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Manchester



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CITY COUNCIL

Improving health in Manchester - Tackling health inequalities



Manchester Public Health Annual Report **2008**

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Foreword

This Public Health Annual Report has been produced jointly by the public health team of NHS Manchester and the Joint Health Unit based at Manchester City Council.

It complements the recent publication of the Manchester Joint Strategic Needs Assessment (JSNA), which describes in detail the future health, care and well being needs of the Manchester population.

The Annual Report does not repeat the analysis contained in the JSNA, which can be accessed at www.manchester.gov.uk/jsna. Instead it focuses on describing our approach to tackling health inequalities in Manchester, building on the recommendations contained in the 2007 Public Health Annual Report.

Finally we would like to dedicate this report to the memory of Fliss Green, who was Director of Public Health for Central Manchester Primary Care Trust between 2002 and 2005. Fliss made an outstanding contribution to public health in Manchester and was passionate about tackling health inequalities.



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Chapter 1

The Health Profile of Manchester and trends in life expectancy

This Manchester Public Health Annual Report when read in conjunction with the Manchester Joint Strategic Needs Assessment (JSNA) and the Compendium of Statistics, provides a comprehensive analysis of the health needs in Manchester.

This chapter describes the gap in life expectancy between Manchester and England. It examines the major causes of the gap in life expectancy, in relation to deprivation and geography (electoral ward).



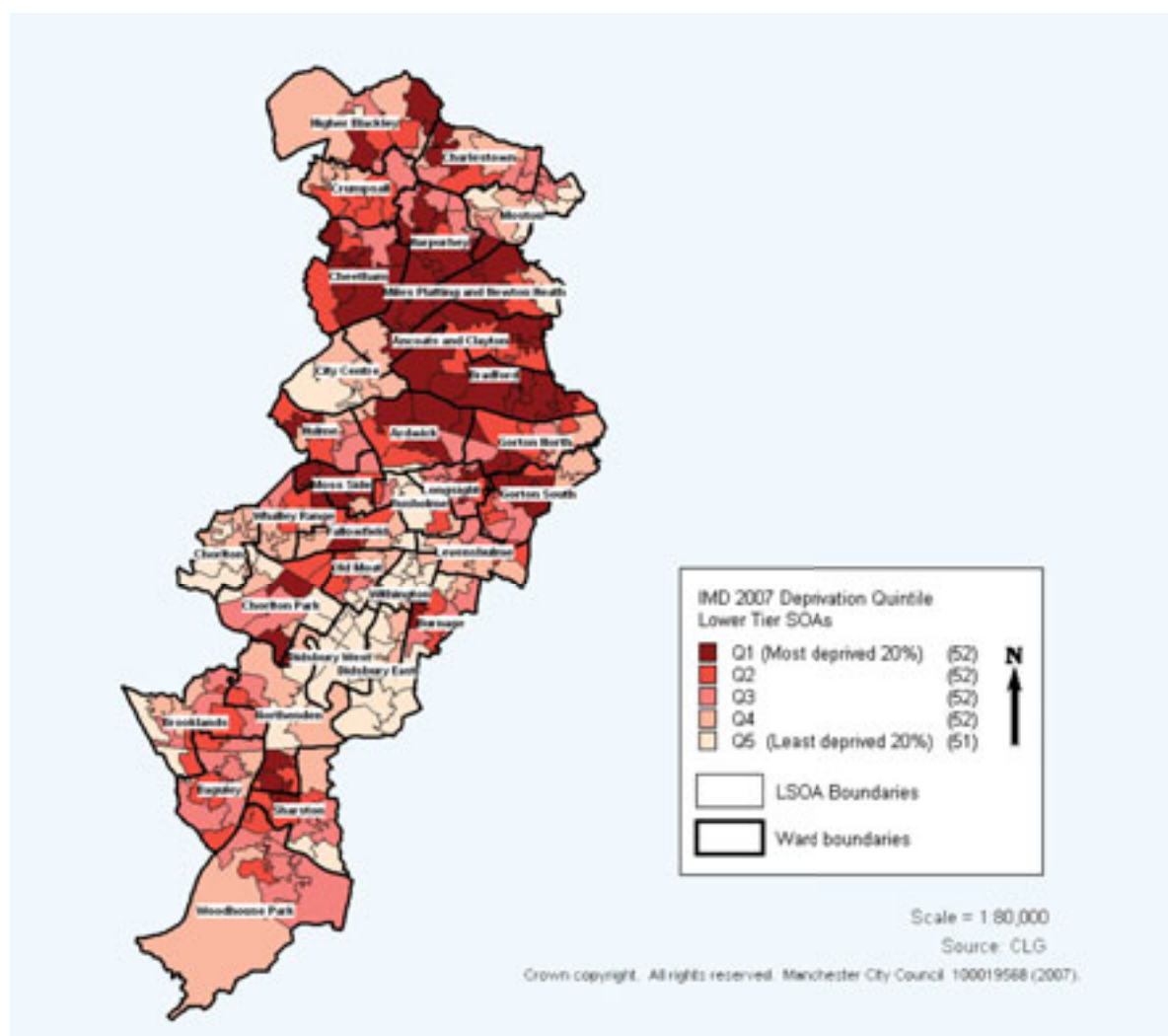
Life expectancy – reducing the gap

Life expectancy among Manchester's men is the second worst in England, while among women it is the fourth worst. Nationally, men in the local authority with the highest life expectancy (Kensington and Chelsea, 83.7 years) can expect to live 10 years longer than men in Manchester. Male life expectancy in Manchester is 73.4 years and female life expectancy 78.9 years. However, overall the life expectancy gap between Manchester and the national average has narrowed by 0.4 years for women and 0.7 years for men since 2000.

Current scale of Internal Inequalities

Poor health is known to be strongly associated with deprivation. Manchester has been ranked by the Index of Multiple Deprivation (2007) as the fourth most deprived local authority in the country. Inequalities in health outcomes and access to health services mirror the local pattern of deprivation for most conditions. A key exception to this in Manchester is seasonal excess deaths which have been found not to be higher in the most deprived areas and for Manchester as a whole to have remained lower than the national average for the previous five years. The reasons for this are unknown, but may be linked to a small older population, high levels of provision of social housing for older people and campaigns to increase uptake of benefits among the older population.

The map shows small areas within Manchester and their level of deprivation. These have been grouped into quintiles (fifths) of deprivation for analysis. The darkest red areas are the most deprived 20% of areas and are grouped as quintile one (Q1).



While there has been improvement in health for the population of Manchester as a whole in terms of life expectancy, the pattern of premature deaths in Manchester shows that inequalities remain within communities and between areas in Manchester (internal inequalities). The health of those living in the most affluent areas has improved more quickly and contributed more to the overall improvement in life expectancy than those in the most deprived areas.

Grouping the causes of death into a 'scarf chart' (Figure 1) we can show the percentage contribution of various causes of death to the life expectancy gap between the Most Deprived Quintile (fifth) of Manchester and the city average. Figure 2 presents this information in summary terms by cause of death.

Directly Standardised Mortality Rates (DSR) for all causes of deaths and the diseases which contribute most to the internal inequalities in Manchester have been analysed by quintile of deprivation and electoral ward.

This provides a baseline picture of inequalities and is being used to target initiatives more directly at groups of people who share common characteristics and are at greatest risk of premature death.

Fig. 1; Life expectancy years gained if the Most Deprived Quintile (MDQ) of Manchester MCD had the same mortality rate as the city average for each cause of death.

