public health
annual report 2009
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As this will be my last Public Health Annual Report as the Joint Director of Public Health for the Borough of Rochdale, I thought it would be interesting to reflect on what has changed in the Borough since I took up this post on the 1st October 2002.

In that time the Local Strategic Partnership work promoting good Health and Well Being has strengthened. Some of the more tangible measures of this are the appointment of a council health improvement officer and the establishment of the Joint Health Unit. In addition Health and Wellbeing is now firmly established as a priority area for the Partnership and a key part of Pride of Place.

The Health statistics over this time period also reflect this improvement. This is reported in more detail in the body of this report but it is worth noting that life expectancy has increased over the period between 2001-3 and 2006-8: from 73.8 years for men to 75.6 years and from 78.8 years for women to 79.8 years.

Over this time we have also seen the age standardised death rates for Heart Disease fall significantly and those for cancer also reduce. The age standardised death rate is a statistical method that allows us to compare Rochdale figures with those of other Boroughs with different age and sex profiles in their populations.

The ASDR for cardiovascular (heart) disease has fallen from 148.10 in the period 2002-4 to 105.59 in the period 2006-8. More importantly the rate in the worst off 3% of the Borough i.e. those suffering the worst inequalities, has fallen from 234.73 to 189.59 in the same period. The ASDR for cancer has fallen from 144.73 in the period 2002-4 to 120.89 in the period 2006-8 and the rate in the worst off 3% started at 176.94 and increased to 218.29 initially; however this has recently fallen back to 188.46 just prior to the recent cancer chancer campaign. I believe that this innovative social marketing campaign will have helped us to reduce these figures even more.

With the worldwide recession and the resulting local economic impact these are challenging times for the Borough; however one thing I’ve learnt since first coming to work in the Borough of Rochdale in 1992 is that this Borough is well placed to meet that challenge. The people who work and live in the Borough are fully aware of these challenges and are committed to meeting them head on and will turn them into opportunities to improve the Borough further.

I have really enjoyed working with and for the residents of Rochdale and will miss them and my colleagues but particularly those within Public Health. However I know that they will continue to work to reduce the health inequalities experience locally and hopefully we will see the health statistics continue to improve despite the recession.

I would like to thank all of those who have contributed to this report but I’d particularly like to thank Wendy Meston and Shabana Khan for their support in its production.
INTRODUCTION

Previous annual reports as well as a lot of other partnership documents have clearly set out the challenges facing the local strategic partnership in addressing health inequalities and in particular the local life expectancy gap.

This report aims to update the current situation with regards to the major contributors to health inequality and reduced life expectancy as set out in the public health annual report (and JSNA) for 2008.

The worldwide recession has resulted in a significant reduction in the amount of new money available for investment in activities and developments aimed at improving health and life expectancy within the Borough. These same economic forces will also impact on the overall health and wellbeing of the Borough directly as the economic environment is a major determinant of health.

Despite the challenge that these changed circumstances present to the agencies responsible for health and wellbeing they also provide an opportunity to improve the impact that our core services and investment have on health and wellbeing.

In meeting the aims of financial recovery and in seeking to do more with less, providing we build in quality and improved outcomes as key drivers in achieving that aim, we can still see an improvement in local health and a reduction of the life expectancy gap experienced by our communities.
LIFE EXPECTANCY

The first completed Joint Strategic Needs Assessment for the Borough was combined with the Director of Public Health’s Annual Report for 2008 and focused on Life Expectancy. This section of this year’s Public Health Annual Report is intended to provide an update on our progress in this area.

