Our Ref JG
Your Ref HSC/JG
Date 12 October 2016
Please ask for Julie Gallagher
Direct Line 01612536640
Direct Fax
E-mail julie.gallagher@bury.gov.uk

Legal & Democratic Services Division

Jayne Hammond LLB (Hons)
Solicitor
Assistant Director of Legal & Democratic Services

TO: All Members of Health Scrutiny Committee

Councillors : P Adams, N Bayley, M D'Albert, J Grimshaw, S Haroon, K Hussain, S Kerrison (Chair), O Kersh, J Mallon, A McKay, Susan Southworth and R Walker

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Thursday, 20 October 2016
Place:	Meeting Rooms A&B, Bury Town Hall, Knowsley Street Bury BL9 OSW
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	**A pre-meeting briefing will commence at 6.15pm**

AGENDA

1 **APOLOGIES FOR ABSENCE**

2 **DECLARATIONS OF INTEREST**

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 **PUBLIC QUESTION TIME**

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

4 **MINUTES** (Pages 1 - 12)

Minutes of the meeting held on the 28th July 2016 and 11th October are attached.

5 **ANNUAL ADULTS SOCIAL CARE COMPLAINTS REPORT** (Pages 13 - 26)

Sharon Wells Customer Engagement Manager, Bury Council will attend the meeting. Reports attached.

6 **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT** (Pages 27 - 76)

Lesley Jones, Director of Public Health will attend the meeting to present her Annual Public Health Report. A hard copy will be sent to Members.

7 **URGENT BUSINESS**

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

Agenda Item 4

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 28 July 2016

Present: Councillor S Kerrison (in the Chair)
Councillors P Adams, M D'Albert, J Grimshaw, S Haroon, K Hussain, O Kersh, J Mallon, A McKay, Susan Southworth and R Walker

Also in attendance:
Councillor Trevor Holt, Cabinet Member Health and Wellbeing
Pat Jones Greenhalgh, Executive Director Communities and Wellbeing
Stuart North, Chief Operating Officer, Bury Clinical Commissioning Group
Heather Crozier, Social Development Manager
Jon Hobday, Public Health Consultant
Helen Smith, Public Health and Social Care Intelligence Manager
Andy Hickson, Assistant Director of Commissioning, North West Ambulance Service
Chris O'Neal, Blackpool Clinical Commissioning Group
Sue Lock, North Manchester Clinical Commissioning Group
Julie Gallagher, Principal Democratic Services Officer

Public Attendance: 2 members of the public were present at the meeting.

Apologies for Absence: Lesley Jones, Director of Public Health

HSC.181 DECLARATIONS OF INTEREST

Councillor Joan Grimshaw declared a personal interest in respect of all items under consideration as a member of the Patient Cabinet.

HSC.182 PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting.

HSC.183 MINUTES OF THE LAST MEETING

It was agreed:

The minutes of the meetings held on 20th June 2016 be approved as a correct record.

HSC.184 MATTERS ARISING

Julie Gallagher, Principal Democratic Services Advisor reported that she would liaise with Karen Whitehead, Strategic Lead in respect of minute number HSC.55 Speech Therapy Millwood Primary School.

HSC.185 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Jon Hobday, Public Health Consultant and Helen Smith Public Health and Social Care Intelligence Manager attended the meeting to provide members of the Committee with an update in respect of recent developments with the JSNA.

A JSNA is defined as an assessment of the current and future health and social care needs of the local community. These are needs that could be met by the local authority, CCGs, or the NHS Commissioning Board. The JSNA will act as a broader support for all services related to supporting residents around the wider determinants of health such as housing, education, business, planning and employment

The Public Health Consultant reported that the new JSNA will be an online, dynamic and iterative suite of documents. The document will be more up to date and accessible for users and will support policy and strategy makers as well as commissioners in making effective decisions to ensure the best use of resources.

The JSNA is currently still at the soft launch phase, the official launch is scheduled for the 25th August 2016. Following the official launch the JSNA will be promoted through a number of mechanisms; in addition training on how to effectively use the JSNA will be available for all council staff, members and partner agency staff.

The Public Health and Social Care Intelligence Manager provided members of the Committee with a demonstration of the JSNA site.

The Chair invited questions from those present and the following points were raised:

In response to a member's question in respect of involvement of Black and Minority ethnic groups in the development of the JSNA, the Public Health Consultant reported that he had meet with representatives from ADAB to discuss how they could share information. There are further plans to broaden engagement with BME community as the JSNA develops.

With regards to statistical data, the Public Health and Social Care Intelligence Manager reported that comparative data is included on the website; there are a variety of different reporting methods including comparisons with statistical neighbours.

In response to a Member's question the Public Health Consultant reported that the JSNA will be of most value to commissioners and policy officers and will assist in the shaping and redesigning of services. There is no statutory guidance as to what a JSNA should or should not include. In respect of reconfiguration of hospital services, the JSNA may be used to provide data with regards to disease

prevalence, life expectancy etc but will not be able to identify what hospitals are required where.

With regards to the availability of health and social care services, the Social Policy Manager reported that the Bury Directory has been developed to provide members of the public with information in respect of services/courses and support available.

The Public Health Consultant reported that a JSNA governance structure has been established with identified leads to ensure that no information will be included on the website that could breach data protections or patient confidentiality.

It was agreed:

The Principal Democratic Services Officer will circulate to Members of the Committee a copy of the link to the JSNA and Bury Directory websites.

HSC.186 HEALTH AND WELLBEING BOARD ANNUAL REPORT

Councillor Trevor Holt, Chair of the Health and Wellbeing Board and Heather Crozier, Social Development Manager attended the meeting to provide members with an overview of the Health and Wellbeing Board Annual Report. The report contained the following information:

Councillor Holt reported that during the municipal year 2015/16 a number of key improvements were made to the HWB which included:

- Strengthened governance arrangements
- Developed a performance framework
- Identified leads for each priority area
- Additional members on the Board including two extra elected members and a representative from Greater Manchester Fire and Rescue Service
- The Board has overseen the development and creation of the new JSNA and the Bury Directory

Councillor Holt reported the Board has also been responsible for signing off the Better Care Fund, Bury's Locality Plan and Pharmaceutical Needs Assessment.

The Chair invited questions from those present and the following points were raised:

In response to a Member's question, the Social Development Manager reported that the Strategy performance reports will be presented for consideration to the Board, information will be collected from a variety of sources including data from the public outcomes framework. The Board have set a number of ambitious targets in respect of the Strategy including targets to improve air quality.

Councillor Mallon raised concerns in respect of the decision to move equipment that monitors air quality from its position adjacent to the M60 motorway. The Principal Democratic Service Officer reported that she would liaise with Lorraine Chamberlain, Head of Environmental Protection to provide the committee with further information in respect of the decision.

With regards to the reliance on self prevention and care to produce the required cost savings to the health and social care economy, the Social Development Manager reported that a number of schemes have been developed/are being developed. This will include the "Helping Yourself to Wellbeing Programme, the neighbourhood working trailblazer sites and healthy lifestyle advice via the Bury Directory.

Members of the Committee expressed concern that targeting services to the most deprived wards may result in some of the more affluent wards, with only small pockets of deprivation being overlooked. The Social Development Manager reported that it is envisaged that neighbourhood working would eventually be rolled out to all wards across the Borough.

It was agreed:

1. Councillor Trevor Holt and Heather Crozier, Social Development Manager be thanked for their attendance.
2. Democratic services will liaise with the Head of Environmental Protection and provide members of the Committee with information with regards to the movement of the M60 Motorway Air Lab
3. Copies of the health and wellbeing strategy info graphic performance reports will be circulated to the Health Overview and Scrutiny Committee.

HSC.187 NON URGENT PATIENT TRANSPORT SERVICE

Andy Hickson, Assistant Director of Commissioning, North West Ambulance Service; Chris O'Neal, Blackpool Clinical Commissioning Group; Sue Lock, North Manchester Clinical Commissioning Group attended the meeting to provide members of the committee with an update in respect of the new provider of the non urgent patient transport service. The presentation contained the following information:

The new five year contract was awarded to North West ambulance service as of the 1st July 2016. The service will be provided to Greater Manchester CCG registered patients only, to and from any NHS treatment centre for NHS funded treatment.

The new contracts contains revised and simplified Key Performance Indicators (KPIs) as well as three service specifications

- Enhanced Priority Service - renal dialysis and oncology
- Planned - advanced bookings & appointments
- Unplanned - 'on the day'

The Assistant Director of Commissioning reported that the service has been future proofed to enable seven day operating and service reconfiguration.

The Chair invited questions from those present and the following points were raised:

In response to a Member's question, the Assistant Director of Commissioning reported that a non eligible patient would be signposted by a representative from

the booking centre to either an information line, alternative provider or if appropriate another CCG.

With regards to the types of vehicles predominately used by NWAS; the Assistant Director of Commissioning reported that the majority of the service with be provided by traditional Ambulance vehicles; volunteer drivers and St. John Ambulance service will also provided additional support and capacity. The Assistant Director of Commissioning reported that if required NWAS has up to 400 ambulances at its disposal, providing flexibility if there is ever a serious untoward incident and extra support is required.

Members of the Committee sought assurance from Blackpool CCG that the issues that arouse in respect of Arriva miss reporting performance data, would not be repeated with a new provider. The representative from Blackpool CCG reported that new stringent KPI's will improve the quality of the services provided. The quality element will be incentivised as well as improving the availability of service by extending the service through the weekend. The data collection system has also been improved to enable the CCG to better compare and contrast data that is presented. The Assistant Director reported that NWAS is a NHS organisation therefore the performance reporting information provided to Blackpool CCG is validated and open to scrutiny and must also complete a thorough internal auditing process.

In response to a Member's question, the Blackpool CCG representative reported that commissioners have contributed an extra £1 million pounds towards the new non urgent patient transport service.

The Assistant Director of Commissioning reported that there are a number of challenges in providing the new service and there is no room for compliancy, it is envisaged that within the first 100 hundred days the NWAS Trust will be in a position to accurately say how they are performing. The Assistant Director reported that he was concerned that activity may increase once patients are aware that NWAS are back providing the service.

The North Manchester CCG representative reported that a great deal of work has been undertaken to ensure that patient feedback in respect of provision of the new service is captured and if necessary acted upon.

HSC.188 CITY OF MANCHESTER SINGLE HOSPITAL SERVICE

Stuart North, Chief Operating Officer, Bury CCG attended the meeting to provide members of the Committee with an update in respect of the decision of Manchester's Health and Wellbeing Board to recommend proceeding to a single hospital service across Manchester.

The Chief Operating Officer reported that at the last meeting of the Manchester HWB the Board agreed that Central Manchester NHS Foundation Trust and South Manchester NHS Foundation Trust will join together from the 1st April 2017 and that the process of North Manchester General Hospital separating from the Pennine Acute NHS Trust will not now take place until October 2018.

Members of the Committee expressed their concerns in respect of the proposals, particular concern was expressed in respect of the lack of consultation, a lack of

data to justify the decision, lack of accountability and a lack of information in respect of the sustainability of the Pennine Acute NHS Trust, following this decision.

In responding to those concerns; the Chief Operating Officer reported that health and social care is not sustainable in its current form and there will have to be fundamental changes in how service will be delivered. The proposals do not include a determination as to what services will be provided where, but rather a recommendation that it would be better if the hospitals within Manchester worked together. The proposals are at this stage are organisational changes not service changes.

The Chief Operating Officer reported that if there is to be changes to the way services are to be provided that can only be undertaken if there has been consultation with the public and relevant stakeholders including the local scrutiny committees.

In response to a Member's question, the Chief Operating Officer reported that it is not for Manchester's HWB to decide whether to proceed to a Single Hospital Service. A recommendation from the Board will need to be considered by NHS Improvement and the Competition and Collaboration Panel.

With regards to the decision to restructure the organisations, Councillors expressed their concerns that they had not been involved in the discussions, particular concerns were expressed with regards to the possible closure of North Manchester General Hospital which includes a maternity provision for Bury residents. The Chief Operating Officer sought to re-assure Councillors and reported that the current maternity provision at North Manchester oversaw the delivery of 5000 live births last year, there is not the capacity within the city of Manchester hospital sites to accommodate these births.

It was agreed:

1. The Chief Operating Officer Bury Clinical Commissioning Group, be thanked for his attendance.
2. Sir David Dalton, Interim Chief Executive Pennine Acute NHS Trust will be invited to a special meeting of the Health Overview and Scrutiny Committee, date to be confirmed, to discuss concerns in respect of the Pennine Acute NHS Trust, including the CQC report and the City of Manchester Single Hospital Service.

COUNCILLOR SARAH KERRISON
Chair

(Note: The meeting started at 7pm and ended at 9.30pm)

Minutes of: **SPECIAL HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 11 October 2016

Present: Councillor S Kerrison (in the Chair)
Councillors P Adams, N Bayley, M D'Albert, S Haroon, K Hussain, J Mallon, A McKay, Susan Southworth and R Walker

Also in attendance: Lesley Jones, Director of Public Health
Professor Matt Makin, Executive Medical Director, Pennine Acute NHS Trust
Stuart North, Chief Operating Officer, Bury Clinical Commissioning Group
David Latham, Programme Manager, Bury Clinical Commissioning Group
Julie Gallagher, Principal Democratic Services Officer

Public Attendance: 4 members of the public were present at the meeting.

Apologies for Absence: Councillor J Grimshaw and Councillor O Kersh

HSC.304 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HSC.305 PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting.

HSC.306 PENNINE ACUTE NHS TRUST CARE QUALITY COMMISSION

Professor Matt Makin, Executive Medical Director, Pennine Acute NHS Trust attended the meeting to provide members of the Committee with an update in respect of the Care Quality Commission inspection report and subsequent action plan. A copy of the CQC inspection report had been circulated to Members prior to the meeting. The presentation contained the following information:

Following a comprehensive inspection, the CQC rated Pennine Acute Hospitals NHS Trust inadequate in both safety and well-led domains. In line with CQC policy the inspection team considered recommending the trust go into special measures, such is the level of concern identified around quality and safety. Immediately following the CQC inspection, Salford Royal NHS Foundation Trust was asked to assume leadership of the Trust. Salford's leadership team, rated outstanding by the CQC put in place a comprehensive plan for further investigation into the challenges faced by Pennine Acute.

The Salford Royal Diagnostic, identified additional critical risks to patient care & safety; unsafe/unreliable staffing, variation in care delivery and outcomes for patients; governance systems that are broken or do not exist; Board that is disconnected; Poor leadership; Cultures that normalised sub standard care; Staff that are disengaged and poor external relationships and unreliable service design and structures.

A summary action plan has been developed with six key themes. Four services have been identified as "fragile"; maternity services, urgent care, paediatrics and critical care. An Improvement Board has been established, under the Chairmanship of Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership.

The Executive Medical Director reported that systems in place at Salford Royal would be implemented at Pennine Acute NHS Trust, these include systems in respect of, Risk Management and Assurance, Nursing Assessment and Accreditation; Open and Transparent Reporting, Visible Leadership and Quality Improvement Methodology.

The Executive Medical Director reported that part of the action plan is the proposed break-up of the centralised management within the Trust. The creation of a new site placed leadership with the appointment of nurse directors, medical directors and managing directors at each site; as well as a clear accountability framework to deliver on improvement plans and strengthen locality relationships and planning.

Since the inspection report 104 new registered nurses and midwives have been recruited, 14 doctors (consultant and middle grades) as well as 69 health care support workers.

The Chief Operating Officer reported that two main themes have emerged from the CQC, staff shortages and poor leadership. The CCG have confidence in the new leadership to address the issues and concerns highlighted in the CQC report.

Those present were given the opportunity to ask questions and make comments and the following points were raised:

In response to Member's concerns in respect of the new management arrangements, the Executive Medical Director reported that the proposed site management system would allow for greater autonomy on a site by site basis. Discussions are still ongoing as to where the overall responsibility will sit in respect of the Trust Board.

With regards to staff feeling unable to raise concerns, the Executive Medical Director reported that there were a number of issues; high turnover of senior and middle grade management, inconsistency of information and a lack of visibility of senior staff. The new interim Chief Executive has made regular visits to all sites, as well as other senior staff. Lines of accountability within the Trust have been improved as well as the development of governance and risk management processes coupled with the new site management structure. Improvements have been put in place but it may 2 to 3 years before the full benefits will be realised.

In response to Member's concerns in respect of funding, the Chief Operating Officer reported that there is a significant shortfall in monies being available within social services department, this has resulted in delays in discharging patients back in to the community at a cost to the Acute Trust.

The Executive Medical Director reported that the Trust spent £20 million on Locum Agency staff last year. The reasons for this is multi-factorial; there is a national shortage of nursing staff, the working environment in some of the Buildings at the NMGH site could be improved as well as problems with recruiting in what is a very competitive market. The Trust is working to retain existing staff and plans to visit India to recruit a number of middle grade doctors.

The Executive Medical Director reported that a significant amount of work has already be undertaken to make the required improvements, new systems have been put in place, including systems to ensure lessons have and would be learnt from serious untoward incidents; specialists from other hospitals are providing support to departments identified as fragile. Senior staff have been out meeting patients and GPs to engage and discuss concerns at the Trust.

Members of the Committee expressed their concerns that the problems at the Trust had escalated to such a degree that it should not have taken a visit from the CQC to identify the issues at the Trust. The Chief Operating Officer Bury CCG reported that they had raised concerns with NHS England, the Regulator, the CQC and the Scrutiny Committee. The CCG reported that the biggest challenge was problems with the Leadership, this has however improved significantly with the appointment of Salford Royal staff.

The CQC report also highlighted problems with the Leadership on the Trust Board, including problems with oversight and a clear direction from the Board, these problems as well as problems with the management at the Trust have been allowed to develop over a number of years.

Councillor Mallon wanted to place on record his concern that there had been systematic failures across the Trust. In responding to those concerns, the Executive Director reported that significant lessons had been learnt from the CQC inspection process.

Councillor Walker reported that a number of the issues highlighted within the report had been discussed at meetings of the Joint Committee for Pennine Acute. The Trust have always responded to concerns raised however it is very difficult as lay representatives to sometimes challenge the information presented.

It was agreed:

An update report on the Pennine Acute NHS Trust Care Quality Commission Action Plan will be considered at a future meeting of the Health Overview and Scrutiny Committee.

HSC.307 CITY OF MANCHESTER SINGLE HOSPITAL SERVICE

Professor Makin, Executive Medical Director Pennine Acute NHS Trust, attended the meeting to provide members of the committee with an update in respect of the proposals for a City of Manchester Single Hospital Service.

Manchester City Council Health and Wellbeing Board (MCCHWB) had appointed Sir Jonathon Michael as an Independent Review Director with a commission to produce a report on the proposed SHS. The review was set out in two phases:-
Phase 1 – Benefits Assessment (completed April 2016)
Phase 2 – Governance and Organisational Arrangements (recommendations submitted to the Manchester City Council Health and Wellbeing Board on 8 June 2016. A copy of the report had been circulated.)

The review has recommended the creation of a new NHS Trust to encompass the three hospitals in Manchester (UHSM, CMFT and PAT). This would deliver a Local Care Organisation and enable a single commissioning function that would also support the Manchester Locality Plan. The MCCHWB agreed to request CMFT, UHSM and PAT to enter into discussions to consider the creation of a new single organisation and to provide an initial assessment on implementation requirements and timescale.