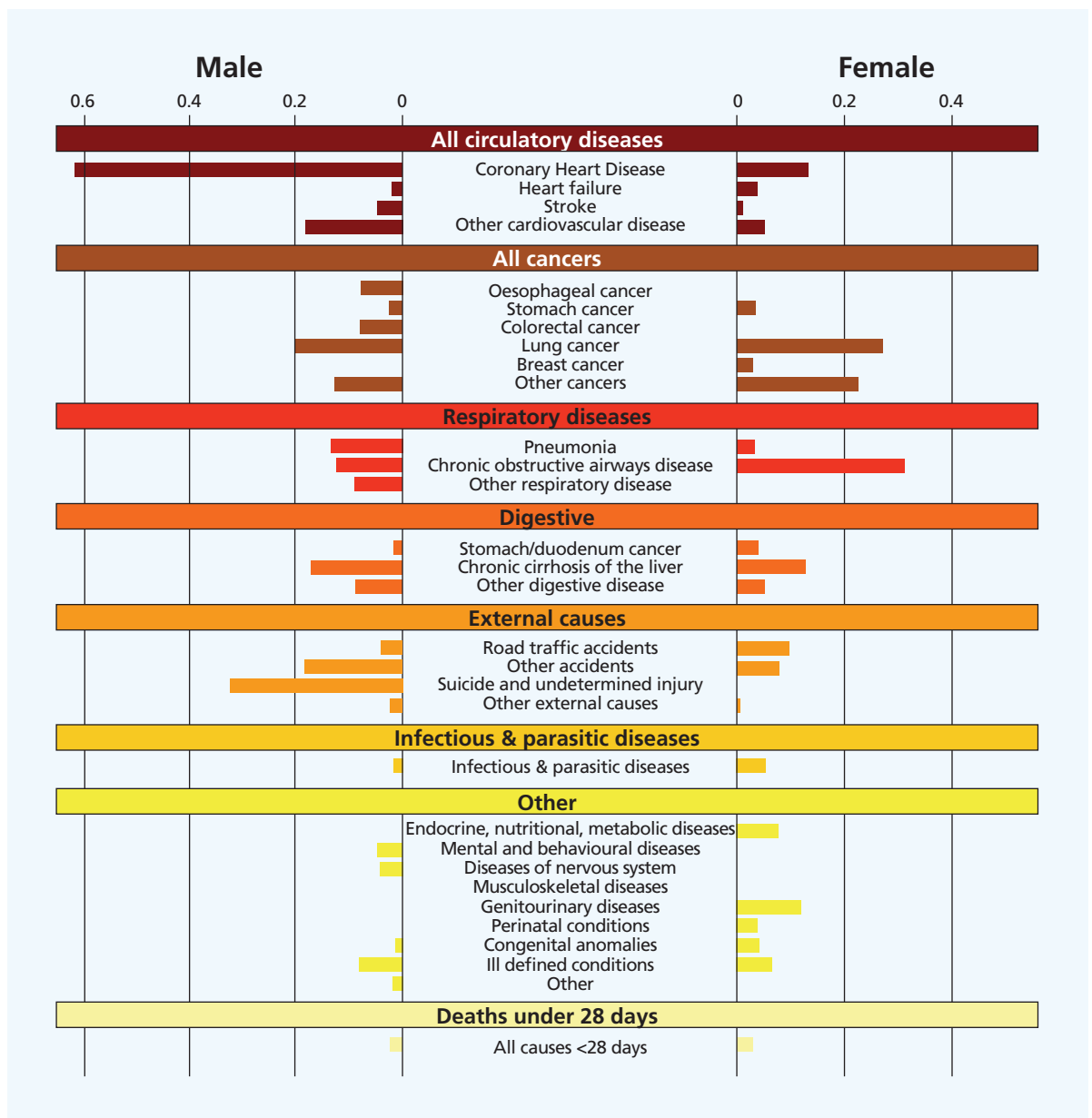
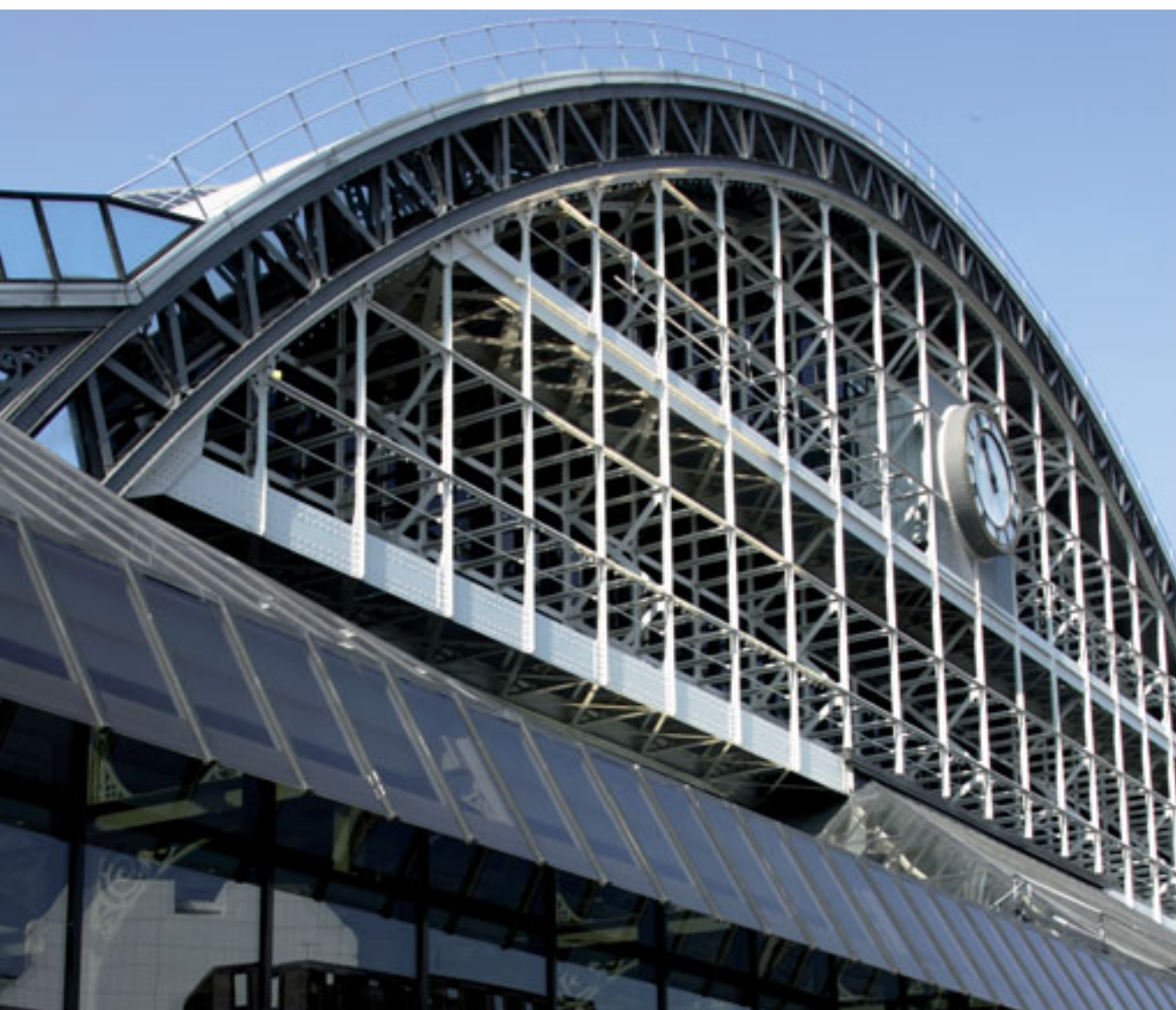
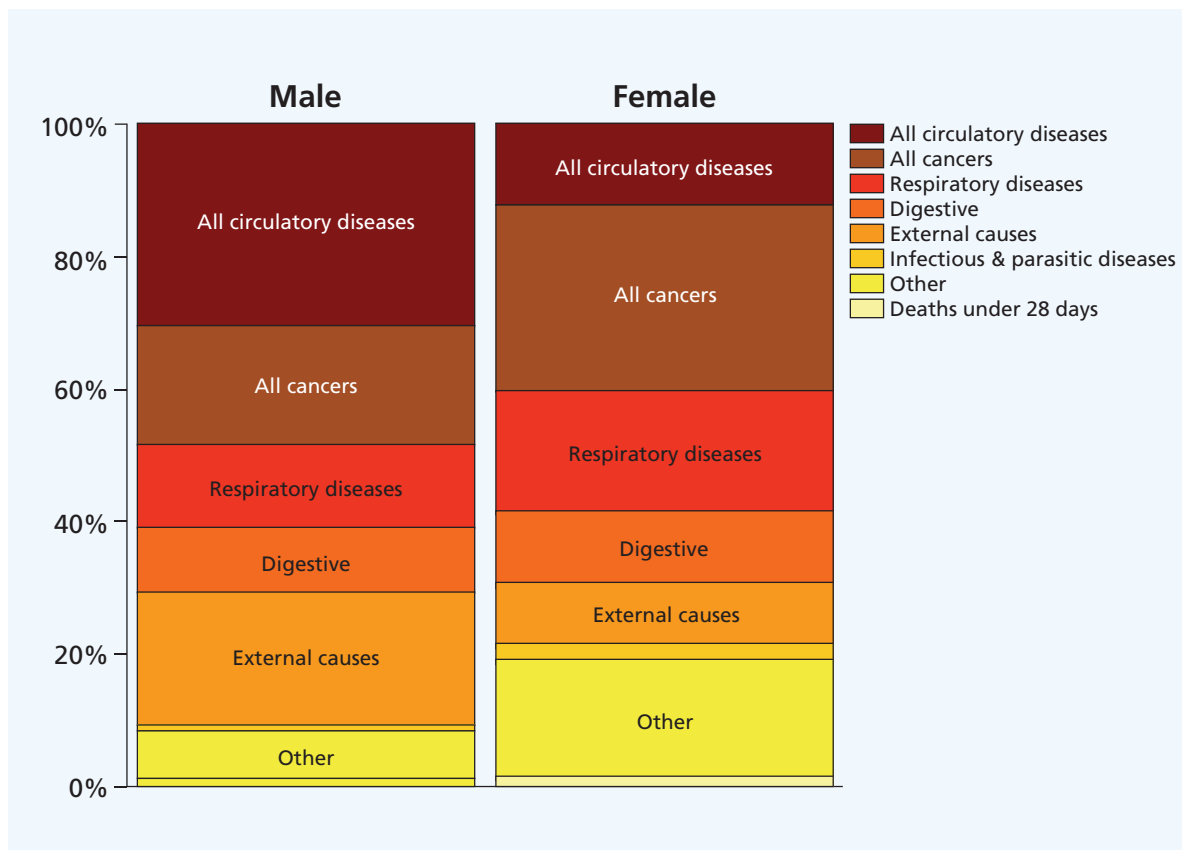


Fig 2: Breakdown of life expectancy gap between the Most Deprived Quintile (MDQ) of Manchester and the city average by cause of death



Mortality from All Causes of Death

Figure 3 shows rates of death from all causes (all ages) by quintile of deprivation. The graph shows the city average as a red line. For each rate, confidence intervals have been applied to indicate the range within which the true value may be. Graphs that contain data with a large number of wide and or overlapping confidence intervals should be viewed with caution.

The most important factor is the difference between the most deprived quintile and the least deprived. The death rate in the most deprived quintile (Q 1) is 60% higher (rate ratio 1.6) than the least deprived (Q 5). The rate in the least deprived quintile of wards is significantly different to other quintiles. 19% of the population are living in the least deprived quintile, while 41% of the population live in the two most deprived quintiles (1 and 2).

Figure 4 shows that when the data is analysed by individual ward that 7 wards have mortality rates for All Causes of Death which are significantly above the average for the city. These wards are Harpurhey, Ardwick, Miles Platting and Newton Heath, Gorton North, Old Moat, Bradford and Charlestown. Eight wards (Chorlton, Moss Side, Withington, Whalley Range, Brooklands, Didsbury West, Didsbury East and City Centre) are significantly below the city average.

