

Lessons from the past, planning for the future: working together for the public's health



Salford Public Health Annual Report 2013/14



Contents

Click on a
page number

Foreword	
Introduction:	The origins of public health in Salford
Chapter one:	Health in Salford 2013/14: where are we now?
Chapter two:	Measuring Health Inequalities in Salford: the Salford Health Inequalities Tool
Chapter three:	Public Health impact: case studies
Chapter four:	Update on recommendations in last year's report
Conclusion	
Appendix	

Foreword

Local government was first given the statutory duty to promote the social, environmental and economic wellbeing of the area of its responsibility in 2000. But the history of local government leading the improvement of health and wellbeing for its population goes back to the 19th century and the pioneering founding fathers of the public health movement. The North West and Salford, in particular, had much to do with shaping the forerunners of modern day public health. Today Salford has a proud heritage of action to improve the health of its local population, now matched by new powers and authority since 1 April 2013.

It's likely that in future times we will look back on this date as a defining moment for the public health system, with the responsibility for leading the health and wellbeing agenda along with the local Public Health Team moving from their home (since the early 1970s), in the NHS back to what many would say is their natural place in the local authority.



I am pleased to join in presenting the first Public Health Annual Report from the first official year. This report demonstrates the way in which the Public

Health Team are now embedded within the local authority.

The work they have done has been well received by elected members, directors and by the City Mayor.

Cllr Margaret Morris
Assistant Mayor for Health and Wellbeing

We will explore the background to public health in Salford and its origins in the 19th century, using life at that time to show the, perhaps unanticipated, parallels between public health action then and now. It is disappointing to have to say that, in many cases, the challenges remain the same today, with additional challenges that the diseases of modern day lifestyles bring.

To signal the significance of the change this has brought we break from tradition and produce a joint report between the Director of Public Health and the Assistant Mayor for Health and Wellbeing, the political lead for the council.



David Herne
Director of Public Health

Introduction The origins of public health in Salford

Salford's greatest period of expansion was in the 19th century, when the industrial revolution led a shift to factory based employment and an increase in home working. The population rose from 12,000 in 1812 to 70,244 in 1842, and to 220,000 by the end of the century. This rapid increase, one of the fastest in the country, led to large areas of poor quality housing being built throughout the Victorian period, when overcrowding created significant social problems. Houses were jammed together, as many as 80 to the acre.

Salford became one of the greatest of the cotton towns with several vast mills, the Manchester Ship Canal, the newly-built docks together with its brewing heritage all being significant parts of the local economy. However, average wages were well below subsistence level. An 1898 report for the Manchester Statistical Society found that over 40% of working men were 'irregularly employed', and 61% could be defined as 'very poor' with a weekly income of less than four shillings (20p) per week.



The casual nature of employment was a major contributor to the city's poverty. In the days before any welfare provision, there was no sick pay - if you couldn't work, you weren't paid. Payments from the Manchester and Salford District Provident Society's Poverty Fund in the winter of 1878-79 revealed that the vast majority of qualifying applicants were casual and seasonal workers.

The life expectancy of a working man in Salford in the 1870s could be as little as 17 years. The city had little or no policy on sewage disposal until the late 19th century, even in 1907 only about one-third of the city's privies were water closets. Such water closets as there were before the 1870s simply ran directly into the Irwell, from which most people obtained their drinking water. Cholera was common to the city but airborne diseases and pulmonary tuberculosis in particular accounted for the greatest mortality figures.

This industrialisation and the rapid growth of the city directly contributed to environmental problems such as poor housing, unclean water supplies, 'bad air' and the impact that these had on the health of the working population. It was in this environment that the public health movement was born, with the three founding fathers of public health:



The first national Public Health Act

Name: **Sir Edwin Chadwick**
Lived: 1800 – 1890
Born: Longsight, Manchester
Profession: Barrister



Chadwick was an active campaigner on poor housing, working conditions and sanitary reform. His **Report on an inquiry into the sanitary conditions of the labouring population of Great Britain**, 1842,

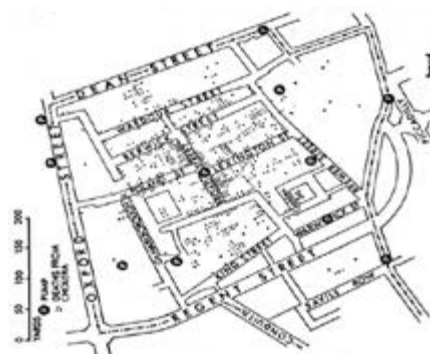
contained a mass of evidence supporting the relationship between environmental factors, poverty and ill health. It recommended the establishment of a single local authority, including expert medical and civil engineering advice, to administer all sanitary matters. Six years later the national Public Health Act (1848) was passed and the first Board of Health was established. This illustrates the effect public health had on shaping local government responsibilities.

The Broad Street Pump

Name: **John Snow**
Lived: 1813 – 1858
Born: York
Profession: Physician

The importance of clean drinking water for Salford residents was established in 1854 by John Snow; another of public health's leading lights of the time. He was investigating the role of drinking water in the spread of cholera in London and had observed that people who had drunk water provided by one water company were more likely to contract the disease than those who had not. By plotting the cases of cholera on a map, Snow was able to establish that all those falling ill were getting their water from a single pump, which drew its supplies from the sewage-contaminated River Thames. People using nearby wells to obtain their water had escaped infection. The connection between cholera and contaminated water was established, before bacteriology was able to identify the causative organism. Having identified the source of the infection, he went on to remove the handle of the Broad Street water pump and halted the outbreak of cholera in Soho, London. This was a defining example of public health practice in outbreak management - making the link between the disease, and the mode of its transmission, a fundamental of modern day practice.

This need for clean water for the local population was achieved at around this time in the North West, through the creation of the reservoir system, providing relatively clean drinking water into the city for the first time from the completion of Longdendale and Thirlmere reservoirs.



The 1866 Sanitary Act

Name: **John Simon**

Lived: 1816-1904

Born: London

Profession: Surgeon

John Simon became medical officer to the Board of Health established by Chadwick in 1855. Advised by a team of scientists and engineers, Simon was instrumental in helping a number of towns to install their first sewage systems. In 1866 the Sanitary Act placed a duty of inspection on local authorities and extended their range of sanitary powers.

Today the work of these three public health campaigners is still held in the highest regard. Sanitation and the efforts of Snow and Chadwick in particular, were rated the greatest medical advances of the last 150 years in a 2007 poll by the British Medical Journal. Their influence on Salford can be seen in many ways; for example, through the opening of the first workhouse in 1852, a year which also saw the creation of the Manchester and Salford Sanitary Association, which promoted public health and sanitary reform as well as a vigorous programme of education for the masses and the isolation hospitals for the worst disease cases.

These measures had a significant impact in improving the health of the city's residents with an immediate reduction in cholera and typhoid. In 1862 the first full time Health Visitor (known as a Ladies' Visitor) was appointed in Salford; working class women appointed to educate the poor about child rearing and health.

Much as today, reports and surveys of the 19th century told the same story, with life expectancy directly related to wealth. A direct consequence of the poor wages, impossibly long working hours, dangerous and unsanitary working conditions, unsanitary dwellings, little or no health provision was high infant mortality and a short life expectancy.

It is sad to say that many of the themes seen in this turn of the century picture remain as challenges today. The link between wealth and health is as strong today as it was then and sustainable employment particularly for the young is a consistent challenge. Great strides have been made in improving housing and sanitary conditions but new communicable disease threats continue to emerge e.g. MRSA, Healthcare Acquired Infections and flu pandemics.

At the inception of the NHS in 1948, Salford's then Medical Officer for Health (the forerunner of the modern day Director of Public Health), Dr Lance Burn, described his role very much in terms which would have credence today; "My job has been to make health attractive and help people to live healthier lives". Interestingly, at the time, the medical officer for health was based in the local authority, acknowledging the key role that local government had to play in safeguarding the public health contrasting with the curative work which would be the responsibility of the new NHS.

Dr Burn's wide ranging responsibilities in 1948 included managing health visiting, midwifery and child welfare services, school health, environmental pollution, food inspection and food and drug legislation. He also had responsibilities for infectious disease, fever hospitals, sanatoria (hospitals specialising in treatment and recuperation from an infectious disease) and mental hospitals, together with a role in acute hospital provision. An increasing focus on these health services for the local population signalled a gradual move of the public health role, eventually ending with the transfer into the NHS in the 1970s. His wide-ranging brief can be seen as a forerunner for the 21st century Director of Public Health role, which has responsibility for a range of mandated services, health protection functions and driving and shaping both health service commissioning and effective local government strategy and policy.

The 21st century role for public health

Local authorities are now major players in health. Their responsibilities for housing, planning, urban design, transport, early years and parenting, leisure and culture, education, skills and employment have always made that the case. The transfer of the public health function has presented both a challenge and an opportunity for local leaders in times of severe financial pressure. A recent Kings Fund report suggests this is an opportunity to use public health outcomes as part of the decision-making processes within local government. We will explore how this might be done in chapter 2 of this report, looking at it through the use of the Health Inequalities Tool, developed with the support of Liverpool John Moores University.

The King's Fund¹ argues that an understanding of how to reduce health inequalities and maximise wellbeing should become a key determinant of how Local Government budgets are shaped and resources allocated, suggesting that:

- Public health should be part of all policies and strategies.
- Prevention and early intervention should be an approach common to all service planning.
- A joined-up approach to spatial planning, green spaces and transport can simultaneously boost people's levels of physical activity, reduce obesity and improve wellbeing.

1. King's Fund (2013) Improving the public's health: a resource for local authorities



They set out nine key areas where public health impacts should be considered, which align well with the priorities of Salford's Joint Health and Wellbeing Strategy (JHWS) as well as Health and Wellbeing Board key areas of interest, as they comprise:

- The best start in life
- Healthy schools and pupils
- Helping people to find good jobs and stay in work
- Active and safe travel
- Warmer and safer homes
- Access to green and open spaces, and the role of leisure services
- Strong communities, wellbeing and resilience
- Public protection and regulatory services
- Health and spatial planning

These areas of interest provide a golden thread back to the earliest times of public health activity, linking housing, public protection, employment, access to clean open spaces and the environment, across two centuries of public health and local government activity.

Building from Salford's existing position

Work is already ongoing in Salford to make effective links between public health outcomes and core local government activities, including:

- Work with the trading standards team aimed at reducing sales of alcohol to young people and illegal tobacco sales.
- Programmes led by the Health Improvement Service addressing community resilience, community food and healthy eating projects.
- Involvement of Health and Wellbeing Board members in the development of a new Strategic Planning Document, limiting approvals for takeaway / fast food restaurants near to schools.
- Involvement of Public Health and Health Improvement in the development of a new Local Plan for Salford, as well as joint working with regeneration professionals, to maximise the health impacts from initiatives such as the improvements to the Bridgewater Canal and Port Salford Greenway, as well as strategic planning around new housing areas.
- Preparation of needs assessments for key sectors of the Salford population, for example older people, people with alcohol addictions, Lesbian, Gay, Bisexual and Trans communities, and Gypsy Roma Traveller communities, as well as to explore the health impacts of domestic violence.

We will expand on some of these examples in chapter 3 of this report.

The changing nature of the Director of Public Health role

'Healthy Lives, Healthy People'² set out the policy of moving public health responsibilities from the NHS to local authorities including Salford City Council and also described a new role for the Director of Public Health, who 'will be ideally placed to embed public health across the work of the authority'.

The legislation suggested the Director of Public Health (DPH) should be:

- The principal adviser on health to elected members and officials.
- The officer charged with delivering key new public health functions.
- A statutory member of the Health and Wellbeing Board.
- The author of an annual report on the health of the population.

It also pointed to a key role with local partners such as the Police and Crime Commissioners to promote safer communities; and engaging with wider civil society to enlist their support in fostering health and wellbeing. In short, the DPH is now a critical player in ensuring that health and wellbeing is central to everything Salford is about. It is clear already that the role for the DPH is changing, bringing a range of additional corporate responsibilities and broadening the focus on its activity around the wider determinants of health. Whilst some of the leadership around health protection and screening and vaccination remains, this is now in a much changed role, more about holding other parts of the system to account, assuring our local population of local preparedness and less one of direct delivery or responsibility.

2. Healthy Lives, Healthy People: Our strategy for public health in England (2010) Department of Health

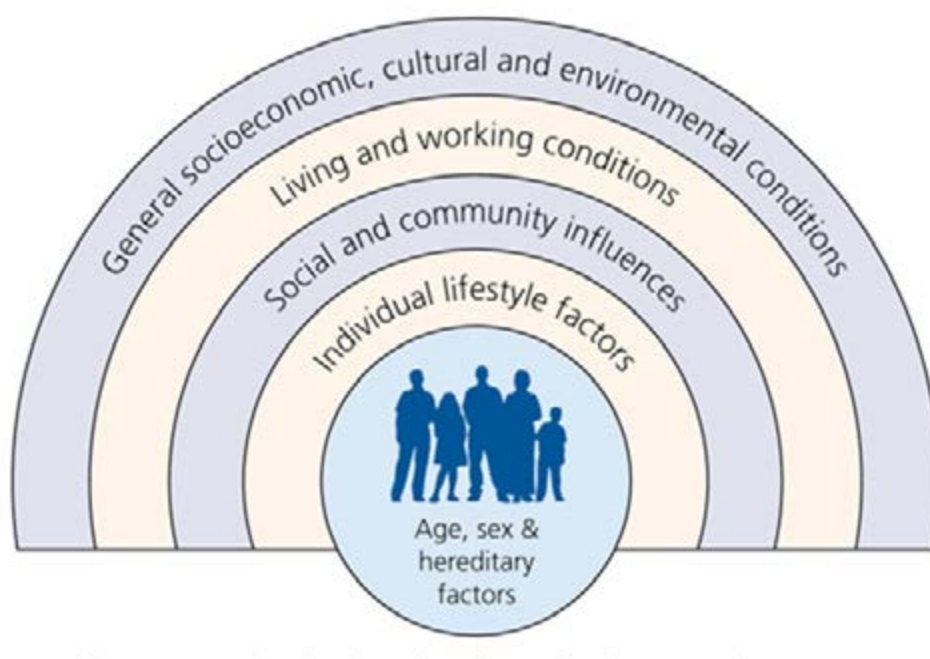


In summary

Even with this new emphasis, the challenges facing the founding fathers for public health still strike a chord. In fact, the challenges of poverty and inequality remain, with the potential impact of the recent economic downturn, relative reductions in incomes, unemployment and a squeeze on the benefit budget: all have possible health consequences. In this report we will show how modern day public health is quickly getting to grips with the so called 'wider determinants' or the causes of the causes of ill health.

We show how, by working with our new council colleagues, we are beginning to re-shape the local environment and challenge some of these issues, for example, by managing the availability of food from takeaways in the vicinity of schools, seeking to understand the needs of our most challenged families better, and the impact of domestic abuse on the area. Work to address the lifestyle agendas of smoking, alcohol and overweight and obesity continues but, increasingly, through the wider approaches which our new home in local government allows.

The Wider Determinants of Health (1992) Dahlgren and Whitehead



Source: Dahlgren G and Whitehead M (1991) Policies and strategies to promote social equity in health. Stockholm, Institute for Futures Studies



Chapter one Health in Salford 2013/14: where are we now?

The health and wellbeing challenges faced by the people of Salford in 2014 are, in many ways, not so different from those faced by residents in the 19th century. Communicable diseases have decreased, largely as a result of improvements in sanitation and advances such as vaccination. The average life span and years of life spent in good health (healthy life expectancy) are improving. However, people in Salford still die earlier on average than in many other places in England. Just as 150 years ago, deprivation and worklessness remain associated with higher rates of disease and poorer health outcomes today.

The Public Health Team uses a process called the Joint Strategic Needs Assessment (JSNA) to find out about the current health and wellbeing needs of our Salford communities. There is a programme of topic or community specific needs assessments that contribute to the overall JSNA. National data can be added to local information. Examples of relevant national data are shown in the Health Profile (later in this chapter) and are used in Salford's Health Inequalities Tool (see chapter 2).

There is more detail and further information on Salford's population and health outcomes in the appendix.

Salford's Joint Strategic Needs Assessment (JSNA)

The Joint Strategic Needs Assessment is a strategic assessment of current and future needs of local communities. Health, wellbeing and social care are a focus of the assessment, but a range of other information is also included. The assessment can be used to help local organisations to choose their priorities and plan local services.

Needs Assessment

Needs assessment is a systematic method for reviewing the health and social care issues facing a population, leading to agreed priorities and resource allocation that will improve health and wellbeing, and reduce inequalities. The population chosen for a needs assessment might be a particular ethnic group, a group of people who use a certain service or a group who share particular characteristics, e.g. people with autism.