The outcome of the discussions would be reported back to the MCCHWB within 6 weeks. In addition, the review also highlighted that further discussions were required on the strategic alignment between the Manchester Single Hospital Service review and the North East sector review. This would include minimising any adverse impact from the realignment of North Manchester General Hospital on the sustainability of either the remaining clinical services provided by Pennine Acute Trust or the proposed new City wide Hospital Trust.

Members of the Committee discussed the implications for the three remaining hospital sites as well as issues with patient pathways and patient flows into NMGH. Members expressed their concern that uncertainty around the future of the Trust would not help alleviate the problems identified within the CQC report.

The Executive Medical Director reported in order to assist with some of the problems associated with recruitment and retention within the Trust, it would be helpful if a decision is taken sooner rather than later in respect of the City of Manchester Single Hospital Service.

It was agreed:

The Health Overview and Scrutiny Committee would receive regular updates in respect of the City Of Manchester Single Hospital Service.

HSC.308 URGENT CARE REDESIGN

Stuart North, Chief Operating Officer Bury CCG, gave a verbal update on the current engagement with the public to support the configuration of Urgent Care Services in Bury. A review of current service provision had concluded that the system was disjointed, had areas of inequality and supported duplication of some

services in Bury. It was reported that the new model of service provision would not be about saving money but was about public engagement, ensuring that investment in services was being made in the right areas in order to provide a more simpler and efficient service.
The Chief Operating Officer reported that the result of the engagement exercise will form part of the report that will be considered by the CCG Board in December 2016.

The Programme Manager reported that a series of engagement exercised had been undertaken by the CCG including presentations at all six Township forums.

The Chief Operating Officer reported that the purpose of the review is to ensure that the right care and the right treatment is provided in the right place. There will be six clinical hubs all providing a range of services providing equality of service provision across the Borough.

In response to a Member's question the Programme Manager reported that the proposals would looked to include a Primary Care front end service at Fairfield General Hospital. This service would provide a primary care presence and would allow GPs to triage patients.

The Programme Manager acknowledged that there had been initial teething problems with the NHS111 service, it is envisaged that the service would be developed to provide a localised Bury response.

In response to a Member's question the Chief Operating Officer reported that of the 67,000 patients seen in the walk in centres in 2015/16 could have been seen in a suitable alternate provision.

With regards to communication and engagement the Chief Operating Officer reported that the CCG would need to ensure all the information in respect of services provided is kept up to date and easily accessible to members of the public. The Chief Operating Officer reported that he would be very reluctant to double run services, as evidence suggests that the more services made available to the public the more patients will use them.

The Chief Officer reported that these proposals were not about saving money. The proposals would ensure that patients access the services via the most appropriate patient pathway. A front-end primary care service at Fairfield Hospital will help to alleviate some of the pressures on A&E centres as well as being able to treat patients that would have previously attended a walk in centre.

The Chief Officer reported that the proposals will involve re-educating patients in where to get the best most appropriate treatment, provide information and advice with regards how to self care and encourage patients to use their local pharmacist.

It was agreed that:

Once the outcome of the engagement exercise in respect of the Urgent Care Redesign has been considered by the Board of the Clinical Commissioning Group, Members of this Committee will have an opportunity to re-consider the proposals.

HSC.309 URGENT BUSINESS

There was no urgent business reported at the meeting.

COUNCILLOR SARAH KERRISON
Chair

(Note: The meeting started at 7pm and ended at 9.30pm)

Agenda Item 5

REPORT TO HEALTH SCRUTINY COMMITTEE

Bury COUNCIL

Title:	**ANNUAL COMPLAINTS REPORT – ADULT SOCIAL CARE SERVICES – FOR INFORMATION ONLY**
Date of Meeting:	**Governance Meeting 15 August 2016** **Health Scrutiny 20 October 2016**
Report from :	**Pat Jones-Greenhalgh, Executive Director of Department of Communities & Wellbeing**
Contact Officer :	**Sharon Wells, Customer Engagement Manager**

1.0 PURPOSE/SUMMARY

There is a statutory requirement to produce an Annual Complaints Report relating to Adult Social Care Complaints. This report is to update Members and provide current information in respect of complaints related to Adult Social Care Services. The report looks at the period 1 April 2015 to 31 March 2016 and the purpose in presenting the report is for Members to oversee the extent and complexity of Adult Care Services' span of activity and to receive information relating to the quality of services delivered.

Members are asked to note the content of the report.

2.0 INTRODUCTION

2.1 In line with guidance from the Department of Health, Local Authorities are required to publish an Annual Complaints Report covering the council year.

2.2 This report is to update Members and provide information in respect of complaints related to Adult Social Care Services during 2015/16. More frequent monitoring is undertaken by the Department of Communities and Wellbeing's Governance Committee to review performance and agree, as appropriate, any remedial action in response to concerns.

2.3 Members' comments regarding the report are invited.

3.0 BACKGROUND

3.1 A complaint is generally defined as 'an expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a local authority's adult social care provision which requires a response.'

3.2 Complaints principally concern service issues, including the perceived standard of services and their delivery by service providers. Recorded figures however only represent a percentage of instances where people are dissatisfied as many complaints/concerns are managed and resolved at the time, avoiding the need for people to resort to the more formal statutory complaints process.

3.3 Within the regulations which govern the process, the Council adopts a flexible approach which prioritises local resolution of complaints although people still have the option to take their case to the Local Government Ombudsman should they remain dissatisfied.

3.4 Some customers find it emotionally difficult to make an initial complaint. The process is therefore designed to ensure that all complaints are treated seriously, in confidence, investigated and given due attention. Integral to this is the role of the Customer Engagement Manager who provides a degree of independence and support to the complainant whilst ensuring the complaint follows the statutory procedure. Customers may also make complaints through advocates providing any necessary and appropriate consent has been received which enables personal information to be shared.

3.5 A Councillor or Member of Parliament cannot make a complaint using the statutory complaints procedure on behalf of their constituent. However, they are able to raise a concern or make a representation on behalf of a constituent. These are logged and recorded as 'Concerns.' A Local Authority does not generally have to obtain the express consent of an individual to disclose their personal information to an elected member. In these circumstances, the individual has provided implied consent to the sharing of their personal data that is reasonably necessary to pursue the complaint.

3.6 The Complaints Procedure is not designed to deal with allegations of serious misconduct by staff. These situations are covered under separate disciplinary procedures of the Council.

3.7 In order to ensure any safeguarding issues which are contained within social care complaints are captured and processed through the Safeguarding Procedures, the Customer Engagement Manager and the Safeguarding Adults Strategic Manager have an agreed protocol regarding joint working which is accessible on the Council's website.

4.0 ANALYSIS OF COMPLAINTS

4.1 The attached appendix 1 provides statistical data in graph format for the period 1 April 2015 to 31 March 2016 and includes:-

- A comparative study of the number of complaints received for the period 2013/14, 2014/15 and 2015/16 (Fig. 1)
- A comparative study of the nature of complaints received for the period 2014/15 and 2015/16 (Fig. 2)
- The number of complaints received by Teams for the period 2014/15 and 2015/16 (Fig. 3)
- A comparative study of the time taken to resolve complaints for the period 2014/15 and 2015/16 (Fig. 4)

- A comparative study of the number of concerns raised by Local Councillors, Members of Parliament and the Local Government Ombudsman for the period 2014/15 and 2015/16 (Fig. 5)
- The number of compliments received and the service area they relate to 2015/16 (Fig. 6)
- The attached appendix 2 shows the number of complaints received relating to categories of Equality and Diversity
- The attached appendix 3 shows Evidence of Learning and improvements made to services as a result of complaints

4.2 Following a major re-configuration of the Assessment and Care Management Community Teams in July 2014, there was a split into three locality teams. It is considered that a Localities Model provides the most efficient and effective service whilst ensuring delivery is closer to the customer and the community in which they live. This model is also connected to the wider Social Care and Health Agenda.

The Locality Teams cover the following areas:-

Locality Team 1 covering Prestwich and Whitefield
Locality Team 2 covering Bury East and Ramsbottom
Locality Team 3 covering Tottington and Radcliffe

4.3 The total number of complaints received over the last year has decreased quite significantly by 10 when compared to 2014/15.

4.4 The formation of Persona in October 2015 as a Local Authority trading company may have deflected some complaints from the Department. The services which make up Persona were previously delivered in-house by Bury Council e.g. day support and residential stays provided at Elmhurst, Grundy, Spurr, Pinfold etc

4.5 Out of 69 complaints received 22 were not upheld.

4.6 With respect to timescales, 74% of complaints were responded to within 30 working days of the complaint being received.

4.7 The number of concerns raised by Members of Parliament and local Councillors increased by 1 from 19 to 20 during the last year.

4.8 The number of Local Government Ombudsman (LGO) enquiries the Department received and dealt with during 2015/16 was 10 – an increase of 8 or 500% on the previous year.

4.9 To put the total number of complaints in context, the Department provides services to approximately 5570 individuals. 69 complaints therefore equates to 1.2% of customers.

4.10 The Department received 365 compliments about the work carried out by individuals/teams. These are also recorded and celebrated in recognition of the good work that is taking place.

4.11 Complaints (and compliments) can give valuable feedback and alert managers to issues with regard to service quality or delivery. The Department seeks to

learn from such occurrences and recommendations made as a result of complaints made during 2015/16 have resulted in improvements or changes to services. These are listed in Appendix 3.

5.0 CONCLUSIONS

5.1 The number of complaints has decreased significantly (by 10)

5.2 The process has been designed to reduce barriers for complainants.

5.3 The Department monitors feedback and uses these experiences to learn and improve operations. This approach will continue and steps will be taken to minimise dissatisfaction although this continues to be a challenge in an environment of rising demand and diminishing resources.

6.0 THE FUTURE

6.1 In April 2016 the Customer Engagement Team started to test a pilot scheme to explore the possibility of storing complaints information on the Department's electronic recording system which currently stores customers' social care records.

The pilot scheme will be reviewed in the Autumn 2016 to evaluate its effectiveness.

Hard copies of information and correspondence relating to complaints currently need to be stored for a period of 6 years, in line with the Information Commissioner's guidance. The new system, if fully adopted, will, in due course, eliminate the need for hard copy storage as well as providing a more secure storage facility.

The Department continues to work jointly with the local NHS Trusts to ensure co-ordinated responses to complaints are sent to complainants. This is in line with both the statutory Complaint Regulations and fits with the wider Social Care and Health agenda.

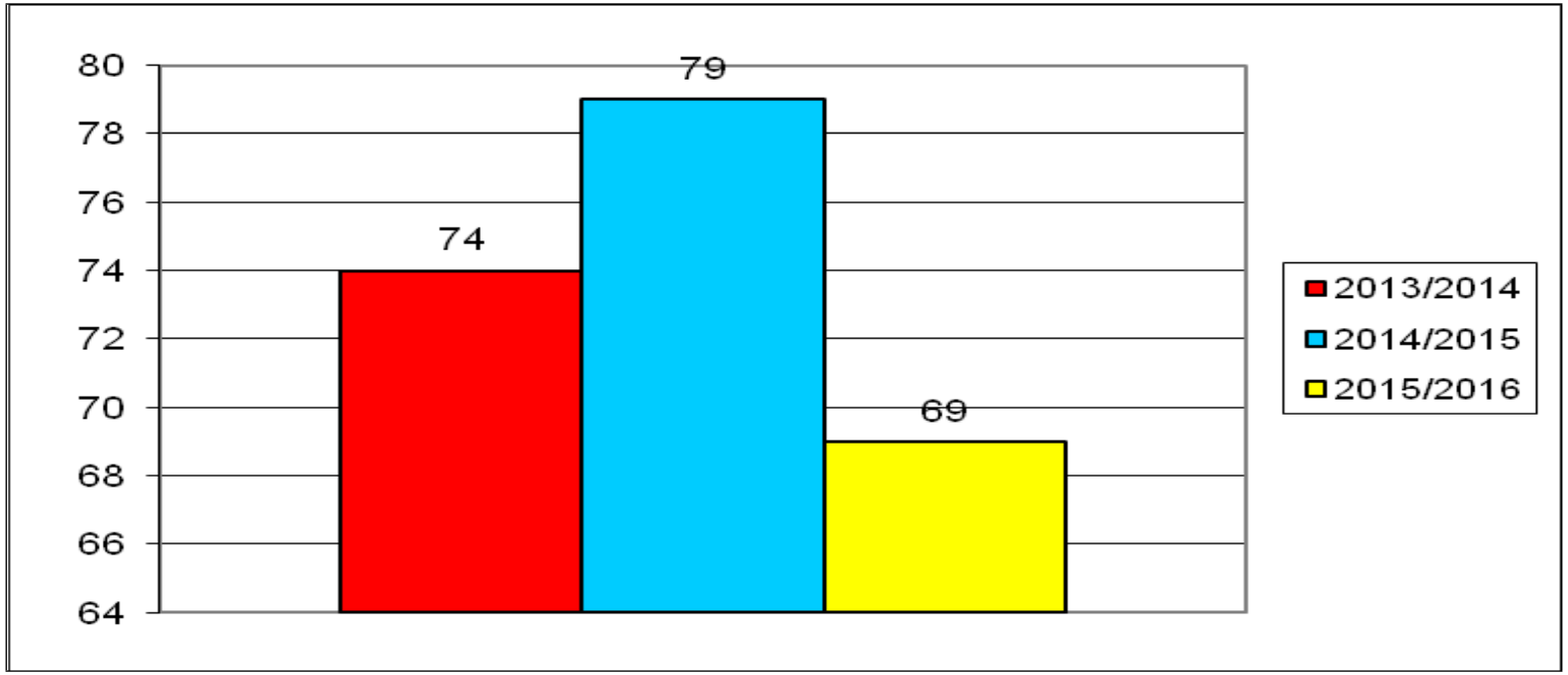
Appendices 1, 2 and 3 attached

Appendix 1

Adult Care Services Annual Complaint Report
1st April 2015 – 31st March 2016

Figure 1

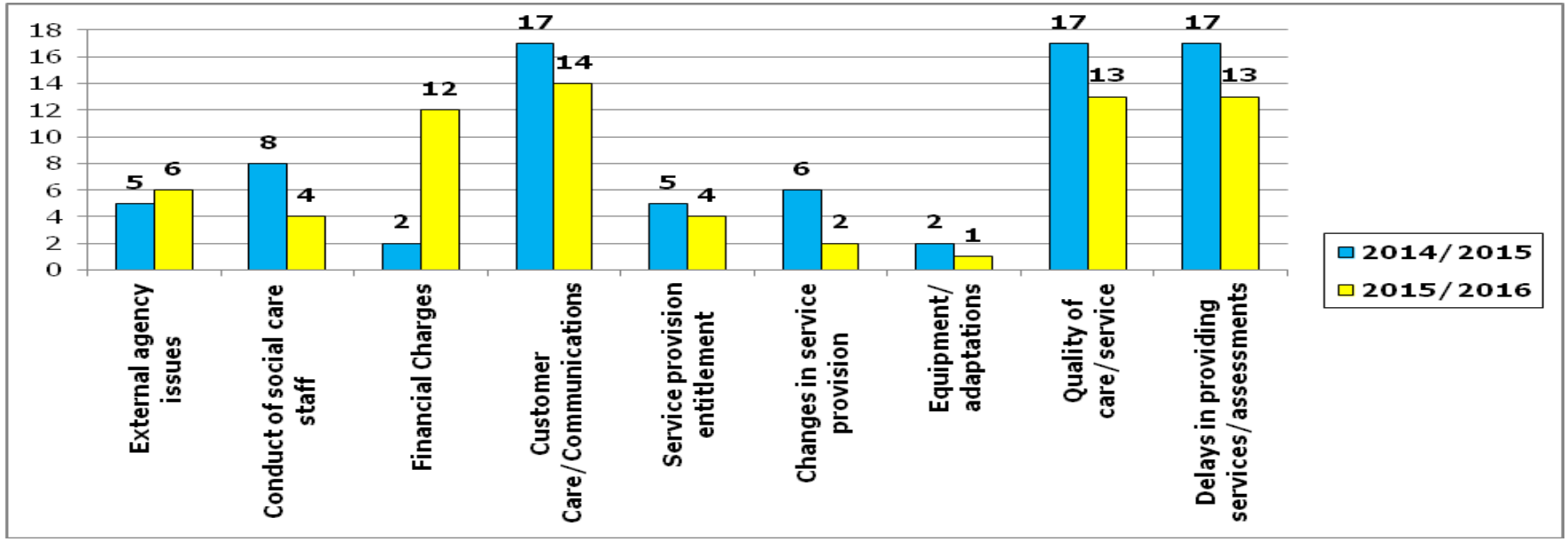
A comparative study of the number of complaints received for the period 01/04/2013 – 31/03/2014, 01/04/2014 - 31/03/2015 and 01/04/2015 - 31/03/2016.



- The total number of complaints in 2015/2016 has decreased by 12.7% when compared to the 2014/15 year and by 6.8% when compared 2013/2014.

Figure 2

A comparative study of the nature of complaints received for the period 01/04/2014 - 31/03/2015 and 01/04/2015 - 31/03/2016.



Key Findings

- Just 2 areas (External Agency and Financial charges) showed an increase
- All other areas showed a decrease

Increased Number of Complaints

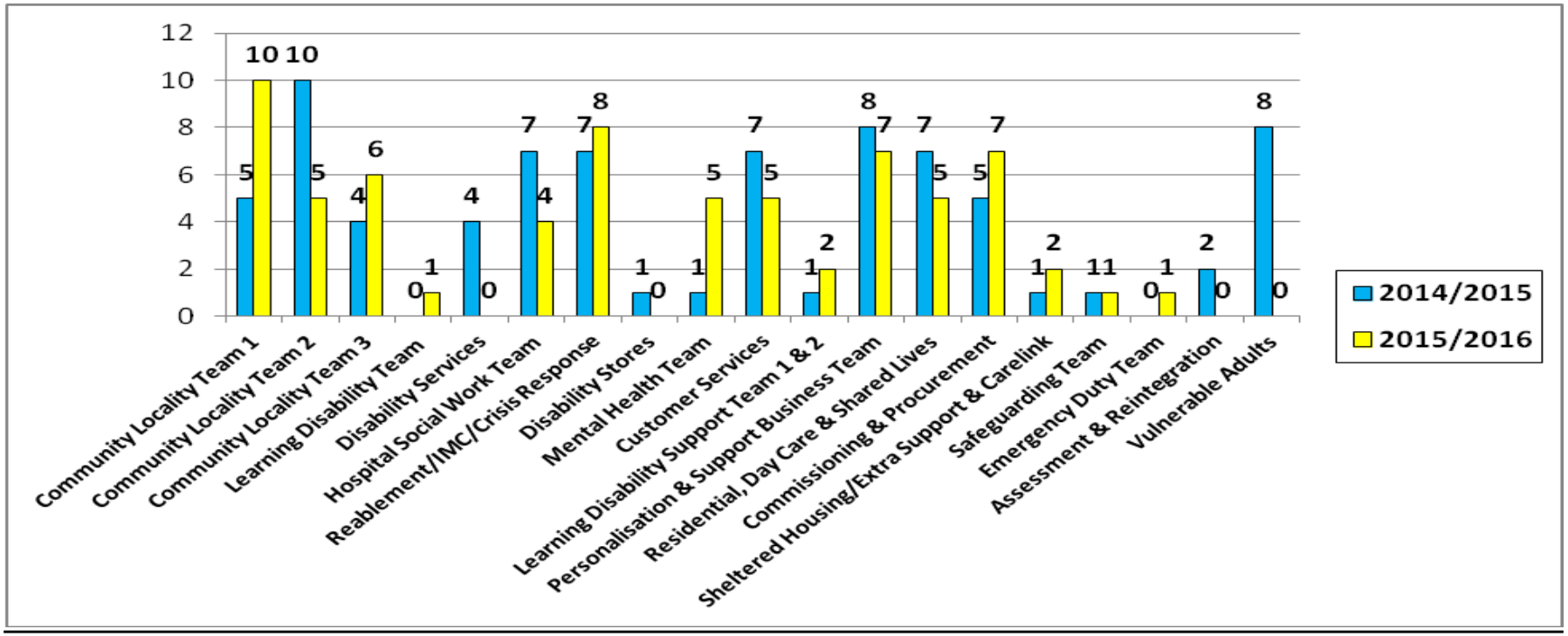
- 20% (1) increase in complaints relating to External Agencies
- 500% (10) increase in complaints relating to Financial Charges

Decreased Number of Complaints

- 50% (4) decrease in complaints relating to conduct of social care staff
- 20% (4) decrease in complaints relating to changes in service provision
- 23.5% (4) decrease in complaints relating to quality of care/service
- 23.5% (4) decrease in complaints relating to delays in providing services/assessments

Figure 3

Complaints received in respect of Adult Care Services by teams for the period 01/04/2014 – 31/03/2015 and 01/04/2015 – 31/03/2016.