Figure 3. All causes of death (all ages) by quintiles of deprivation

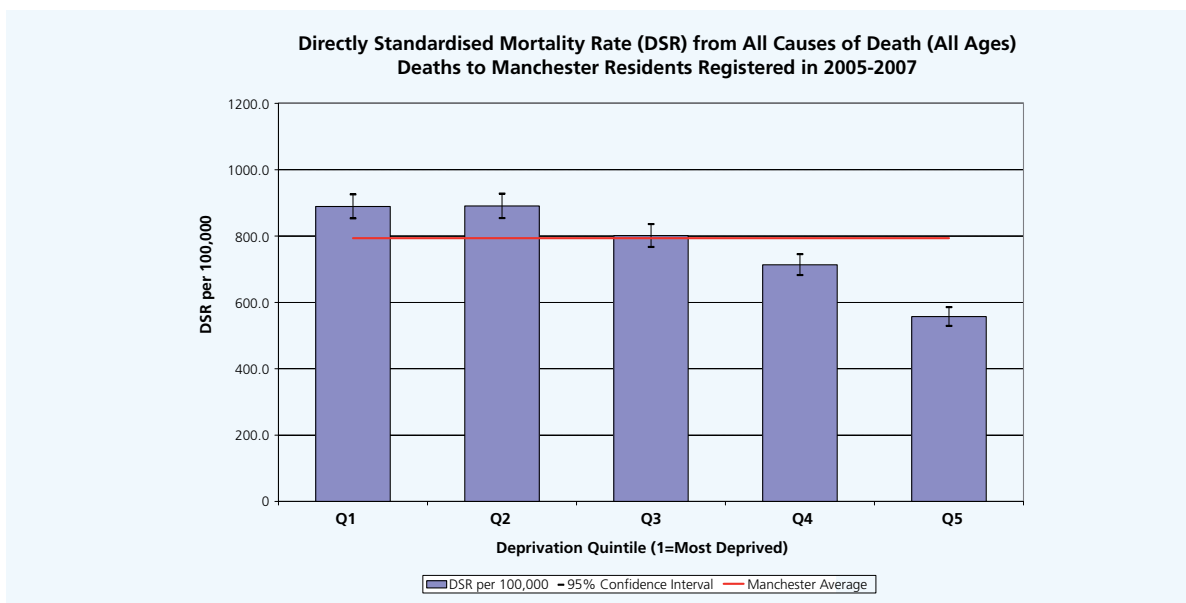
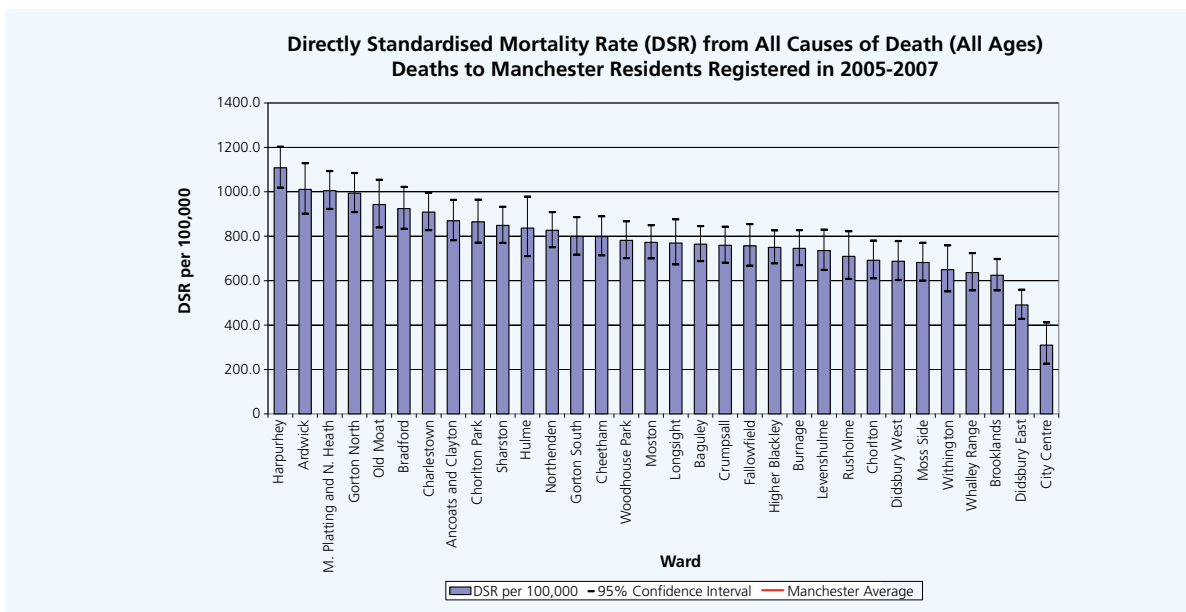


Figure 4 All causes of death (all ages) by ward



Circulatory Diseases (0-74 years)

Circulatory diseases contribute to 30.6% of the gap in life expectancy for men in the most deprived quintile and 12% of the gap for women (see Figure 2).

Figure 5 shows mortality from circulatory diseases (0-74 years) for the years 2005-2007 to Manchester residents by quintile of deprivation. Premature deaths from circulatory diseases are more than twice as high in the most deprived quintile than in the least deprived quintile. Death rates in the two most deprived quintiles (1 and 2) are not significantly different to each other, but both are significantly higher than the average for the city and the two least deprived quintiles.

Figure 6 shows the mortality rate from Circulatory disease (0-74 years) for each ward. The rates in two wards are significantly higher than the Manchester average. They are Bradford and Miles Platting and Newton Heath. Premature deaths in Miles Platting and Newton Heath are nearly three times (rate ratio 2.8) higher from circulatory disease than those in Didsbury East (the lowest rate).

Figure 5. Premature deaths from circulatory disease by quintile of deprivation

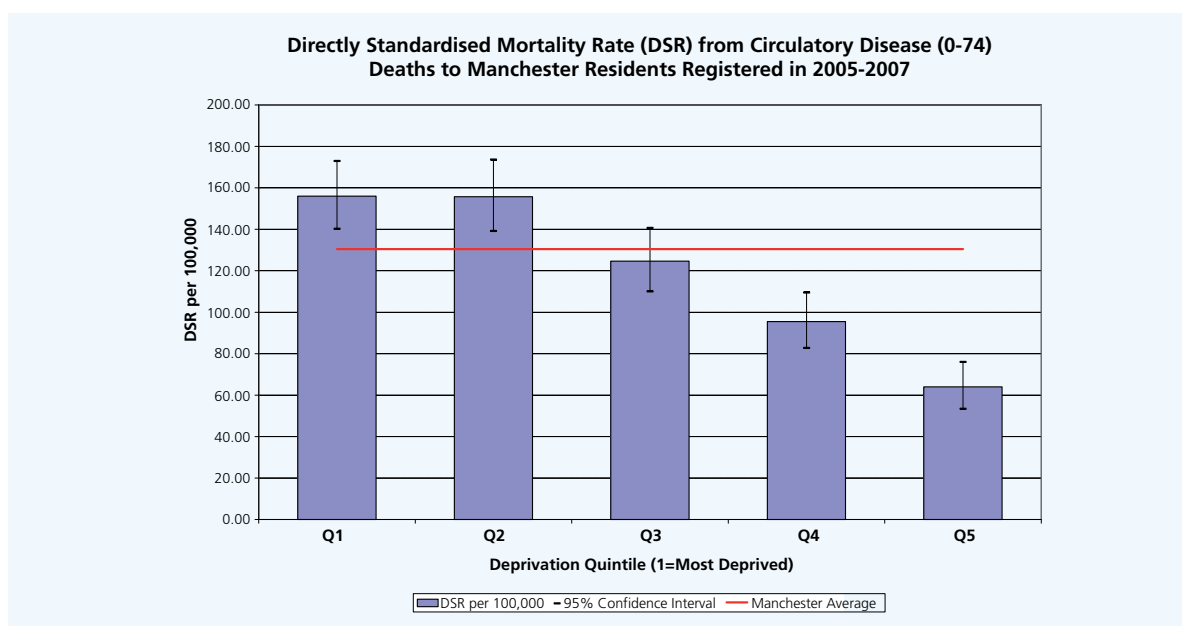
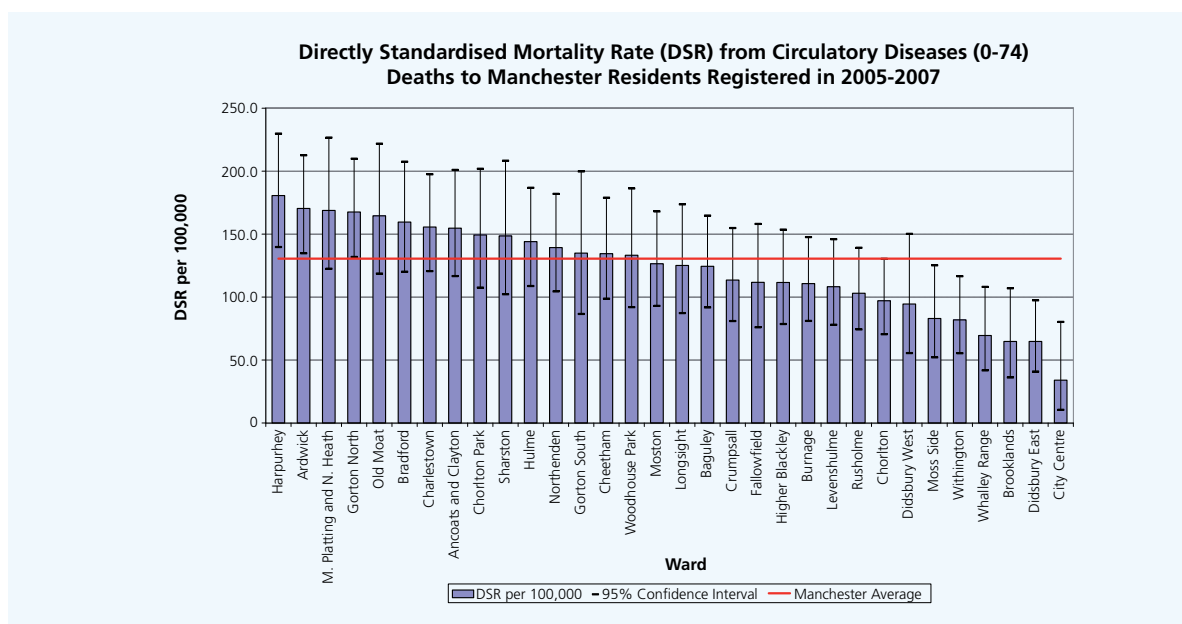


Figure 6. Premature deaths from circulatory diseases by ward



Cancers (0-74 years)

Cancers contribute to 18% of the gap in life expectancy for men in the most deprived quintile and 28.6% of the gap for women (see Figure 2).

Figure 7 shows death rates from cancers (all Malignant Neoplasms) ages 0-74 years by quintile of deprivation. Only the most deprived quintile was significantly higher than the average. People in the most deprived quintile were 40% more likely to die early from cancer than those in the most affluent.

Figure 8 shows premature deaths from cancer by ward. None of the wards has a significantly higher than the average death rate and Didsbury West, Whalley Range and Didsbury East had rates significantly lower.