Contributing factors to the health of Salford's population

Deprivation

If an area is described as deprived this means that there are low socioeconomic conditions and these affect the people living there. Deprivation is measured across England and Salford has higher than average deprivation. About 70% of Salford's population live in areas classified as highly deprived, with 5% of Salford residents living in the least deprived (best off) areas. Demonstrating the impact of this, men in Salford live, on average, three years less than the average for England, while women live around two and a half years less. There are variations across Salford, with life expectancy for men 11.5 years lower in the most deprived areas than in the least deprived areas, and 8.5 years lower for women.

These differences in average life-span and in healthy life-span, are examples of health inequalities for Salford as a whole in comparison with England, and within Salford, related to levels of deprivation.

Population trends

Looking at Salford's population over time, we are able to predict changes in the future. By 2025, it is estimated that Salford's population will have:

- A higher proportion of young children and young adults than the national average.
- A moderate growth in the older age groups, with a smaller elderly population increase than the national average.
- A wider population spread than the national average for adults aged 20–44 years.

Ethnicity is a contributory factor to health. Salford has a high proportion of white population (90%). The majority of the 10% of the population from Black Minority Ethnic groups is of Asian origin (40% of this group). 3.3% of Salford's population is from the Orthodox Jewish community, compared to 0.5% for the whole of England. The full impact of economic migration into Salford is difficult to quantify, but has effects on the size and structure of the population.

What do people in Salford die of?

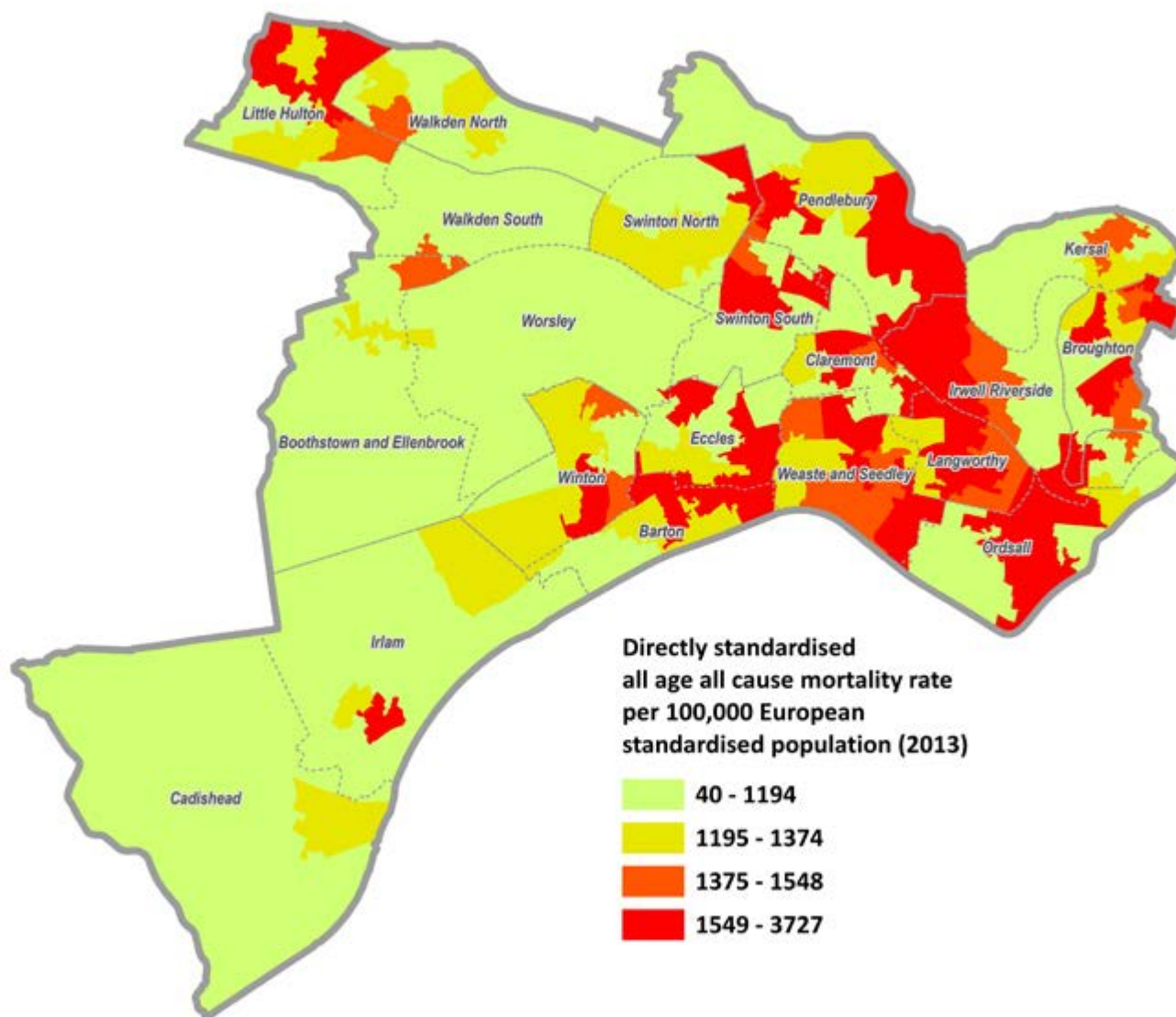
Over the past ten years, all-age all-cause mortality rates (see box) have fallen, meaning an increased life expectancy for Salford residents. This improvement in Salford has been matched in the whole of England, so Salford continues to show a similar gap in healthy life expectancy compared with the rest of the country.

The three top causes of death in Salford are circulatory diseases, cancer and respiratory diseases, which together account for 74% of deaths. Early death rates from cancer, heart disease and stroke have fallen. Deaths from digestive diseases, including cirrhosis, have increased for both men and women over the past 14 years. Salford has high rates of alcohol related deaths.

All-age all-cause mortality rate

This is used as an overall figure for assessing overall public health for a population. It is the annual number of deaths from any cause in a given population. It helps to compare rates of death over time and in assessing trends.

All-age all-cause mortality in Lower Super Output Areas (LSOAs) 2011-13



Lower Super Output Areas (LSOAs) are geographic areas, developed by the Office for National Statistics. They each include between 1000 and 3000 people, who live in a maximum number of 1200 households. There are 150 LSOAs in Salford.

Lifestyle factors

As well as the effect of where people live, their work and life opportunities, everyday choices they make affect their health and wellbeing. Estimated levels of adult 'healthy eating', smoking rates and physical activity are worse in Salford than the average for England, while a higher proportion of 10-11 year olds are classified as 'obese'. This pattern can also be seen in rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm.

Smoking is the single biggest preventable cause of premature death. Stop smoking work in the city has supported smokers to quit, and the proportion of Salford residents smoking has dropped from an estimated 34% in 2004 to 25.4% in 2013. There is a time-lag for the effects of people quitting smoking to show in terms of a reduction in the number of deaths due to lung cancer, but rates already show fewer deaths as a result of men stopping smoking.

Health profile

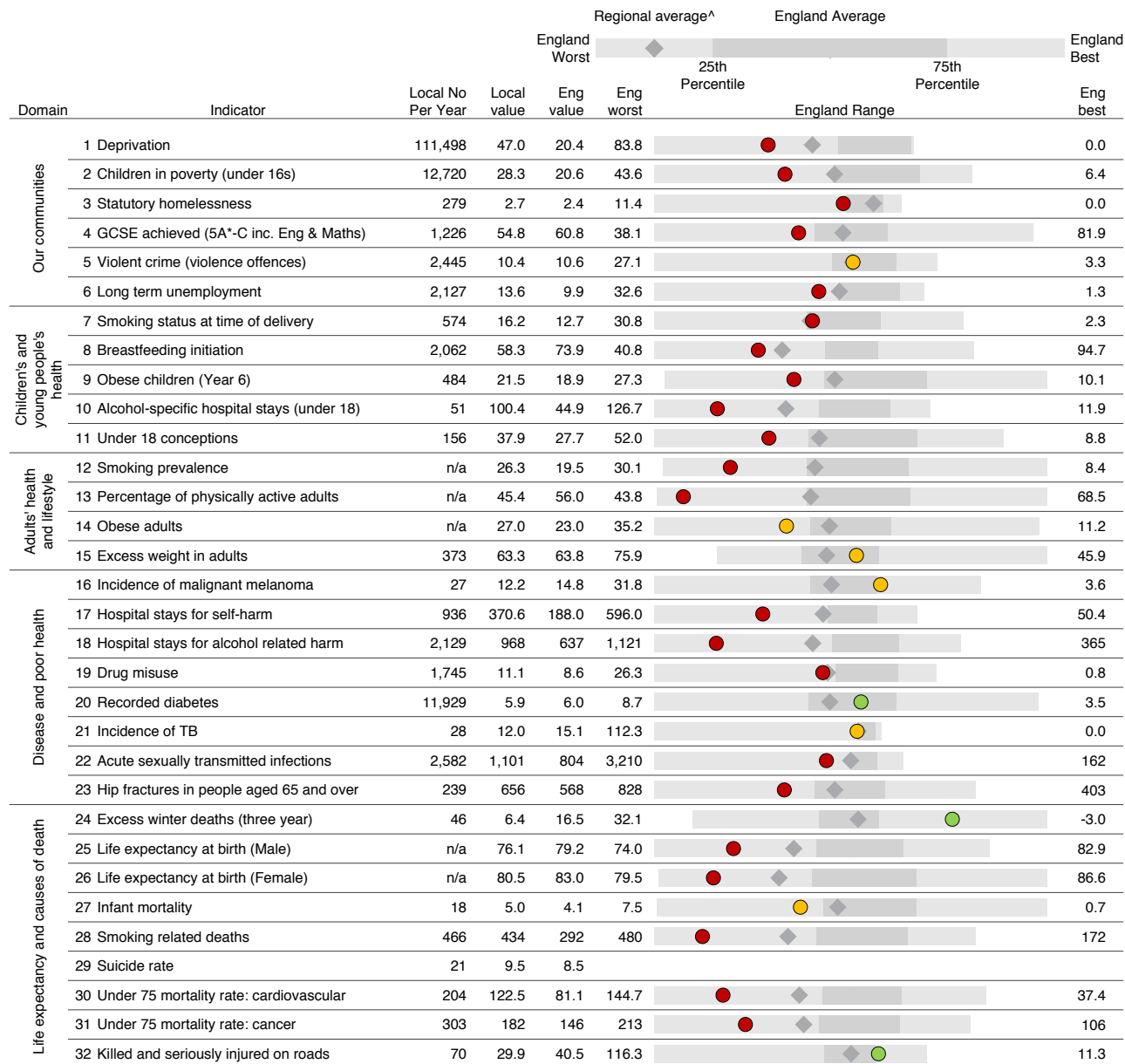
Health profiles include a number of direct health measures and measures of wider determinants of the health of the local people. They provide a snapshot in time of overall health for Salford and compare it to other areas and to England as a whole.

In the profile, on the following page, the average for all of England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as the grey bar. A red circle means that Salford is significantly worse than England for that indicator. Yellow indicates that Salford is similar to England, while green means that Salford has a better than average outcome (although there may still be a significant public health issue).

- Three indicators are significantly better than the average for England.
- Six indicators are not significantly different to the average for England.
- 22 indicators show worse health outcomes than the average for England.

Health Summary for Salford

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



Source: www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=salford&SPEAR=

How are we working to improve the health of Salford?

Many early deaths could be prevented by individual lifestyle changes, including quitting smoking, drinking alcohol sensibly, eating well and exercising regularly. Programmes such as Being Well (see page 34) support people to make these changes.

Work to raise awareness of the early symptoms of cancer supports an increase in rates of early detection. As well as media campaigns, Salford has volunteers from the Healthy Communities Collaborative spreading the messages, as well as incorporating them in staff training through Making Every Contact Count and in a section on the Way to Wellbeing portal (see page 35). NHS Health Checks programme (page 32) fosters early detection of vascular disease. The Alcohol Harm Reduction Strategy has redesigned hospital services to focus support more effectively on those who attend regularly for alcohol related reasons.

Strategies to improve the wider factors which impact on health, such as income and employment, debt, education, transport, housing, the environment and leisure are central to improving the health and wellbeing of Salford into the future. Poverty, employment and the environment are strong themes in the city's Health and Wellbeing Strategy. Many of these are the 'causes of the causes' of people smoking, drinking and eating unhealthy diets.

Further sections of this report will look at the work of public health on some of these wider determinants of health and wellbeing.

Looking at the challenges for the health and wellbeing of Salford, it is clear that we can only tackle these in a whole-systems way, working together with Salford's Clinical Commissioning Group, all Salford City Council directorates, with the voluntary, community and social enterprise sector and, most importantly, with the people of Salford.

Cllr Margaret Morris



Chapter 2

Measuring Health Inequalities in Salford: the Salford Health Inequalities Tool

Fair society, healthy lives

For decades the available evidence has shown that persistent health inequalities are a consequence of the circumstances in which people live and work. As long ago as 1980, **The Black Report** made the link. More recently the 2010 independent Marmot review 'Fair Society, Healthy Lives'¹, comprehensively set out this relationship. This was commissioned by the then Secretary of State for Health to propose the most effective evidence-based strategies for reducing health inequalities in England. Some major conclusions from the report include:

- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

Current public health policy has developed from an approach based on influencing individual lifestyle and improving access to services. This report sets out how the combination and inter-relationship of a range of the so called 'wider determinant' factors produces the greatest impact on the health and wellbeing of individuals and communities: 'the causes of the causes'. The shift of public health leadership from the NHS to Local Government acknowledges this and places public health in the best environment to influence these factors more readily.

1. Marmot, M (2010) Fair Society, Healthy Lives: The Marmot Review

Healthy lives in Salford

In Salford there is a recognition of the effects of social inequalities on health, but a clear and coherent story about how the interplay of these factors influences local health and wellbeing has been less well developed. Since 2005, the annual Health Profiles (see chapter 1) produced by the Public Health Observatory have provided a set of data that local authorities are able to use to inform local strategic planning and commissioning decisions. But these only provide a snapshot in time of the overall health in the local population and highlight potential problems through comparison with other areas and with the England average. Until quite recently, understanding the interrelationship of these individual factors has not been possible.

Life expectancy can be used as a measure of the overall mortality within the Salford population. It describes the average number of years that a newborn baby can expect to live if current mortality rates continue to apply. One of the aims of public health policy nationally and in Salford is to reduce the difference or 'gap' in life expectancy at birth between people and communities thereby reducing health inequality. The key figures for Salford are the three years less that people live compared to the national average and the 12 years (for men) and eight years (for women) difference in life expectancy between the best and worst wards in Salford.

Working with colleagues at the Centre for Public Health in Liverpool John Moores University, the Salford City Council Public Health Team have developed a unique tool to help understand these interrelationships and their collective impact on improving life expectancy at birth for the local population. The Interactive Health Indicator Tool, or I-Hit as it is known, is a web-based programme that models the relationship between life expectancy for males and females, and other health indicators included in the national Health Profiles. The analysis has shown that 27 of the 32 indicators included in the Health Profiles have a strong statistical association with each other, meaning that when one changes the other can be expected to do so as well. The tool does not establish a cause and effect relationship between life expectancy and the other health indicators but does show where associations exist and how strong they are.

This chapter shows how important it is for people to make changes in their lifestyles as part of improving health and wellbeing in our city. The challenge for us, as a service provider, is to engage with people to encourage them to adopt healthier lifestyles.

Cllr Margaret Morris

Life expectancy and all-age all-cause mortality

In chapter 1, we used all-age all-cause mortality to discuss the health of Salford's population. Life expectancy is a similar measure of an entire population and measures the average life span. It is closely related to all-age all-cause mortality which measures the average age of death.

1

Life expectancy Male	74.7
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Life expectancy Female	79.6
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2

Smoke in pregnancy	19.52
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Obese adults	23.466
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Deaths: smoking	355.98
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Deaths: heart disease/stroke	104.63
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Drugs misuse	11.592
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Infant deaths	5.9
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3

Self harm	380.89
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Diabetes	5.6593
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Healthy eating adults	23.8
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GCSE's	49.807
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Deaths: cancer	149.5
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Adults who smoke	28.41
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Obese children	19.729
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Child tooth decay	1.21
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Breastfeeding initiation	63.29
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Teenage pregnancy	58.7
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Child poverty	29.44
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Tuberculosis	13.978
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Unemployment	8.39
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4

Alcohol admissions	2967.1
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Melanoma	12.7885
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The strongest relationships with life expectancy are with those aspects in sections two and three (coloured red and blue), with less strong relationships in section four (green).

The I-Hit allows the user to explore how changing associated factors can affect life expectancy. For example, it allows you to predict how much life expectancy would increase if smoking rates dropped by 10%. It can also work by setting a 'goal' for life expectancy (for example increasing life expectancy to 80 years old for women or 78 years old for men) and then it will tell you how much improvement is required in the associated factors to achieve that goal. This enables planners to identify where to focus improvement activity and to plan for the required scale of change to deliver the objective.

