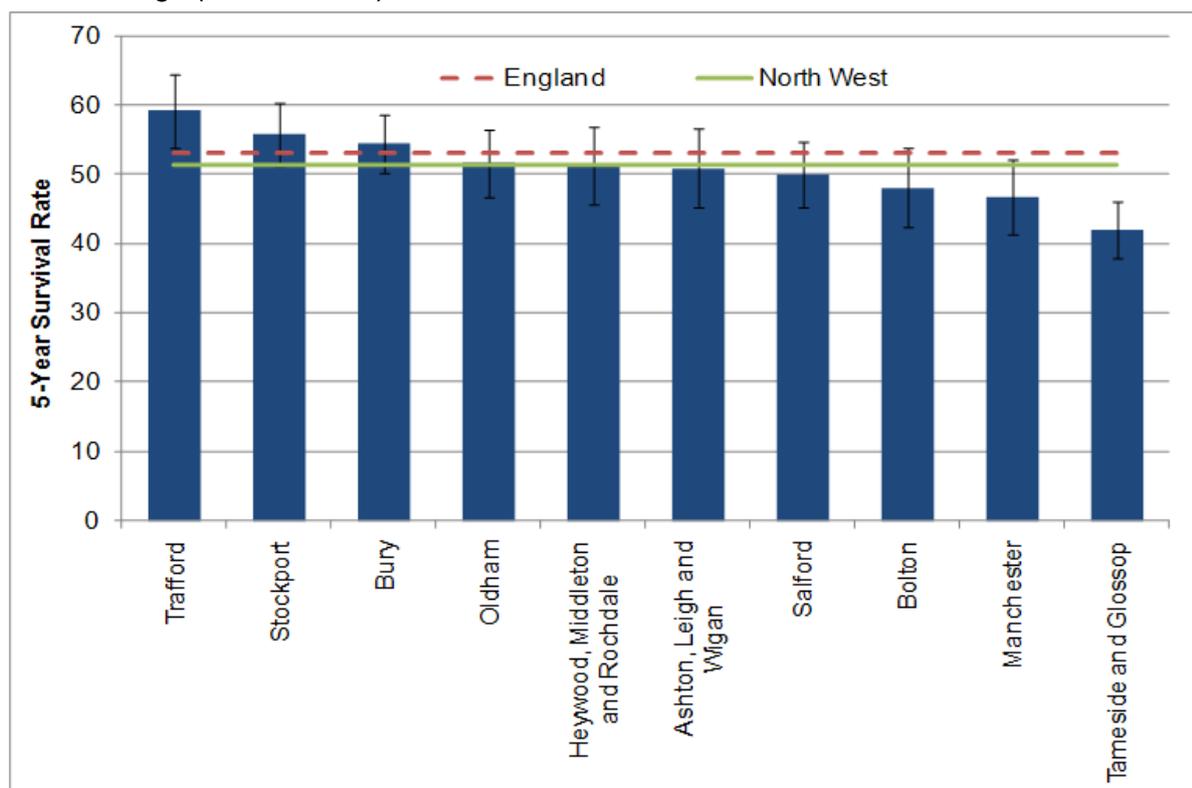
Mortality from all cancers: directly standardised rate, <75 years, 2012



Source: NHS Information Centre 2013

- Of the common cancers death rates for lung, bowel and breast are above, and for prostate the same as, the England average. 5 year survival for bowel cancer is currently the lowest in Greater Manchester.

5 year survival rate (%) for bowel cancer in Greater Manchester, with England and North West average (2001 to 2005)



Source: NHS Information Centre 2012

- There is significant variation in death rates from lung cancer between wards in Tameside and Glossop, and screening uptake also varies between general practice populations.
- Deaths from cancer make a significant contribution to the excess deaths that result in a life expectancy gap between Tameside and England, making up 22% of the difference for men, and 20% for women. [Health Inequalities Intervention Toolkit](#)

Policy context:

- [Improving Outcomes: A Strategy for Cancer DH 2012](#). The NHS Cancer Plan and [Cancer Reform Strategy](#)
- [‘Our Life in Tameside’ – Tackling health inequalities and improving health 2009-2019](#)
- PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop. June 2010.

What interventions work?

About 50% of cancer is preventable, and survival is improving for all cancers with early detection and better treatments. PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop, sets out how the challenge of reducing the impact of cancer on local communities will be met. Alcohol and obesity make significant contributions to cancer risk. Effective and timely treatment is also essential to reducing cancer mortality.

What are we doing now?

The key issues for action in PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop are grouped into four work-streams summarised below.

Work-streams for cancer prevention, early detection and inequalities strategy in Tameside and Glossop

Works-stream 1: Reducing Inequalities	
Gender:	Ensure all appropriate projects within this Strategy are accessible to men
Social deprivation:	Regular review of progress of milestones in all work-streams of this Strategy that give priority to deprived communities
Age:	Review and monitor local over 75yrs cancer mortality.
Ethnicity:	Local adoption of good practice in promoting awareness in South Asian communities identified by GM&C Cancer Network pilot project
Disability:	Review local implementation of national guidance on access to screening programmes

Work-stream 2: Lifestyle	
Reduce the prevalence of smoking	Implementation of Tameside Tobacco Harm Reduction Strategy
	Smokefree Homes programme
	AGMA initiatives on illicit and illegal tobacco trading
	Review of local smoking cessation service
Improve the diet of the population	Tameside area-based action plan to ensure healthy diet for children
	Tameside and Glossop Obesity Strategy and Action Plan
Reduce the prevalence of obesity and overweight	Practice-based one-to-one weight management service
Increase the amount of physical activity	Tameside Sport and Physical Activity Strategy implementation
Reduce excessive consumption of alcohol	Tameside Alcohol Strategy

Workstream 3: Targeted programmes	
Reduce exposure to specific causes of cancer	
Reduce the spread of infections that can cause cancer	

Workstream 4: Early detection	
Improve communication about cancer signs and symptoms	
Make diagnostic pathways follow best practice and be available to all	
Improve attendance at cancer screening especially in disadvantaged groups by implementation of T&G Cancer Screening Promotion Action Plan	

Source: *PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop 2014*

What needs to happen next, and by whom?

- Stopping smoking, as well as taking up healthy eating, physical activity and reducing alcohol intake all help to prevent cancer. There are partnership strategies in place to address each of these and these should be actively supported as part of cancer prevention.
- Deliver priorities for local action within PREVENTABLE and TREATABLE: A Cancer Prevention, Early Detection and Inequalities Strategy for NHS Tameside and Glossop.
- Consistent achievement of good NHS Cancer Waiting Time performance.