Figure 7 Premature deaths from cancers by quintile

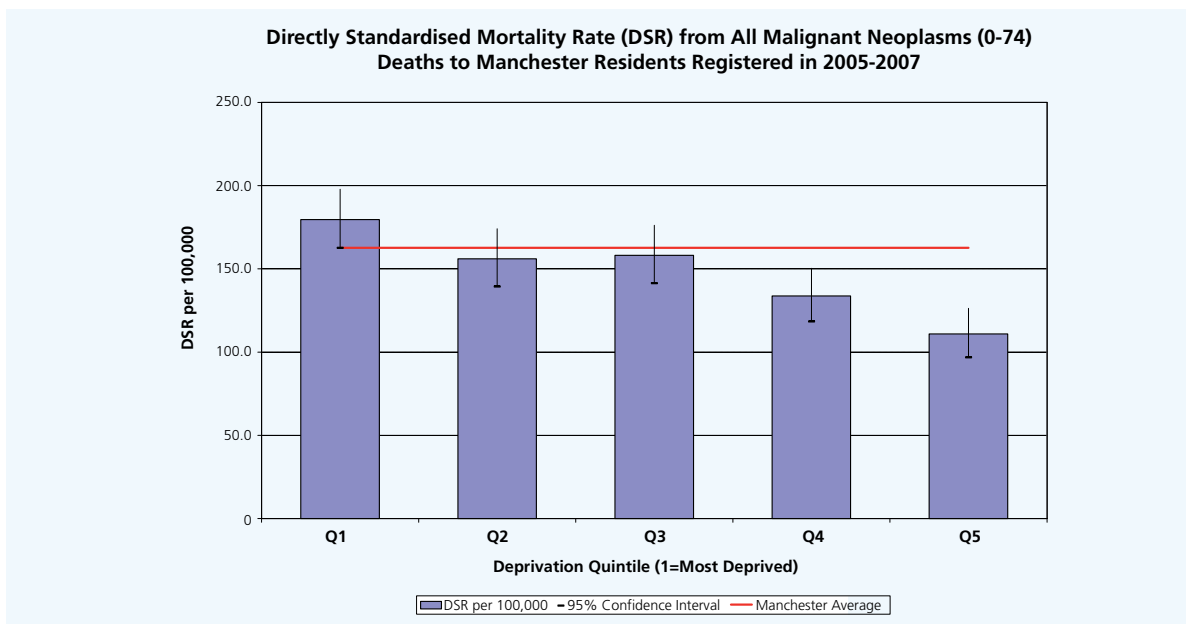
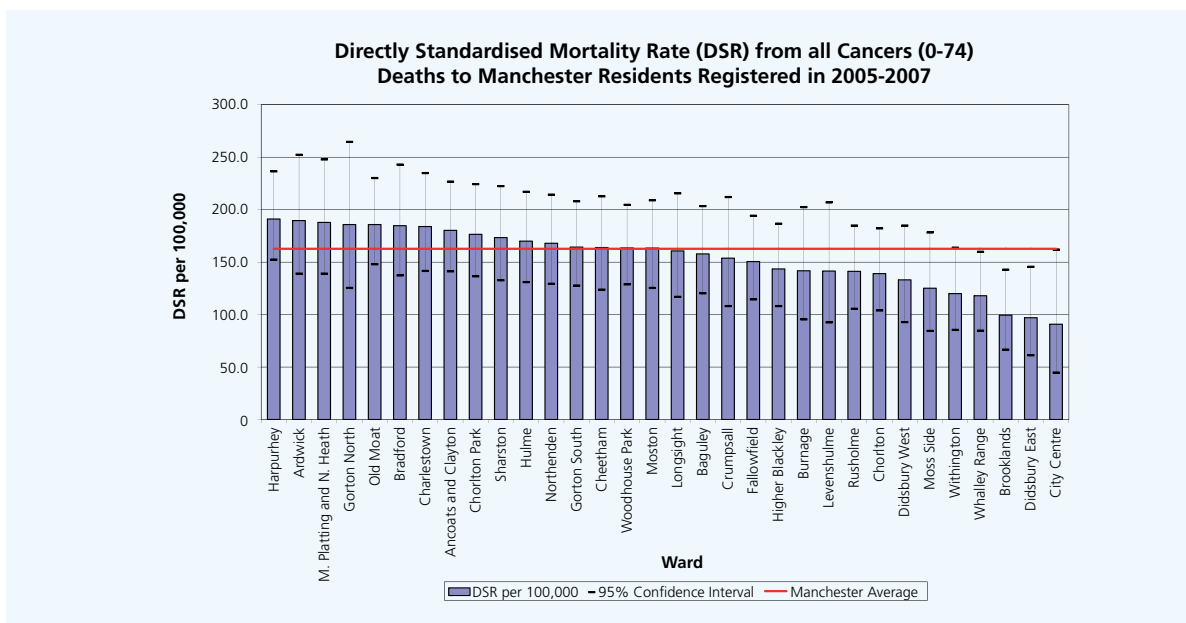


Figure 8 Premature deaths from cancer by ward



Respiratory Diseases (0-74 years)

Respiratory diseases contribute to 12.5% of the gap in life expectancy for men in the most deprived quintile and 17.7% of the gap for women (see Figure 2).

Figure 9 shows deaths from respiratory disease (0-74 years). Only the most deprived quintile has a rate significantly above the average. Premature deaths in the most deprived quintile are almost three times higher than in the least deprived.

Figure 10 shows that five wards have rates significantly higher than the average for respiratory disease: Harpurhey, Ardwick, Old Moat, Miles Platting and Newton Heath and Gorton North. Premature deaths in Harpurhey are five times higher from respiratory disease than in Didsbury East.

Figure 9. Premature deaths from respiratory disease by quintile of deprivation

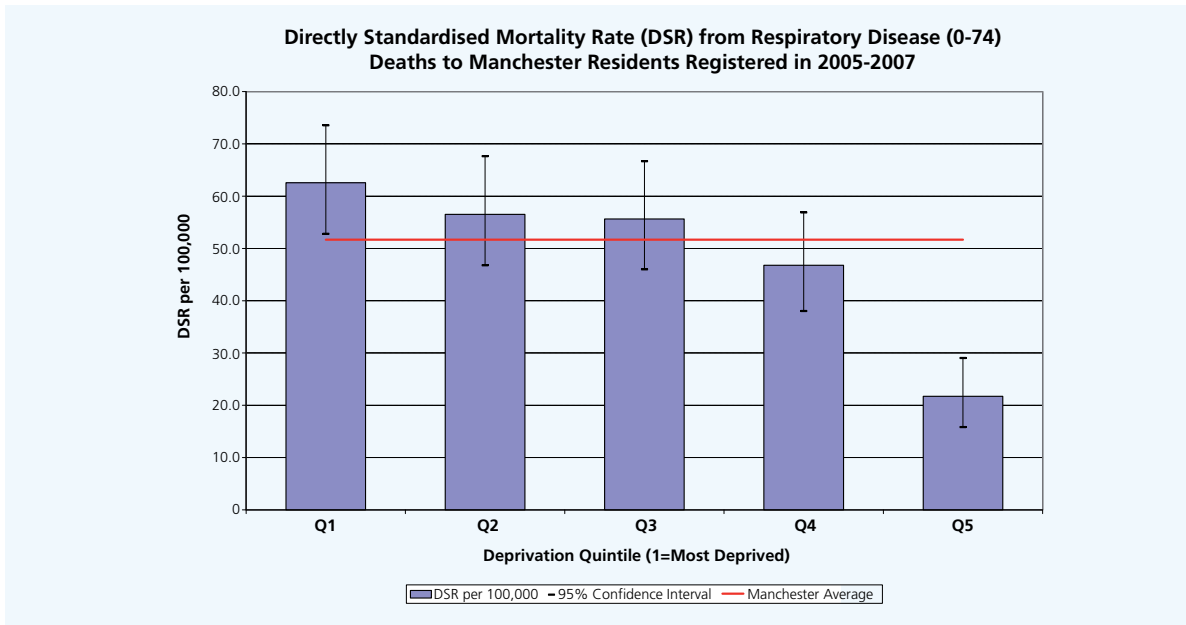
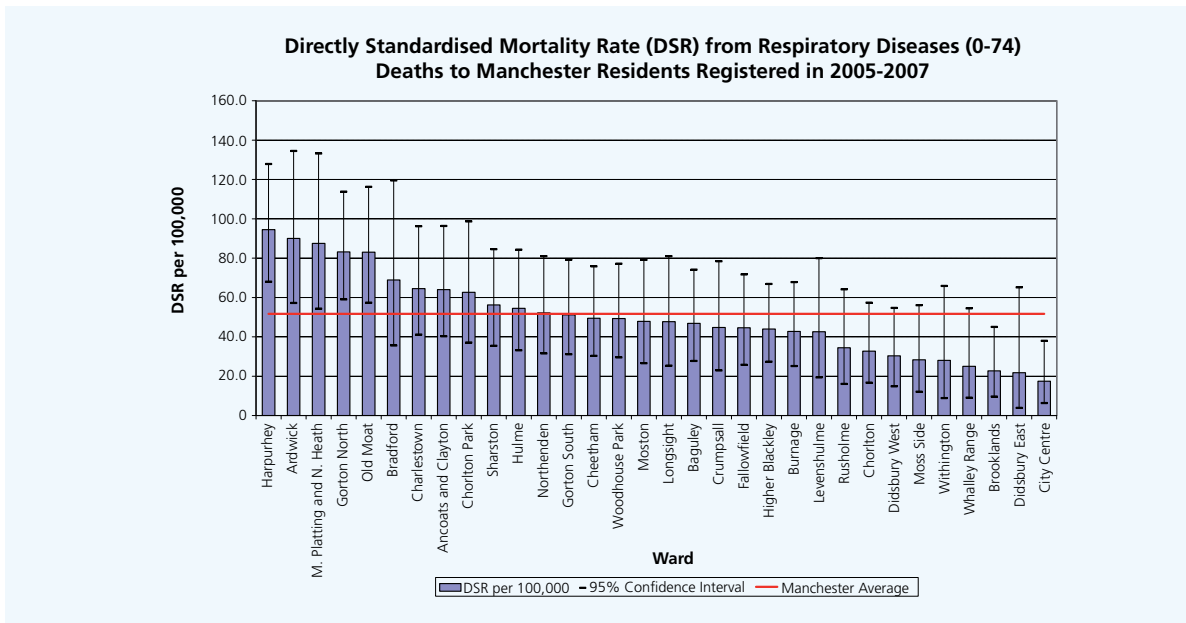


Figure 10. Premature deaths from respiratory disease by ward



Digestive diseases (all ages)

Digestive diseases contribute to 9.8% of the gap in the life expectancy for men in the most deprived quintile and 11% of the gap for women (see Figure 2).

Figure 11 shows deaths from digestive disease by quintile of deprivation. None of the quintiles is significantly above the average death rate for the city but both 4 and 5 are significantly below the average. There is no significant difference between quintiles 2, 3 and 4 (confidence intervals overlap),

Figure 12 shows deaths from digestive disease by individual ward. At ward level the confidence intervals are very wide indicating the small numbers involved. Four wards have significantly higher than average rates: Harpurhey, Ardwick, Ancoats and Clayton and Miles Platting and Newton Heath. Only Moss Side and Brooklands have rates which are significantly below the average for the city.