If our aspiration is to see Salford people have as healthy and happy lives on a par with the best parts of England we can use the I-Hit to calculate what this might mean in very tangible ways. For example achieving a 25% reduction in the life expectancy gap between Salford and the national average would require us to deliver changes across a wide range of issues, a sample of which are shown below:

Increase	By	From	To	Baseline measure
Healthy eating in adults	16%	23.8%	27.6%	% adults, modeled estimate using Health Survey for England 2006-2008
GCSE attainment	10%	49.7%	55.0%	% at Key Stage 4 2009/10
Breastfeeding initiation	10%	63.3%	69.6%	% of mothers initiating breastfeeding where status is known 2009/10
The proportion of adults who are active	15%	10.2	11.7	% aged 16+ 2009/10

Decrease	By	From	To	Baseline Measure
Smoking in pregnancy	17%	19.5	16.1	% of mothers smoking in pregnancy where status is known 2009/10
Numbers of adults who smoke	15%	28.4	24.1	% adults aged 18+, 2009/10
The numbers of adults who are obese	7%	23.5	21.8	% adults, modelled estimate using Health Survey for England 2006-2008 (revised)
The numbers of children who are obese	13%	19.7	17.1	% of school children in Year 6, 2009/10
Drug misuse	27%	11.6	8.4	Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09
Teenage pregnancy	22%	58.7	45.3	Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional)
Numbers of people with diabetes	9%	5.65	5.1	% of people on GP registers with a recorded diagnosis of diabetes 2009/10
Child poverty	26%	29.4	21.7	% children in families receiving means-tested benefits and low income 2008
Child tooth decay	19%	1.2	1.0	Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09
Violent crime	21%	17.7	13.9	Recorded violence against the person crimes crude rate per 1,000 population 2009/10
Alcohol related admissions	18%	2,967	2,433	Directly age and sex standardised rate per 100,000 population, 2009/10
Unemployment	29%	8.4	6.0	Crude rate per 1,000 population aged 16-64, 2010

As a result, the scale of the shift across the wide range of indicators simply to narrow the gap in life expectancy by 25% (about nine months) can be seen for the challenge it is. To achieve this goal, a whole system shift would be needed, with some significant changes in areas that are challenging to influence over a short time period, e.g. a 29% reduction in unemployment, a 21% reduction in violent crime and a 10% increase in GCSE attainment. These are not about a definite cause and effect relationship but show how the picture would have to change before we could expect life expectancy to be nine months closer to the England average.

The tool has also been useful in demonstrating the health gain that individual wider determinant markers like child poverty and educational attainment can contribute for Salford. This is because the user can adjust the value of any of the 27 indicators and observe the predicted values of all the other measures that then result, including, most importantly, life expectancy. For example, if the proportion of adults who smoke in Salford were reduced by just 3.41% (from 28.41% to 25%), the modelled life expectancy for men would increase from 74.70 to 75.42 years and for women from 79.60 to 80.13 years.

Similarly, if child poverty was reduced by 4% (from 29% to 25%), the modelled change in life expectancy for men would increase to 75.14 years and for women to 79.92. For the first time it is possible to model the interrelationships with the wider determinant issues like unemployment and educational attainment, providing the basis for a different type of public health conversation with our colleagues across the city council, and our partners: one which is based on a real appreciation of the impact their services can have on the health and wellbeing of the Salford population.

This tool illustrates the innovation which Salford has gained a reputation for. It is a work in progress with some very clear limitations; for example, it uses data from the Health Profiles for a single year and doesn't change to reflect the revised versions, and it has only been modelled for Salford not any other districts. However Public Health England have now committed to taking on the tool and developing it further to address these issues and make it nationally available. It will link to the indicators in the Public Health Outcomes framework and measures local authorities will be judged against in the future.



Chapter 3 Public Health impact: case studies

This report so far has looked at how the health challenges for Salford have developed. It has given a snapshot of the health and wellbeing of the city today with some suggestions of what we need to do to decrease the health gradient within Salford and the health gap between our city and the rest of England. During our first year in the local authority, the Public Health Team, working with local authority colleagues, have helped shape a number of changes. Some case examples are presented here to show how our work is transforming Salford City Council into a public health organisation, ensuring benefits for the residents of Salford, and to give a sense of how our work will develop over the coming years.

The shift of public health responsibility has given the local authority the responsibility to reduce health inequalities and improve the health and wellbeing of the local population. In order to ensure that we are targeting the right areas we first identified a number of key health themes including tobacco, alcohol, drugs, nutrition, physical activity, sexual health, cancer, cardiovascular disease, capacity building, injury prevention and support services. We then reviewed all the key national and local public health-related documents relevant to Salford City Council. We identified the health themes prioritised by each document. Every time a document mentioned one of the key health themes, a point was awarded. The overall priorities were calculated by adding up the number of points each of the themes had.

In addition to this, we used the I-Hit tool (as outlined in chapter 2) to identify which health outcomes would have the biggest effect on life expectancy if they were improved. Those with maximum impact on overall life expectancy were prioritised.

A method called SPOT (spend and outcomes measures tool), a form of programme budgeting, was used for assessing investment in the health programmes. Finally, a method called multi-criteria decision analysis was used. This involves describing criteria, then arranging them on a performance matrix and assigning ratings for each programme option. The user then interprets the performance matrix to reach a conclusion.

Based on this scoring system, it was identified that Salford City Council's top priorities should include:

- Alcohol
- Nutrition
- Mental health
- Capacity building

We are using these results in planning for the future.

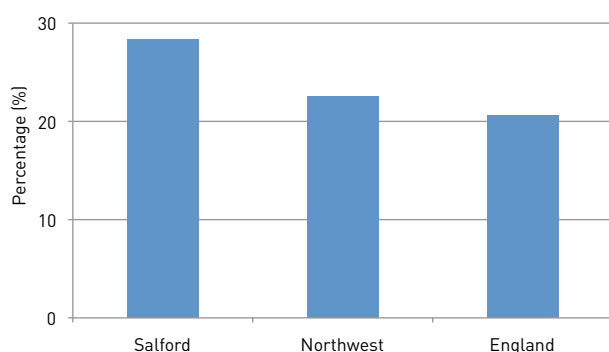
Capacity building

This includes activities which assist the community and community groups to support themselves to improve their communities' health – for example

- training for community members on specific health topics
- providing venues for meetings
- offering advice and support

Welfare reform and public health

Children under 16 living in poverty



Income, employment and housing significantly influence our health and quality of life.

The Coalition Government's welfare reforms introduced the most far-reaching changes to the benefits and tax credits system since the founding of Britain's modern welfare state, reducing existing benefit and tax credit support levels.



The Salford picture

These changes affect a large proportion of our Salford population, who are now facing difficult changes to their income levels and how they live their day to day lives. Salford has 12,720 (28.3%) under-16s living in poverty, which is significantly higher than the North West (22.5%) and England (20.6%). Childhood poverty can contribute to early death and poorer health outcomes in later life.

Salford also has over one in five of all residents (21.7%) with a limiting long term illness, and significantly higher rates of adult and elderly residents using mental health services than England. Areas that are more deprived will have more residents receiving benefits, and are more likely to feel the impact of welfare changes.

Recognising the likely impact of the welfare changes on vulnerable communities across Salford, the council's Public Health Team supported The Centre for Economic and Social Inclusion to conduct an independent review of the impact of welfare reform on money worries and debt and the effect this will have on mental health services in Salford.

The review found that the change from Incapacity Benefit to Employment Support Allowance (ESA) and Jobseekers Allowance (JSA) meant:

- Approximately 5,500 Salford claimants were found fit for work and experienced a reduction in benefit of £40 per week.
- Further changes from the Housing Benefit Reform saw approximately 5,000 Salford households with a reduction in housing benefit as they were living in properties deemed to be larger than they needed.

This has left residents with the option of trying to find the extra rent or move and uproot their families from their existing communities and support networks. The change in the housing benefit cap also may lead to families going into rent arrears and being at risk of homelessness.

The review also described the relationship between debt and mental health. It is not as simple as one causing the other, but we know that:

- The extent to which people worry about debt can have more of an impact on their mental health than the level of the debt itself.
- Debt can bring feelings of uncertainty.
- People with debt and mental health problems often do not seek help with their finances.

There are already a number of wards in Salford where deprivation is high and where the demand for mental health services is increasing. Unemployment is set to increase further and wage growth in Salford is lower than average. Despite the fact that the city has relatively low living costs compared to the region as a whole there is evidence that many households in the city are already struggling financially and it is likely that this number will rise further.

Welfare rights and debt advice in Salford

Alongside reductions in state spending on benefits and tax credits, there has been a decrease in spending on most public services including the council's Welfare Rights and Debt Advice Service. These reductions come at a time when those at risk will need more guidance and advice in relation to changes in their welfare, finances and how to access wider support. In 2011/12, around 5,000 people were advised concerning their welfare benefits entitlements and 500 people supported to deal with their debt problems.

Welfare Rights and Debt Advice as a Public Health Service

Public Health provide a range of health improvement services to help reduce harm from issues which impact on health, such as alcohol and smoking. We also support those services that help improve the wellbeing of Salford people and support communities to be resilient to changes such as welfare reform. Clients who need welfare support or debt advice are very often the same people who would benefit from our wider wellbeing services.

In order to ensure improvements in health outcomes the service is developing closer links with our wider wellbeing services and building on the successful Making Every Contact Count programme (see page 35). This will help create welfare rights skills and capacity across all public health commissioned services. We are also developing our online offer and investing in creating skills across all frontline workers and developing the Way to Wellbeing portal (see page 35) to support all Salford residents who require support on welfare rights, debt advice or wider health and wellbeing issues.



Integrated Youth Support Service redesign

Salford's Integrated Youth Support Services (IYSS) reached 3,939 young people aged 11-19 years in 2012/13. The service works across all neighbourhoods, and is particularly successful with vulnerable groups such as young people from traveller, Yemeni, Czech Roma and Orthodox Jewish communities and young people who are LGBT or have disabilities. The service offers informal and formal education programmes, group work, one-to-one casework, street work and activity-based sessions in centres across the city. IYSS works closely with partners, taking referrals for vulnerable young people who may not traditionally access generic and specialist services.

IYSS can make sure these vulnerable young people, who may go on to become teenage parents, smokers and drinkers, have their health behaviours and needs routinely screened and assessed. They can provide health education/brief interventions and increase their access to health services through referral and hand-holding into services. This includes a commission to deliver quit smoking support to young people. For pregnant teenagers and teenage parents, health assessments are provided along with targeted work on smoking in pregnancy, breastfeeding and infant feeding and repeat conceptions. IYSS will also work to promote young people's voice on health issues.

In the service outcomes there are clear links with the health and wellbeing benefits that the Public Health Team want to see for Salford young people, and the team are working with IYSS to make sure the service is able to deliver these and provide added social value, in conjunction with other commissioned services like the school nursing service.

A recent review of the Salford School Nursing Service described the health and social care needs of school-age children in Salford. It identified high levels of obesity in Year 6 children, high numbers of teenage pregnancies, high numbers of vulnerable children and just under a third of pupils eligible for free school meals, for example. These needs cannot be addressed by any one agency alone, highlighting the need for an integrated approach between services.

As the local authority already commissions the school nursing service establishing the expected outcomes alongside those of the IYSS presented an opportunity to look at all the identified health and social care needs of school-age children. Work is on-going to design a clear offer for children and young people within school and across the wider community. The commissioning of health visiting and the Family Nurse Partnership programme will come to the local authority in October 2015. This will mean that there is an opportunity to look at services for children and young people 0-19 years together and plan a more joined-up service.

Therefore in 2014/15 it will be important to:

- Implement the recommendations in the school nursing service review.
- Review and redesign the IYSS to ensure that it works with the school nursing service and other partners to offer an integrated service to school-age children.
- Prepare for the transfer of health visiting and Family Nurse Partnership services to the local authority in October 2015.

Social value in Salford

'Social value' includes the social, environmental and economic wellbeing of Salford as a place and the people who live there.

Since January 2013, the council, Salford Clinical Commissioning Group and other public bodies have had to consider social value as part of their commissioning activities, both as part of contract specifications and as 'added value' from the way a service is delivered. For example, a stop smoking service that employs and trains local people, paying them the Living Wage, provides more social value and wellbeing for Salford residents than just the number of people that stop smoking.

The Health and Wellbeing Board has been looking at how to get maximum social value from all health and care services, and it believes that Salford should seek social value from all public investment in the city, not just services the council pays for.

The Board has commenced work on five tasks to bring social value to Salford:

- Publishing a Social Value Charter for partners to sign up to (so all projects include social value).
- Testing and analysis of current practice to seek the best ways of achieving social value.
- Developing a toolkit to aid the delivery of social value.
- Running a programme of training about the social value toolkit for staff.
- Developing a framework for reporting the social value that has been achieved.

Including social value in the process of planning and evaluating services allows the opportunity to obtain better value – and not just financial value – from the investment of public money in the city. In Salford, we will look for relevant social, environmental and economic value from everything that we do, including service delivery, commissioning and procurement; and aim to use the 'Salford pound' to obtain the greatest benefit for local citizens. Social value considers more than just the financial transaction and includes:

**Happiness ❁ Wellbeing ❁ Health ❁ Inclusion
❁ Empowerment ❁ Poverty ❁ Environment**



Special Planning Guidance – hot food takeaways in Salford

Many people who live in Salford are overweight or obese, and this is part of a national issue. Latest figures show that 63.3% of Salford residents aged over 16 are overweight or obese and 9.1% of Reception and 21.5% of Year 6 children are obese (23% overweight or obese four to five year olds, 36% overweight or obese 10-11 year olds).

Weight affects health in many ways and can make individuals more likely to develop diabetes or cardiovascular disease and also affects wellbeing. Diets high in fat and lack of physical activity are key causes of obesity. Factors in our environment can mean it is harder for people to make healthy choices, for example: lack of green space to exercise, long working hours restricting time to prepare food, and lack of healthy options at eating establishments. Public health teams in local authorities are ideally positioned to work with their colleagues across the council to tackle some of these aspects of the 'obesogenic' environment.

Under the leadership of Salford Health and Wellbeing Board, Salford City Council decided to address the issue of hot food takeaway applications. Although hot food takeaways do not directly cause obesity, evidence shows that the majority of premises offer food which is energy dense and nutritionally poor, which can contribute to obesity. Both the Chartered Institute for Environmental Health and the Department of Health advise that local authorities should limit the opening of new outlets, particularly in sensitive areas such as around schools.

Research also shows that the more overweight a person is and the earlier in life they become overweight, the greater the impact on health. If obesity develops in childhood, it is likely to continue into adulthood. So it is important to establish healthy eating habits from an early age, to help people maintain a healthy weight, reduce rates of overweight and obese children and to prevent the physical, psychological and social consequences of childhood obesity for our city.

The most popular time for young people to buy food is after school and secondary school children may also leave school premises at lunchtime. Fast food outlets close to schools, especially when there are several, have been found to make it harder for secondary school children to choose healthy eating.

Recognising this, the city's hot food takeaways supplementary planning document (SPD) has been updated. It is intended to guide prospective takeaway owners to encourage the submission of good quality planning applications. The new SPD includes the following conditions for planning permission to be granted for a hot food takeaway outlet:

- Limits on the opening hours of hot food takeaways within 400m of secondary schools.
- Where there are existing concerns about antisocial behaviour or financial contribution CCTV may be a required condition.
- Where there are not enough litter bin facilities, an outlet may be required to provide them.
- The total number of takeaways can be a factor in agreeing planning.

Healthy catering award

Alongside taking action to limit certain types of food retailer, Salford City Council has signed up to the Greater Manchester healthier catering award which aims to make it easier for people to choose a healthier option when they eat out. The scheme recognises those businesses that have a national food hygiene score of three or more and have demonstrated a commitment to reducing the level of saturated fat, sugar and salt in the food and drinks sold. This will contribute to helping people in Salford maintain a healthy weight and a longer life as a result.

Development of Salford City Council's housing strategy

It has long been recognised that housing plays a vital part in public health. Poor quality, badly insulated, unsuitable housing can have significant negative impacts on individuals' and communities' health. Effective planning and design of new houses and neighbourhoods can have a range of positive impacts on health.

Well designed houses and neighbourhoods can:

- Reduce accidents.
- Reduce winter related deaths.
- Reduce respiratory problems.
- Reduce infectious diseases.
- Encourage people to socialise (improving mental health).
- Promote more forms of active travel such as cycling and walking (improving cardiovascular health and reducing pollution).
- Encourage the use of local shops/businesses (supporting the local economy).
- Encourage the use of green spaces encouraging walking, sports or outdoor activities.
- Reduce antisocial behaviour and crime.