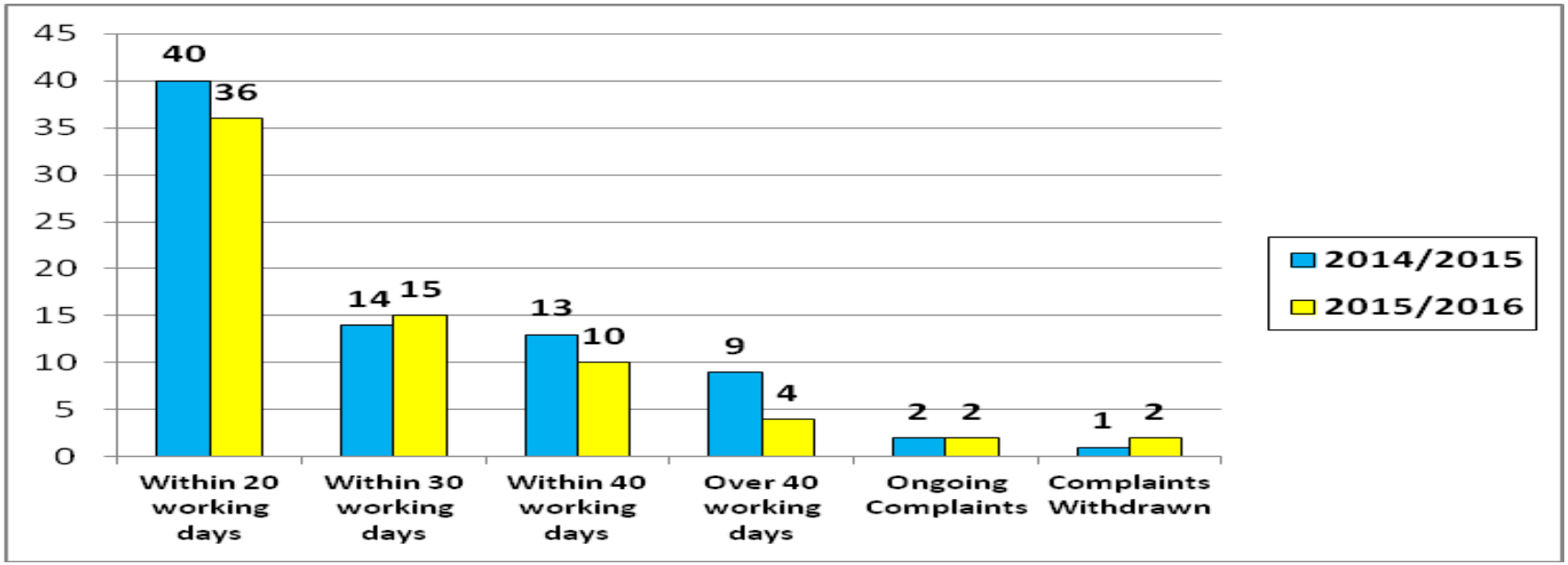


Key Findings

- 14.5% of complaints (10) related to the Community Locality Team 1
- 11.6% of complaints (8) related to Reablement/IMC/Crisis Response

Figure 4

Timescales for complaints for the period 01/04/2014 – 31/03/2015 and 01/04/2015 – 31/03/2016.

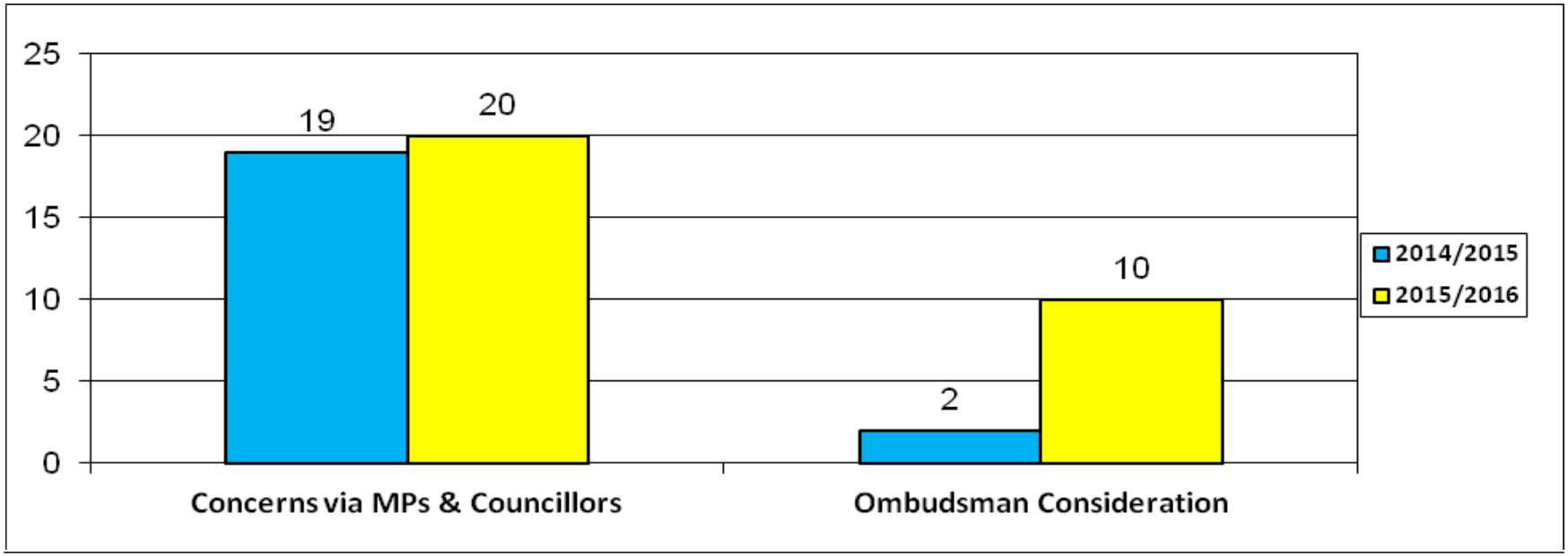


Key Findings

- Total number of complaints dealt with within 20 working days decreased by 10% (4)
- Total number of complaints dealt with within 30 working days increased by 7.1% (1)
- Total number of complaints dealt with within 40 working days decreased by 23.0% (3)
- Total number of complaints dealt with over 40 working days decreased by 55.6% (5)
- Total number of ongoing complaints remains the same
- Total number of complaints withdrawn increased by 50% (1)

Figure 5

Number of MP and Councillors concerns and Ombudsman considerations/enquiries for the period 01/04/2014 – 31/03/2015 and 01/04/2015 – 31/03/2016.

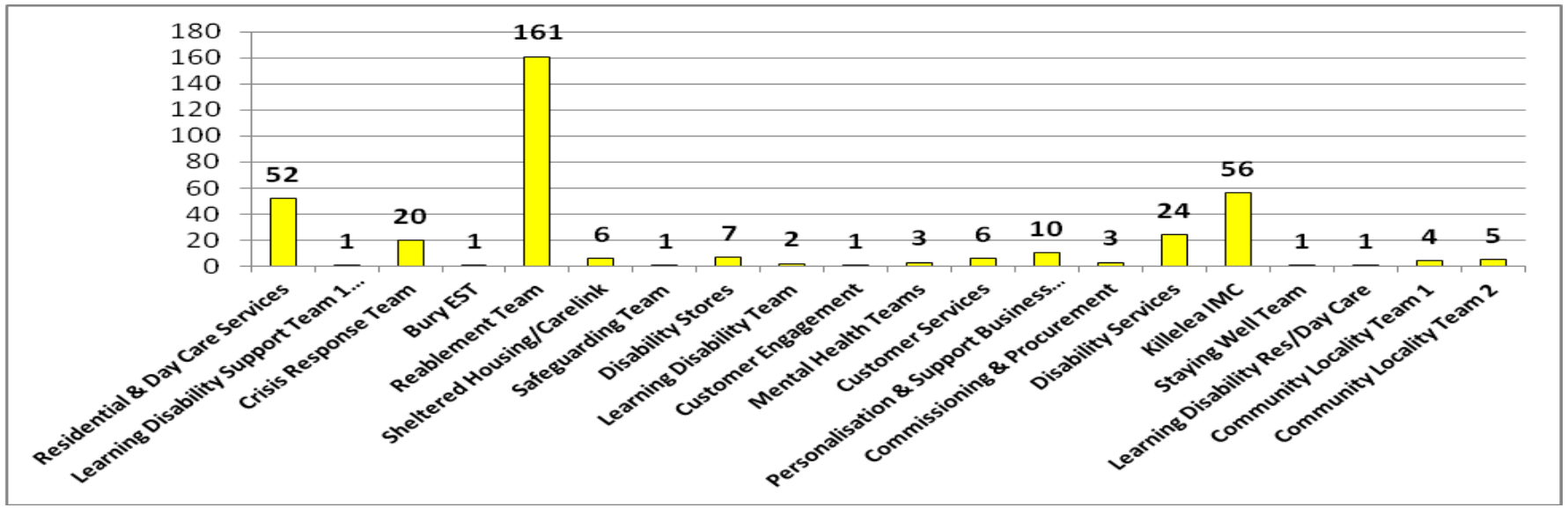


Key Findings

- Total number of concerns via MP's & Councillors has increased by 5.3% (1)
- Total number of Ombudsman Consideration/Enquiries has increased by 400% (8)

Figure 6

365no. of compliments received and the service area they relate to for the period 01/04/2015 – 31/03/2016.



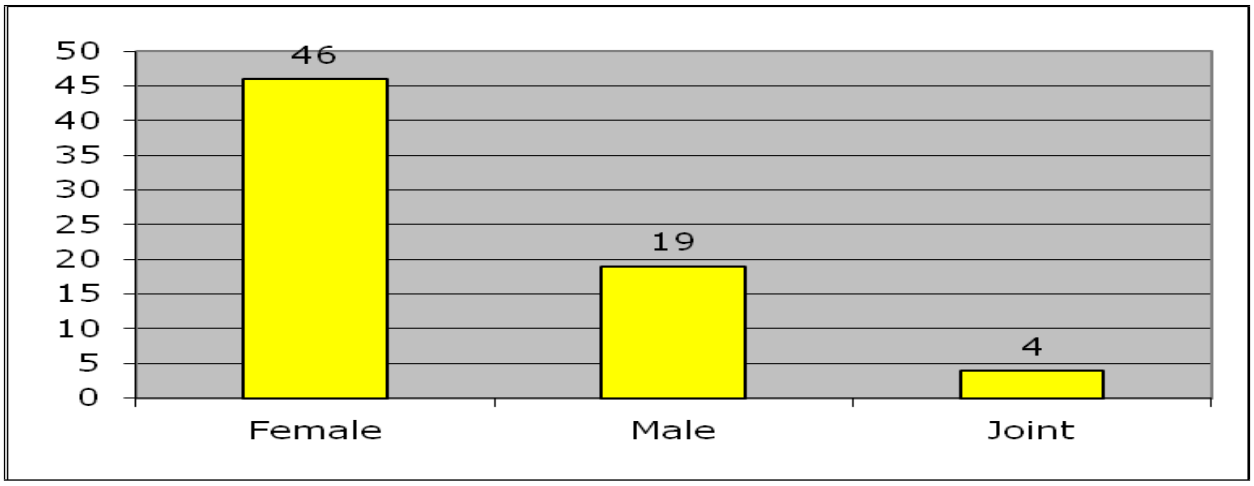
Key Findings

- 44.1% (161) of compliments received were in respect of the Reablement Team
- 296 more compliments than complaints were received

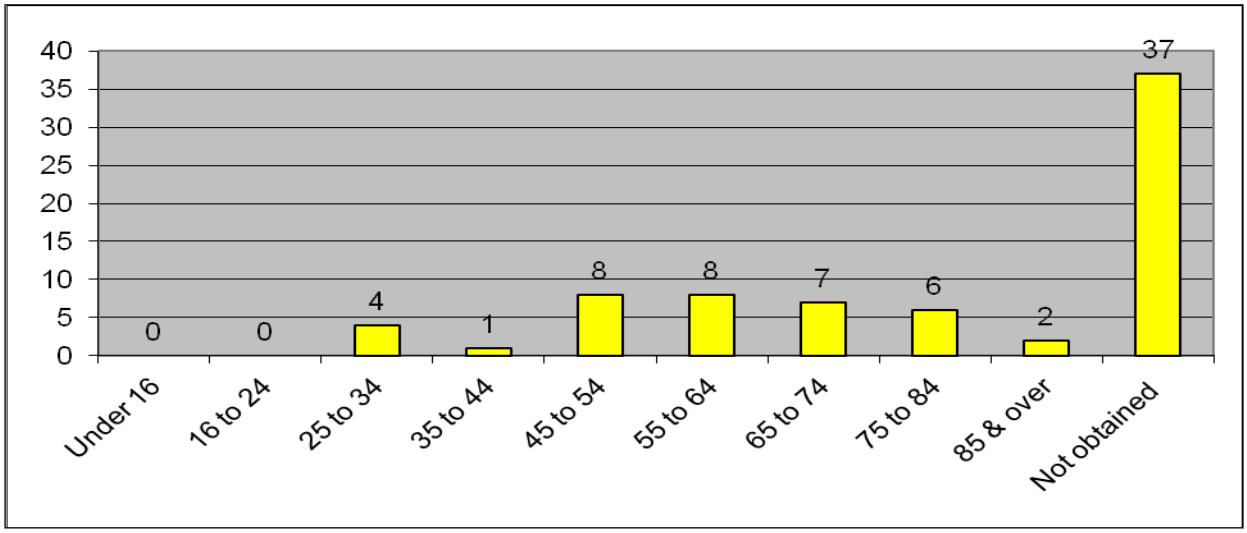
Appendix 2

E & D COMPLAINTS MONITORING
1st April 2015 – 31st March 2016

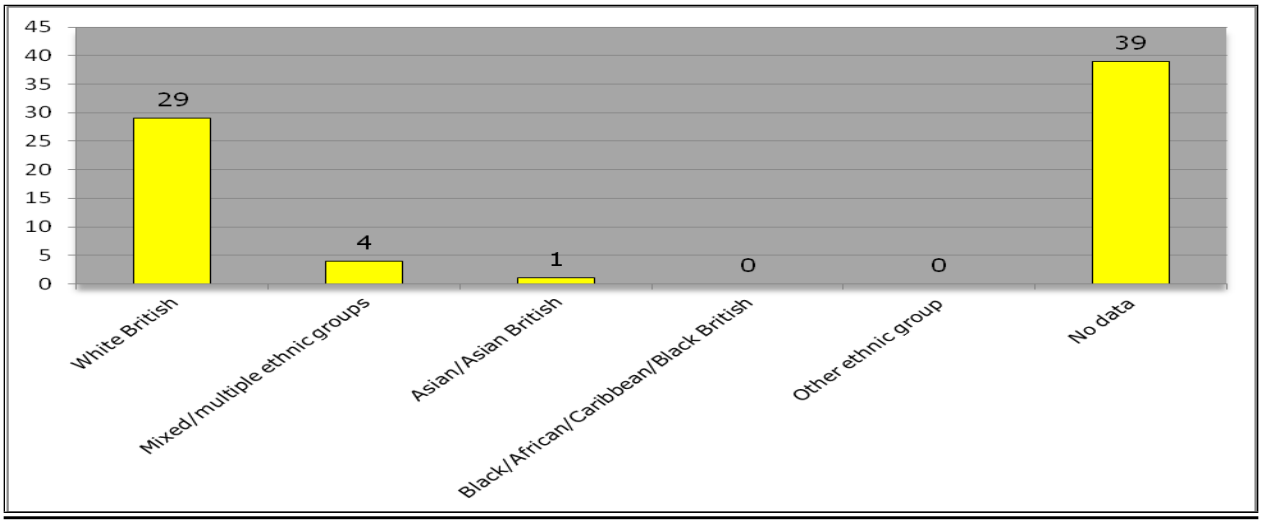
GENDER



AGE



ETHNIC ORIGIN



This page is intentionally left blank

Appendix 3

Evidence of Change and Learning from Complaints 1 April 2015 to 31 March 2016

Following a complaint regarding a delay in bed raisers being fitted, the Manager of the Equipment Store has implemented the following two actions:-

1. A new procedure has been issued which details the actions which should be taken if, for any reason, a piece of equipment cannot be fitted.

2. Van Drivers who deliver and install aids and equipment in customers' homes now ensure they carry all combinations of bed/chair raising equipment.

3. The Manager of the Blue Badge Team have reviewed and amend the data protection statement on the Blue Badge application form to reflect the national web application form.

4. The Advanced Practitioner of the Connect and Direct Hub (Contact Centre for Adult Care Services) has ensured that customer advisors do not have the authority to downgrade a Safeguarding alert made on an accident and emergency referral document.

5. The Manager of the Personalisation and Business Support Team has reviewed training for staff and the wording of letters in respect of the Deferred Payments Scheme to ensure clear communication.

This page is intentionally left blank

FAIRNESS FIRST

Addressing inequalities in Bury

Director of Public Health Annual Report 2015/2016

Bury COUNCIL

CONTENTS

FOREWORD

I am delighted to present my second independent Director of Public Health Annual Report for Bury. The focus of this year's report is health inequalities. There has been growing recognition of the existence and the injustice of the geographical inequalities within our borough. This has started to shape our policy response through our economic development strategy and our service response via the development of neighbourhood working. This report intends to extend our understanding of health inequalities within our communities by focusing on the experiences of key groups of people. It highlights how social, cultural and practical barriers prevent individuals from gaining access to the resources and services required to achieve good health.

Beyond the legal framework there is a moral and an economic case for being concerned about inequalities. Those who experience inequalities endure hardship, misery, stigma and isolation, which no-one in a civilised society would wish to inflict on another. It is also clear that unequal societies have poorer outcomes in a range of measures including obesity, drug dependency, mental illness and infant mortality. In addition, more unequal societies have higher rates of teenage pregnancy, lower educational attainment and lower levels of child wellbeing. These issues generate greater demand on services and the public purse and reduce economic productivity.

THE REPORT IS PRESENTED IN THREE PARTS:

Section 01

reflects back on last year's annual report and provides an update on progress against each of the recommendations.

Section 02

looks in detail at some of the key groups of people who experience inequalities highlighting the factors which contribute to these along with trends or patterns.