Figure 11 Deaths from digestive diseases (all ages) by quintile

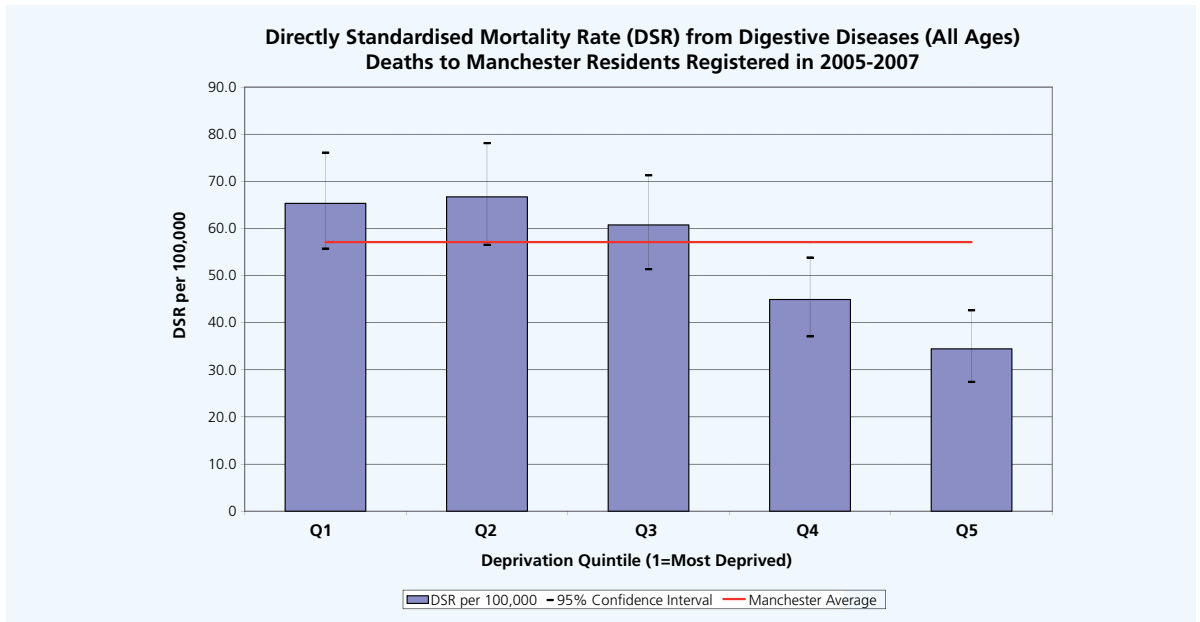
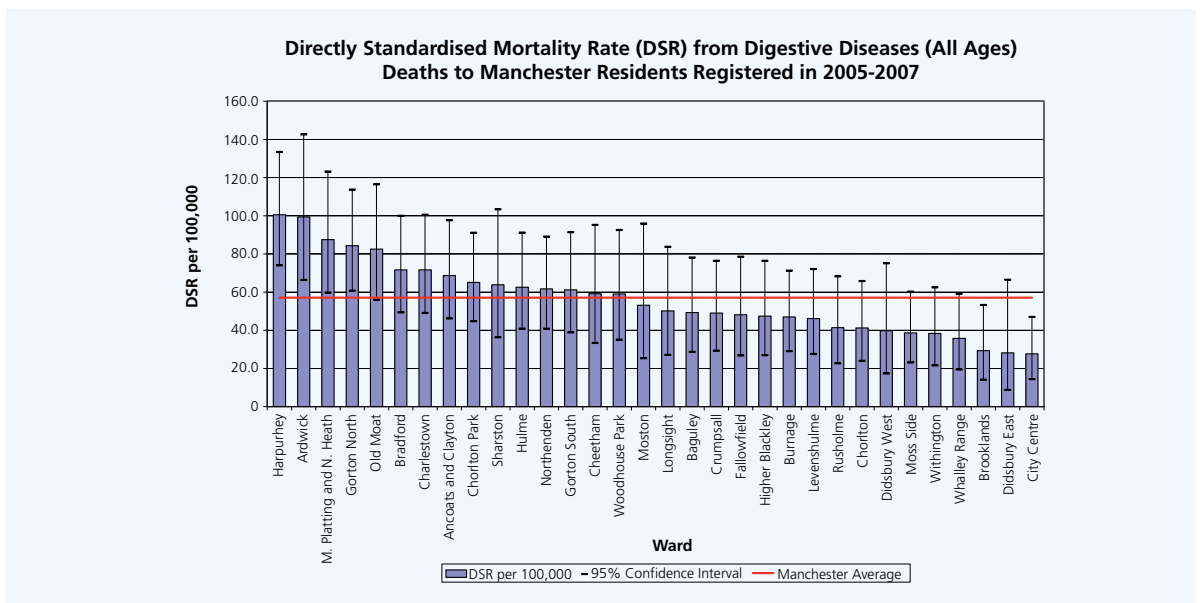


Figure 12. Deaths for digestive diseases (all ages) by ward





Chapter 2

The Manchester approach to tackling health inequalities

Health Inequalities can be defined as unfair and unnecessary differences in health and health outcomes between groups in society. The reasons for these differences in health are, in many cases avoidable – a consequence of differences from birth in opportunity, in access to services, and material resources, as well as differences in the lifestyle choices of individuals.

The national target for inequalities is:

By 2010 to reduce the inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

The aim of the target is to close the health gap by reducing relative differences in two dimensions of the target:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual group and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

Progress towards the national targets has been monitored regularly through a series of independent status reports, the last of which was published in March 2008¹. The report found that despite absolute improvements in health, inequalities remain. Health improvements among better off groups have occurred at a faster rate than other groups within the population. The less affluent have seen much smaller improvements in their health, so that the health inequality gap between rich and poor has increased.

It concluded that in the short term (to meet the 2010 target) focused action by the NHS is required. Areas with the highest levels of deprivation and poor health were designated "Spearhead areas" and charged with improving the health of their populations at a higher rate than other areas. High Impact Changes for PCTs and Local Authorities were identified through modelling.

These "Public Health High Impact Changes" were adopted by Manchester as central to tackling health inequalities as described in Manchester's Public Health Annual Report 2007.

The High Impact Changes continue to provide the structure to Manchester's health inequalities programme.

As a Spearhead area, Manchester has been at the forefront of developing a programme which puts evidence of what works into action locally. The challenge in Manchester is to continue to improve the health of the whole population to reduce the gap between Manchester population as a whole and the average for England, while narrowing internal inequalities between the most deprived and least deprived areas and groups of people.

In 2008, the Manchester Public Health Framework was developedⁱⁱ. The Framework describes the broad approach being taken to public health improvement and the key themes that are being worked on, so that everyone involved in the public health system can clearly see where their work contributes to the whole. It has been developed jointly by the Public Health Department of NHS Manchester and Manchester Joint Health Unit. It is informed by the Joint Strategic Needs Assessment for Manchester and the Public Health Annual reports of 2006 and 2007. It is consistent with Manchester's Community Strategyⁱⁱⁱ, the Local Area Agreement^{iv} and NHS Manchester's Commissioning Strategic Plan^v.

The Manchester approach is characterised by:

- working in partnership to deliver strategic change;
- a focus on reducing inequalities, both within Manchester and between the city and the rest of the country;
- evidence based action, both in terms of following through on actions that have been identified nationally as high impact changes and in ensuring that work is appropriately targeted through robust health intelligence;
- industrialisation of scale, matching the scale of the intervention to the scale of the problem;
- integration of public health thinking into a wide range of local policy, reflecting the diverse determinants of health.

The approach is reflected across two broad themes for local action:

- providing high quality preventative and treatment services;
- a multilevel focus on the determinants of health.



Some traditional health services are, of course, core to protecting and promoting public health, and these remain central to Manchester's approach. These include:

- encouraging uptake of immunisations and vaccinations;
- strong infection and communicable disease control measures;
- encouraging uptake of appropriate screening opportunities;
- ensuring that primary care services identify high risk groups and provide appropriate preventative services.

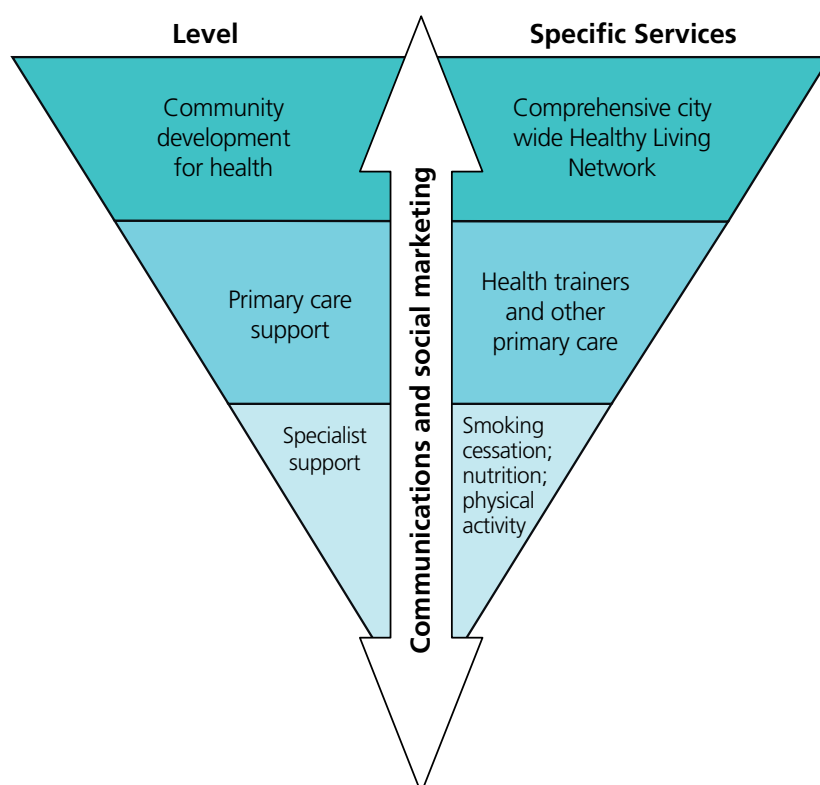
As the determinants of health are complex and wide ranging, our comprehensive approach to public health improvement requires action on many levels.

Manchester people are at the heart of the public health strategy. There are inequalities related to a wide range of factors, including age, sex, race, sexuality and disability. Public health policy will seek to redress these inequalities, in part through use of health equity audit. The Manchester approach to public health recognises that promoting equality by tackling discrimination is likely to contribute to long term reductions in inequalities. All organisations in Manchester have a role to play in reducing discrimination in the workplace and in access to and outcomes from services. Specific groups of people in Manchester whose health is likely to improve with increased equality include those from black and minority ethnic communities, people with learning disabilities, lesbian, gay, bisexual and transgendered communities and older people.

As future health is influenced by early years, maternal and child health and promoting breastfeeding are core to the long term public health strategy.

Empowering communities to aspire to good health is one of the interventions identified as a high impact change for public health and tackling health inequalities. Evidence suggests that community development and capacity building can be successful in creating and sustaining effective networks for local change and that this can deliver health gains. Manchester's approach to improving lifestyle in the context of community development is described in the diagram below.

Figure 13 - Manchester's approach to improving life style in the context of community development



A strong economy is good for health and tackling worklessness is a major public health priority. During the economic downturn it will be vital to ensure that a greater focus is given to programmes that provide appropriate training opportunities for people, linked to support packages. These support packages will help individuals and their families deal with the health and social impacts of the downturn with a strong emphasis on positive mental health. We will ensure that the NHS, City Council, Job Centre Plus and other partners enhance existing advice and support services at a locality level.