Therefore, integrating health considerations into all new developments and regeneration related to housing is essential. To ensure this, Salford's Public Health Team has been an integral partner in the development of Salford's new housing strategy 'Shaping Housing in Salford 2020'. We clearly outlined what should be included:

- The importance of having adequate homes (decent homes) is beneficial, as a hazardous indoor environment with exposure to agents such as asbestos, carbon monoxide, mould and lead can be detrimental to health.
- Emphasis on the impact of overcrowding and its link to poor mental health.
- Information on ensuring that developments of housing are linked with the wider infrastructure effectively e.g. access to education, health services, healthy shops, local amenities.
- The importance of design of homes and neighbourhoods for social cohesion and safe environments as a significant contributor to positive mental health.
- The use of green space, road design for safety, walking/cycling/active travel facilities is also a key element of housing as it supports and encourages physical activity and positive mental health.
- Active play facilities for children and young people and families.

Including these elements in the strategy will help ensure that work of the housing department fosters the health of the population.

Salford Helping Families programme

The government launched a programme to help troubled families turn their lives around. They identify a 'troubled family' as one where two or more of the following things exist:

- Youth crime and / or family anti-social behaviour.
- A young person not attending education.
- An adult not employed and on out of work benefits.

There are almost always other issues going on for 'troubled families'. The Think Family work by the Social Inclusion Task Force (2007) showed that some families face multiple problems including living in poor quality housing, mental health problems, longstanding limiting illness or disability and inability to afford food and clothing items. There was a greater concentration of families with multiple problems in disadvantaged areas. Many of these other issues may be the reasons why it is difficult for families to change. If services can spot these wider issues, families can be supported to prevent them from becoming 'troubled'.

To reflect this emphasis, the Salford programme is called Helping Families, in recognition of the need to support some families more to enable them to make changes. In order to assist the Salford Helping Families Team to understand the issues facing certain Salford families, a needs assessment was undertaken in 2013 to look at what health and social issues were more common amongst these families. The Public Health Team led this work. The aim was to help decide whether more could be offered to families at an earlier stage.

The first part of the needs assessment was to understand what the potential health issues were for the families. This work was undertaken anonymously, using care records, so that no individuals could be identified. It also only captured certain data. Further work is planned to understand the issues better. However, this showed a broad range of health conditions experienced by the families, including high levels of obesity, smoking and alcohol use.

The next stage is to understand what this means in more detail, to look at what actions we need to take to support families earlier and what services are needed based on this assessment. This work will be done in the current year.



Domestic abuse and refuge

Domestic abuse is a key public health issue. It occurs in every socio-economic group and occurs citywide across all neighbourhoods and communities. Domestic abuse is not just violence – it includes psychological, physical, sexual, financial and emotional abuse. As well as life-changing impacts on individual's lives there is a huge financial cost associated with domestic abuse. From a health perspective the physical injuries lead to increased accident and emergency attendances and the psychological impacts lead to increased mental health problems. Other related costs to the criminal justice system, social services, houses and refuges and civil legal services are huge.

To ensure Salford is doing everything it can to address domestic abuse, the Public Health Team has carried out a needs assessment (see page 11 for more on needs assessment). This looked at the number of reported cases, where these cases are and who it affects most. It also lists what services Salford has in place to identify and address domestic abuse and the evidence on which services work best. In combination with partners involved in domestic abuse services, recommendations have been developed along with an action plan.

In addition, the Public Health Team have supported the redesign of refuge services which provide a safe haven for those experiencing domestic abuse. Public Health identified and agreed a number of health outcomes which the refuge service should provide. This is to ensure we are able to measure the effectiveness of the services and they are having a positive impact on health. These involve supporting clients of the service in:

- Improving their health and emotional wellbeing.
- Improving their quality of life.
- Making a positive contribution.
- Exercising choice and control.
- Freedom from discrimination and harassment.
- Improvements in economic wellbeing.
- Personal dignity and respect.



Residential care

Nationally, the number of people aged over 65 is projected to rise by 12% between 2012 and 2022. With this rise there will be an increase in complex health and social care problems in a time of reducing financial budgets. The Salford Integrated Care Programme (ICP) is planning for this challenge by integrating health and social care so that in the future older people have co-ordinated quality care. One aim of the programme is to help older people to stay in their own homes longer and so to reduce admissions to permanent residential care homes.

The Salford Joint Strategic Needs Assessment (JSNA) for 2013/14 supported this aim by looking at the factors which lead to admission to residential care in Salford. Pathways to care were assessed, professional views collected, research checked and the population and hospital admission trends described. It was found that admissions were prompted by the complexity of needs that resulted from a general deterioration of health over time. Only 15% of admissions were related to a sudden problem and were of people not already receiving social care support. The average age of people admitted to homes was 85 and this was found to be increasing only slightly when compared to previous years. The average length of stay in a care home was 19 months.

Particular trigger factors to admission to care homes are:

- A change in family ability to take a carer role. For example, carer ill health or strain.
- Progression of cognitive impairment or dementia.
- Personal health factors which required both day and night time support, for example reduced mobility and continence problems.
- Social isolation.
- Previous admissions to care homes.

Many of the health problems seen in people admitted to care homes were long term conditions. This highlights the importance of actions to prevent conditions developing, preventing them getting worse, and helping people support themselves earlier in life. Health checks and other screening are important tools to identify risk factors and provide early regular support for long term conditions.

The JSNA project also explored factors which helped people maintain independence in their own homes and found some evidence for aids and equipment, including telecare. Early introduction was a recommendation. Greater involvement of housing providers will support identifying opportunities for earlier intervention with equipment and also to spot social isolation. There was good evidence for carer support and education therefore community based support programmes with good evaluation which are part of the Integrated Care Programme are continuing to develop.

More information on the ICP can be found in our report from last year (2012/13) and on page 36.

Health checks:

Everyone is at risk of developing heart disease, stroke, diabetes, kidney disease and some forms of dementia. These conditions can often be prevented by changes in lifestyle. NHS Health Checks assess the risk of developing these health problems for an individual and give personalised advice on how to reduce them.

The NHS Health Check is for adults in England between the ages of 40 and 74. In Salford we have:

- Worked with GP practices to increase the number of people who come for a health check.
- Arranged for the Health Improvement Service (HIS) to deliver the checks on the Health Bus in areas where GP practices have not signed up to deliver them.
- Begun recruiting a small number of community pharmacies to deliver NHS health checks next year.



Health protection in Care Homes

The Director of Public Health has a duty to protect the health of the population. This includes protection from infections that are associated with health or social care. The Public Health Team nurses are part of the public health department. They work closely with Health and Social Care teams in Salford City Council and partners in health care to make sure that residents of care homes receive safe, clean care and that infection prevention and control standards are improved and maintained across the city. A range of approaches are used and include:

- Supporting the commissioners of care homes to develop robust infection prevention control requirements in all new contracts.
- Undertaking infection prevention audits in all care homes and producing action plans for areas that require improvements and following up progress of action plans to ensure actions are completed in a timely manner.
- Providing infection control training in all care homes to ensure that all levels of staff have the necessary knowledge and skills to deliver safe, clean care at all times.
- Supporting the Care Quality Commission and Salford safeguarding teams in investigating any complaints, to ensure that these are justified and also that the appropriate actions are put in place to prevent any risk of harm.
- Working with carers and other professionals such as district nurses and GPs to ensure that the management of individual infections is appropriate and the risk of spread of infection is reduced.
- Immediate response and specialist advice during outbreaks of infection such as Norovirus (Winter Vomiting Infection) has ensured that the risk of spread has been kept to a minimum and that patients, staff and visitors have the correct information to help protect them from infection.

Repeat audits in care homes have demonstrated an improvement in infection control standards across the city, in addition this has also supported a reduction in the number of patients with healthcare-associated infections such as MRSA (multi-resistant staphylococcus aureus) and CDiff (clostridium difficile). Investigations into these infections have identified further areas of work to identify the cause of underlying infections such as urine infections that may be associated with catheter care.

Recommendations include undertaking further work in partnership across health and social care partners to explore the possible causes of urinary tract, leg ulcer and wound infections and identify ways to prevent these and therefore reduce the use of antibiotics and the growing problem of antibiotic resistance.

The case examples in this chapter show how the Public Health Team have integrated with council colleagues to work in partnership with all directorates as well as the people of Salford and other partners.

Cllr Margaret Morris



Chapter 4 Update on recommendations in last year's report

In the Public Health Report for 2012/13, the theme of **integration** was described in three different programmes. Work on all three of these is continuing and this section provides a review of progress.

In last year's report, we told you about the Way to Wellbeing System and provided an outline of the Being Well Service, the Way to Wellbeing website and Making Every Contact Count.

Being Well

The service has recruited 14 Wellbeing Coaches and there are two apprentice roles and 14 active volunteers. They have started to deliver activity to full capacity. One of the aims of the service was to support clients over a 12-month period to achieve their wellbeing goals. Clients coming into the service tend to have a combination of lifestyle and wellbeing factors they want to manage better; for example 20% of clients have low levels of physical activity, high alcohol use and low mood. To make change, clients are supported to increase their confidence to change as well as reducing their alcohol use and increasing their physical activity.

Almost 1,000 clients were referred into Being Well over the year and the service had 600 active clients.

- 78% reported making good progress on their goals.
- For those who worked on an alcohol goal, 50% had reduced their drinking level.
- For those who reported a weight goal, 35% had reported a reduction in weight.
- For people who smoked, 60% had either quit or reduced their smoking.
- 70% of all clients attending 10 or more sessions reported improved mental wellbeing.

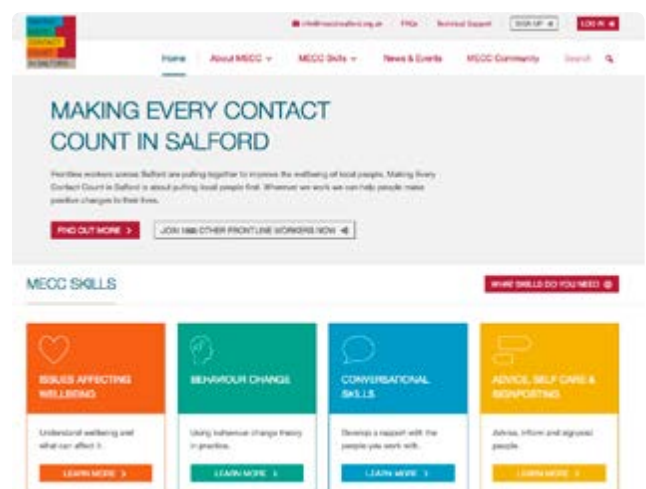
Way to Wellbeing website

During 2013/14, the content and style of the Way to Wellbeing website was completely reviewed. The process of developing the design and content for the website was complex, but did provide a starting point for offering a web-based service to support people to self-manage areas of their wellbeing. We quickly learned, through user feedback, that the wellbeing journey though the website was too complex. The new look website has some of the same features; for example, it uses a wellbeing checker to help the user explore areas of their wellbeing, but the supporting content is much simpler to work through. www.way2wellbeing.org.uk



Making Every Contact Count

During 2013, we commissioned an evaluation of the impact and approach to delivering Making Every Contact Count (MECC). The evaluation highlighted a number of significant areas for development and review, which has led to repackaging the MECC offer. Individuals and organisations involved in MECC recognised the value of making every contact count, but the process of getting engaged in the programme didn't suit all organisations. From May 2014, the new MECC offer will provide all front line workers in the city with a simple-to-access opportunity to develop their MECC skills and knowledge base, by signing into the MECC website. We have worked hard to simplify the whole process and the support offered to staff and volunteers who register with MECC. Coupled with that, we wanted to ensure there is a MECC Community to encourage engagement, to share what works and to champion MECC across Salford. www.meccinsalford.org.uk



Integrated Care Programme for Older People

During 2013/14 the Integrated Care Programme launched a neighbourhood collaborative which comprised three key workstreams to undertake small tests of change to determine what integrated care should look like in Salford. 'Sally Ford' and her family, though fictional characters, have profiles typical of many people living in Salford and the work undertaken by the programme has kept Sally at the heart of all its activities.

The three workstreams are:

- Local Community Assets- to enable older people to remain independent, with greater confidence to manage their own care.
- An integrated Health and Social Care Contact Centre- to act as a central hub, supporting multi-disciplinary groups, helping people to navigate services, and provide health coaching and access to more specialist services as well as promote the use of assistive technology .
- Multi-disciplinary Groups- to provide a targeted support to older people who are most at risk of ill health, and have a population focus on screening, primary prevention and sign posting to community support.

The initial work was undertaken in two of Salford's eight neighbourhoods. Building on the learning from the work streams a model for integrated care in Salford has been developed and will be rolled out across Salford from April 2014.

Multi-disciplinary Groups (MDGs) will be established in all neighbourhoods in Salford, where health and social care professionals will agree shared care plans with at risk individuals to help maintain their health and independence. The MDGs will be embedded initially in the pilot neighbourhoods of Swinton and Eccles but from July will be phased into the remaining areas.

The Centre for Contact will, during 2014, bring the Adult Social Care Contact Centre, the Intermediate Care Single Entry Point and District Nursing administrative support together under one roof to develop a streamlined response from all services through a single point of contact.

Integrating drug and alcohol services

In last year's Public Health Report we detailed our intention to establish integrated and recovery focused drug and alcohol services in Salford. During 2013/14 we conducted an extensive selection process that resulted in a Lead Provider contract being awarded to the Greater Manchester West Mental Health NHS Foundation Trust (GMW). Our new services opened on 1 October 2014 with GMW coordinating the delivery of NHS and voluntary services to ensure that people get the right services, at the right time, and in the right place.

The emphasis placed on recovery will see more and more people who have experienced drug and alcohol problems volunteering to help others and give something back to their communities.

This will mean our new services adding further to what we have already seen this year in Salford:

- Volunteers in recovery supporting others coming into treatment.
- Volunteers in recovery developing local housing for people in treatment and recovery.
- Volunteers in recovery developing small businesses e.g. horticulture, cycle maintenance, furniture restoration, and other small enterprise with a view to future employment.
- Volunteers in recovery working to improve local neighbourhoods e.g. helping with local youth activities with a view to future employment.

We also expect to see even better health and social outcomes that will benefit the people who use our services, their families, and their communities:

- Better treatment engagement – people will want treatment.
- Better treatment completions – more people will finish treatment.
- Better mental health and wellbeing.
- Reduced crime and fear of crime.
- Better family life and neighbourhood life.



Conclusion

In this report we have tried to show how the roots of public health lie in local government and that the transfer of responsibilities for public health from the NHS is in many ways a coming home. Although many of the challenges for Salford may have changed, parallels with our early work remain, with emergent communicable disease threats and the continuing economic challenge which underpins local health inequalities. The development of our health inequalities modelling tool allows us to demonstrate the scale of the challenge which making relatively small improvements in life expectancy may require across the Salford system. Alongside this, the case studies in this report illustrate how public health is integrating with the council. Key to this is the Joint Strategic Needs Assessment, which frames local priorities and provides in-depth understanding to underpin future planning, with examples shown in the report which demonstrate how public health intelligence is finding a new role.

These needs assessments will underpin the work of the Health and Wellbeing Board, particularly as it grapples with the reform of the public sector which the austerity programme demands.

Whilst this report focuses on the role of local government and the capacity for public health work across other parts of the council, we are mindful of the important role that our partners in the healthcare sector play. Salford's Clinical Commissioning Group has also navigated significant change to arrive in its current status; public health will continue to support them with our mandated advice for healthcare planning. Their enlightened approach in supporting local innovation has enabled the voluntary, community and social enterprise

sector to demonstrate their capacity to deliver hugely innovative approaches within small budgets. Alongside this, Salford Royal demonstrates the capacity for the acute sector to look beyond its core business and innovate in areas of broader public health.

Finally, I should include my thanks to the team for their efforts in managing a challenging year with such good humour and an innate ability to stay focused on the task in hand; they are a credit to any organisation. I also wish to thank Councillor Morris for agreeing to provide commentary within this report. The decision to do this wasn't taken lightly, because we understand the risk of this being seen as compromising the independent nature of the report. However I wanted to acknowledge the support and guidance she has provided for the team in its first year, smoothing our transition into the organisation; we count her both as part of the team and a critical friend.

David Herne
Director of Public Health

This report records the work done this year in embedding the Public Health Team into Salford City Council and continuing our successful partnership working. We have laid a strong foundation, and I am looking forward to continuing our successful partnership working in the future.