Section 03

identifies what could be done locally to address these inequalities, illustrated by examples and case studies.

Once again there have been a large number of people who have contributed to this report to whom I am extremely grateful.

I would however like to particularly thank Jon Hobday, Consultant in Public Health, for developing and collating the content, the Bury Council Performance and Intelligence Team for providing the data analysis, Josie Neil and Lemon Zest Creative Ltd. for their support with design and production.

LESLEY JONES
Director of Public Health

I am pleased to endorse the 2015/2016 Public Health Annual Report. Having worked in a range of capacities on the equality and diversity agenda - the topic of inequalities is very close to my heart and I am delighted this has been the focus of the report. Nationally and locally the challenge of addressing inequalities is one which we have been working towards for a number of years. I am particularly pleased the report has highlighted the inequalities experienced by those with mental health issues, as these can often get overlooked against other physical disabilities and health issues.

The report captures the vision we are aiming towards, the challenges we are up against, along with all the hard work which is going on. Finally, I would like to thank Andrea Simpson, the previous Cabinet Member for Health and Wellbeing as she did a fantastic job in driving forward the recommendations from last year's annual report.

Trevor Holt

TREVOR HOLT
Cabinet Member for
Health & Wellbeing

INTRODUCTION

It is a statutory requirement that the Director of Public Health produces an annual report with the aim to improve the health and wellbeing of the people in Bury. The key theme of this year's report is health inequalities in Bury based on gender, disability, ethnicity, mental health, sexuality and geography.

Health inequalities are differences in health, wellbeing and life expectancy between groups within society. These differences are a result of the social, cultural and economic circumstances in which we live. These inequalities have continued to persist within our society despite them being a key priority for successive government policy for a number of years.

In examining health inequalities for each population group, measures of life expectancy and healthy life expectancy will be used as key overall indicators of health status. Each section will then explore differences in the experience of the social and economic factors such as employment, education and housing; lifestyle risk factors such as smoking, alcohol consumption, diet and physical activity; and thirdly access to services, all of which contribute to life expectancy and healthy life expectancy.

It is estimated that social, economic and environmental factors make a 45% contribution to our health and wellbeing, health behaviours around a 40% contribution and health care approximately making up the rest (15%).

WIDER DETERMINANTS

A key wider determinant of health is employment. Evidence shows that being in good employment has a positive impact on health and conversely, unemployment contributes to poor health. Therefore getting people into work is critical for reducing health inequalities. However, to achieve this, jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also an opportunity for in-work development, flexibility for work life balance and protection from adverse working conditions.

Patterns of employment both reflect and reinforce the social gradient and there are serious inequalities of access to labour market opportunities. Rates of unemployment are highest amongst those with no or few qualifications or skills, people with disabilities and mental ill health, those with caring responsibilities, lone parents, those from Black and Minority Ethnic (BME) groups, older workers and young people.

Insecure and poor quality employment is associated with increased risk of poor physical and mental health. There is a graded relationship between a person's position at work and how much control and support they have e.g. generally people in more senior positions have more control over the management of their work.

Lower levels of job control are linked to biological effects that increase the risk of ill-health.

Educational attainment is also a key wider determinant of health. Those who achieve higher levels of education are more likely to go on to gain paid employment, earn more money, live in a better standard of housing and have better health outcomes. Achievement gaps significantly reduce social mobility. Those children from the most deprived backgrounds and some minority groups such as Gypsy and Traveller children, have notoriously low levels of educational attainment.

Educational attainment is influenced by a range of factors prior to children starting school including early help learning, structured activities, maternal aspirations for higher education, and how far parents and children believe their own behaviours affect their lives and children's behaviours.

Housing and the environment can also play a significant part in contributing to health inequalities. Those in the lower socio-economic groups are more likely to live in poorer quality housing and experience overcrowding. This can lead to increases in respiratory problems due to damp and mould, higher number of accidents due to poor designs and a lack of safety features and potentially an increase spread of communicable disease due to overcrowding. In addition these homes are more likely to be in areas which have less green spaces, are more built up and in many instances have higher levels of pollution due to being close to industry or busy roads. These areas also tend to have higher levels of reported crime which can encourage people not to go out, increasing social isolation. All these factors have a negative impact on people's physical and mental health, further increasing inequalities.

LIFESTYLE RISK FACTORS

Smoking, poor diet, physical inactivity, and alcohol contribute to all the major causes of death and ill-health in Bury, including mental illness. They also generate significant demand on a range of services. Those who smoke are at increased risk of a range of health conditions including cardiovascular disease, respiratory issues and certain cancers. We know those in the lower socio-economic groups are more likely to smoke, with evidence suggesting this can often be due to using smoking as a coping mechanism linked to poor life circumstances.

Physical activity levels are also lower in certain groups including those with disabilities and mental health issues. Evidence has attributed this to major deficits in provision and opportunities. In order to get some key groups who experience inequalities physically active, the appropriate types of provision and opportunities need to be provided and promoted in effective ways.

Alcohol misuse plays a huge factor in poor physical and mental health outcomes both locally and nationally. Again those in the lower socio-economic groups (and men in general) are more likely to misuse alcohol in a way that impacts their health. Evidence suggests social norms and risk taking behaviours particular amongst young men are key factors in this.

ACCESS TO SERVICES

The accessibility of health services plays an important role in contributing to health outcomes. A factor known as 'the inverse care law' is linked to access and provision and is known to contribute to inequalities. The law suggests those who most need medical care are least likely to receive it. Conversely, those with least need of health care tend to use health services more (and more effectively). This situation initially arises due to inequalities and then further contributes to these inequalities.

There is considerable evidence that many populations, particularly those living in areas of high socio-economic deprivation, suffer on all three counts: they use poor quality services, to which they have relative difficulty securing access and they suffer multiple external disadvantage. National evidence suggests in areas with high needs, such as inner cities and deprived areas, there tend to be fewer doctors working with higher caseloads and sicker patients. Another demonstration of the law is that rates of immunisation, and screening for cervical and breast cancer, are significantly lower in people from more deprived areas – whereas the cancer mortality rates in these areas are higher.

SECTION 01

PROGRESS AGAINST PREVIOUS RECOMMENDATIONS

Last year's report was my first Independent Annual Report as Director of Public Health for Bury. The report 'Putting Health at the Heart of Our Business' focused on how Bury Council could fulfil its ambition to become a 'Public Health Council' following the transfer of responsibilities for Public Health from the NHS to Local Government in April 2013.

The report showcased what the Council, working with partners, was already doing to improve health and wellbeing in Bury and made recommendations on how this work could be built on to achieve even greater benefits for our communities. The report focused on the following themes:

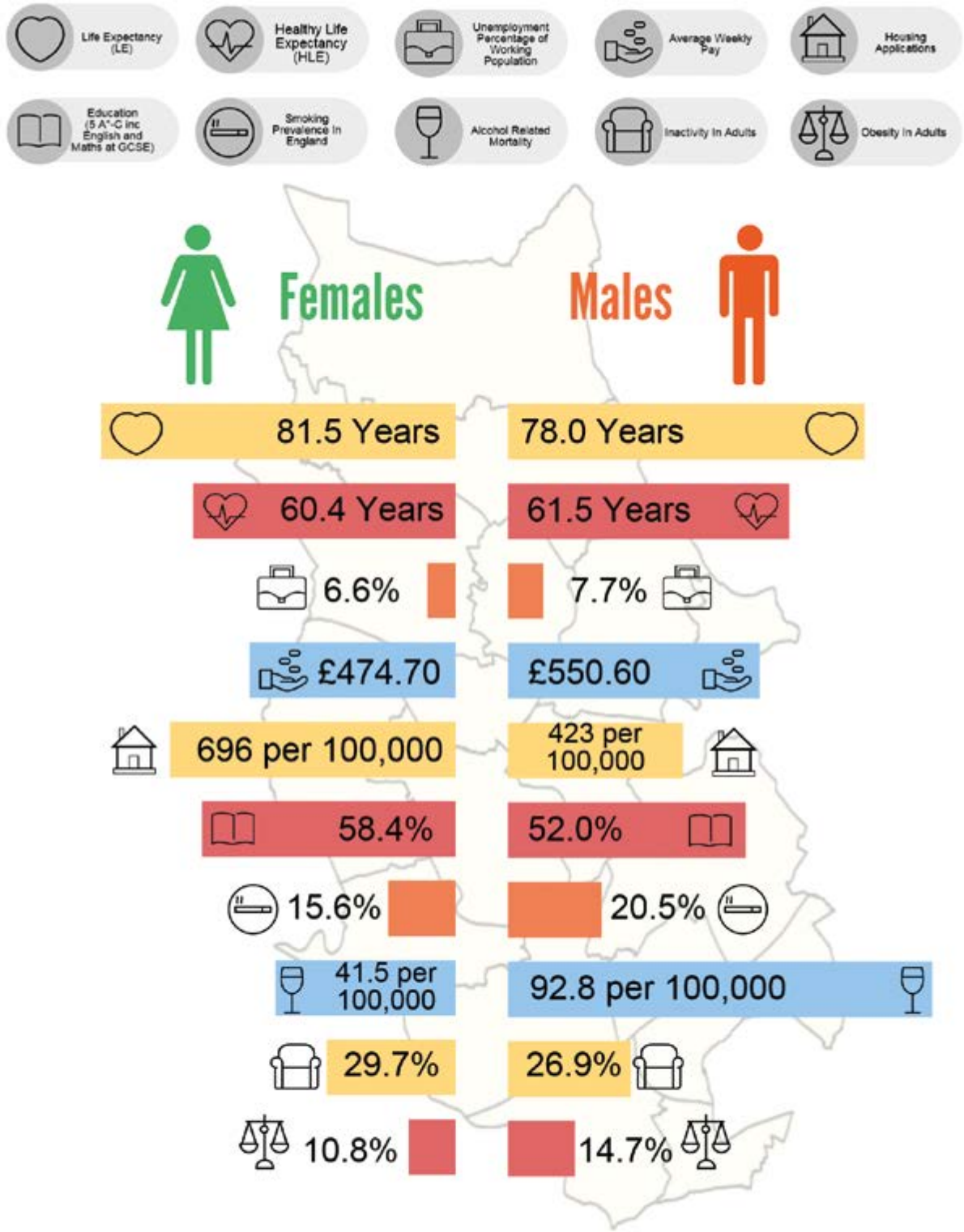
- Ensuring the best start in life
- Healthy schools and pupils
- Helping people find good jobs and stay in work
- Active and safe travel
- Warmer and safer homes
- Access to green and open spaces and the role of leisure services
- Strong communities, wellbeing and resilience
- Public protection and regulatory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

The report contained 35 recommendations which were all accepted by Council Cabinet on 14th October 2015. Appendix 1 provides an update on progress against those recommendations and I am delighted that despite these financially constrained times, significant progress has been made in implementing the vast majority. Even where less progress has been made against one or two recommendations, I am assured that plans are being developed and they will be implemented in time. This achievement is a testament to the hard work and dedication of all those involved and the commitment by the Council to this agenda.

SECTION 02

GROUPS WHO EXPERIENCE INEQUALITIES

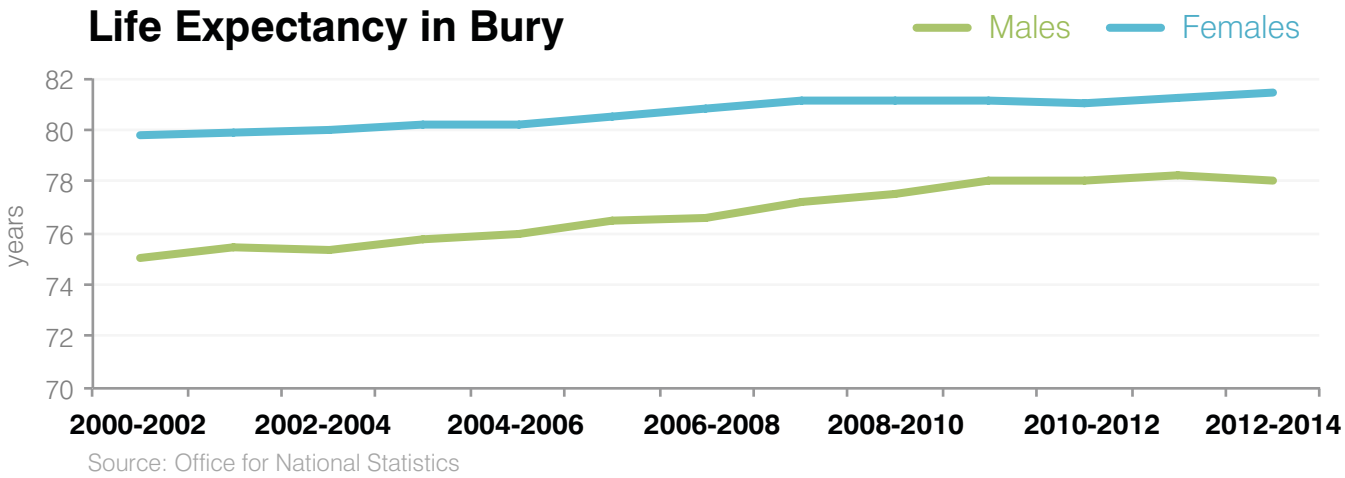
GENDER INEQUALITIES



LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY

Health inequalities between men and women continue to exist in England and locally within Bury. In Bury, Life Expectancy at birth is significantly worse than the England average for both males and females.

Life Expectancy has been steadily increasing over a number of years for both men and women, however in recent years this has levelled off at around 81 years for women and 78 years for men.



Source: Office for National Statistics

The good news is the gap between males and females has been closing locally, from 5.4 years in 1991-93 to a low of 3 years in 2011-13. However, the latest data shows that gap has now widened slightly to 3.5 years.

INTERESTING FACTS

'MEN IN BURY LIVE ON AVERAGE 1.5 YEARS LESS THAN MEN IN THE REST OF ENGLAND'

'WOMEN IN BURY LIVE ON AVERAGE 1.7 YEARS LESS THAN WOMEN IN THE REST OF ENGLAND'

'WOMEN IN BURY CAN EXPECT TO LIVE 3.5 YEARS LONGER THAN MEN'

'LIFE EXPECTANCY FOR WOMEN IN BURY HAS INCREASED BY 2.7 YEARS OVER THE LAST 12 YEARS'

GENDER AND DEPRIVATION

Differences in Life Expectancy between the least and most deprived groups in Bury can be measured by a 'slope of inequality'. The slope of inequality in Bury shows that women in the most deprived groups of Bury live on average 7.2 years less than women who are in the least deprived groups. While men in the most deprived groups in Bury live on average 10.9 years less.

The below figure outlines the trend over time for the slope index of inequality in both males and females in Bury. For females in Bury, the slope of inequalities scores have fluctuated over time more so than in males, with the last three time period measures showing a steady decline in inequalities. In contrast, the slope of inequality for males in Bury has remained relatively stable over time, with a slight increase in the most recent score.

'THERE ARE GREATER INEQUALITIES IN LIFE EXPECTANCY WITHIN MEN THAN WITHIN WOMEN IN BURY'

'INEQUALITIES BETWEEN WOMEN IN THE LEAST AND MOST DEPRIVED GROUPS IN BURY IS DECREASING'

HEALTHY LIFE EXPECTANCY

An equally important measure of inequality is Healthy Life Expectancy. This is the average number of years a person might expect to live in "good" health in their lifetime.

Bury has seen differences in the trends for Healthy Life Expectancy, between both males and females. Healthy Life Expectancy for females has been decreasing on the whole in the borough, but for males it has remained stable.

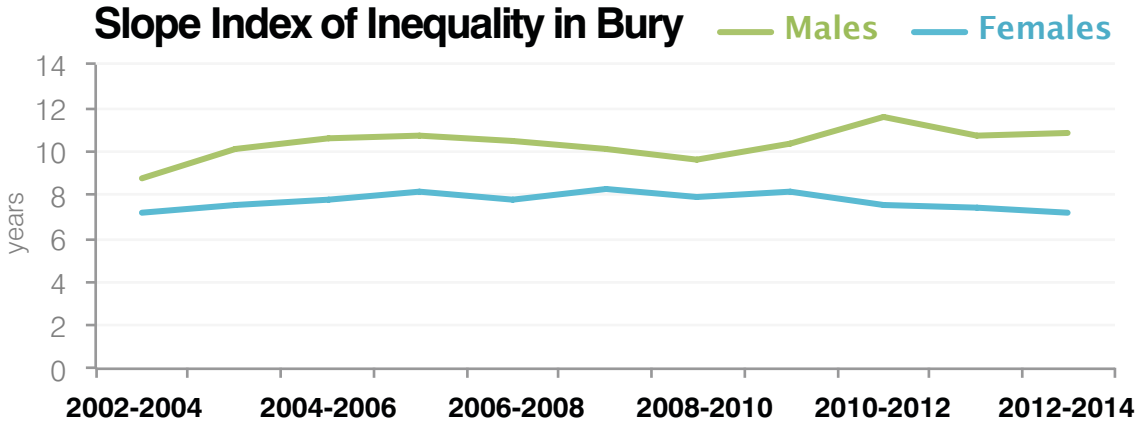
COMPARING BURY TO ENGLAND

When comparing Healthy Life Expectancy in Bury to England for females there is an increasing gap between England as a whole and Bury – this currently this stands at 3.6 years.

In contrast, males in Bury have followed the plateauing Healthy Life Expectancy of England. At present, a 1.9 year gap exists, with Bury Healthy Life Expectancy being 61.5 years and England 63.4 years.

'MALES IN BURY LIVE A LONGER LIFE IN HEALTH THAN FEMALES DO, EVEN THOUGH FEMALES HAVE A GREATER LIFE EXPECTANCY THAN MALES.'

'OVER 1 IN 4 ADULTS IN BURY ARE INACTIVE – WITH MORE WOMEN THAN MEN BEING INACTIVE'



Source: Public Health Outcomes Framework

WIDER DETERMINANTS

Unemployment by Gender

Female unemployment in Bury has been higher than the rate for the North West (NW) and Great Britain (GB) over recent years. The rate has also been increasing; this is in contrast to the regional and national trends.

Male unemployment in Bury has also been higher than the rate for NW and GB for the last four years. The rate of unemployment in Bury has also increased for the last two years, which is in contrast to the regional and national trends.

	Female unemployment	Male unemployment
Bury	6.6% (2,900 people)	7.7%
NW	5.5%	6.2%
GB	5.3%	5.6%

Inequalities in Pay

Gross weekly pay in Bury is higher than for the NW overall, but lower than that for GB. Male full time workers earn on average £550 per week compared to £474 per week for females.

Earnings by residence (2015)			
	Bury (£'s)	North West (£'s)	Great Britain (£'s)
Gross Weekly Pay			
Full-time Workers	516.8	492.0	529.6
Male Full-time Workers	550.6	529.9	570.4
Female Full-time Workers	474.7	441.8	471.6
Hourly Pay - Excluding overtime			
Full-time Workers	13.13	12.44	13.33
Male Full-time Workers	12.88	12.84	13.93
Female Full-time Workers	13.17	11.80	12.57

Lower levels of pay or income are linked to deprivation, which is associated with poor health outcomes. Therefore the differences in the weekly pay could potentially put women at increased risk of deprivation and poor health outcomes.

'UNEMPLOYMENT RATES HAVE BEEN INCREASING IN BURY IN RECENT YEARS'

Housing

The demand on social housing within Bury is high, as in most areas within the UK. The majority of the applicants are existing council tenants and aged 25-34. 63% of the applicants are female.