The quality of the built environment is crucial to health and wellbeing. It can have direct effects on mental health and also make a huge difference to the lifestyles people lead. We will therefore seek to build health into urban planning and regeneration wherever possible and in particular to promote a healthy transport system that encourages people to be more physically active; in particular through taking up walking and cycling as everyday transport options.

Evidence is building that exposure to the natural environment is an important factor in health – particularly mental health. We will therefore support action to improve access to, quality of and use of green space, including parks and allotments. We will also support efforts to increase Manchester's biodiversity.

Climate change is, in the long term, one of the most significant threats to public health at a global level. We will act to reduce our own impact on the climate and to mitigate the impact of any changes on health at a local level.

This multi-level approach will be taken to all key lifestyle and health related behaviour issues, which are as follows:

- tobacco use
- obesity
- drug and alcohol use
- food and diet
- physical activity
- sexual health and teenage pregnancy
- oral health
- uptake of cancer and cardio-vascular disease (CVD) risk factor screening
- mental health and wellbeing
- accident prevention.

Reference

- i Tackling Health Inequalities: 2007 Status Report on the Programme for Action. Department of Health, March 2008.
- ii Public Health Strategy
- iii **The Manchester Community Strategy (2006-2015)**
The Manchester Community Strategy (2006-2015): "The Manchester Way" sets out the vision and priorities for the city over the next decade. By 2015 if the vision is achieved, Manchester people will be wealthier, live longer, be healthier and enjoy happier lives.
- iv **Local Area Agreement (2008)**
The Local Area Agreement (LAA) is Manchester's delivery plan for the next three years of the Community Strategy. Its aim is to accelerate the reduction in deprivation in Manchester and fulfil the Community Strategy vision for a World Class City which includes healthier communities. The LAA sets out shared priorities, targets and a framework for monitoring progress. Promoting health and well being is a priority within the LAA. Key issues highlighted were preventing premature deaths, preventing teenage pregnancy and reducing its impact on children's health and supporting children to have a healthier diet and exercise.
- v Improving Health in Manchester; Commissioning Strategic Plan: NHS Manchester 2009-14





Chapter 3

Updates of actions in 2008

Manchester's Public Health Annual Report 2007 described the progress made to reduce the gap in life expectancy between Manchester and England. It detailed the High Impact Changes required to meet the 2010 targets. Additionally, it identified obesity and alcohol as key factors which contribute to health inequalities in Manchester. The report also focused attention on work to protect vulnerable babies and work in the area of health protection. This chapter provides an update of actions taken in 2008 in all of these areas.

High Impact Changes

1. Know the gap in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a strong impact upon the gap

Health Intelligence

The Public Health Annual Report 2007 recommended that the PCT invest in further public health intelligence in Manchester. A business case to develop capacity in data analysis was submitted via the Local Delivery Plan - "Improving Health in Manchester" investment programme. Funding was successfully secured.

Infant mortality

The infant mortality rate is regarded as an important measure of the health of a community, as deaths occurring in the first year of life usually reflect a wide range of factors. As identified in the Joint Strategic Needs Assessment, Manchester's infant mortality rates have fallen steadily over the past decade, but remain significantly higher than the average for England and Wales, making tackling infant mortality one of our priority areas. In addition, prioritising investment to reduce the infant mortality gap is one of the high impact changes known to have the greatest impact on improving health. In response to this, in 2008 the Manchester Infant Mortality Strategy Group was established, bringing together key players to develop a strategy and joint action plan for reducing infant mortality across the city.

The Manchester Infant Mortality Strategy (currently in late draft) identifies nine headline objectives that will be central to closing the health inequalities gap in infant mortality. These objectives have been closely linked to the Commissioning Strategic Plan and Local Area Agreement to achieve the greatest reduction in infant mortality.

Throughout 2008 there have been many notable examples of initiatives to improve outcomes in infant and maternal health, including:

- Working to achieve UNICEF Baby Friendly Initiative across maternity and health visiting services to improve breastfeeding support;
- Commitment to expand the Family Nurse Partnership programme to support first-time teenage parents;
- Partnership working on initiatives to reduce health risks in infants: Stop Smoking, "Be Cot Safe", Social Marketing Campaign and Specialist Midwifery Services.

2. Make smoking history – reduce smoking prevalence and target cessation services and campaigns in deprived areas and groups

Manchester Stop Smoking Service continued to develop its programme of drop-in services in clinics, hospitals, community centres and markets across Manchester. Additional support and information for young people has been offered via the website.

In December 2008, Manchester Stop Smoking Service held a Smokefree Homes Celebration event with free family activities and trained stop smoking advisors on hand to offer help to quit smoking ahead of Christmas and the coming New Year.

The National Health Inequalities Intervention Tool has been used to model the impact of the stop smoking programme on inequalities between the most deprived areas of Manchester and the city as a whole¹. This analysis suggests that a 50% increase in the number of people successfully quitting after



4 weeks (from around 4,400 to around 6,600 quitters a year) would have the effect of narrowing the gap between the most deprived quintile and Manchester as a whole from 4.0% to 3.9% for men and from 2.2% to 2.1% for women (a fall of 3.2% and 6.5% respectively).

3. Target prevention of cardiovascular diseases using prevalence models to identify areas of unmet need alongside a case finding strategy

The 2007 Public health Annual Report recommended investment in an evidence-based, preventative programme of cardiovascular disease (CVD) risk assessment and management. In October 2008, NHS Manchester approved the business case. This programme of work is to include:

- Implementing predictive CVD risk registers by means of a contract with General Practice
- The medical management of individuals identified as high risk within General Practice
- Commissioning a multi-disciplinary, nurse-led programme to provide intensive support in convenient local settings, for individuals with a very high risk of CVD, enabling them to adopt healthier lifestyles
- Contracting with community pharmacists, optometrists, dentists and other providers to provide lifestyle advice
- Identifying gaps in cardiac rehabilitation service delivery and developing services to meet need
- Funding education programmes in schools

In a partnership between NHS Manchester and a software developer, a cardiovascular primary prevention assessment tool was designed and, to date, has been installed in 98% of Manchester General Practices. This product supports the prioritisation of individuals for in-depth risk assessment and the building of predictive CVD risk registers.

4. Improve detection of disease in local communities

The Healthy Communities Collaborative Project has been established to promote the Early Presentation of Cancer Symptoms

This is a partnership between NHS Manchester and the Improvement Foundation. The project supports local volunteers in raising awareness of breast bowel and lung cancer symptoms. The aim is to deliver the message that "early presentation with cancer symptoms to your GP can save lives".

In 2008, the focus of the project was on community engagement. Team members spoke to individuals and groups in target areas of North Manchester. The Healthy Communities Collaborative has also raised awareness via the media; including local radio interviews, newspaper articles and a television programme.

Don't be a Cancer Chancer

"Don't be a Cancer Chancer" is a targeted social marketing campaign aimed at local people over the age of 50 years. It was developed in collaboration with the Manchester Versus Cancer Alliance. The aim is to encourage people to go to their GP with any suspected cancer symptoms. The intention is to raise awareness of the possible signs and symptoms of bowel, breast and lung cancer and to take away the fear that cancer is a killer.

The campaign has a simple message:

"Don't be a Cancer Chancer; Catching it Early Could Save Your Life; See Your GP."

The campaign was piloted in Harpurhey in 2007. Due to the success of the pilot it was agreed to roll the programme out in 2008, targeting North and East Manchester.

An independent evaluation of the 2008 campaign was undertaken on behalf of the Manchester Versus Cancer Alliance. Product recall in the target groups was very good. When asked about their reaction to the campaign messages, over half claimed the adverts would make them go and see their doctor.

Equitable access to cancer screening

In 2008, a major survey was conducted of Wythenshawe women's experience of being invited for breast screening. The aim was to understand why women from Wythenshawe were not attending routine breast screening appointments in the mobile van located at Withington Community Hospital.

4715 letters were posted out to women who had been called for routine breast screening appointments, asking them to share their views and experiences and what factors led to some of them not attending. Various options were given to women to respond; writing, telephone, email and text.

In total 570 responses were received giving a response rate of 12 per cent.

Positive comments were made about staff attitude, clinical care, advice and support and car parking at Withington Community Hospital.

Areas for future work to improve access and uptake were identified in terms of location, choice of facility, transport, communication, dignity, choice of appointment and access for disabled women.

As a result, the following has been done:

- An action plan has been agreed, to respond to the "Top Ten" patient experiences.
- Opportunities have been identified for women who expressed an interest in further involvement in breast care services.

In addition, work has continued through 2008 to improve ethnicity recording in primary care, secondary care and screening services to enable equity audit and appropriate screening commissioning.

5. Ensure the quantity of primary care in disadvantaged areas is sufficient to address need and is of high quality. Focus Health Trainers and Life Check Programmes on tackling health inequalities

Health trainers

Increasing the number of Health Trainers, particularly in primary care, has been recognised as a priority and is in the Commissioning Strategic Plan for NHS Manchester.

There are currently 13 Health Trainers in post. Another 14 were recruited in November 2008 and will start in February 2009.

New Health Trainer placements in 2008 include Primary Care Mental Health Teams, the "Supporting Health" Programme, the Expert Patients Programme, George House Trust and the Tree of Life Project. The numbers of people referred through their GP or other Primary Care Professionals is increasing. In addition to their role in Primary Care teams, Health Trainers now work within a range of settings. These include the Manchester Diabetes Centre, Withington Hospital's Choice Team, NHS Podiatry team and Physiotherapy clinics, the Christie Hospital out-patients' department, Manchester United Foundation, Manchester Carers Centre, Job Centres, Surestart, the Heart & Lung smoking team at Wythenshawe Hospital and Healthy schools teams citywide.

Oral Health

Oral Health is an integral part of overall health and well being. It is a good indicator of general



health. Oral health is closely associated with social deprivation and is a key marker of the health of a community.

Levels of oral health are poor in Manchester and oral health inequalities are seen within Manchester wards and between Manchester and surrounding areas in the North West. For example, in a 2005/06 survey of Manchester five year olds, 62% had experience of tooth decay, compared with 47% in the North West and 38% across England as a whole.

NHS Manchester Board approved an Oral Health Strategy in January 2008.

6. Empower disadvantaged communities to aspire to good health

Healthy Living Network

The Healthy Living Network organisations have developed citywide programmes of work to support communities to articulate their own concerns about food and support them to take positive steps to improve their own diet. Three Community Food Workers have been appointed through the Healthy Living Network structure to lead this work.

A review of the South Manchester Healthy Living Network and the ZEST Healthy Living Network has been completed. As a result, a business case was written to support the development of a citywide healthy living network and was approved by NHS Manchester.