Cllr Margaret Morris

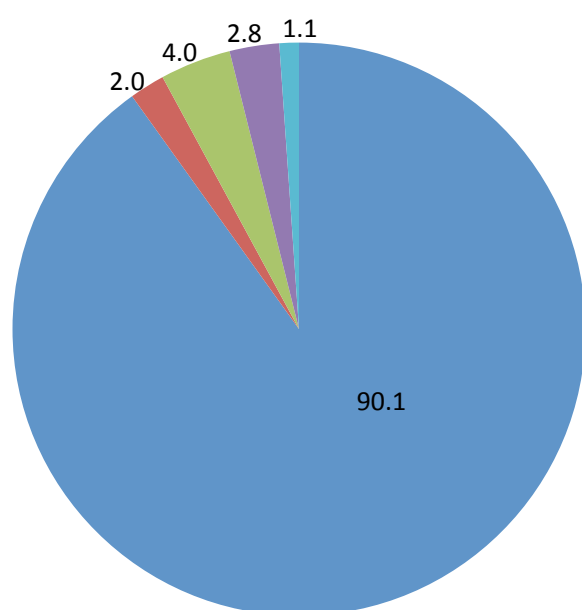
Appendix

Data Appendix

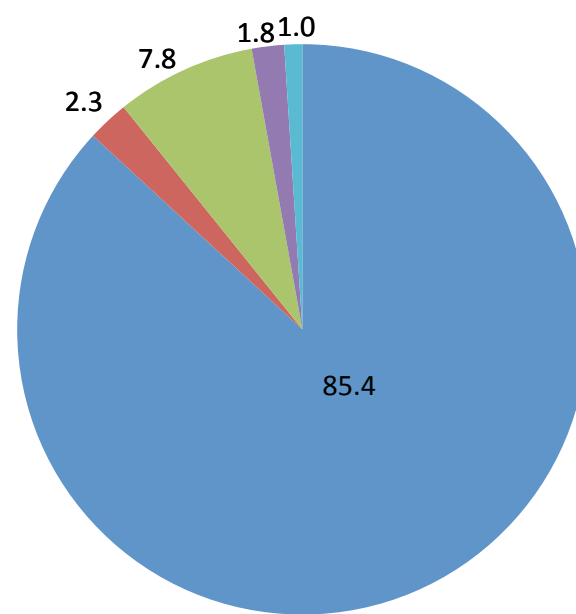
This is a summary, for more detail and information please see the JSNA link <http://www.salford.gov.uk/salfordjsna.htm> (accessed 05/08/14)

Ethnicity

Percentage of Ethnic Groups in Salford, 2011



Percentage of Ethnic Groups in England, 2011

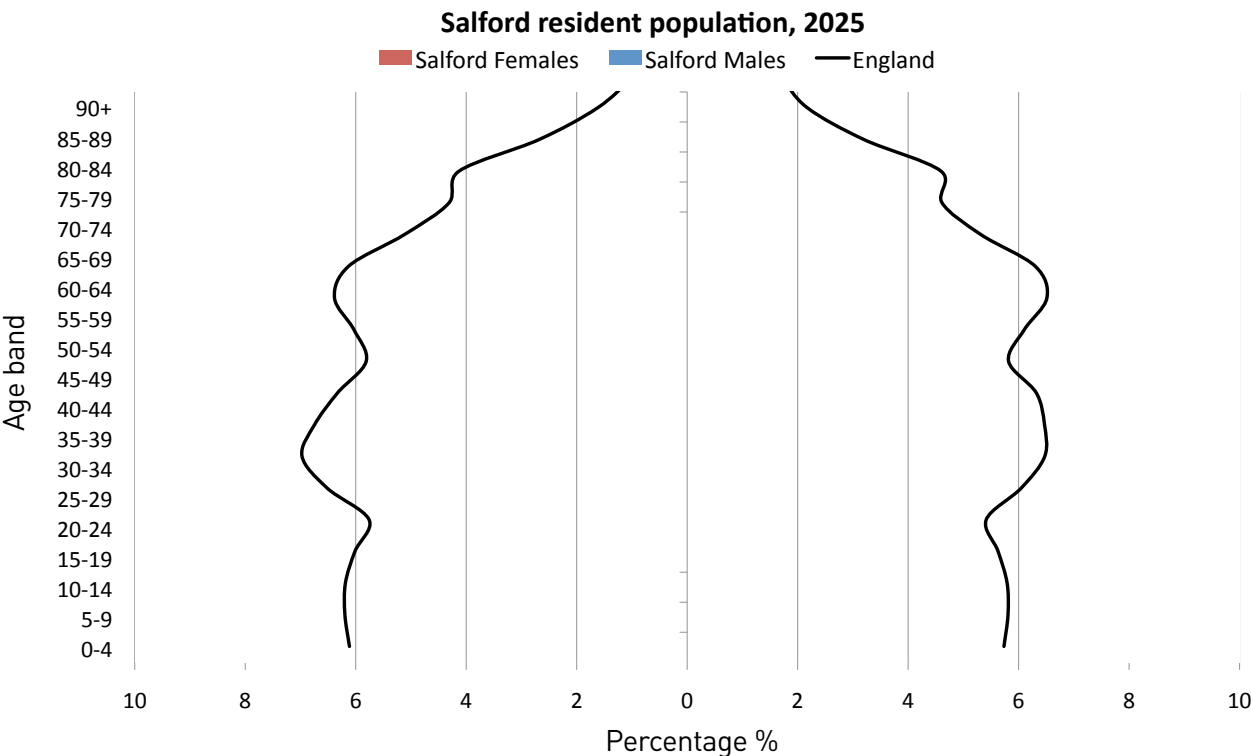
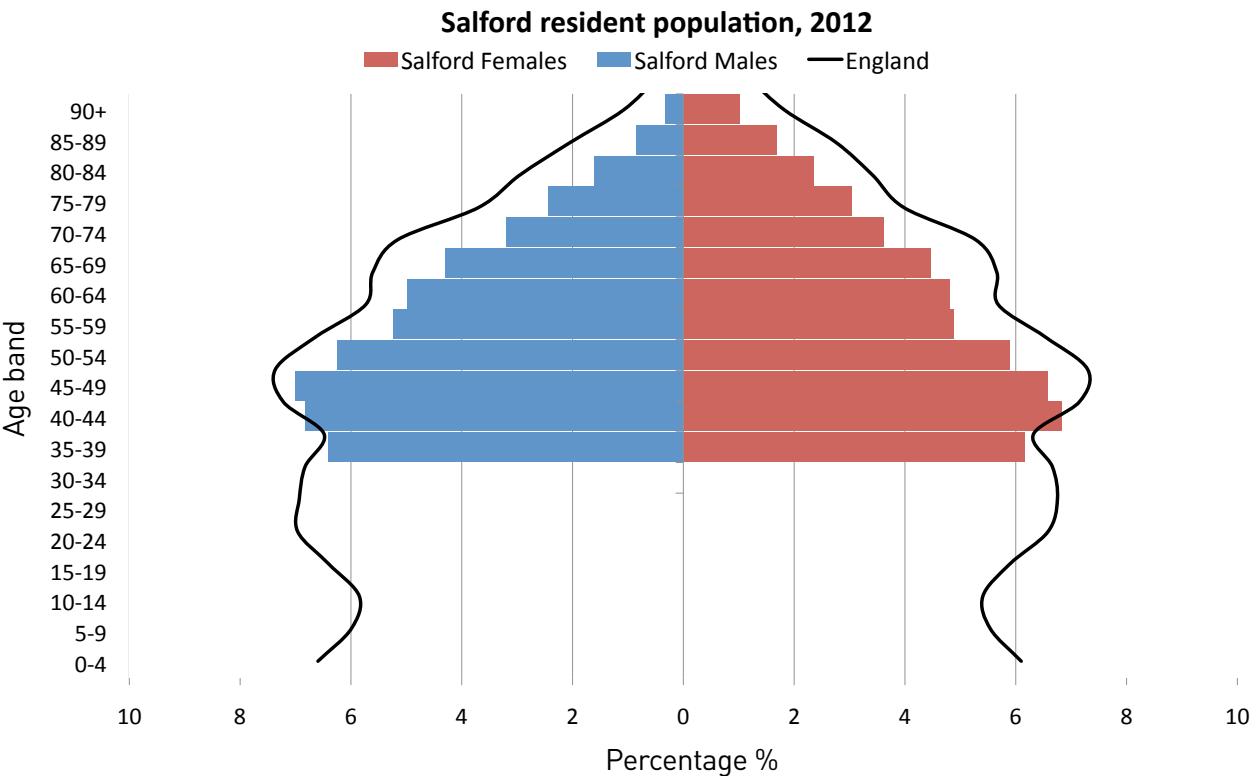


White Mixed/multiple ethnic groups Asian/Asian British Black/African/Caribbean/Black British Other ethnic group

Source: Official Labour Market Statistics, NOMIS
<http://www.nomisweb.co.uk/> (accessed 28/04/2014)

Population

Age structure of the population across both Salford and England in 2012 and the forecast changes by 2025



Source: Population projections, Office for National Statistics (ONS)
<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Projections#tab-data-tables>
 (accessed 01/08/14)

Deprivation

Salford Population: Analysed by Quintiles of Deprivation

Quintile of Deprivation	Mid-2010 Population Estimates	% of Population	% England population
Q1 – Most deprived	106,416	46%	20%
Q2	55,762	24%	20%
Q3	36,534	16%	20%
Q4	19,168	8%	20%
Q5 – Least deprived	11,112	5%	20%
Total	228,992	100%	100%

Source:

Population estimates (2010), Office for National Statistics

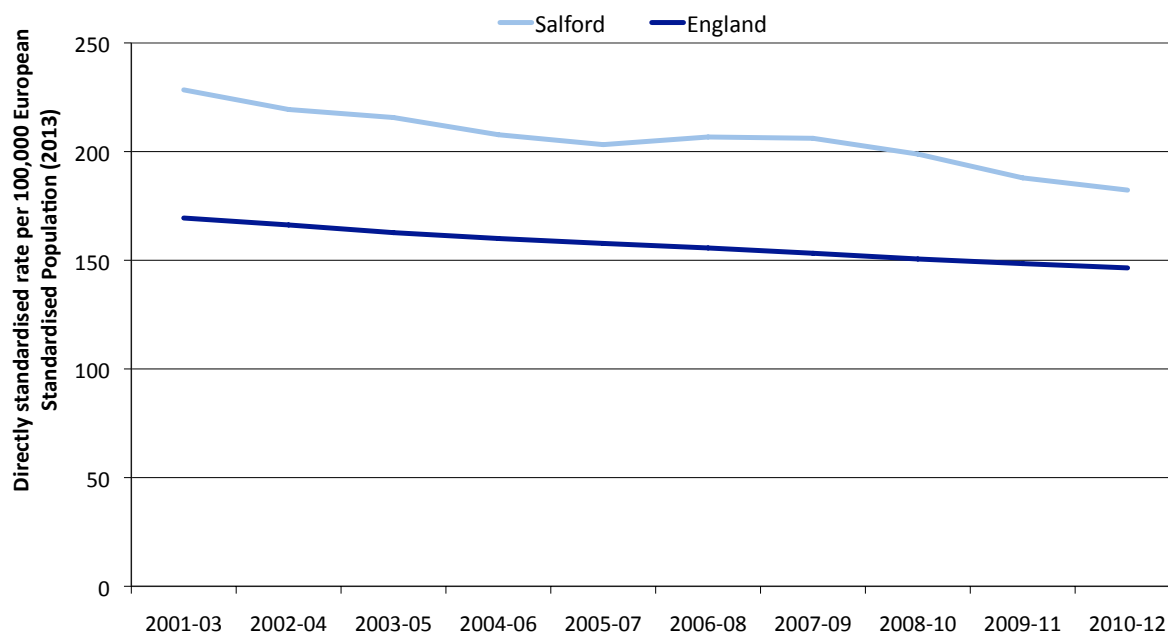
Indices of deprivation (2010), Data.gov.uk

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates#tab-data-tables>
(accessed 01/08/14)

<http://data.gov.uk/dataset/index-of-multiple-deprivation> (accessed 07/08/14)

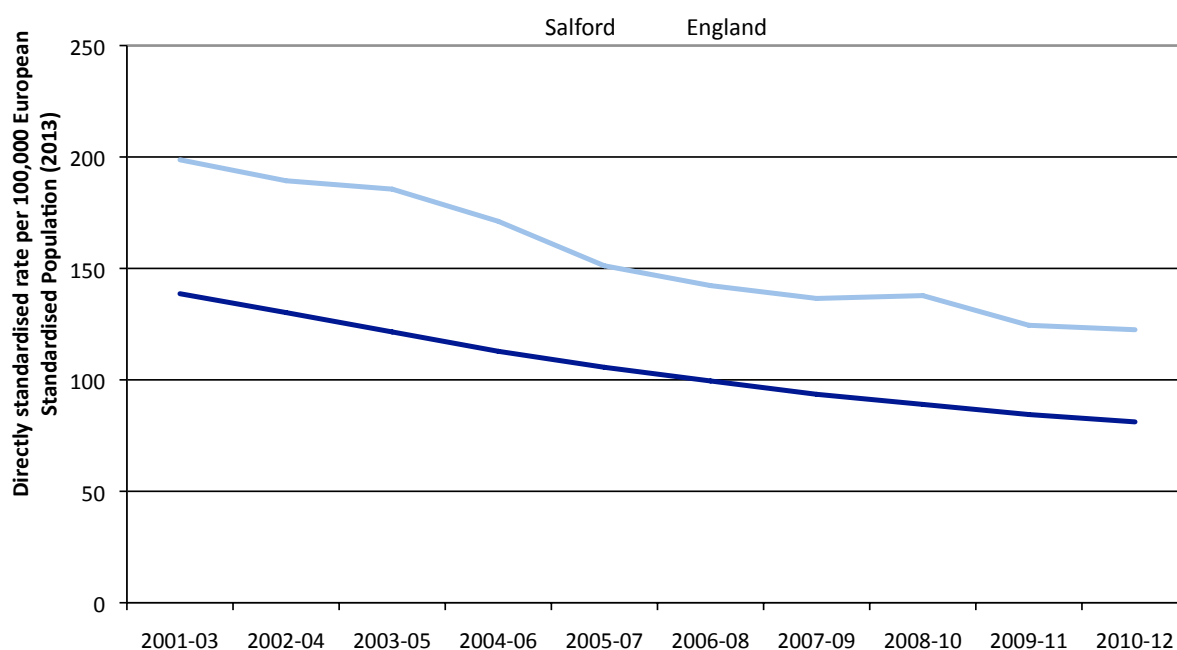
Mortality

**Under 75 mortality rate from all cancer, Salford,
2001/03 - 2010/12**



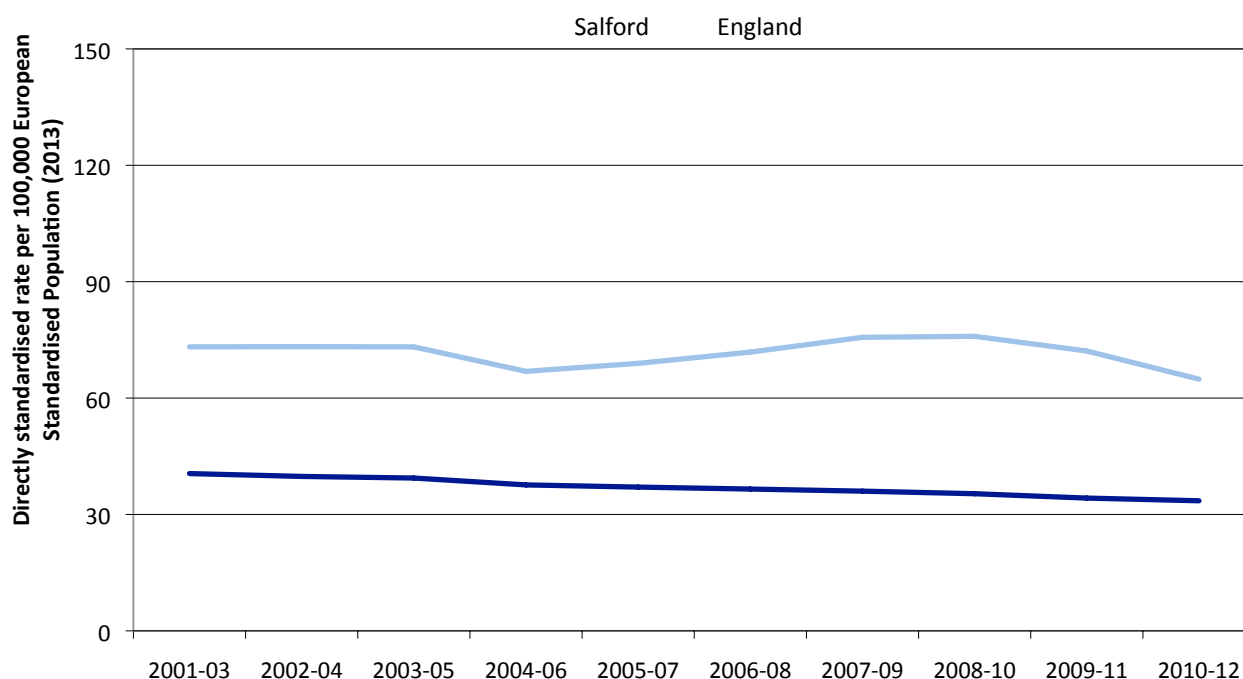
Source: Public Health Outcomes Framework (PHOF), Public Health England
<http://www.phoutcomes.info/> (accessed 05/08/14)