Education

A key measure of inequalities in educational attainment is the difference between male and female GCSE results. Trends over time indicate whether these inequalities are getting better or worse. Overall for both boys and girls in the borough there was a decrease in the number achieving 5 GCSEs at A*-C, including English, in 2015 when compared to 2014.

When these results are broken down by gender for 2014 vs 2015, for girls there has been a reduction of 0.8% for a first entry sitting of GCSEs; for boys there has been a reduction of 2.3% for a first entry sitting of GCSEs.

In contrast, at a national level between 2014 and 2015 there has been an increase for girls with 5 A*-C passes on first entry sitting of GCSEs (currently at 62.1%). For boys, national data suggests 52.7% achieved 5 A*-C on first entry.

'IN BURY RATES OF PHYSICAL ACTIVITY IN WOMEN HAVE INCREASED IN RECENT YEARS'

LIFESTYLE

Smoking

There is no gender breakdown for smoking rates at Bury level, however nationally evidence suggests:

- Men are more likely to be smokers than women, but at age 15 females are more likely to smoke than males.
- Men have a higher rate than women of deaths from lung cancer.
- Females are more likely to set a quit date and be successful at quitting (based on data provided by the Stop Smoking Service).

Alcohol

A key way to measure the impact of alcohol within groups is to measure the numbers and rates of alcohol related admissions and alcohol related mortality. In Bury, the rate of male alcohol-related hospital admissions is around double than that for females (1869 per 100,000 versus 936 per 100,000). This pattern is similar for alcohol related mortality with 92.8 deaths per 100,000 in males compared to 41.5 deaths per 100,000 in females.

'IN BURY THERE ARE TWICE AS MANY ALCOHOL RELATED ADMISSIONS IN MALES THAN THERE ARE IN FEMALES'

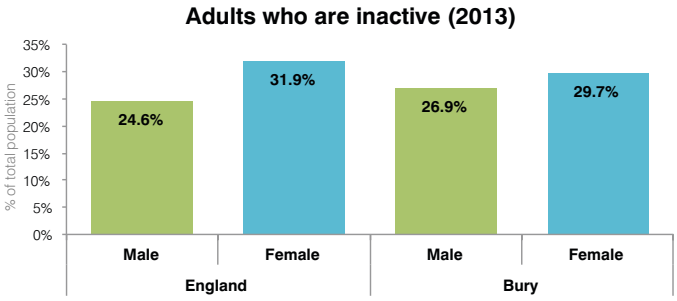
''BURY HAS OVER TWICE AS MANY ALCOHOL RELATED DEATHS IN MALES THAN IN FEMALES'

Physical Activity

In Bury, more females (29.7%) than males (26.9%) are inactive, although the inactivity rate for females decreased between 2012 and 2013, while for men it increased.

Nationally, inactivity has decreased slightly for both genders, with 24.6% of males and 31.9% of females inactive as of 2013.

Levels of inactivity in Bury and England 2013



Source: Active People Survey

Diet and Obesity

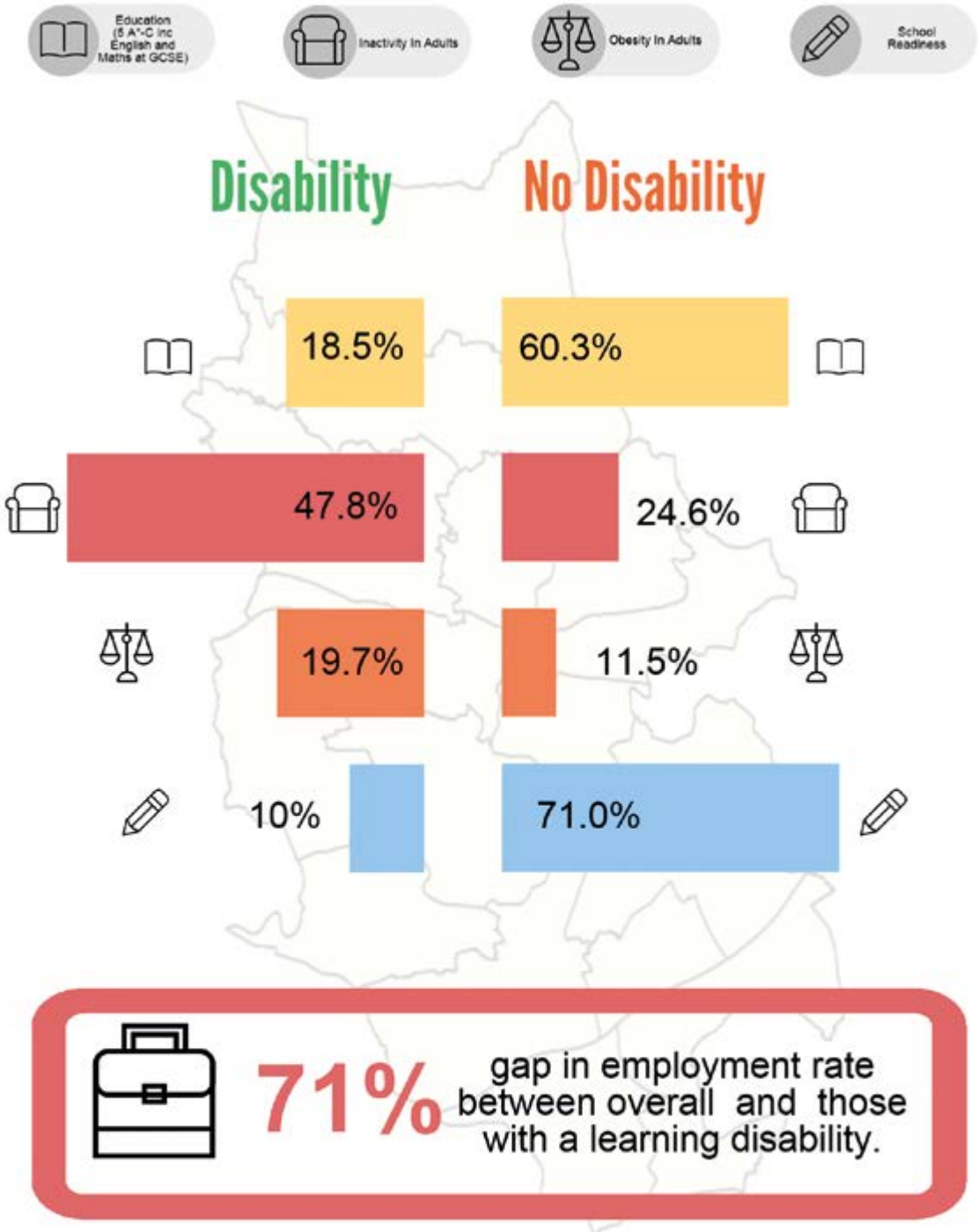
A balanced diet, including 5 or more portions of fruit and vegetables a day, can assist in achieving and maintaining positive health and a healthy weight. In Bury, more females (59.4%) than males (48.2%) eat 5 portions of fruit and vegetables a day.

'IN BURY, THE PROPORTION OF PEOPLE EATING 5 PORTIONS OF FRUIT AND VEGETABLES IS OVER 11% HIGHER IN FEMALES THAN MALES'

In Bury, adult females are less likely to be obese than males. Although this broadly reflects the national trend, Bury has a bigger gender gap than seen nationally (3.9% vs 1.9% respectively).

'IN BURY 14.7% OF MEN AND 10.8% OF WOMEN ARE OBESE'

DISABILITIES AND LEARNING DISABILITIES



Sources:

Active People Survey

Early Years Foundation Stage Profile Outcomes (Academic Year 2014/15)

Bury Council, Children's Services

Based on national projections, it is estimated that there are 3431 people with some form of learning disability in Bury.

LIFE EXPECTANCY / HEALTHY LIFE EXPECTANCY

Nationally we know people with learning disabilities have shorter life expectancy than other people. They also have poorer physical and mental health. These are not inevitable; they are examples of health inequalities that can, to a significant extent, be avoided. Bury health services are responsible for meeting the health needs of people with learning and physical disabilities, and have a legal responsibility to reduce the health inequalities experienced by people with disabilities.

WIDER DETERMINANTS

Employment

There are significant differences in both levels of employment and educational attainment in those with disabilities. These differences contribute to health inequalities.

The employment gap has been increasing over the last 4 years from 64% in 2011/2012 to 71% in 2014/2014.

Education

In 2015 in Bury, 18.5% of those with a Special Educational Need (SEN) achieved 5 A*-C at GCSE, compared to 60.3% of those with no identified SEN (a 42.8% difference).

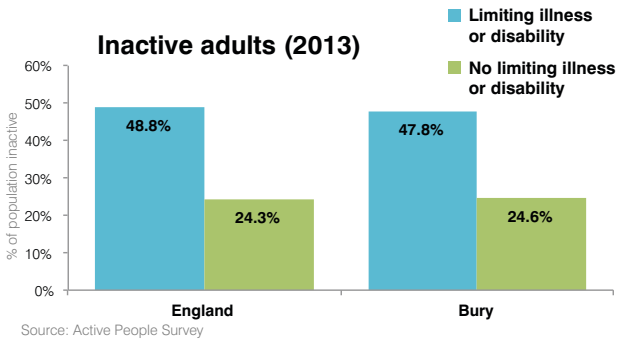
'THOSE WITH A DISABILITY ARE 71% LESS LIKELY TO BE EMPLOYED'

LIFESTYLE

Physical Activity

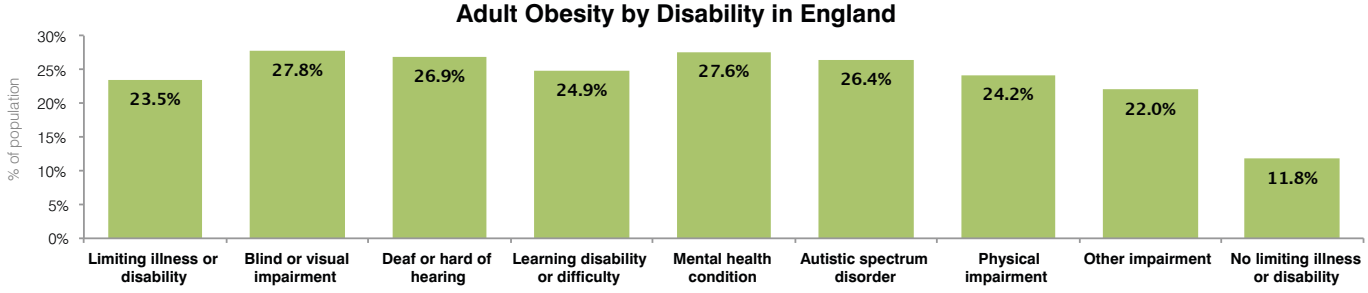
In Bury, just under half of all those with a disability or limiting illness are inactive.

'IN BURY IF YOU HAVE A DISABILITY OR LIFE LIMITING ILLNESS YOU ARE ALMOST TWICE AS LIKELY TO BE INACTIVE AS THOSE WITH NO DISABILITY'



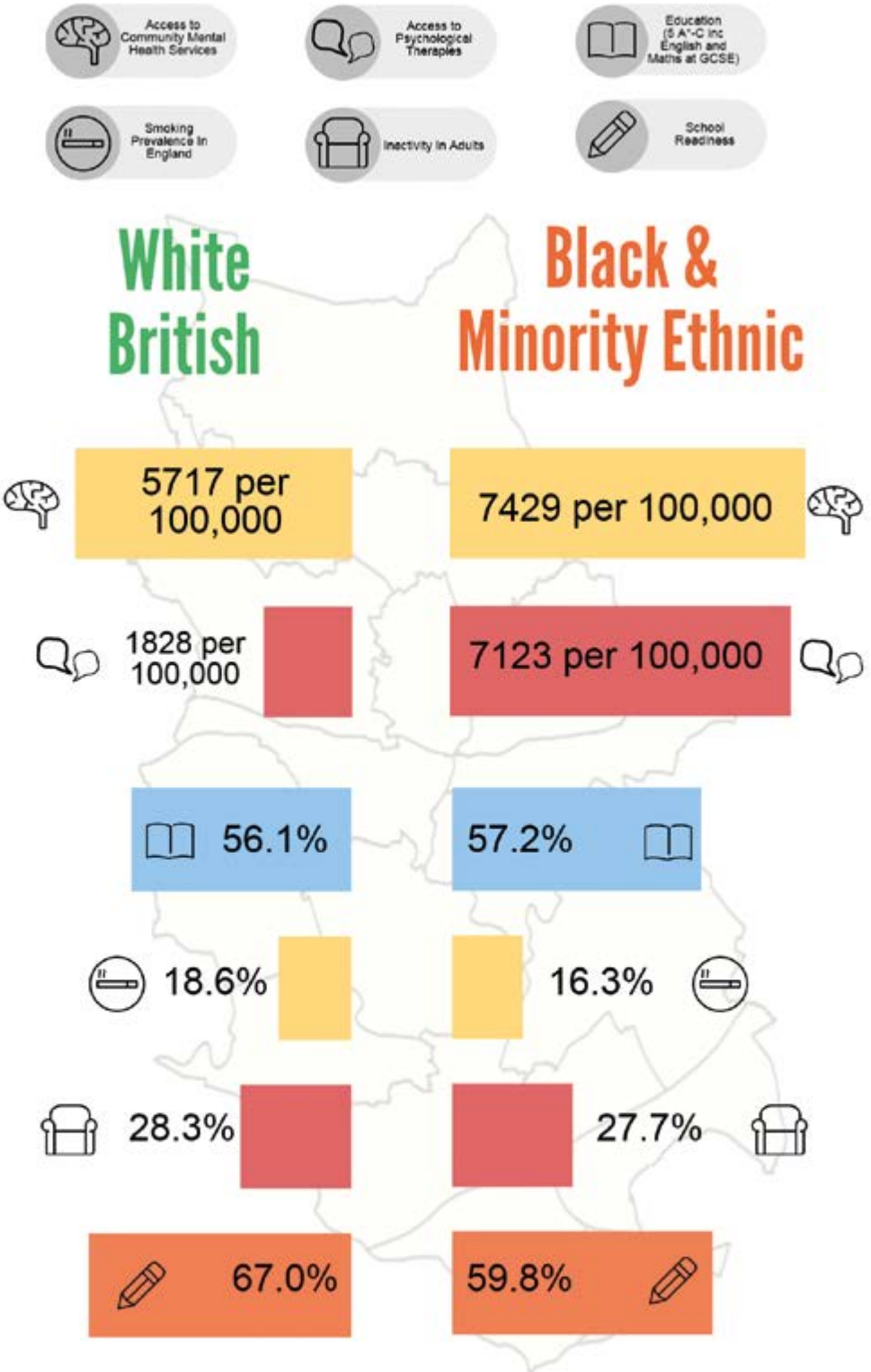
Source: Active People Survey

Levels of inactivity in those with limiting illness or disability compared to those with no disability in England and Bury.



Source: Active People Survey

BLACK AND MINORITY ETHNIC GROUPS



Sources:

Mental Health and Learning Disabilities Data Set (MHLDS)

Improving Access to Psychological Therapies (IAPT) and 2011 Census

Active People Survey

Local Tobacco Control Profiles, Public Health England

Early Years Foundation Stage Profile Outcomes (Academic Year 2014/15)

Bury Council, Children's Services

The most recent data from the Office of National Statistics (ONS) from the 2011 Census suggests 10.8% of Bury's population is made up of BME residents, which is lower than the overall England average of 14.6%. Evidence on BME inequalities in health is typically based on poor quality data and research, with differences in health often described in terms of mortality or specific diseases. This makes it difficult to determine the underlying reasons for such inequalities. Work on social and economic causes of inequality show the main drivers of health inequalities within BME groups include poor job opportunities and predominantly lower paid, poorer quality jobs.

In addition to our largest BME group in Bury (made up of predominantly South Asians within Bury East ward), two other important minority groups within Bury are the Jewish community and the Gypsy and Traveller population. There is limited data available locally on these groups however; work has been done nationally on the Gypsy and Traveller community. In addition, a neighbouring local authority (Salford) has done research into the community health of their Jewish population, which can potentially provide an insight into the types of inequalities Bury's Jewish population may experience.

WIDER DETERMINANTS

Education

As outlined earlier, educational attainment is a key measure of inequalities. There are significant differences in educational attainment by ethnicity. In Bury, Chinese young people have the highest levels of attainment at GCSE level, with 66.7% of young people achieving 5 A*-C. Asian young people in Bury have the lowest GCSE attainment, with 50.0% achieving 5 A*-C. 56.1% of White British children achieve 5 GCSEs at A*-C.

National research suggests that Gypsy or Irish Travellers have the highest proportion with no qualifications of any ethnic group (60%). This is approximately three times higher than that for England and Wales as a whole. No data is available on educational outcomes of the Jewish community from the Salford report.

Housing

Bury carries out a regular housing condition survey. The housing conditions survey looks at the conditions and the energy efficiency of the privately owned and rented housing in Bury. It gives an indication of the number of homes which are substandard and may be hazardous to the health of their tenants. If homes are classified as hazardous they are captured as category 1. Information from the 2013 survey in Bury highlighted that the ward 'Bury East' has the highest proportion of homes which are classified as category 1. Bury East also has the highest proportion of BME residents of any ward within Bury (23.4%). This is significantly higher than the Bury average proportion of BME residents of 10.8%. Therefore, this suggests that those from BME communities may be at an increased likelihood of living in poor quality hazardous homes, which may be creating or reinforcing health inequalities.

'BURY EAST WARD HAS THE HIGHEST PROPORTION OF HAZARDOUS HOMES IN BURY'

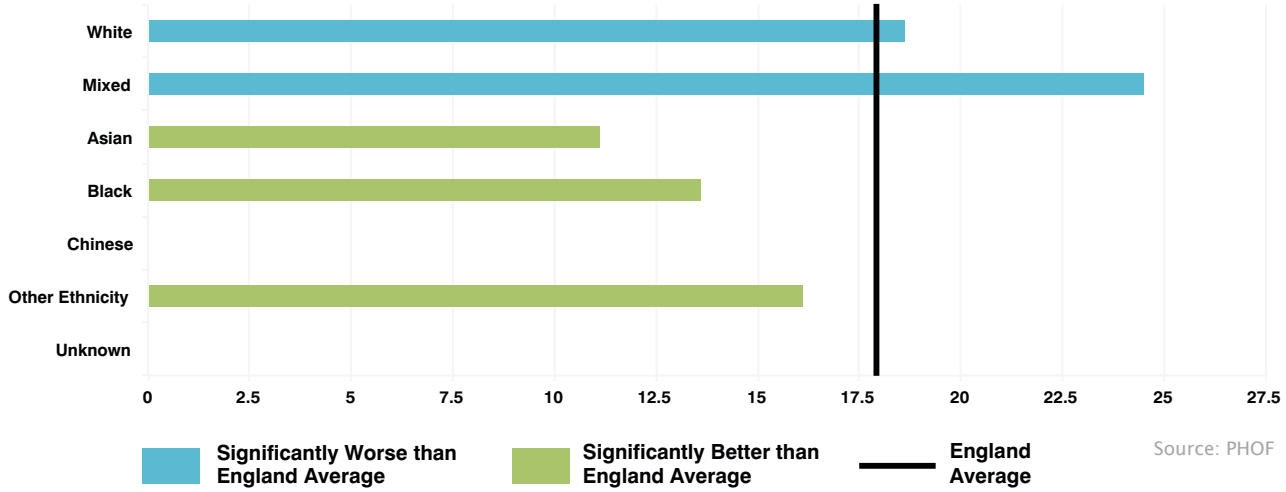
Housing and the impact of housing is a significant issue for the Gypsy and Traveller community. Evidence shows that accommodation insecurity negatively impacts on Gypsies and Travellers physical and mental health. National research also suggests unauthorised and authorised sites are often situated in environments which promote poor health e.g. near busy roads and beside heavy industry. Bury's authorised Gypsy and Traveller site reflects this national trend and is situated next to a civic amenity site (recycling facility) on a road heavily used by industrial vehicles. National evidence from site surveys also indicate that the Gypsy and Traveller community are more likely to experience poor environmental conditions such as vermin, overcrowding, fire hazards, poor drainage and low quality paving, which can contribute to an increase in accidents.