7. Reduce harm from Alcohol

In order to address identified need, for those who are drinking at increasing and higher risk levels, a number of new initiatives have been funded through the Improving Health in Manchester process.

An Alcohol Capacity and Needs Analysis, conducted in 2007 on behalf of NHS Manchester and the Manchester Drug and Alcohol Strategy Team, identified the need to invest more in prevention and early intervention for increasing and higher risk drinkers, as currently the bulk of investment is in services for dependent drinkers.

Alcohol and Primary Care

Work is currently in progress to establish an Alcohol Identification and Brief Advice pilot in 20 GP Practices across the city, with priority given to those Practices delivering services in the most deprived wards.

In the first phase this pilot will be funded from the Department of Health Alcohol Early Implementer Site funding, of which Manchester is one of the participants.

In addition to the Alcohol Identification and Brief Advice pilot, final guidance is due in 2009 for the introduction of a Directed Enhanced Service (DES) for Alcohol which focuses on screening all newly registered patients aged 16 and over in primary care.

Accident & Emergency (A&E)

In addition to the pilot in Primary Care, work is also taking place to establish Identification and Brief Advice programmes within the 3 A&E departments in Manchester, building on the pilot work which was undertaken with Manchester Royal Infirmary. The main aim of the programme is to deliver an evidence based intervention to patients who are drinking at increasing and higher risk levels but are not yet dependent. Evidence shows that 1 in 8 people will change their behaviour as a result of this Identification and Brief Advice.

The needs of dependent drinkers would be addressed through the role of the care facilitator who would ensure appropriate referral through to community based services. It is anticipated that the development of this role will improve the care pathway from acute services into community treatment services, ultimately impacting on the number of days people stay in hospital beds.

Access for women

In order to improve access to alcohol services for women, all new community service specifications will include a target and monitoring information about the uptake of services. This information will be collected and remedial action taken if targets are not being achieved. In addition it has been agreed to extend the eligibility criteria to include spaces for women as part of a capital development programme for an inpatient residential rehabilitation unit. This will enable women to access this particular service within the city. Needing to access residential rehabilitation outside of the city has previously been identified as a block to uptake, particularly by women with caring responsibilities.

Alcohol as part of the parenting strategy

A parenting worker is based with the Family Intervention Support Service (FISS) and delivers evidence based parenting courses to parents who engage in substance misuse. In addition the Drug and Alcohol Strategy Team also fund a parenting support worker with Eclipse to provide support to parents whose children/young people are involved with substance misuse. Use has also been made of the 'tipsheet' for parents on talking to children and young people about substance misuse, which was produced by the Manchester Parenting Board

Public Health Development Service (PHDS) Training

Throughout the year, we have trained 392 frontline staff either as part of the core Sexual Health & Harm Reduction Training programme or bespoke courses delivered in-house. Staff have attended from health and social care organisations as well as housing workers, student nurses, mental health practitioners, and staff at HMP Styal.

Identification and Brief Advice Trainers

As part of the Improving Health in Manchester process, funding was made available for two Identification and Brief Advice (IBA) Trainers. One trainer is based with the Community Alcohol Team and is taking a lead on IBA work with GPs and healthcare staff in Primary Care; with a particular emphasis on GP Practices who are participating in the Primary Care Alcohol Pilot and Alcohol Directed Enhanced Service (DES). The second trainer is based with the Public Health Development Service and will be involved in IBA training work with staff who work across various organisations in Manchester.

Alcohol Awareness Raising

Drink Smart won "campaign of the quarter" in September 2008 with the 'know your limits' team.

This illustrated self-help guide was designed for Manchester residents want to know more about alcohol but whose drinking habits aren't in need of professional help. It includes units and calories of common drinks, facts on how much is too much and a drinks' diary with tips and exercises for cutting down or having a break from alcohol. A text service continues to be advertised in prime locations such as community pharmacies, libraries, health centres, and some workplaces. In 08/09 the text subscription service has so far recruited 80 members of the public to receive the Drink Smart by post.

Safer drinking for over-50s

A social marketing campaign was launched at the Town Hall in June 2008 using a mixture of outdoor advertising, dedicated website, patient information leaflet and training for frontline staff. There were 1,450 website hits during the 2-week advertising campaign using postcodes to target adverts across the city and 97 frontline staff have so far participated in alcohol identification and brief advice training.



“Calling Time”

The training booklet for alcohol retail staff was presented at the International Club Health conference in Ibiza (June 2008). Now in its third year, it was designed to increase awareness in bars, pubs, clubs and off-licences of the law and the legal duty to prevent alcohol sales to under 18s and sales to intoxicated customers. It has been updated this year and is soon to be re-launched as the “Responsible Alcohol Service” guide.

Off-Licence Forum; Community safety partnerships

Off-Licence Forums continue to develop across the North of the city and most recently in Wythenshawe; setting up a similar forum in the South. Conflict Management training has been offered this year to new and existing members of these forums and in partnership with Greater Manchester Police and Community Safety Coordinators, 31 members of staff took part in this training which aims to increase their confidence in refusing sales thereby promoting responsible and legal sales of alcohol.

Healthy Schools Partnership “Losing It”

The thoughts, feelings and actions from a group of young people were used to produce a DVD and support education materials to help teachers to deliver alcohol education in secondary schools. Using young people’s perspectives helps their peers to understand the risks and consequences of binge drinking

All of the secondary schools have received the DVD and teaching materials with the expectation that they will incorporate them into the drugs and substance misuse programme of work.

There are 167 schools engaged in the Healthy Schools programme, of which 105 have achieved National Healthy Schools status (NHSS). Part of the Personal Social Health Education programme is drug education and substance misuse. Therefore those schools who have achieved NHSS will have in place a substance misuse policy and a programme of study on drug and substance misuse

8. Maximise the use of Local Area Agreements and other local plans to focus on health inequalities

The recommendations for 2007 were to;

- Ensure the Local Area Agreement (LAA) included health inequalities as a major theme
- Develop the Joint Strategic Needs Assessment (JSNA) to deliver improvements in health inequalities

Both of these recommendations were met and promoting health and well being and reducing health inequalities are an integral part of the LAA. There are specific targets relating to life expectancy, alcohol related harm, childhood obesity, teenage pregnancy and mental well being.

Using the JSNA as a foundation, Public Health Consultants in NHS Manchester have continued to work with colleagues in Practice Based Commissioning to develop local public health action plans.

9. Local Authority Scrutiny Committees – use their powers to reduce health inequalities

In 2008 the Manchester Health and Wellbeing Overview and Scrutiny Committee scrutinised programmes relating to alcohol misuse, physical activity, obesity, tobacco control and food and nutrition. The work of the Committee has focused on health inequalities and the contribution of policy development to the improvement of life expectancy in Manchester.

The Manchester Health and Wellbeing Overview and Scrutiny Committee has also been key in

scrutinising far reaching strategies that have an impact upon the health and wellbeing of local communities such as employment , transport and environmental improvements through the Strategic Regeneration Framework Planning.

10. The duty of wellbeing enables Local Authorities to improve the quality of life, opportunity and health of their local communities

Manchester City Council has continued to prioritise improvements to public transport in partnership with the Greater Manchester Transport Executive and work has now commenced on the planned Metrolink extensions to East Manchester and Chorlton. In addition, cycle networks have been enhanced. The City Council has championed the benefits of Active Travel Plans that place a greater emphasis on walking, cycling and public transport use that will help to reduce the carbon footprint of major employers.

Health Protection

Immunisation

Vaccination is one of the most successful achievements of medical science. 'The two public health interventions that have had the greatest impact on the world's health are clean water and vaccines' (World Health Organization). NHS Manchester is responsible for ensuring the effective implementation of the national immunisation programme across our city.

New challenges are being tackled, particularly the introduction of new vaccines such as HPV (cervical cancer) vaccine from 2008, and the current campaign to provide 'catch-up' vaccination to children who have previously missed out on MMR vaccination. Measles remains a threat as recent outbreaks in the region have shown. These challenges add to the work needed to maintain and improve overall immunisation coverage in Manchester.

Healthcare associated infections

The NHS needs to keep patients as safe as it possibly can, including by preventing them acquiring infections whilst they are receiving healthcare. Healthcare Acquired Infections (HCAIs) are a significant cause of ill-health, particularly in hospital patients, but also can occur when healthcare is provided in the community. Whilst HCAI rates have been reduced, preventing HCAIs remains a key priority for the NHS.

References

- 1 Association of Public Health Observatories (APHO). Health Inequalities Intervention Tool. June 2008 (see http://www.lho.org.uk/Health_Inequalities/Health_Inequalities_Tool.aspx.)





Chapter 4

Future plans and recommendations for 2009

As in the previous chapter, the actions for 2009 are described in terms of high impact changes and identified priority areas.

1. Know the gap in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a strong impact upon the gap

Health Intelligence

The role of Health Analysts within Practice Based Commissioning will be developed during 2009. Locality Joint Strategic Needs Assessments will be produced to support Practice based Commissioners in the further development of local Public Health Action Plans.

Infant mortality

In line with the objectives identified in the Infant Mortality Strategy, further investment and prioritisation is recommended through partnership working in the following key areas:

- Improving service delivery.
- Improving services for BEM (black and ethnic minority) communities.
- Raising awareness of the infant mortality gap between Manchester and the population as a whole.
- Improving data quality and strengthening the evidence base.
- Teenage pregnancy – further developing systems to plan, implement and monitor services.
- Reducing Sudden Unexpected Death in Infancy (SUDI).
- Smoking in Pregnancy – working towards reaching all our pregnant smokers.
- Maternal and Infant Nutrition – improving breastfeeding support and supporting a healthy weight for pregnant women.
- Improving access to maternity care/early booking – in particular for vulnerable groups and communities.

Safeguarding

During 2009/10, NHS Manchester will continue to play its key role as a core member of the Manchester Safeguarding Children Board (MSCB) and will ensure that it continues to meet the expectations of Core Standard 2¹ and Working Together 2006².

Additionally it intends to further strengthen its safeguarding systems in the light of findings from Serious Case Reviews. (SCRs) It will be investing in additional support to general practice, improved arrangements for child protection medicals and for unaccompanied asylum seeking children, additional strategic work with Looked After Children and improved information sharing between hospitals and community services. This work is designed directly to meet the needs identified by SCR's and should lead to a concrete improvement in safeguarding systems in Manchester.

Via partnership structures, such as Manchester Children's Board and MSCB, NHS Manchester will continue to develop outcome based performance measures to ensure that service delivery and policy development make a positive impact on children's lives in Manchester.