**Under 75 mortality rate from all cardiovascular disease, Salford,
2001/03 - 2010/12**



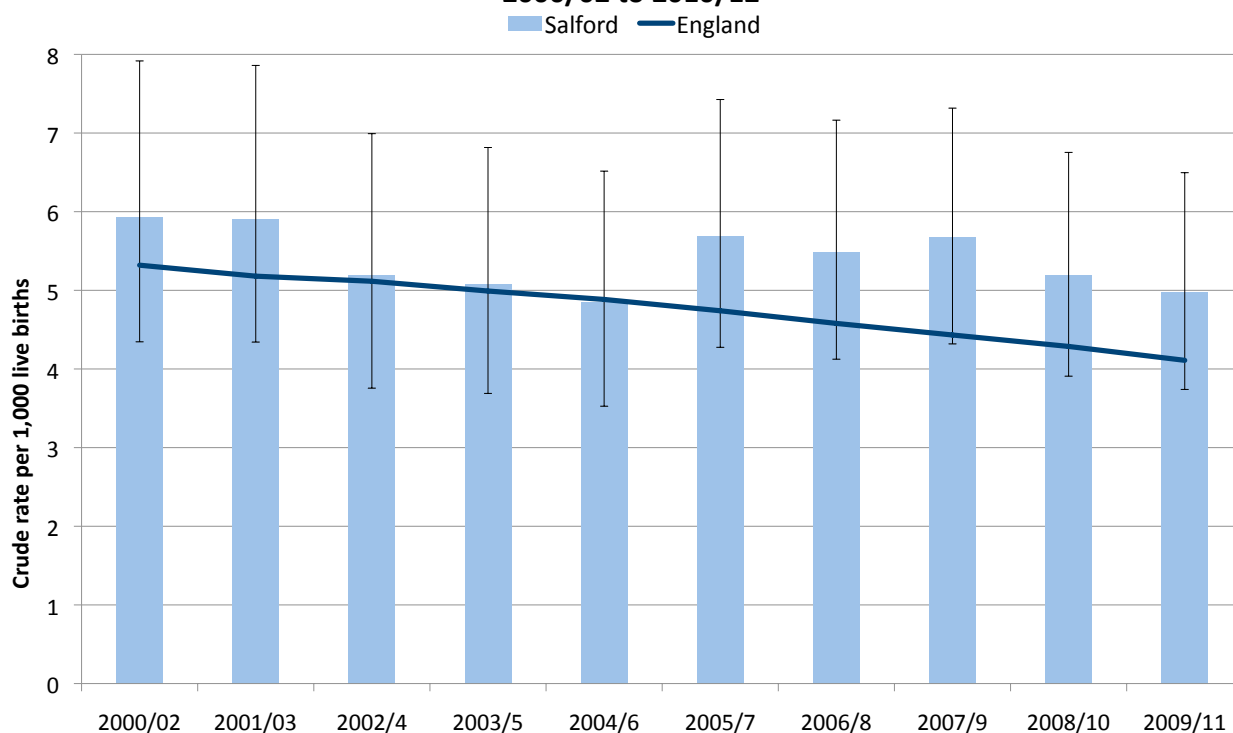
Source: Public Health Outcomes Framework (PHOF), Public Health England
<http://www.phoutcomes.info/> (accessed 05/08/14)

Under 75 mortality rate from all respiratory disease, Salford, 2001/03 - 2010/12



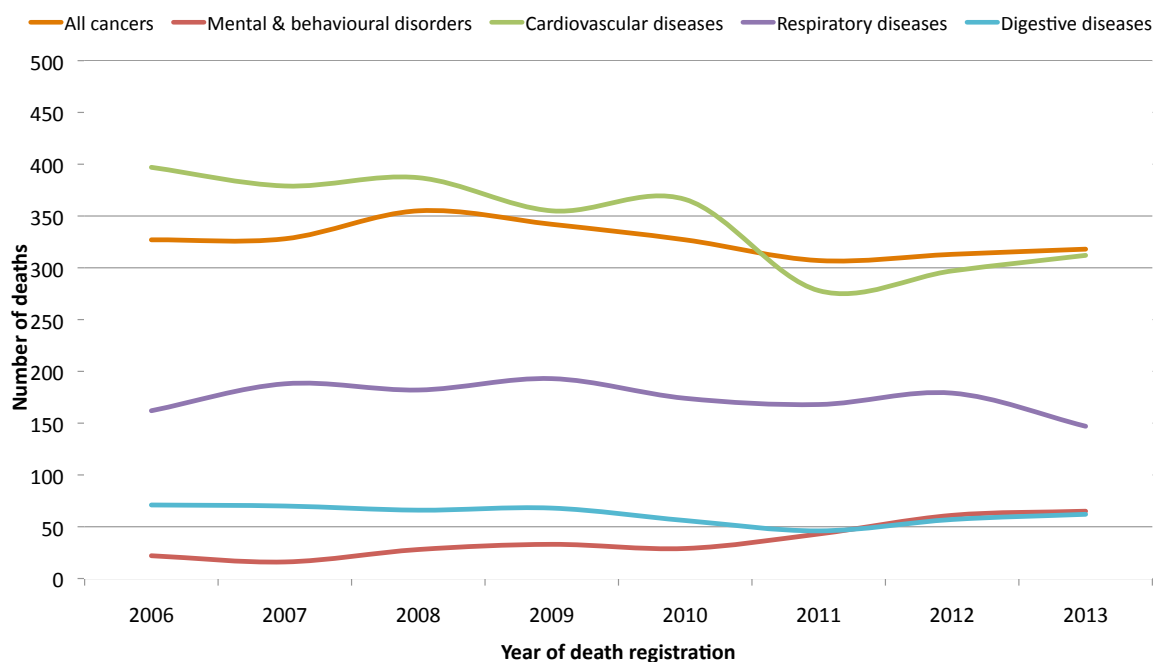
Source: Public Health Outcomes Framework (PHOF), Public Health England
<http://www.phoutcomes.info/> (accessed 05/08/14)

Infant mortality under one year, Salford, 2000/02 to 2010/12



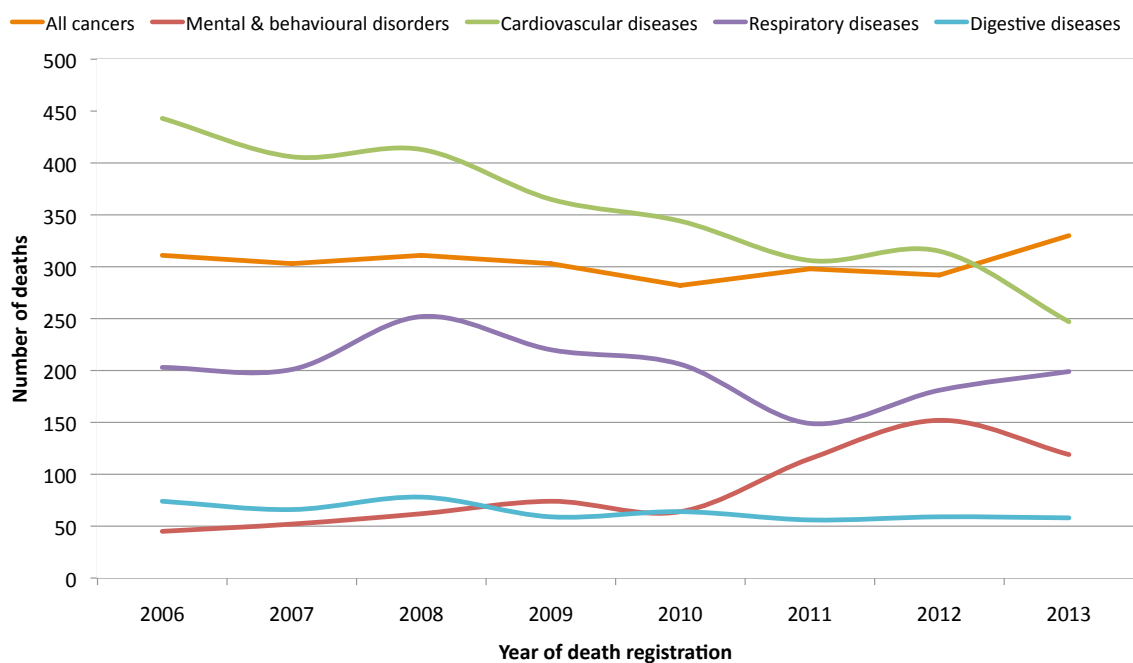
Source: Public Health Outcomes Framework (PHOF), Public Health England
<http://www.phoutcomes.info/> (accessed 05/08/14)

Top five causes of male death in Salford 2006-2013



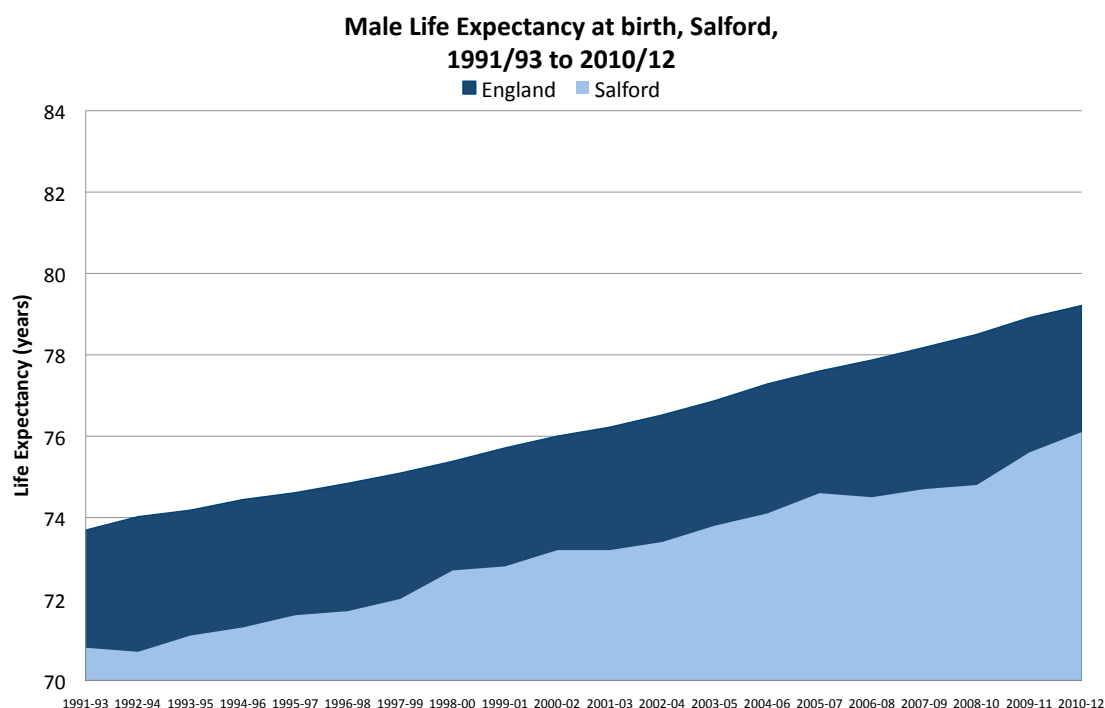
Source: ONS Primary Care Mortality Database (PCMD), Salford City Council

Top five causes of female death in Salford 2006-2013

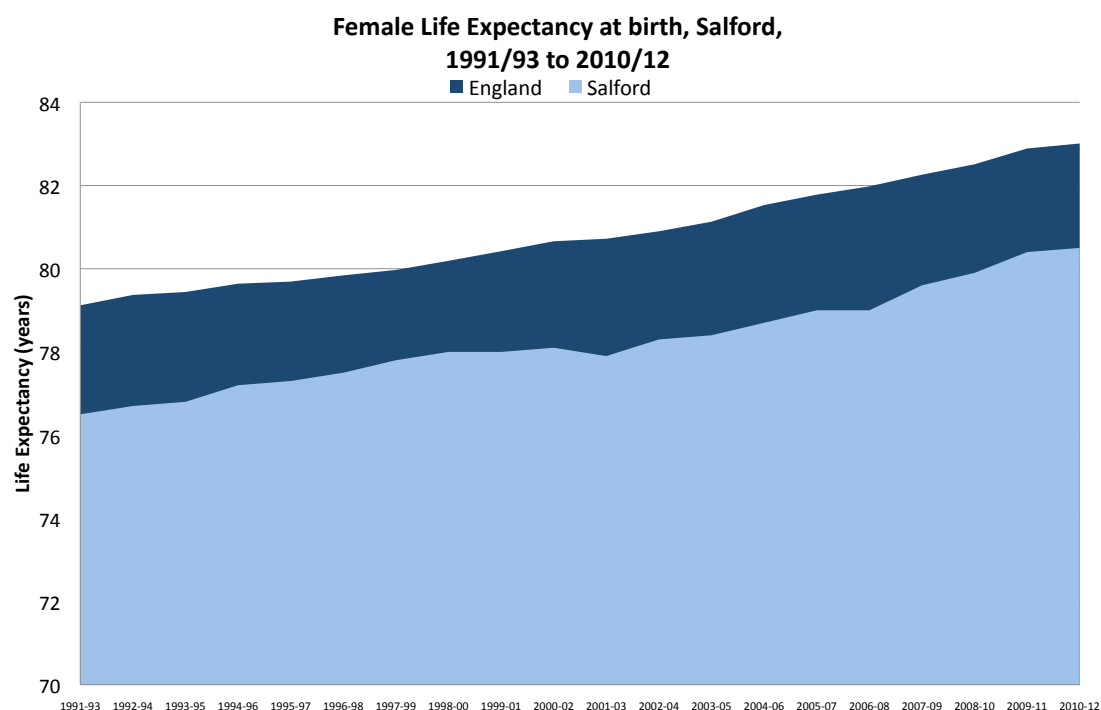


Source: ONS Primary Care Mortality Database (PCMD), Salford City Council

Life Expectancy

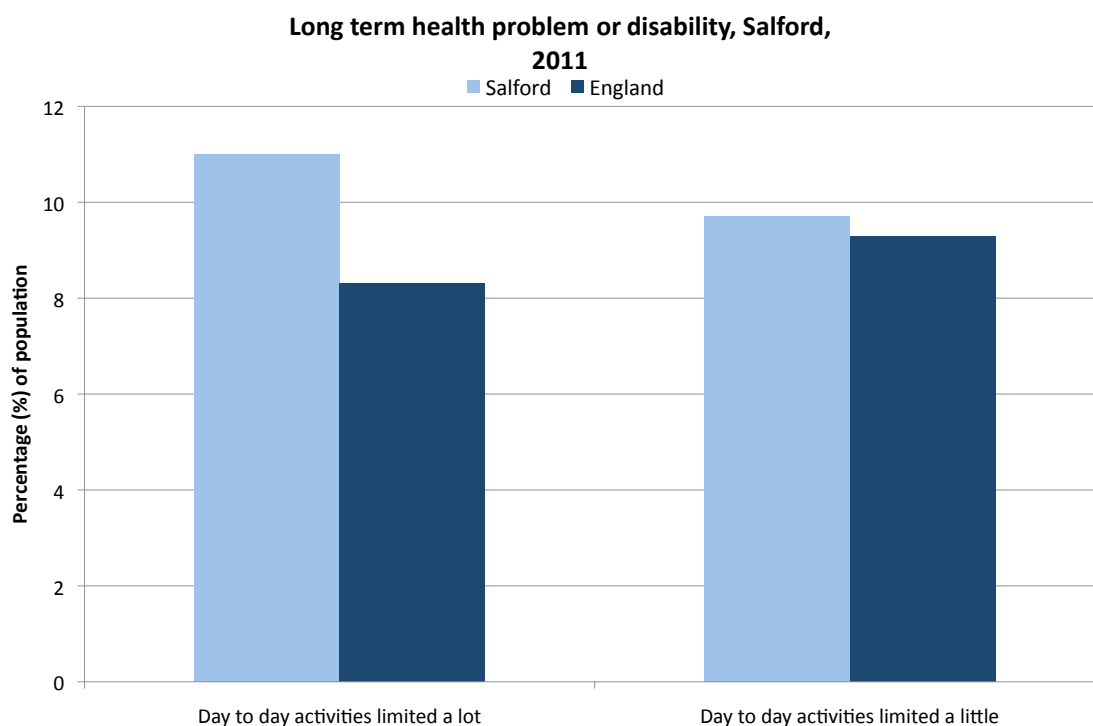


Source: Health and Social Care Information Centre (HSCIC)
<https://indicators.ic.nhs.uk/webview/> (accessed 01/08/14)