LIFESTYLE RISK FACTORS

Smoking

Smoking remains the biggest contributor to premature mortality, having a significant impact on life expectancy. Groups with higher rates of smoking are more likely to experience poorer health. Smoking rates vary by ethnicity, national figures suggest those who are mixed race have the highest rates (24.5%) with those in the white group having the second highest rate of 18.6%. While the rates within the Asian ethnicity are as low as 11.1%.

Smoking Prevalence In Adults - Current Smokers (IHS) 2014 By Ethnicity



There is no Bury based data on the smoking rates within the Jewish population; however evidence from the Jewish Community Health Research Project done in a neighbouring local authority (Salford) found that 98.5% of respondents to the survey never smoke. Of the remainder, less than ½ percent smoke more than 10 per day. If this reflects smoking habits within Bury's Jewish community the smoking rates are substantially lower than other minority groups.

National data on the smoking habits of the Gypsy and Traveller community suggest 21% are smokers, and these were typically reporting heavy nicotine use (20+ cigarettes per day). This is 3% higher than the national average.

Physical Activity

In Bury, levels of inactivity are lower in those from BME backgrounds (27.7%) than those who are White British (28.3%). This suggests a higher proportion of the BME communities are more active than the White British population. These figures are different from the national data where levels of inactivity are higher in BME groups. This suggests BME groups in Bury are more active than BME groups at a national level.

There is no detailed data providing a breakdown of levels of inactivity by the different ethnicities within the BME group, therefore there could be significant variations within this group, which could mask high levels of inactivity in some groups.

Evidence from the Salford Jewish Community Health research suggests 51% of those taking part in the research met the recommended levels of physical activity, which is significantly below the England average. The research further broke down the data by gender and there was a concern that there was a real lack of physical activity in Jewish men, with only 36.5% meeting the recommended levels of 150 minutes of moderate physical activity per week.

There is no local or national data available on physical activity levels in the Gypsy and Traveller community.

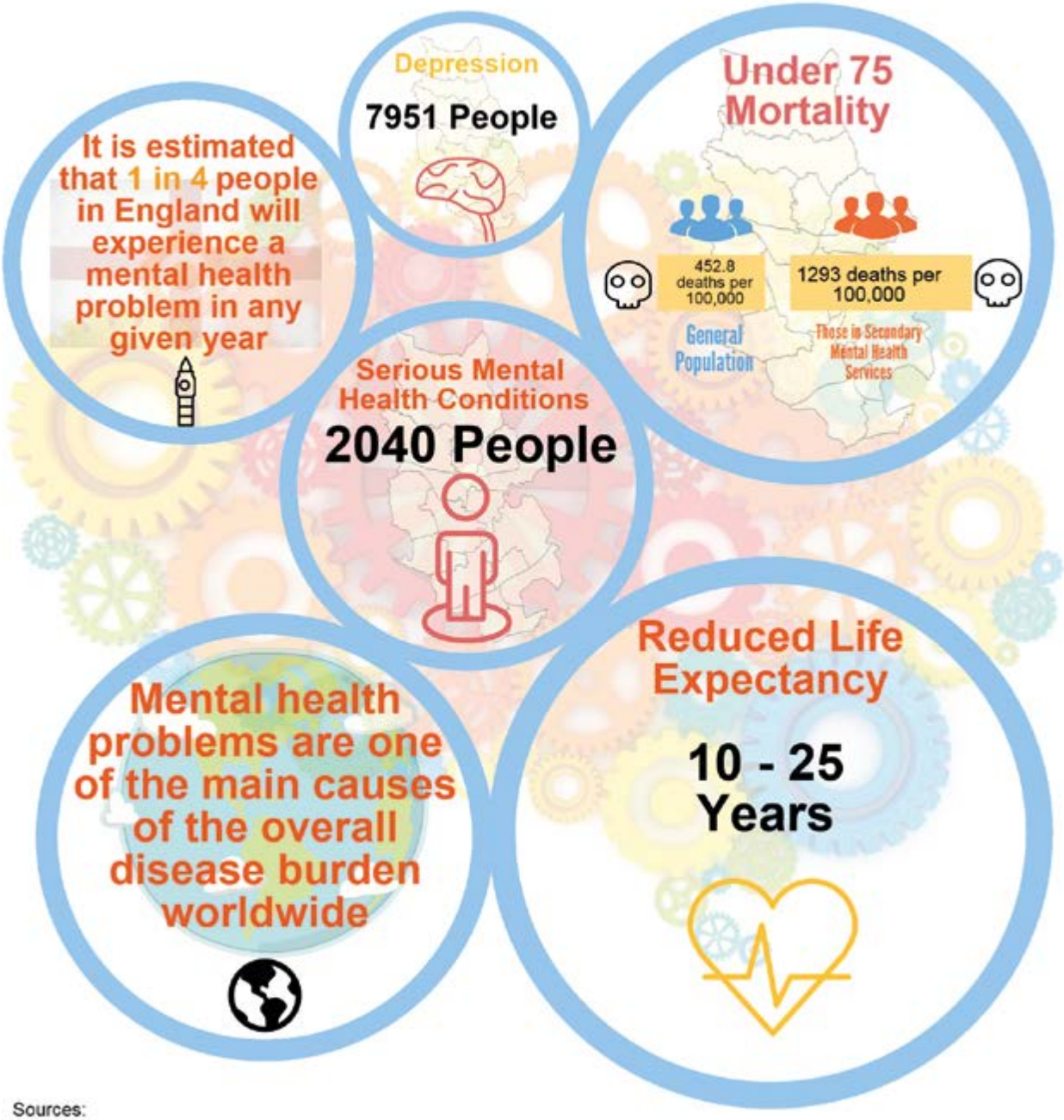
Diet and Obesity

There is limited data available locally on diet and obesity, however nationally, those in BME groups are less likely to eat 5 portions of fruit and vegetables per day (46%) than those in the White British group (52.4%). Local data from a neighbouring Jewish community suggests 25% of their population consume the recommended '5 a day'; over 40% have 3-4 portions with the rest having 3 portions or less. There is no local or national data available on Gypsy and Traveller community fruit and vegetables consumption.

National data shows 11.4% of adults in BME groups are obese, compared with 14.2% of those in the White British group (14.2%). When the BME group is split further, the group with the highest rate is Black with 16.2% obese, and the lowest group is Asian with 9.1%.

In children, obesity is highest in the Black group with 15.4% obese at reception, rising to 25.7% at year 6. Asian children have the second highest rates with White children having the lowest levels of obesity.

MENTAL HEALTH



Sources:

HSCIC

Vos, T., et al. (2013) Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study. The Lancet. 386 (9995). pp. 743-800.

World Health Organisation (2015). Information sheet: Premature death among people with severe mental disordershttp://www.hscic.gov.uk/pubs/psychiatricmorbidity07

McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (eds) (2009). Adult Psychiatric Morbidity in England 2007: results of a household survey. NHS Information Centre for Health and Social Care. [online] Available at: http://www.hscic.gov.uk/pubs/psychiatricmorbidity07

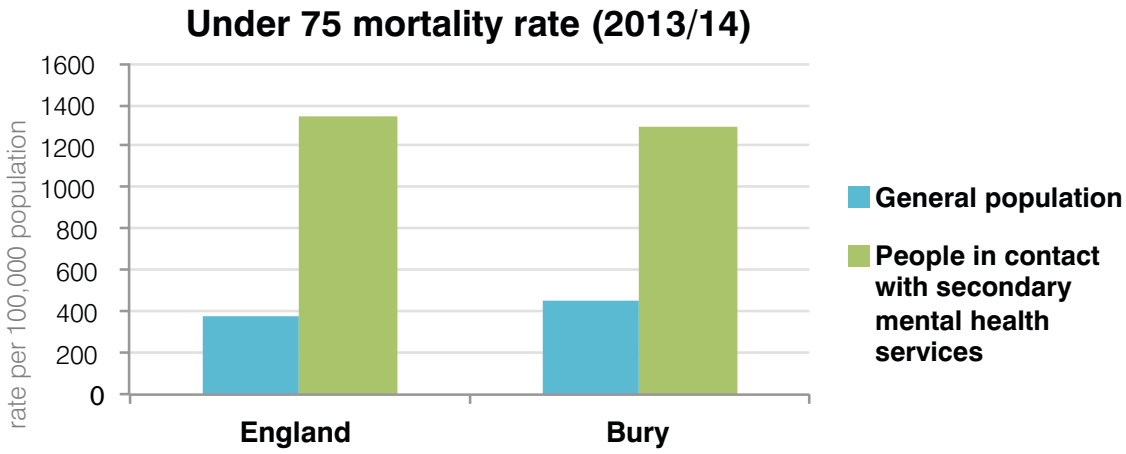
LIFE EXPECTANCY / HEALTHY LIFE EXPECTANCY

This is a measure of the extent to which adults with a serious mental illness die younger than adults in the general population.

Like England, in Bury those who are in contact with secondary mental health services are around three times more likely to die early when compared to the general population.

Mental health was highlighted as a significant factor in the Jewish Community Health Research Project done in Salford. A range of pressures were found to contribute to this, including the pressures of large families and the lack of appropriate culturally sensitive services and support. Over 78% of respondents in the research said mental health has either 'some' or a 'big stigma' related to it (with more females reporting it had a stigma). This stigma seems to be reflected in the reporting of mental health issues with GP data from doctors in the Jewish areas reporting significantly lower levels of depression compared to doctors in non Jewish areas (2% vs 8.1%).

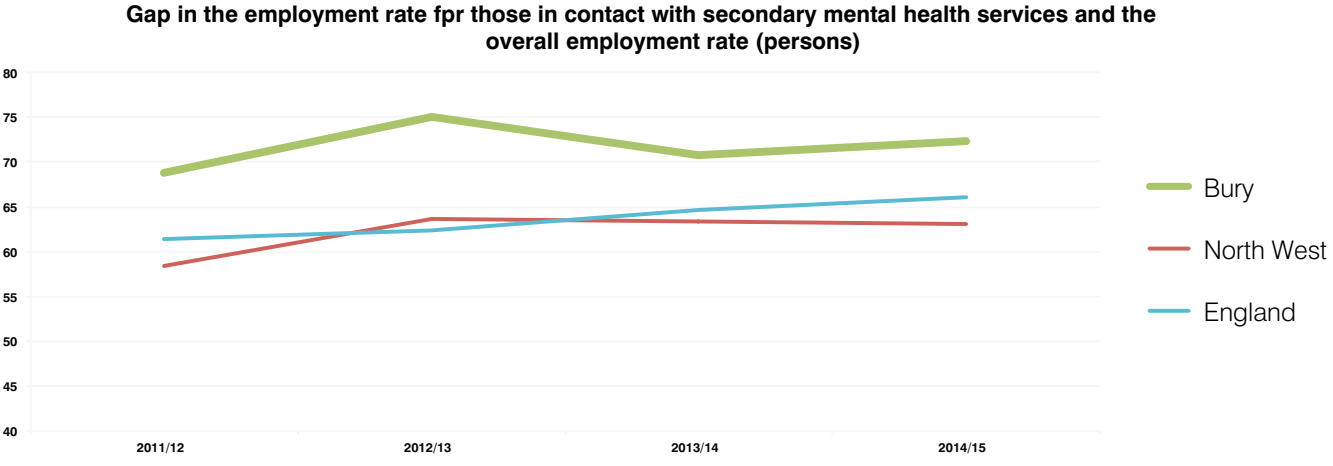
National research on the Gypsy and Traveller community suggests that they are nearly three times more likely to be anxious than average and twice as likely to be depressed.



WIDER DETERMINANTS

Employment

In Bury the rate of employment in those accessing secondary care mental health services is 72% lower than the general population. In addition, this gap in employment rates has been increasing over recent years and is bigger than the gap we see regionally and nationally which is 63% and 66% respectively.



Source: PHOF

LIFESTYLE

Smoking

Tobacco smoking rates amongst people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions. This association becomes stronger relative to the severity of the condition, with the highest levels of smoking found in psychiatric in-patients. It is estimated that of the 10 million smokers in the UK, about 3 million have a mental health condition.

As a result of high smoking rates, people with a mental health condition also have high mortality rates compared to the general population. Therefore quitting smoking is particularly important for this group, since smoking is the single largest contributor to their 10-20 year reduced life expectancy.

Since the mid 1990s, smoking in the general population fell from around 27% to 19% by 2014. By contrast, smoking rates among people with a mental health condition have not fallen and have remained stable at around 40%.

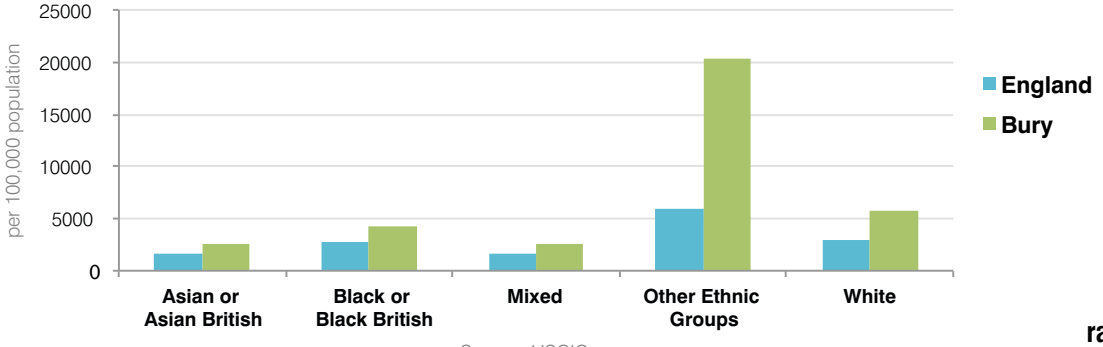
ACCESS TO SERVICES

Overall, Bury has a higher rate of people accessing community mental health services than England as a whole, but generally follows the national pattern:

Data provided by our community mental health provider organisation suggests Asian or Asian British and Mixed are the groups least likely to access therapies, while 'Other' Ethnic Groups are the most likely (especially for Bury, where this group had over three and a half times the rate of the next highest group). It is unclear why there is such a high proportion of those classified as 'Ethnic Other'.

The Black or Black British group is less likely to access therapies than the White group.

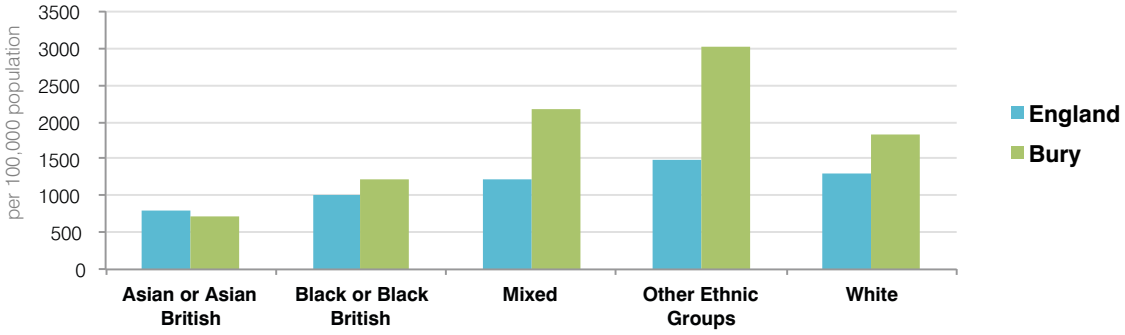
People accessing community mental health services (2014/15)



Source: HSCIC

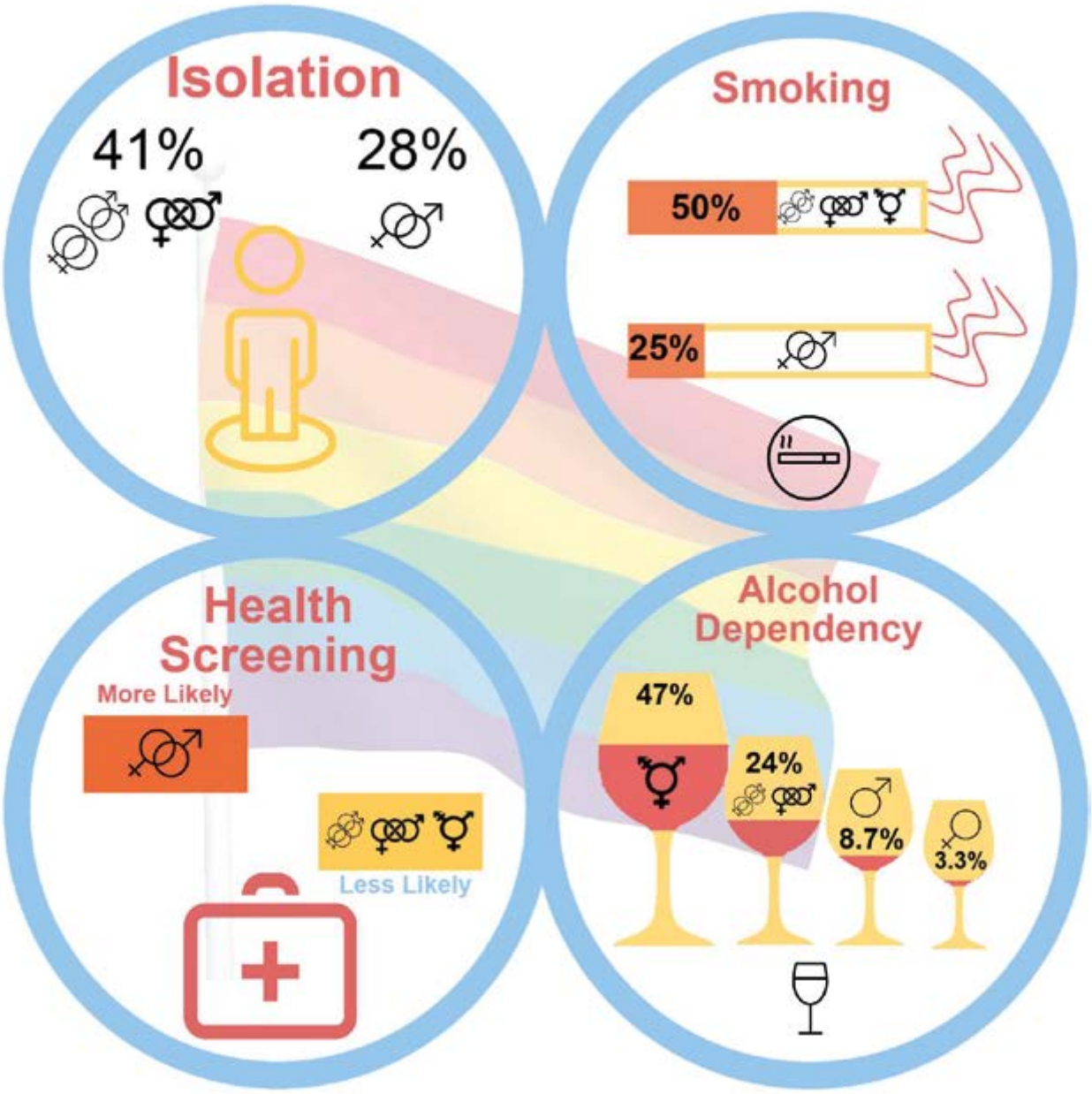
There is no recorded data available on the rate Gypsy and Traveller or the Jewish population accessing community mental health services.