2. Make smoking history – reduce smoking prevalence and target cessation services and campaigns in deprived areas and groups

Manchester's Stop Smoking Services are among the best in the region, providing a high quality of service and consistently meeting their targets around the number of people they support to quit smoking. However, in common with many other similar services, Manchester is increasingly finding it difficult to recruit new clients. We are therefore commissioning a new approach, in addition to



the existing services, focusing social marketing campaigns and new service opportunities on key wards with high smoking rates. This approach, which aims to de-normalise smoking in target areas as well as increasing uptake of Stop Smoking Services, will be piloted in six wards per year and rolled out across the city if successful.

3. Target prevention of cardiovascular diseases using prevalence models to identify areas of unmet need alongside a case finding strategy

The CVD Prevention Steering Group will use prevalence data for hypertension and coronary heart disease, to target identify gaps between expected and actual numbers on disease registers. Using a case finding approach, we will audit exemptions from disease registers and develop an exemption strategy to ensure that patients are not inappropriately removed from registers. We will use this information to identify areas where greatest impact may be made.

We will procure services identified in the Commissioning Strategic Plan, in order to improve the systematic identification and management of increased cardiovascular risk.

We will implement the national vascular checks programme as detailed in "Putting Prevention First"³. Prior to full implementation we will pilot and evaluate models of service delivery in a range of settings, in order to commission services which are accessible to all of our diverse populations.

4. Improve detection of disease in local communities

We will use the findings of the Healthy Communities Collaborative Project to Promote the Early Presentation of Cancer Symptoms to inform the roll out to other areas.

We will repeat the successful "Don't be a Cancer Chancer" campaign across the City.

Via the NHS Manchester Cancer programme Board, we will ensure that our commissioned cancer screening services are meeting the needs of and are accessible to all Manchester people.

We will continue to engage with local communities to inform our commissioning and improve the performance of cancer screening services.

5. Ensure the quantity of primary care in disadvantaged areas is sufficient to address need and is of high quality. Focus Health Trainers and Life Check Programmes on tackling health inequalities

Health Trainers

Health Trainers will implement the mid-life check during December 2009.

There are recommendations for the further development of the Health Trainer Programme in the following areas:

- Improve efficiency of record keeping and reporting of contact with clients
- Follow up sign-posted clients and increase feedback from clients
- Record objective, measurable criteria to evidence behaviour change outcomes
- Work towards a cost-benefit analysis to assess the impact of the Health Trainer Programme
- Set progressive targets for Health Trainer client contact and reaching clients living in Manchester's most deprived wards
- Set progressive targets for Reaching all BME groups, young people and male clients
- Build on the holistic approach employed by Health Trainers

- Increase work placement opportunities in PCT settings whilst maintaining a community presence
- Embed reflective practice into all levels of the Programme's work
- Set new goals for the on-going evaluation of the Manchester Health Trainer Programme

Oral Health

There is a need to support providers of dental services to contribute effectively to the delivery of the oral health strategy. However, Oral Health improvement cannot be delivered by dentists and their teams alone. It will require collaboration with others in the community.

There has been evidence of demand (through monitoring of calls to NHS Direct and the PCT) for improved access to NHS dentistry in Manchester.

A recent procurement process has attracted new service providers to Manchester and stimulated current NHS practices to accept new patients. Many people have not accessed dental care for some time, and commissioners are working with local clinicians to ensure appropriate care and advice is being offered to those in greatest need. At least six new NHS dental practices will be opening at locations across the city in 2009/10.

NHS Manchester will also commission a dental helpline in 2009; this will provide information to the public about capacity within the system. It will also provide clinical advice, where applicable and offer a direct booking facility.

A needs assessment and review of domiciliary and sedation services is planned for 2009 and a scheme to introduce specialist dental services to primary care is planned for 2009/10.

Sexual Health

Sexual health services have been subject to considerable expansion and modernisation over the last 5 years. We are keen to ensure that the position of services is consolidated in 2009/10, that we increase the partnership working between services and that we increase uptake of services from the most vulnerable groups.

Manchester expects to meet the challenging Chlamydia screening target for 2009/10 through the establishment of additional access points for the service and through improved joint working with related services, such as school nursing, youth services, and the teenage pregnancy programme.

Manchester's citywide contraception and sexual health (CASH) services will be reviewed in 2009/10 to ensure that they are targeting services appropriately and meeting the needs of our more vulnerable populations.

NHS Manchester will be working with providers and with partner agencies to promote the prescribing of long acting reversible methods of contraception (LARC). There is expected to be a social marketing campaign on this, aimed at increasing professional awareness of LARCs and at increasing acceptability of LARCs to young people.

NHS Manchester will also be working with providers, including general practice, to increase uptake of HIV testing, in order to reduce the numbers of people living with undiagnosed HIV. This will have benefits both to the individuals in terms of better treatment options and improved prognosis, and also should assist in the prevention of onward transmission of HIV.

NHS Manchester will offer a new sexual health Local Enhanced Service to GPs from 1st April 2009, increasing the sexual health services offered within primary care.



6. Empower disadvantaged communities to aspire to good health

Healthy Living network

It is recommended that a Citywide Healthy Living Network be established in 2009, to increase life expectancy and tackle inequalities through:

- promoting aspiration, wellbeing and happiness in local communities – delivering sustained improvement to the health of local people through behavioural change, community empowerment and the building of social capital;
- supporting vulnerable residents – engaging, supporting and involving local people and communities in and wellbeing activity;
- developing partnership working – supporting existing and emerging health related partnerships and strategies, including Valuing Older People, Food Futures Partnership, Alcohol Strategy, the Crime and Disorder Partnership, and locality partnership structures such as Ward Co-ordination;
- developing localised and personalised preventative services in partnership with communities and other organisations – establishing community health forums and developing and hosting a wide range of posts with a focus on physical activity, food and nutrition, alcohol misuse and emotional wellbeing;
- promoting community cohesion – supporting NHS Manchester's Race for Health Programme, which focuses on the health inequalities experienced by BME communities including diabetes, coronary heart disease and stroke and mental health.

7. Reduce harm from Alcohol

It is recommended that in 2009 the following actions are taken:

- Evaluate the learning and implement actions from the Alcohol Identification and Brief Advice in Primary Care (IBA) pilot, which is part of our Alcohol Early Implementer programme
- To extend the IBA programme to the 3 Manchester A&E departments and conduct a second level evaluation including patient sample group follow up
- To build upon the initial social marketing campaign, formulate a dedicated over 50s action plan around alcohol.
- To continue to increase availability of the Drink Smart guide particularly focusing on hard to reach groups across the city.
- To continue to promote responsible alcohol service with a particular focus on preventing alcohol sales to intoxicated customers. This will involve booster training for bar staff as well as point of sale tactics to de-personalise and prevent drunkenness and perceptions of drunkenness on and around licensed premises.
- With an additional Alcohol IBA trainer, further training will be made available particularly focusing on prioritised groups for the city for example Manchester Community Health staff, drug workers and midwives / ante-natal staff.

8. Maximise the use of Local Area Agreements and other local plans to focus on health inequalities

In 2009, we will develop a Local Employment Partnership which will focus on maximising employment options to tackle long term worklessness. This initiative will have a specific focus on

individuals who find it difficult to access employment because of poor health. We will continue to build upon existing models of employment advice, developed in partnership with general practice.

Tackling obesity in the community

In 2009 a Healthy Weight Strategy will be developed within which we will take further action on the following issues:

- develop capacity in early years settings to address healthy weight issues with families of the under fives
- further develop programmes in schools to promote healthy lifestyles, improve coverage of the National Child Measurement Programme (NCMP) and develop targeted responses to this.
- provide support to primary healthcare teams to initiate and establish evidence based programmes for overweight and obese patients
- identifying appropriate targeted interventions for BME communities in Manchester

9. Local Authority Scrutiny Committees – use their powers to reduce health inequalities

The Manchester Health and Well Being Overview and Scrutiny Committee and The Manchester Children and Young People's Overview and Scrutiny Committee will work closely together next year with regard to a range of children and adult related health issues. These will include childhood obesity and health, oral health, teenage pregnancy and sexual health and emotional health.

The Manchester Citizenship and Inclusion Overview and Scrutiny Committee and the Manchester Adult Health and Wellbeing Overview and Scrutiny Committee will jointly scrutinise the implementation of the Manchester Alcohol Strategy. This will ensure that the wider determinants are taken into account, including the impact on the wider economy, health, employability, Crime and Disorder and sustainable neighbourhoods.

10. The duty of wellbeing enables Local Authorities to improve the quality of life, opportunity and health of their local communities

We will establish a Built Environment Group for Health. This group will

- Provide a framework to develop healthy planning policy and practice for Manchester which will lead to improvement of the built environment
- Review local development frameworks; working to align the health impact of Manchester's six strategic regeneration frameworks

Health Protection

Immunisation

NHS Manchester PCT must work with its NHS partners to improve immunisation coverage in Manchester by:

- reviewing routine immunisation services across the city (as part of a health needs assessment being undertaken by Manchester University);
- completing the current MMR 'catch-up' campaign for children and teenagers not previously fully immunised;



- building on the work undertaken in 2008 to introduce routine HPV vaccination, by improving HPV vaccination uptake in school year 8 girls.

Emergency preparedness

Planning for potential emergencies, including public health threats, continues to be essential. 'Failing to plan is planning to fail'. Pandemic influenza remains a threat. It is also important that, when emergencies strike, public services have plans in place so that we can continue to provide normal services as far as is possible ('business continuity planning').

NHS Manchester must work with its NHS partners to further emergency preparedness by, in particular:

- making its Pandemic Flu plan widely available, including advice for the public on preventing infection;
- completing plans currently under development for chemical, biological, radiological and nuclear events, to provide a better coordinated approach;
- continuing to develop business continuity plans so that we ensure that services are robust and resilient during emergencies.

Healthcare associated infections (HCAI)

NHS Manchester must work with its NHS partners to further strengthen its infection control systems, in particular to:

- meet our targets for further reductions in the numbers of cases of Clostridium difficile and methicillin-resistant Staphylococcus aureus (MRSA);
- increase the capacity of the specialist service that investigates and provide training, advice and guidance on the prevention of HCAIs in the community;
- establish an MRSA screening service so that patients being admitted to hospital for elective operations are tested, and treated if necessary, for MRSA before they are admitted to hospital.

References

- 1 Healthcare Commission; Core Standard C2; Safeguarding Children (see http://www.healthcare-commission.org.uk/_db/_documents/Core_standard_C2_safeguarding_children_all_sectors.pdf)
- 2 Working Together to Safeguard Children; A guide to inter-agency working to safeguard and promote the welfare of children: HM Government 2006 (see <http://www.everychildmatters.gov.uk/workingtogether/>)
- 3 UK Department of Health; Putting Prevention First vascular checks: risk assessment and management – next steps guidance for Primary Care Trusts." (see http://www.dh.gov.uk/en/Publication-sandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090277)

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