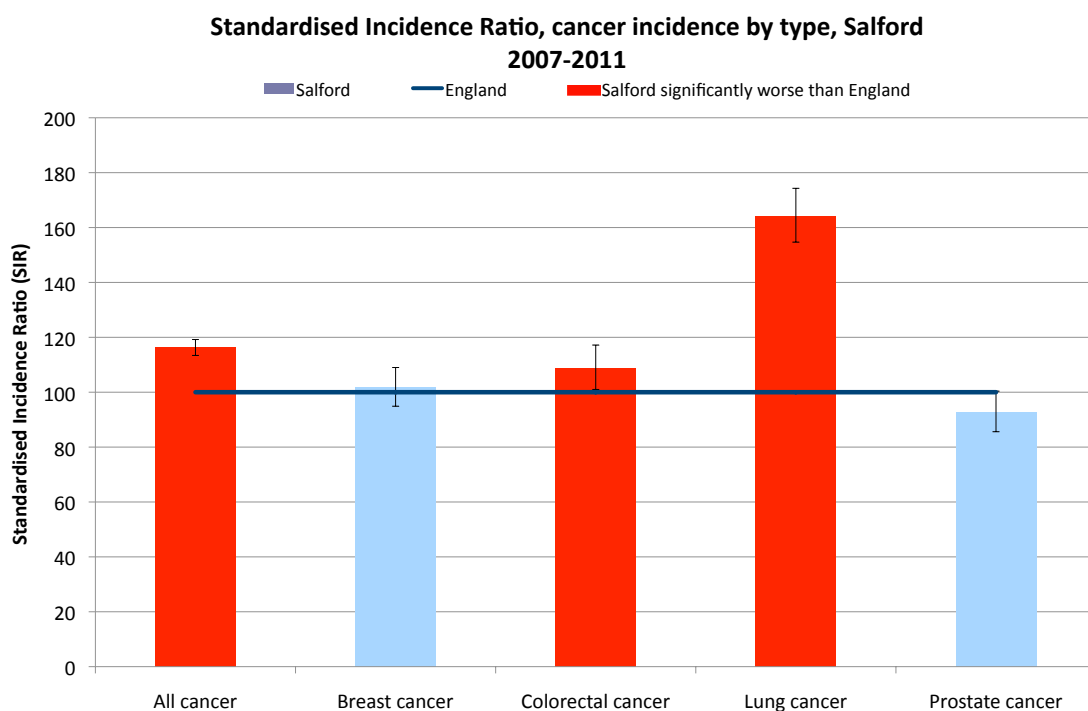
Source: Health and Social Care Information Centre (HSCIC)
<https://indicators.ic.nhs.uk/webview/> (accessed 01/08/14)

Long term conditions



Source: Official Labour Market Statistics, NOMIS

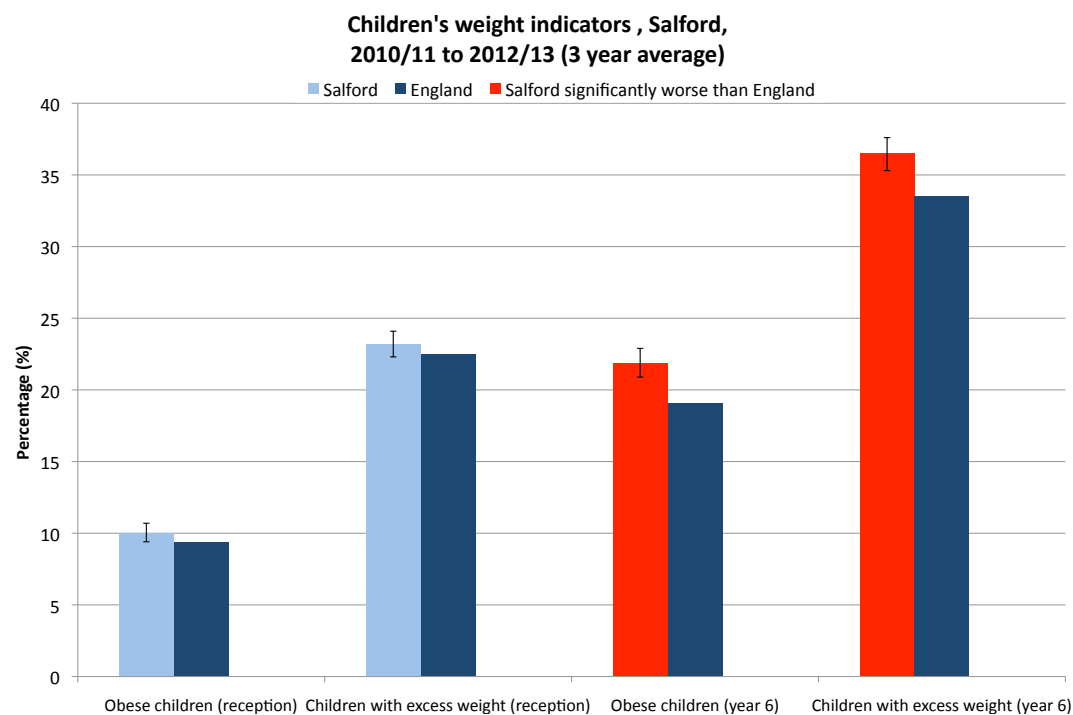
http://www.nomisweb.co.uk/census/2011/quick_statistics (accessed 07/08/14)



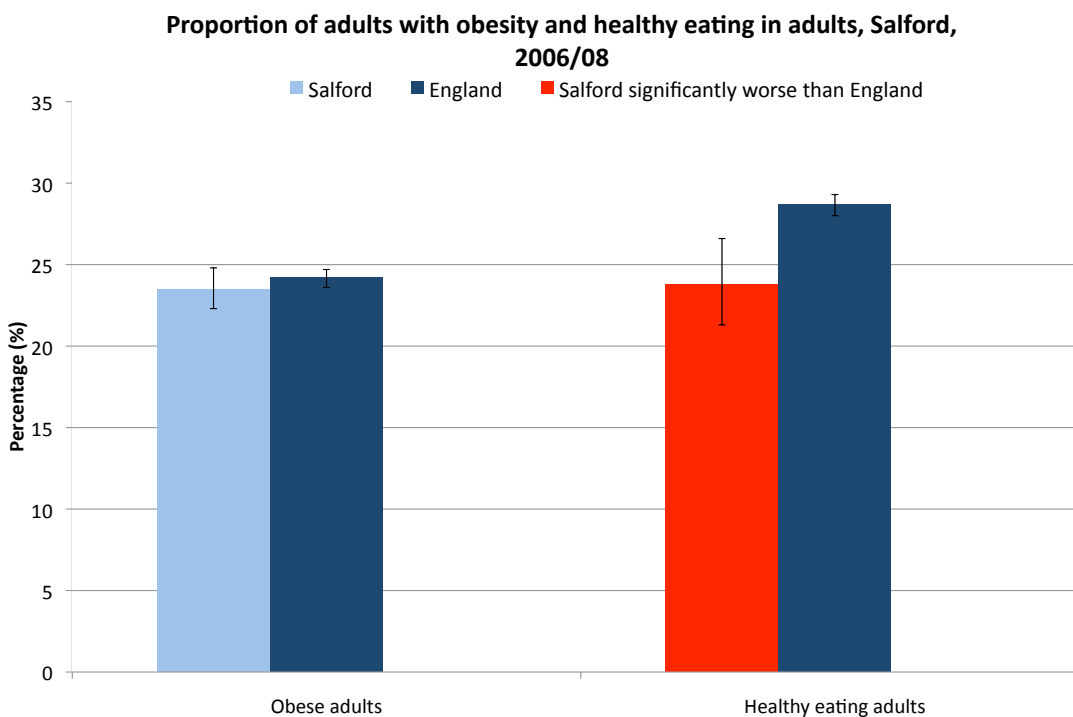
Source: Local Health, Public Health England

http://www.apho.org.uk/default.aspx?QN=HP_LOCALHEALTH2012 (accessed 01/08/14)

Obesity

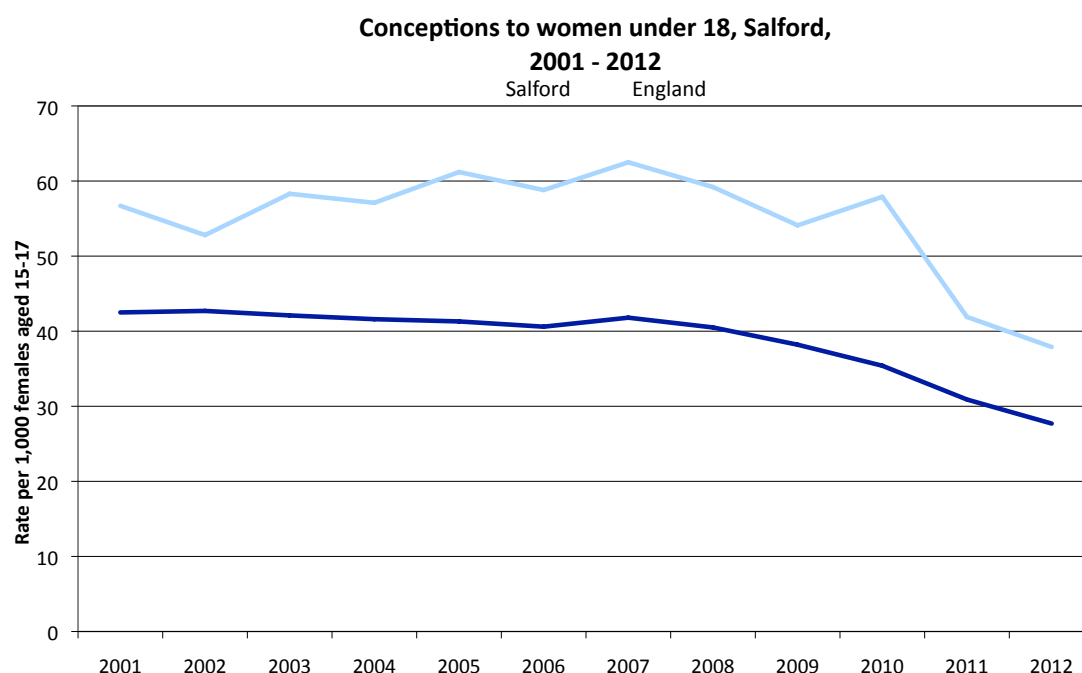


Source: Local Health profiles, Public Health England
http://www.apho.org.uk/default.aspx?QN=HP_LOCALHEALTH2012 (accessed 01/08/14)



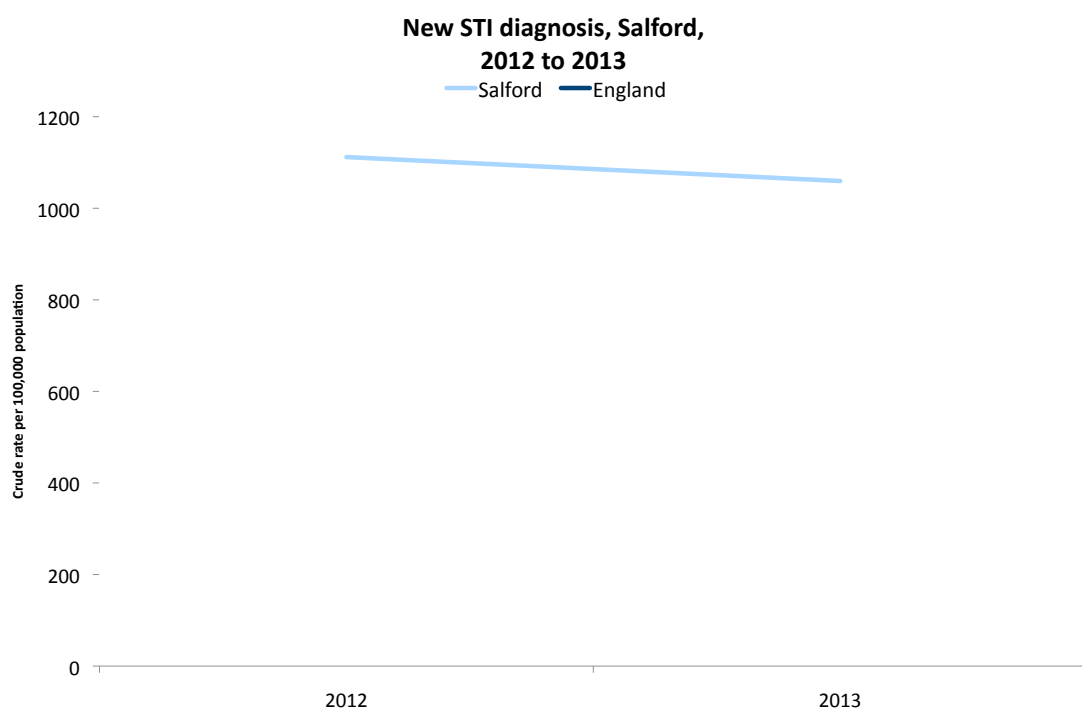
Source: Local Health profiles, Public Health England
http://www.apho.org.uk/default.aspx?QN=HP_LOCALHEALTH2012 (accessed 01/08/14)

Teenage conceptions



Source: Conceptions to under 18s, Office of National Statistics (ONS)
<http://www.ons.gov.uk/ons/datasets-and-tables/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=teenage+conceptions> (accessed 01/08/14)

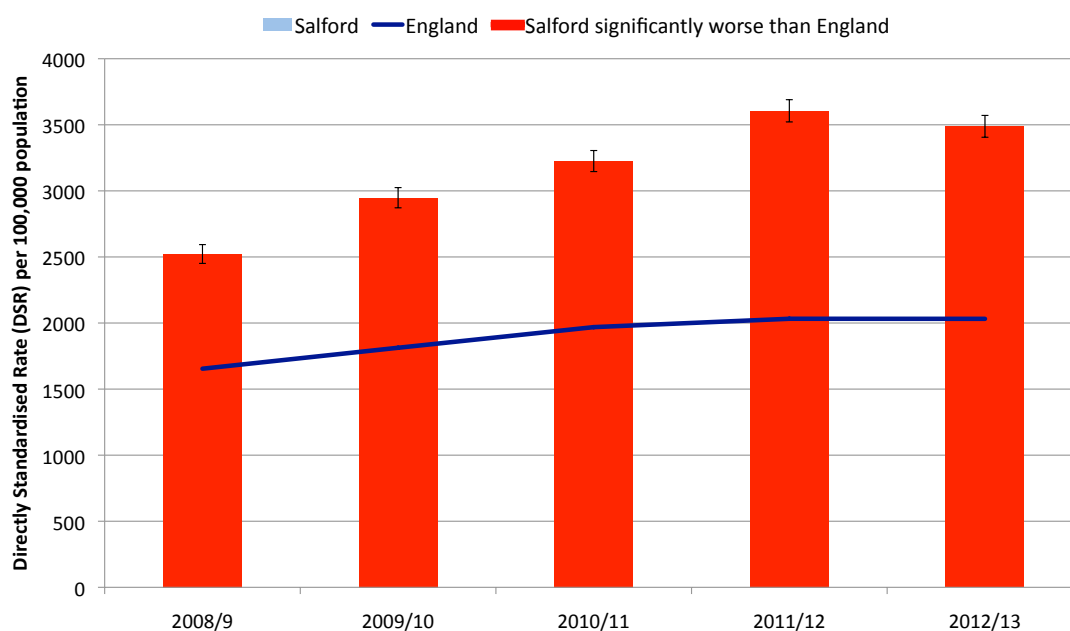
Sexually Transmitted infections (STIs)



Source: Sexually Transmitted Infections annual data, Public Health England
http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203348026613
 (accessed 08/08/14)