People accessing IAPT services (2014/15)



Source: HSCIC

LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT)



Sources:

Stonewall - Lesbian, Gay and Bi-Sexual People in Later Life, Report 2011

LGBT Foundation - LGBT Communities - A Summary for Joint Strategic Needs Assesment

Part of the Picture:
Lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011)

Statistics on Alcohol, England, 2015 HSCIC

Trans Mental Health Study 2012 - Jay McNeil, Louis Bailey, Sonja Ellis, James Morton & Maeve Regan

There is little formal data available nationally or locally regarding the LGBT community around specific inequalities in health. However, national qualitative research from 2011 suggests that people who identify as LGBT can present particular social care and support needs. Findings indicate older LGBT people are at greater risk of isolation and dependence on services. National evidence indicates around 1 in 20 gay and bisexual men are living with HIV and will require social care and support. In addition, LGBT people are far more likely to report having mental health conditions than the general population. This can lead to longer term health conditions, requiring greater care and support needs. Finally, we know older LGBT people are less likely to have made plans for care in times of serious illness or in old age, compared to peers in the general population.

A number of barriers were identified that can prevent LGBT people accessing the care and support they need. These include poor previous experiences such as abuse, discrimination and hetronormativity (assumption that all people are heterosexual), lack of LGBT-friendly environments for care delivery, discomfort disclosing sexual orientation or gender identity to providers, fear of negative treatment, fear of having to 'go back into the closet' and fear their gender presentation may not be respected in a care environment, especially if they lose mental capacity due to dementia. The realities of these barriers are demonstrated through the low levels of uptake of health screening amongst LGBT people.

These risks and barriers can all potentially contribute to reinforcing inequalities experienced by the LGBT community.

LIFESTYLE

Nationally evidence suggests young LGBT people under 26 are more likely to attempt suicide and to self-harm than their heterosexual peers.

The sample size for the Active People Survey (APS) is not sufficient to produce results at Bury level.

Nationally, those identifying as Gay or Lesbian are a lot less likely to be inactive (16.3%) than those in the Heterosexual group (27.9%).

Substance misuse

Nationally alcohol dependency is greater in the trans, bi and homosexual communities when compared to heterosexual communities. Alcohol dependency is linked to an increased risk of a range of physical and mental health including developing high blood pressure, stroke, coronary heart disease and alcohol-related liver disease. Alcohol dependency is also linked to an increased risk of depression and can impact relationships and the individual's ability to work.

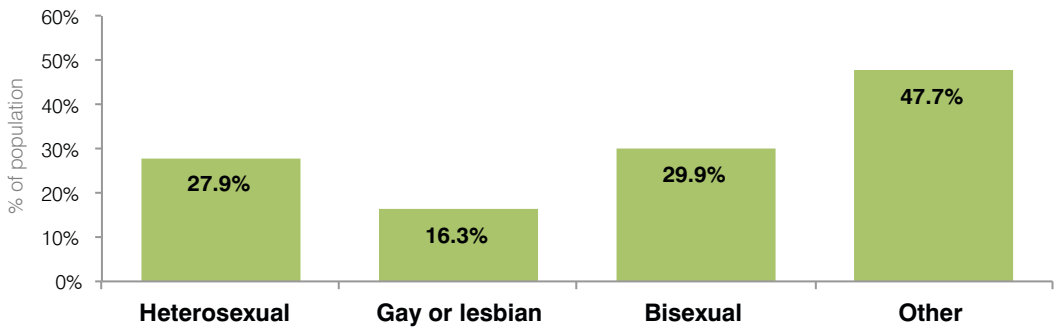
In addition those in the homosexual and bisexual communities are more likely to experience social isolation when compared to heterosexual individuals. Social isolation can affect people's physical and mental health. For example, social isolation is associated with increased risk of coronary heart disease, in part because social isolation and feelings of loneliness can be a physical or psychosocial stressor, resulting in behaviour that is damaging to health, such as smoking.

Lifestyle

Nationally, those identifying as Gay or Lesbian are a less likely (10.4%) to be obese than those who identify as Heterosexual (14%). Those identifying as Bisexual or Other are more likely to be obese, at 18.9% and 19.9% respectively.

Nationally, those identifying as Gay or Lesbian are less likely (50.8%) to eat 5 portions of fruit and vegetables. Those identifying as Bisexual or Other are more likely, at 54.1% and 53% respectively.

Adult Inactivity by Sexual Orientation in England (2013)



Source: Active People Survey

INEQUALITIES BY GEOGRAPHY

This section looks at key inequalities between wards measured by rank. This is based on the Indices of Multiple Deprivation (IMD) score, which is a national measure which looks at data from 7 domains including employment, health, education, skills, crime housing and the environment.

Ranks within Bury
(1=most deprived/highest percentage, 17=least deprived/Lowest Percentage)

Ward Name	Index of Multiple Deprivation (IMD) Score[1]	% Smoking[2]	% Obesity[2]	Alcohol Admissions Rate[3]	Outdoors Living Env Deprivation (Rank of Average Score)[1]	% of Population BME[3]
East	1	1	7	1	1	1
Moorside	2	10	4	3	10	4
Radcliffe West	3	2	1	2	11	9
Besses	4	6	3	5	3	5
Redvales	5	9	5	6	6	2
Radcliffe East	6	3	5	4	7	11
St Mary's	7	5	9	8	8	7
Radcliffe North	8	11	13	7	12	15
Holyrood	9	4	15	9	2	6
Sedgley	10	12	2	11	5	3
Unsworth	11	16	11	12	9	9
Elton	12	13	17	10	14	12
Church	13	15	12	13	13	13
Pilkington Park	14	8	10	14	4	8
Ramsbottom	15	7	16	15	15	14
Tottington	16	14	13	17	17	16
North Manor	17	17	8	16	16	17

KEY INEQUALITIES BETWEEN WARD BY ACTUAL SCORES

The table below outlines the actual IMD score for each ward (the higher the score the more deprived). It also outlines in each ward the proportion who smoke, who are obese, the rate of admissions into hospital due to alcohol, the outdoor living environment deprivation score (the higher the score the worse the living environment) and the proportion of BME residents within the population.

Actual scores/figures

Ward Name	Index of Multiple Deprivation (IMD) Score[1]	% Smoking[2]	% Obesity[2]	Alcohol Admissions Rate[3]	Outdoors Living Env Deprivation (Average Score)[1]	% of Population BME[3]
East	40.94	26.3	21.4	169.3	0.82	27.6
Moorside	39.41	16.6	23.3	143	0.26	16.9
Radcliffe West	30.33	26.1	28.2	146.5	0.26	7.3
Besses	28.57	18.8	23.4	135.7	0.59	11.7
Redvales	28.56	17.3	23.1	126	0.43	26.1
Radcliffe East	28.09	23.9	23.1	139.5	0.43	7.2
St Mary's	23.95	19.6	18.9	118.8	0.43	11
Radcliffe North	22.49	16.4	17.5	122	0.24	4
Holyrood	19.38	21.6	17.4	115.8	0.68	11.4
Sedgley	16.81	15.6	26.2	107	0.51	18.1
Unsworth	16.78	14.9	18.2	106.9	0.36	7.3
Elton	16.55	15.5	16.1	110.3	0.11	7
Church	14.20	15.2	17.8	98.2	0.15	6.3
Pilkington Park	13.19	17.9	18.4	94.6	0.55	9.3
Ramsbottom	11.05	18.2	17.3	92.3	-0.16	4.3
Tottington	9.97	15.4	17.5	88.9	-0.22	2.5
North Manor	7.82	12.1	19.3	89.6	-0.21	2.3

To address these disparities between wards a structured approach is required. Firstly, universal measures are needed to reduce unemployment and improve general health and wellbeing. Then in addition, targeted work is required in the wards with the poorest outcomes. This will then enable those wards with the poorest outcomes to make the largest gains and support the reduction of inequalities.

SECTION 03

WHAT MORE CAN WE DO LOCALLY TO ADDRESS HEALTH INEQUALITIES?

HEALTH INEQUITIES AND INEQUALITIES

Reducing health inequities and inequalities locally is a big challenge; therefore to address this effectively a systematic approach is required. The approach needs to address multiple areas of work including;

- Intelligence – data collection and insight
- Empowerment and advocacy
- Income and employment
- Service provision
- Culture of inequality

There are examples of existing work which is already happening in each of these areas but more can still be done.

INTELLIGENCE – DATA COLLECTION AND INSIGHT

Access to good quality quantitative and qualitative data is the bedrock to identifying, understanding and addressing inequalities within our communities. The production of this report has highlighted that there are significant gaps in the availability of useable data, especially local data relating to different minority ethnic groups and LGBT people.

There are a number of initiatives underway that will help improve the situation. Locally, partners from across Bury have come together to help develop Bury's Joint Strategic Needs Assessment (www.theburyjsna.co.uk). This is a web-based resource that for the first time brings together intelligence from a range of different agencies into a single place to help build a more holistic picture of the needs and assets within our local population. New analytical tools have also been put in place that will allow different data sets to be linked together and the application of market segmentation data, giving greater insights into attitudes and behaviours of different groups.

GM-Connect is an initiative born out of the devolution agenda. It aims to help radically improve data sharing at individual practitioner level, service level and population level by enabling different systems to talk to each other. It does this by creating an information governance system which supports appropriate data-sharing whilst also safeguarding individual confidentiality and privacy.

The ability to share, utilise and analyse existing data sets from different sources will only help bridge part of the existing intelligence gap. There is also a need to improve data collection and recording within services, including equality monitoring. As the old adage goes "Rubbish in means rubbish out". Data collection needs to be accurate, complete and timely and electronically stored to make it retrievable and useable at an aggregated level.

Whilst very valuable, service data cannot tell us much about the needs, assets and experiences of those who do not use services either because they do not need them or because they face barriers to take them up. Therefore, commissioning of primary research, particularly qualitative research to generate understanding and insight is vital.

LOCAL EXAMPLE

Whilst not in Bury, our neighbours in Salford have undertaken some good work in this area which has relevance to the Bury population that we can learn from.

NHS Salford Clinical Commissioning Group (CCG) initiated the commissioning of a piece of work to assess the health needs of the Salford Jewish Communities, whilst exploring the best methods of engagement with the communities. They worked hard to ensure that all sections of the community were represented. The work included training peer researchers, peer lead focus groups and the use of surveys. From the findings they were able to develop a report outlining the health behaviours and challenges experienced by the Salford Jewish Community. They were then able to make a series of recommendations about how these challenges could be addressed effectively.

Without this research there would have been no clear understanding of the health behaviours and challenges experienced by the Jewish Community. Therefore, it would have been unclear as to how to best address any health issues identified. The report will support Salford CCG in making a range of decisions around service developments and commissioning of services and will help to ensure that resources are well spent and will have maximum impact.

RECOMMENDATIONS

- Team Bury to establish and oversee a programme to enable and ensure robust, systematic and comprehensive equality monitoring across services provided by Team Bury partners.
- Establish a programme of qualitative research as part of the ongoing development of the JSNA to generate insight into the needs, assets and experiences of equality target groups living within Bury.
- Establish a programme across Team Bury to move all services to paperless mobile electronic systems in order to optimise the potential of the GM-Connect programme.

EMPOWERMENT AND ADVOCACY

'Empowerment has been defined as the capacity of individuals, groups and/or communities to take control of their circumstances, exercise power and achieve their own goals, and the process by which, individually and collectively, they are able to help themselves and others to maximize the quality of their lives'.

Social movements and advocacy are key vehicles through which to help empower marginalised people and mitigate and overcome the causes and effects of social exclusion, prejudice and discrimination.

Social movements involve a collection of individuals organising together in the pursuit of shared goals. The goals of social movements are often around securing more equitable control over resources, achieving greater representation in local politics, gaining fair access to services and markets or decent living and working conditions. Participation in social movements and networks can also have a direct impact on an individual's health and wellbeing by widening access to skills and resources, supporting resilience and building confidence.

Similarly advocacy can be seen as related to people's rights. Advocacy involves working on behalf of others to help them understand their rights, helping them be heard and empowering and supporting people to take action to assert their rights.

A strong and vibrant voluntary and community sector is vital for stimulating and supporting people to come together to find their voice and take action to maximise and improve their quality of lives. Community and voluntary organisations are often run by those people they intend to benefit, putting people in control of their own lives. The sector also tends to be closer to and able to identify, articulate and be more responsive to the needs of different marginalised groups. They also have the ability to make a little go a very long way. In short, the sector can fulfil a critical role of meeting demands that cannot be met by the public and private sectors and therefore in addressing inequalities.

The role of the public sector is to help create the conditions in which the community and voluntary sector can flourish and to foster collaboration with the sector as equal partners beyond seeing them merely as alternative providers. Effective collaboration between the sectors can have a multiplier effect which helps harness individual and community assets more effectively, strengthens democracy and community resilience, supports economic growth and development and improves outcomes.

Through 'Neighbourhood Working', work is underway to strengthen community engagement mechanisms through redevelopment of the Township Forums, the development of participatory budgeting and strengthening of the volunteer base in each neighbourhood. Dialogue has also been initiated with voluntary and community sector organisations about the future of the sector. Furthermore there has been recognition of the need to change the power dynamic between professionals and individuals engaged with public services to one of co-production where there is an equal and reciprocal relationship between the two.

LOCAL EXAMPLE

Empowerment and Advocacy is taken very seriously within Bury and as such Bury Parents Forum (BPF) are commissioned by Bury Council. BPF is an organisation created by families for families, and aims to empower parents and professionals to make informed choices. They deliver a number of activities related to the Special Educational Needs and Disability agenda.

BPF held participation events with families and were instrumental in the Short Breaks Tender process ensuring that parent's voices were heard and the services commissioned met parents needs.

In addition they provide

- Mystery shopper activities to scrutinize Bury's Local Offer.
- Parenting support on Autistic Spectrum Disease and Attention Deficit Hyperactivity Disorder pathway planning.
- Provide support for the Children With Disabilities team and the Additional Needs team with the Enhanced Health Care Plans and person centred planning.

RECOMMENDATIONS

- Team Bury consider how to ensure robust & sustainable infrastructure support is provided to the community and voluntary sector in Bury.
- Ensure the developing community engagement mechanisms within neighbourhoods extend to, reach and empower marginalised individuals and groups.
- Ensure voluntary & community sector organisations are equal partners in the design and delivery of neighbourhood working.

INCOME AND EMPLOYMENT

Income is the basic prerequisite for achieving a decent quality of life. For most people income is expected on the whole to be attained directly or indirectly through employment. Access to good quality employment that pays the living wage is therefore a key driver for enabling participation in society and improving health and wellbeing.

As we have seen, significant inequalities exist in employment with higher rates of unemployment being experienced by those with a disability, mental health problems and BME groups.

There are a number of national programmes which aim to support people into employment such as the Work Programme and Work Choice but overall they have not been successful in securing sustainable employment for those with the greatest barriers to work.

Access to Work grants are available for individuals who have a disability, physical health or mental health condition who need practical support to stay in work, move into work or self employment. This support can be in the form of equipment, help with travel, a work place job coach and disability awareness training in the workplace.

In Bury there are a number of work initiatives that support people with complex barriers to return to and sustain work. The overarching focus is that 'good work is good for your health and wellbeing'. This includes the Greater Manchester Working Well programme which is designed to support those who have been unemployed for a significant period of time to systematically identify and remove the barriers that prevent good employment.

Bury has been chosen as one of four areas within Greater Manchester to pilot a GP referral route into the Working Well programme which is successfully demonstrating the correlation between good work and good health. Of key importance is the development of partnership working across other supportive services to collectively reduce duplication and ensure the customer journey is simple, productive and work focused.

Other work related programmes in the borough include Six Town Housing: Steps to Success, Greater Manchester Skills for Employment, Greater Manchester Talent Match and Bury Council's commissioned Radcliffe and Prestwich Works. In addition, in October 2016 Bury Council are planning an Employment, Health and Skills Summit. This is an event to provide information, advice and support for people with disabilities to get into and remain in work. It is also an opportunity for individuals with disabilities to engage with employers and skills providers on opportunities to make the most of their assets and the wider health support on offer across the borough.

Bury is also one of 10 chosen pilot areas across England that is delivering a Carers in Employment project. This aims to support working carers to access local services, information and the use of free assistive technology so that they can remain in the work place. This also assists employers to retain valuable staff.

Bury has a dedicated Health and Employment Officer who is responsible for bringing together the two agendas of Health and Work across the borough. This has included working with local businesses in order to assess their current workforce in relation to health and wellbeing, providing advice and guidance, implementing support and good practice where needed and supporting organisations to be recognised locally and nationally as an employer who looks after the health and wellbeing of their workforce.

Skills and skills development across Greater Manchester, and the ongoing discussions surrounding the devolutions of skills budgets to the City region, will have a direct impact on income levels. Ensuring local people can access skills and training provision that meets employer's needs, will increase career mobility and access to higher quality jobs.

For those unable to manage with the income they get, debt can become a huge problem leading to or exacerbating ill-health. It is essential to adopt a new approach which effectively supports with the real issues of debt and welfare by empowering the person and enabling individuals to take control of the high costing cycles of debt and welfare will continue and we are at risk of widening the gap of inequality and poverty in Bury.

In Bury, this has been recognised and for a number of years Citizens Advice Bureau (CAB) has been funded to be based in GP surgeries across the borough. More recently, not for profit organisations such as Supportive Stem, who help individuals with debt and welfare issues, yet empower them and give them the tools to be able to cope and help themselves in the future, have become involved in community work.

LOCAL EXAMPLE

Supportive Stem Community Growth is a not for profit organisation based is Bury. It is specifically designed to support people with debt and welfare issues, preventing further issues, improving health and wellbeing and creating positive personal growth. They deliver a person centred approach, designed to meet the needs of the individual, by empowering the person, teaching self-help and promoting coping strategies. By dealing with all issues at a single point of contact, time delays are prevented, unnecessary signposting avoided and high costing duplication is removed. Adopting an early intervention approach empowers the person and puts them back in control. This helps to prevent crisis management, improve health and wellbeing, and avoid high costing cycles of debt and poverty.

RECOMMENDATIONS

- Work with employers to ensure workplaces are conducive for people with disabilities (physical disabilities, learning disabilities and mental illness) to work in.
- Extend the concept of Bury Council and Six Town Housing Employee Engagement Groups to other employers in the borough.
- Review the extent to which income maximisation, debt management, skills development and employment support programmes and services are addressing the needs of equality target groups.
- To work with employers to become aware of and utilise the resources and support in the borough, to prevent people leaving work due to health conditions and making better use of national support such as Access To Work.

SERVICE PROVISION

Universal services are essential to ensuring everyone in society achieves a decent standard of living. Having the potential to be in contact with every member of a target group means universal services are best placed to mitigate inequities and inequalities. They are also essential for prevention and provide an opportunity to identify issues and problems as they start.