Alcohol

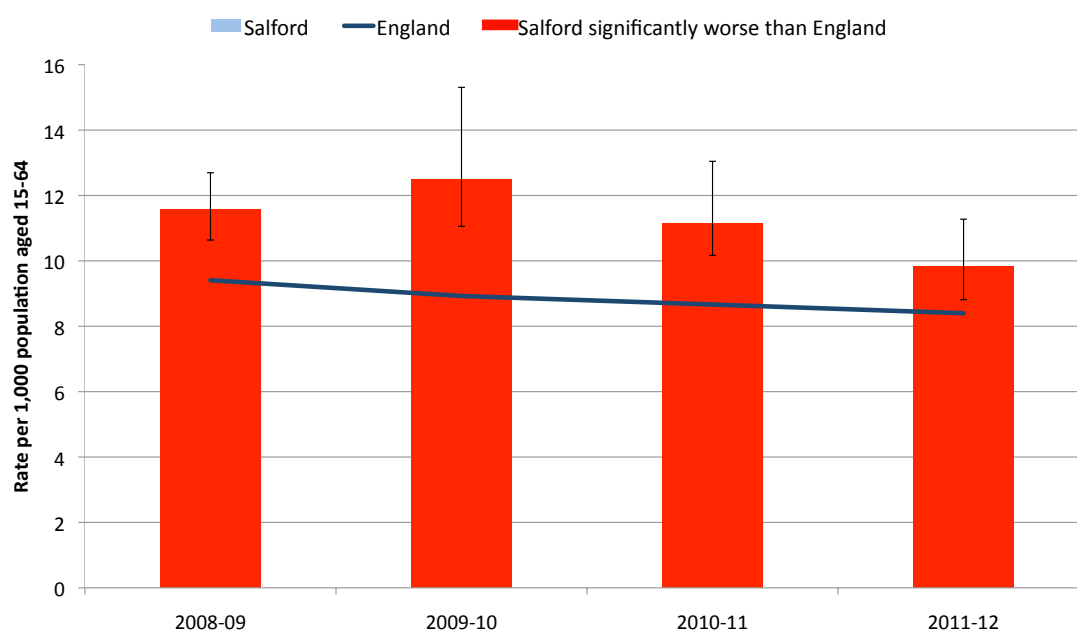
**Hospital admissions for alcohol-related conditions (broad), Salford
2008/9 to 2012/13**



Source: Local Alcohol Profiles for England (LAPE), Public Health England
<http://www.lape.org.uk/> (accessed 01/08/14)

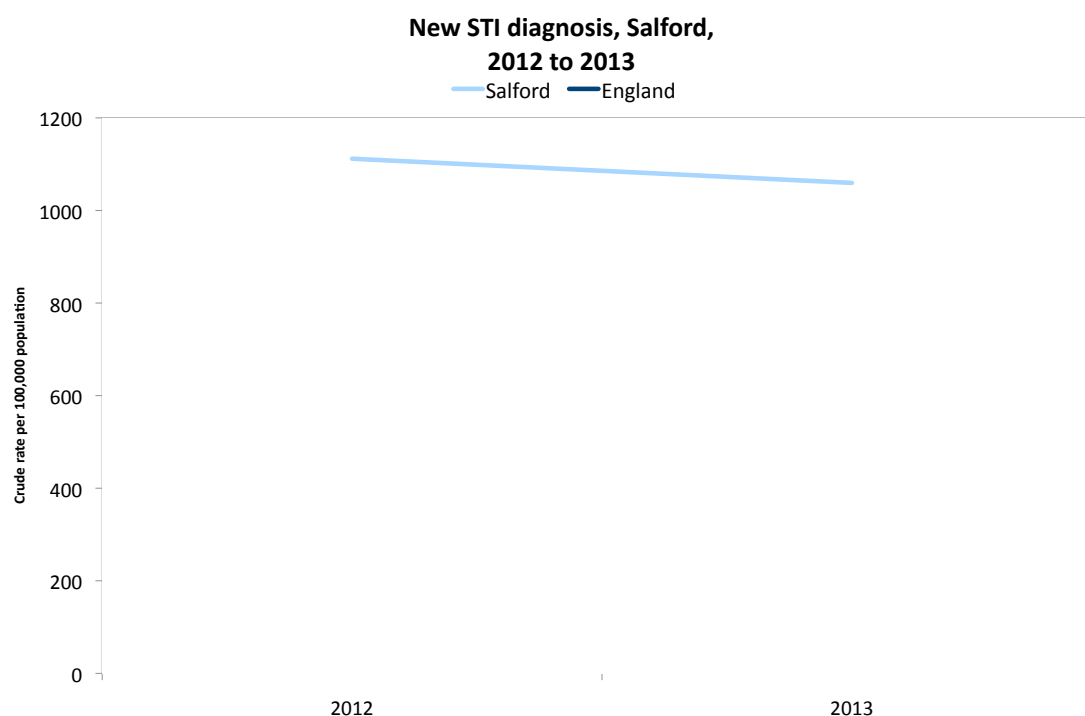
Drug misuse

**Prevalence of opiate and/or crack cocaine users, Salford,
2008/09 to 2011/12**



Source: Hay Estimates, Public Health England
<http://www.nta.nhs.uk/facts-prevalence.aspx> (accessed 11/08/14)

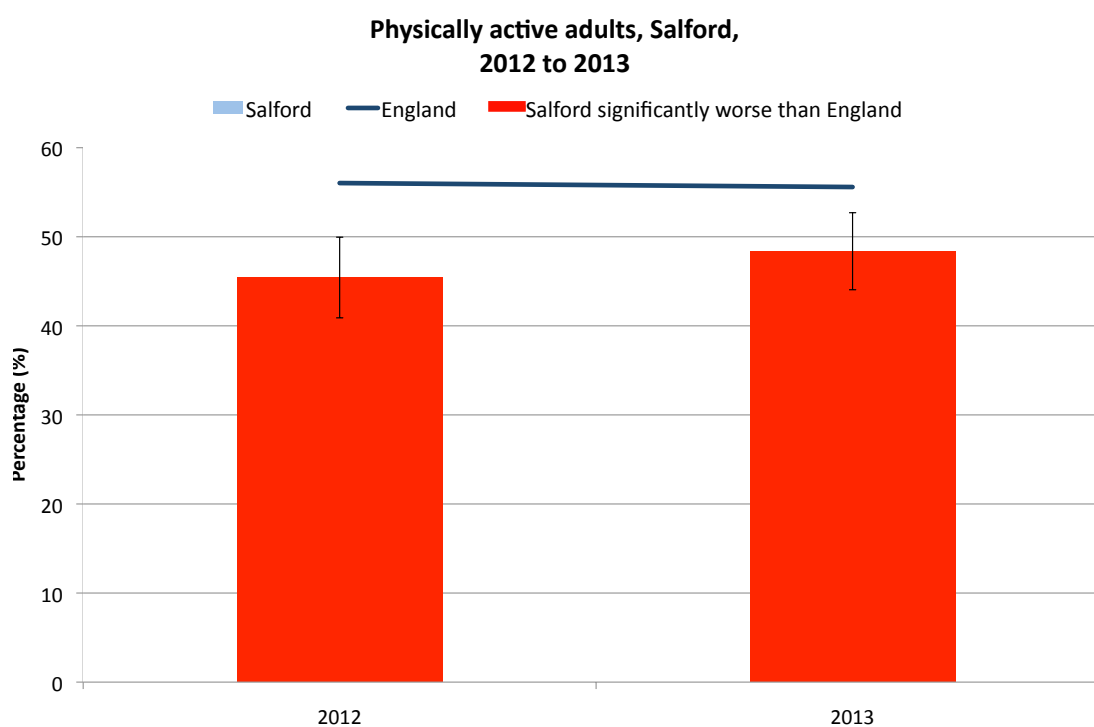
Smoking



Source: Health Profiles, Public Health England

http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES (accessed 01/08/14)

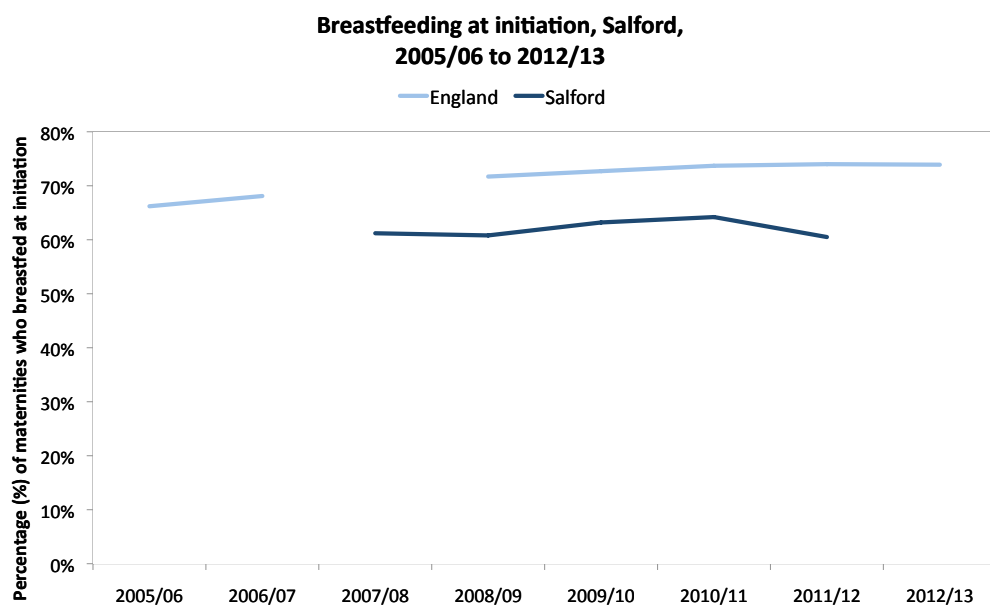
Physical activity



Source: Public Health Outcomes Framework (PHOF), Public Health England

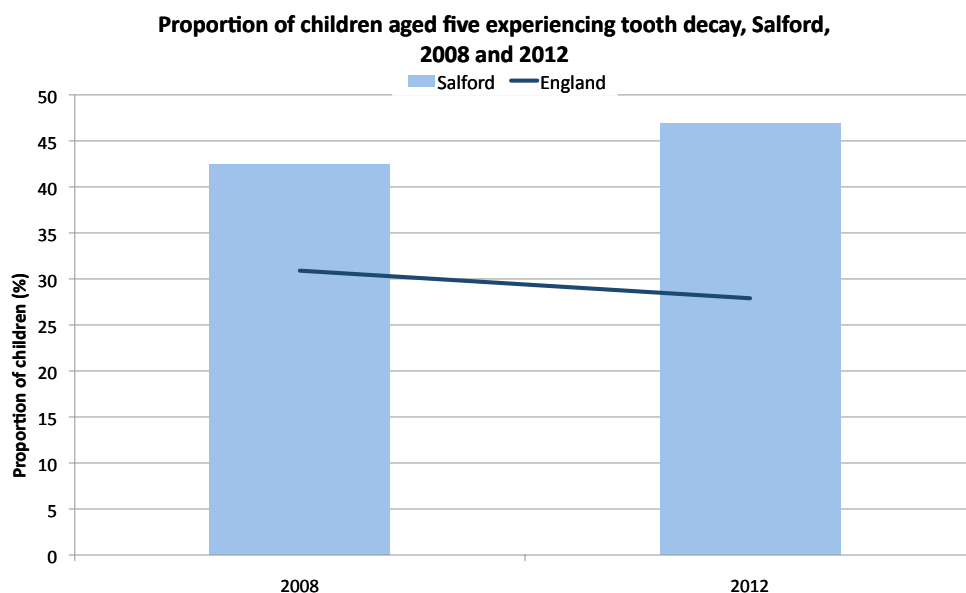
<http://www.phoutcomes.info/> (accessed 05/08/14)

Breastfeeding



Source: Trend in initiation of Breastfeeding, Department of Health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207071/Breastfeeding_initiation_2012-13_Q4__CSV_.csv/preview (accessed 05/08/14)

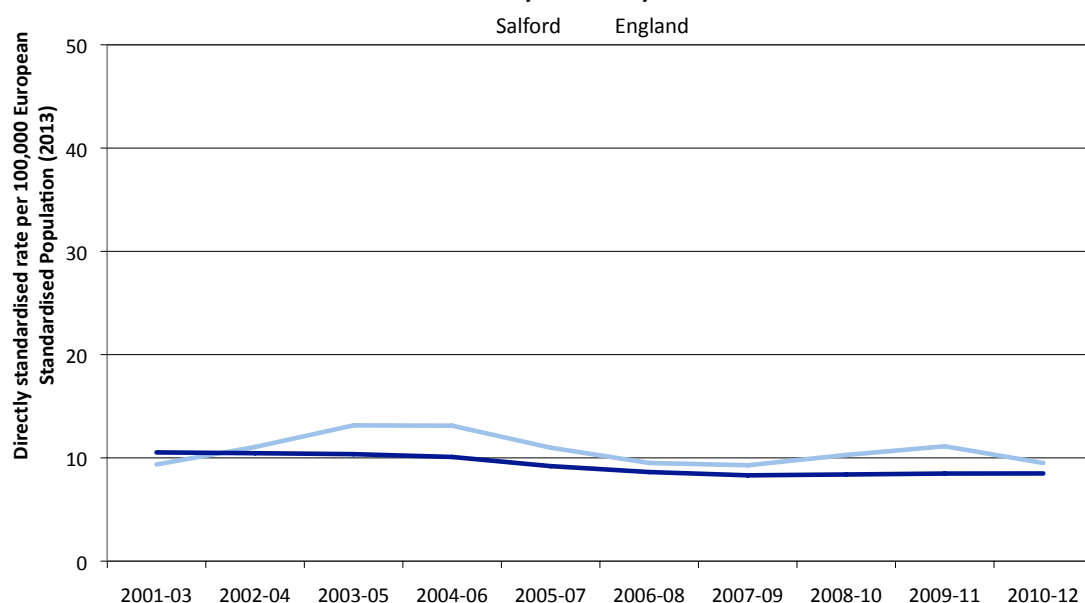
Child dental health



Source: Dental Survey 2012, Public Health England
<http://www.nwph.net/dentalhealth/survey-results5.aspx?id=1> (accessed 01/08/14)

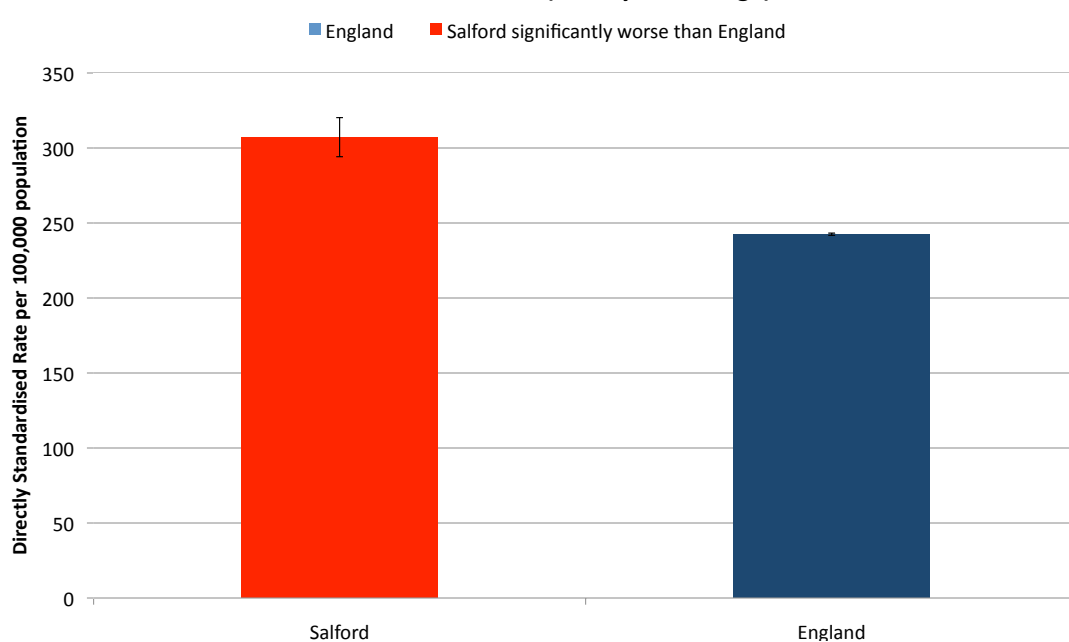
Mental Health

**Suicide rate, Salford,
2001/03 - 2010/12**



Source: Public Health Outcomes Framework (PHOF), Public Health England
<http://www.phoutcomes.info/> (accessed 05/08/14)

**Hospital admissions for Mental Health, Salford,
2009/10 to 2011/12 (three year average)**



Source: Community Mental Health profiles, Public Health England
<http://www.nepho.org.uk/cmhp/> (accessed 08/08/14)

Glossary of terms

Confidence Intervals (indicated by vertical lines on bar charts)

95% confidence intervals are calculated to give an indication of the level of uncertainty in the calculation and to show the variation in the data. The smaller the confidence interval, the more stable the rate. A greater number of events lead to a smaller interval.

Significantly worse than England (indicated by red bars on charts)

If the Salford and England confidence intervals do not overlap, then the Salford value is significantly different to England. This means that the result or relationship is caused by something other than chance.

Standardised Incidence Ratio (SIR)

The SIR for an area tells us if the number of observed cases in a particular geographic area is higher or lower than expected, given the population and age distribution for that community.

Directly Standardised rate (DSR)

This is the number of events that would occur if Salford had the same age structure as England. The Salford age specific rates are then applied. It is usually expressed per 100,000.

Acknowledgements:

Many of the photographs used in this report are from the Innovation Fund and Personalisation Fund projects at THOMAS (those on the margins of society) and from Salford's Healthy Communities Collaborative. We thank them for their permission to use these.

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