Research shows there is a clear social gradient with those in the lowest social groups having the worst health outcomes and those in the highest having the best. This reinforces that not all resources should be targeted solely at the most disadvantaged groups and each social group should be supported proportionately to how much they need it. This concept of providing appropriate levels of support was badged 'Proportionate Universalism' within the 2010 Marmot review. It recognises that different groups and individuals need different levels of service and support to achieve the same outcomes.

Although the provision of universal coverage is essential for achieving equity, this report highlights how inequalities still exist in universal systems. Targeted interventions in the context of universal provision can help to flex and tailor that provision to better meet the needs of specific target groups. It should be noted that there can be a danger associated with targeted provision in isolation of universal provision of further marginalising and stigmatising intended beneficiaries.

LOCAL EXAMPLE

Bury's 'I Will If You Will' programme is part of Bury's Leisure and Wellbeing provision which specifically focuses on getting women and girls in Bury active.

The programme is based on research to understand the barriers and drivers that influence women and girls participation in physical activity. It combines innovative marketing techniques with sports sessions and exercise classes specifically designed to overcome the hurdles that stop women taking part. These can be physical barriers - such as location or time - or emotional ones, such as a lack of confidence or the feeling that sport 'isn't for them'. The programme offers a host of activities from bootcamps to zumba and as a result over 14,000 women have signed up to the programme with an average of 840 attending organised activity sessions each month.

RECOMMENDATIONS

- The value of universal elements of service is fully considered in the development of new systems of service delivery.
- For equity audits and action plans to become embedded standard practice within all services and included in contract monitoring and commissioning reviews.
- For Leisure and Wellbeing services to extend the learning from the 'I Will if you Will' programme to other equality groups and act as a model of best practice.

CULTURE OF EQUALITY

There has been a great deal of valuable work undertaken in Bury to promote community cohesion. Bury has a pro-active approach to hate crime with an emphasis on working with young people. Bury's approach includes work in Schools through initiatives such as the Be Safe Be Cool, Hate Crime Disability Awareness Days, Diversity Days, Inter-school Youth Hate Crime Forum, the Walking Rainbow March and more recently, a multi-faith event run with input by young people called 'the Collabor8 event'.

Strong partnerships have been developed over the past few years placing us in a good position to harness opportunities to work with partners and through the community. In particular, this partnership approach is valued by the work of Bury's Strategic Interfaith Group and the Greater Manchester Police (GMP) Forcewide Hate Crime Working group.

Also as a statutory duty, Bury has taken a measured approach to the Governments Prevent and Channel programmes, bringing together partners who are both willing and able to support and safeguard individuals in the borough of Bury from being radicalised and being drawn into extremist or terrorist behaviours. Work across sectors has allowed Bury to address a number of issues in such a way that brings positive outcomes for the individuals concerned and will allow us to share good practice across the Greater Manchester conurbation.

Sadly following the 'Brexit' vote, incidents of reported hate crime and abuse have increased nationally and within Greater Manchester. Questions are being raised about whether we are becoming a less tolerant society or whether those who have long harboured prejudice against others feel they have more legitimacy to make their feelings known. However, the strong relationships between the council, police, third sector organisation, faith groups and other bodies within Bury are working hard to ensure potential issues are identified and addressed early.

Generating a culture of equality goes beyond the prevention and management of discrimination, hate crime and abuse. The concept of 'valuing diversity' recognizes differences between people and moves beyond tolerance of difference to a celebration. Differences become a valuable asset which are embraced and made positive use of and by doing so enrich everyone. It involves bringing people from diverse backgrounds together, learning and understanding of different values and building appreciation.

Because discrimination and prejudice is often hidden and indirect, positive, proactive and outward signals can be a valuable tool in setting tone and expectations.

LOCAL EXAMPLE

To support addressing inequalities a number of GP Practices including the Fairfax Group Practice in Prestwich have taken on the 'Pride in Practice' support package enabling them to more effectively meet the needs of lesbian, gay and bisexual patients. The 'Pride in Practice' award demonstrates a practice's commitment and dedication to a fully inclusive patient-centred service which ensures the experiences of lesbian, gay and bisexual people using health services are positive.

Dr. Luke Wookey, GP Partner of Fairfax Group Practice, said: "We know the importance of having an open, honest and trusting relationship with your GP is important for everyone, and we strive to deliver excellent and personalised care to every single patient."

Dr. Wookey added "Achieving the GOLD award, means that for lesbian, gay and bisexual people who have had negative experiences of health care before, can be confident that at Fairfax Group Practice, they will be treated with respect and as an individual, like every other patient. We want to make it clear that everyone regardless of sexual orientation, race, faith or anything else - all patients will receive excellent treatment here."

RECOMMENDATIONS

- Build a proactive 'Valuing Diversity' programme into the Neighbourhood Community Engagement programme to complement existing community cohesion work.
- Extend the concept of Bury Council's 'Equality Champion' programme to other employers within the borough.

CONCLUSION

As with other areas of the country, inequalities are having a significant impact on quality and length of life of Bury residents. This report shows that in addition to geographical inequalities, persistent health inequalities are experienced by different groups as a result of barriers to accessing services and resources, social exclusion, stigma and discrimination.

A great deal of work is already happening to address these inequalities which is to be celebrated but as always there is more we could do. I hope I have provided a guide to some of the more structural ways in which we could build on and support existing efforts.

We are at the beginning of far reaching transformational change to the way public services are provided in Bury and in to the how these services work with communities. This provides an ideal opportunity to think long and hard about how through this transformation, we ensure Bury is a fair, rewarding and pleasant place for all.

APPENDIX 1

PUBLIC HEALTH ANNUAL REPORT 2013/14 DIRECTOR OF PUBLIC HEALTH RECOMMENDATIONS

Contribution	Recommendations	Update
The Best Start in Life	» Maximise the full contribution of Bury's existing resources aligned to the implementation of the Greater Manchester Early Years New Delivery Model. » Strengthen the relationships and mechanisms between all services involved in early years provision, including General Practitioners (GPs), to ensure all those eligible for services are offered them and receive timely, co-ordinated and effective support. » Review the scale of provision of the Family Nurse Partnership in relation to local need.	Early Years Services have been mapped across Bury with the intention of reducing duplication and addressing barriers to the implementation of the model. A project has commenced with the outcome being a fully integrated service for children and young people in Bury. The objectives of the project are as follows: » Improve outcomes for children and young people; » Establish a project team and governance structure; » Map and analyse current provision; » Consult with a wide range of children, young people and key stakeholders to understand their views on the current services and expectations; » To procure appropriate service provider's to help develop and deliver an innovative and suitable service for the children and young people of Bury; » To align Health and Social Care services in Bury and reduce duplicity of services; » To improve data storing and sharing systems; » To commission a cost effective service; » To make use of community assets to support services as appropriate; » To develop a single outcomes framework; » Shared risk and returns across both organisations. » The Starting Well Partnership Board have been meeting regularly since January 2015. The Board is enabling and supporting this wider project. » The Family Nurse Partnership has been included in the scope of the integrated Children and Young People's service and will be reviewed accordingly.

Contribution	Recommendations	Update
Healthy Schools and Pupils	» In conjunction with schools and key partners design, develop and embed a local comprehensive Healthy Schools Programme.	Initial stakeholder workshops have been held to inform scope and designing of the programme. A Healthy Schools Project Lead has been appointed to further design and develop programme, in conjunction with stakeholders.
	» Ensure alignment of the School Health Service with the new Healthy Schools Programme.	The School Health Service for Bury was retendered (Pennine Care NHS Foundation Trust were awarded contract in April 16). The specification for the service requires alignment with the Healthy Schools Programme and the service is a key stakeholder in the redesign of the programme.
	» Introduce a regular school-aged children health survey to enable better identification of health needs and trends and support prioritisation of service delivery.	The new School Health Service is required to develop school health profiles. No further progress has been made in the current year to develop and implement a school-aged children's health survey but this intention has been carried forward to next year.
	» Review the provision of advice and support available to help school-aged children make health-related behaviour changes.	The availability of advice and support for school aged children was a key component of the tender and specification for the School Health Service. This includes the provision of drop-in sessions within the school setting. The Healthy Schools Programme will be a key vehicle to facilitate and support health-related behaviour change.
Helping People Find Good Jobs and Stay in Work	» Embed commissioning for social value. The Public Services (Social Value) Act 2012 requires public authorities to have regard to economic, social and environmental wellbeing in connection with public services contracts and for connected purposes. Bury Council should publicise how it is applying the Act in its commissioning and encourage other local businesses and organisations to commit to the spirit of the Act. Bury Council should also use the Act to enhance employment opportunities for those classed as NEETs.	» Develop and implement a local workplace health programme to support local employers to implement the Good Work: Good Health Charter. This is the Workplace Wellbeing Charter for Greater Manchester. It is a toolkit and guide to help businesses on the issue of health, work and wellbeing.
	» Develop and implement a local workplace health programme to support local employers to implement the Good Work: Good Health Charter. This is the Workplace Wellbeing Charter for Greater Manchester. It is a toolkit and guide to help businesses on the issue of health, work and wellbeing.	A healthy workforce booklet was developed in March 2016 giving easy to read information relating to the support available to local businesses. Contact has made with 133 businesses through 3 business events, GM Growth Hub referrals and other avenues. 11 businesses have been engaged and a further 5 visits in the pipeline. Action plans are being developed for 5 businesses referred by the GM Growth Hub. Businesses are also being supported to achieve the Healthy Catering Award with colleagues from Environmental Health. Businesses have the option to complete the workplace wellbeing charter.

Contribution	Recommendations	Update
Helping People Find Good Jobs and Stay in Work	» Implement the Greater Manchester 'Work and Health' programme. This programme aims to change the culture among health professionals, employers and individuals to move away from the assumption that sickness means absence from work and to recognise the rehabilitation benefits that remaining in or returning to work can bring.	This programme is in the development stage. The November 2014 devolution agreement gave GM the opportunity to be a joint commissioner with the Department for Work and Pension (DWP) for the next phase of the Work Programme. GM has been working closely with DWP and has used learning from Working Well to help shape the design thinking for the national Work & Health programme.
	» Bury Council should commit to becoming an exemplar healthy workplace for the borough.	Bury Council launched its Workforce Wellbeing Strategy 2016-2020 in March this year. It has an associated action plan, which will support the Council to achieve its strategic outcome of 'good health and wellbeing for all employees', under the 3 key areas of healthy and active lifestyle, healthy workplace environment and healthy mind. Our progress will continue to be monitored via wellbeing questions in the employee survey and sickness statistics.
	» Develop a strategy for economic growth which aims to reduce inequalities within the borough.	The Economic Strategy and its associated initiatives will continue to be implemented. This will be supported by a Growth Plan that will set out the overarching direction for growth within the borough over the next 20 or so years. This growth will relate to physical and economic growth in terms of new homes and job opportunities for residents. The benefits from growth will be re-invested back into the borough to reduce inequalities and to support our services.
Active and Safe Travel	» Develop and implement an Active Travel Strategy for Bury.	Transport for Greater Manchester has obtained funding and taken the lead in promoting active travel for work, to school and in general for personal travel planning.
	» Walking and cycling considerations should be embedded and prioritised within transport and land use decision making. (This could be furthered by committing to rejecting proposals whose impact on walking and cycling will not be positive).	The 'saved' Unitary Development Plan policies already provide some support for decision making in favour of active travel. The Greater Manchester Spatial Framework and Bury Local Plan should include policies and proposals which will result in developments and physical infrastructure that encourage active travel.

Contribution	Recommendations	Update
Warmer and Safer Homes	» Ensure that the challenges around the Better Care Fund (BCF) for adaptations and other assistance for safer homes are mitigated and that the opportunities presented by the Fund are realised.	Involved in discussions about use of the BCF for major adaptations and agreed appropriate allocation for 15/16 and 16/17: mitigating any risks.
	» Significantly strengthen joint working around strategy and programmes relating to the reduction in falls associated with property condition.	Alignment of the housing and health agenda continues to develop building a strong platform for further developments.
	» Map out the current services which tackle property condition linked to falls. Consider the development of services or programmes to tackle this issue, including in particular the development of handyperson schemes, and link these with hospital discharge schemes.	A review of falls treatment and prevention pathways has been undertaken and the next step will be to consider how to support improvement where property condition is a factor.
	» Improve intelligence of specialist housing provision and projection of future needs across the borough in order to identify and plan for future requirements.	Work is being undertaken across departments to understand the local picture drawing on Greater Manchester research and opportunities.

Contribution	Recommendations	Update
Warmer and Safer Homes	» Undertake an equity audit to understand leisure centre use among different groups in the borough.	A customer response management system has been developed to get better user data, this has supported learning and insight developed through IWIYW. Next steps are to develop wider wellbeing services with improved data capture.
	» Develop a leisure centre 'without walls' approach to future provision.	As part of the leisure offer Bury now has outdoor gyms in 5 parks, there has been an ongoing refurbishment programme for play areas and tennis courts and a range of sustainable activities have been set up in the community through the 'I Will If You Will' (IWIYW) programme.
	» Expand the Welly Café concept across the borough.	This concept has been embraced within the plans to develop neighbourhood working.
	» Work with health and social care professionals to embed physical activity as part of prevention, treatment and care plans.	The CCG and Public Health have jointly developed an initiative aimed at reducing the numbers patients undergoing elective (planned) surgery who smoke and/or are obese. The scheme aims to capitalise on this 'teachable' moment (the patient's planned or anticipated surgery) to encourage the patient to make a lifestyle change and thereby improve their chances of a positive surgery outcome and more importantly make a change that will have significant health and wellbeing benefits in the longer term.
	» Establish an annual walking festival in the borough maximising use of green spaces.	An externally funded walking officer has been appointed and is in position. In addition a programme of walking activities has been put in place along with numerous Sport England 3-2-1 runs/walks established in several parks.

Contribution	Recommendations	Update
Strong Communities, Wellbeing and Resilience	» Adopt participatory budgeting methodology as a mainstream mechanism for allocating funds to local community initiatives and for engaging local people in resource allocation decisions.	Bury Council are currently refreshing the Township Forum meetings and Community Grant process to align them to Neighbourhood Working. Our aim is to re-shape the Township Forum meetings so increase community engagement at a ward level and so they incorporate two Participatory Budgeting (PB) meetings per year and this becomes the new way of allocating all Community Grant funding. We are trying to reduce red tape and make the process for PB and grants much simpler and utilise innovative ways of monitoring spend. We are also trying to bring together all known funding sources available to communities into one place on the Bury Directory so that it is easy to find for both Local Cllrs and the community.
	» Ensure strong and sustainable support to maximise the role of the community and voluntary sector.	This is one of the Cabinet Member for Communities and Safer Neighbourhoods priorities for this year. A workshop is scheduled to invite all community and voluntary sector groups to come together and discuss how to 'ensure strong and sustainable support to maximise the role of the community and voluntary sector'.
	» Develop scaled and coherent mechanisms for community engagement and asset-based community development across all Team Bury partners.	The Social Development Team seeks to provide the support that will create the conditions for effective community engagement and asset-based community development. The team brings together self care programmes, public health campaigns, The Bury Directory, the Township Forums and Community Grants process and a communications function into one team to support the Neighbourhood Working agenda. Neighbourhood Working means working at neighbourhood level to help communities to help themselves, build social capacity and develop and utilise community assets. For those that need greater support, create a multidisciplinary approach to providing services, based in the neighbourhood that will work together to provide the best outcome for the person and wider community. A volunteering strategy and programme for each neighbourhood is also being developed.

Contribution	Recommendations	Update
Public Protection and Regulatory Services	» Introduce restrictions to limit the provision and concentration of takeaways, particularly near schools.	Public Health and Strategic Planning and Development have identified a need to control of hot food takeaways. There is currently no recognised parent policy within the Council's Unitary Development Plan. A decision has been taken to consider this issue as part of a Supplementary Planning Document (SPD) covering a wider agenda of Planning and Health.
	» Bury's Air Quality Action Plan (2002) needs to be updated and linked to an Active Travel Strategy.	Consultation is currently taking place on Greater Manchester's Air Quality Action Plan. Work is being undertaken to develop and deliver active travel activities identified in the Physical Activity Sport Monitoring Framework.
	» Work with partners, businesses and communities to develop and implement a strategy to limit and mitigate the effects of climate change.	Bury council are working with Climate UK and the Environment Agency to develop a matrix to measure progress with the adapting to climate change agenda. Following the Boxing Day storm, support and guidance on flood recovery and resilience was provided to those affected in both domestic and commercial properties as a result advice is now provided on our website.
	» Develop a multi-agency sustainable development strategy for the Borough	A public sector Strategic Estates Group has been formed to ensure sustainable use of public assets.
Health and Spatial Planning	» Adopt the Spatial Planning and Health Group Checklist.	It is recognised that this list is useful in matching national planning policy priorities with public health priorities and has been identified as a major driver for forming a scope for the Planning and Health.
	» Embed Health Impact Assessment (HIA) within the planning process.	This is a long-term goal which will ideally require the formation of an agreed approach towards HIA. The proposed Planning and Health SPD can then provide the impetus for requiring HIAs to be carried out.

Contribution	Recommendations	Update
Health and Social Care	» Review and redesign existing health improvement services to create a single, holistic, healthy lifestyle service.	At the end of 2015, the service adopted a new team name – 'Lifestyle Service', and new leaflets to promote the service were created. The service is now in the process of being reviewed as part of a creation of a Wellbeing Service.
	» Develop and implement a system-wide cohesive digital self-care offer which supports individuals to adopt healthier lifestyles, self-treat minor ailments and self-manage long-term conditions.	Aligned to The Bury Directory, a conversational tool called the 'Quality of Life Wheel (QOLW)' is in development. This highlights which aspects of the person's life is going well and then offers wellbeing plans for the areas of their life that they need support to improve. The wellbeing plan provides information and advice pulled from the Bury Directory and NHS CHOICES that could help and a section on self care courses or Adult Education Courses that could support the person.
	» Embed systematic, scaled primary and secondary prevention within primary care.	The Better Together scheme was rolled out in general practice in Bury in 2015/16. Jointly commissioned by Bury Council and Bury CCG, it was an incentive and support programme to drive up identification of the missing thousands from high risk and disease registers in primary care and ensure systematic best care for all patients. It included a range of medical and healthy lifestyle interventions.
	» Further develop the Healthy Living Pharmacy scheme.	The GM Health and Social Care Partnership (GMHSCP) are currently developing a Standardised GM wide Healthy Living Pharmacy model. Public Health intends to work with GMHSCP to drive this forward locally.
	» Review intermediate care and reablement services to create a greater focus on promotion of independence and rehabilitation.	The intermediate care pathway in Bury was reviewed in 2015 and, since then work has been undertaken to remodel the offer. This includes moving towards a fully operational seven day service, effective discharge planning and embedding a trusted assessment process. This will be secured through an alliance contract which organisations within the pathway will be expected to sign up to.

REFERENCES

Adams, R. (2008)
Empowerment, Participation and Social Work.

Kings Fund (2012)
Clustering of unhealthy behaviour over time.

Kings fund (2015)
Inequalities in Life Expectancy – Changes over time and implications for policy.

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

The Traveller Movement (2016)
Impact of insecure accommodation and the living environment on Gypsies' and Travellers' health.

Weinberg, J and Mann, S. (2015)
Salford Jewish Community Health Research Report.

World Health Organisation (2015)
Information sheet premature deaths amongst people with severe mental disorders.

Public Health
1st floor
3 Knowsley Place
Duke Street
Bury
BL9 0EJ

For further information contact Public Health on 0161 798 6790 or email publichealth@bury.gov.uk