Over the next year this report will be followed by a series of Public Health briefings in the following areas:

• Vascular disease (heart disease, stroke and diabetes)
• Tobacco
• Cancers
• Obesity/Healthy Lifestyles
• Infant mortality
• Mental health including suicide
• Health protection including Flu

The following sections contain updates on our progress towards improving life expectancy, All Age All Cause (AAAC) Mortality rates and the key contributors to reduced life expectancy. The challenge of the current financial context in which we are working will be considered, highlighting the areas that we need to focus on to impact on reducing early deaths.
Life Expectancy at Birth - Male 1991 to 2008

The above charts show our progress over the last sixteen years. Locally we have seen a steady increase in life expectancy for both men and women but the gap between us and the national rate has not been reduced. This local picture is also seen across other spearhead (deprived) areas. Over the sixteen year period shown above we can see that for us:

- Male life expectancy has increased from 72.3 years to 75.6 years (3.3 years)
- Female life expectancy has increased from 77.5 years to 79.8 years (2.3 years)

Looking forward we have now set targets to 2013-15 which are highlighted overleaf. These are challenging and will require multi agency action to achieve. This will rely on tackling the major ‘killers’ (coronary heart disease, cancers, digestive disease etc), improving the critical lifestyle factors (smoking, obesity, physical activity, healthy eating, alcohol) and maximising the positive impact of the determinants of health (housing, employment, income, skills, environment etc) whilst minimising any negative influences.
Life Expectancy

The national target for life expectancy is to increase the average life expectancy at birth in England to 78.6 years for men and 82.5 years for women by 2010 and to reduce the relative gap in life expectancy for spearhead areas and the England average by 10% by 2010.

Rochdale Borough is a spearhead area so the 10% or better reduction in the gap is a target for us. The baseline for setting these targets was 1995-7 (life expectancy calculated as an average of each of the years making up this time period). Despite an increase in life expectancy locally the gap between the Borough and the England average based on the Baseline years (1995-7) has increased by 1.4% for men and 1.9% for women. This is a consistent picture seen across other spearhead areas and the target is more challenging in the current financial climate.

Table below shows details of local life expectancy comparing the JSNA reported figures with latest data from 2006-8.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Life expectancy Borough (years)</th>
<th>Life expectancy region (years)</th>
<th>Life expectancy Eng&amp;Wales (years)</th>
<th>Gap between Borough and Eng&amp;Wales (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men 2003-5</td>
<td>74.4</td>
<td>75.39</td>
<td>76.9</td>
<td>- 2.5</td>
</tr>
<tr>
<td>Men 2004-6</td>
<td>74.9</td>
<td>75.8</td>
<td>77.2</td>
<td>- 2.3</td>
</tr>
<tr>
<td>Men 2005-7</td>
<td>75.1</td>
<td>76.0</td>
<td>77.5</td>
<td>- 2.4</td>
</tr>
<tr>
<td>Men 2006-8</td>
<td>75.6</td>
<td>76.3</td>
<td>77.8</td>
<td>- 2.2</td>
</tr>
<tr>
<td>Men change from 05-07 to 06-08</td>
<td>-0.5 (6 months)</td>
<td>-0.3 (4 months)</td>
<td>-0.3 (4 months)</td>
<td>-0.2 (2.4 months)</td>
</tr>
<tr>
<td>Women 2003-5</td>
<td>78.8</td>
<td>79.9</td>
<td>81.1</td>
<td>- 2.3</td>
</tr>
<tr>
<td>Women 2004-6</td>
<td>79.2</td>
<td>80.3</td>
<td>81.55</td>
<td>- 2.35</td>
</tr>
<tr>
<td>Women 2005-7</td>
<td>79.6</td>
<td>80.45</td>
<td>81.74</td>
<td>2.14</td>
</tr>
<tr>
<td>Women 2006-08</td>
<td>79.8</td>
<td>80.6</td>
<td>71.95</td>
<td>2.15</td>
</tr>
<tr>
<td>Women change from 05-07 to 06-08</td>
<td>-0.2 (2.4 months)</td>
<td>-0.15 (2 months)</td>
<td>-0.2 (2.4 months)</td>
<td>0</td>
</tr>
</tbody>
</table>

Source of Data: Office for National Statistics

Projecting forward, our targets from 2006-8 figures to 2013-15 are

- Male Life expectancy to increase by 2.7 years to 78.3 years
- Female Life expectancy to increase by 2.2 years to 82 years

This table shows that in this time period life expectancy did increase for men and our gap for local men compared with national averages reduced slightly which is an improvement from the last report. However for women we matched the pattern across the country with a slight increase in life expectancy and the gap remaining the same.
Life Expectancy

Additional lives to be saved to meet the 2010 target

An analysis done by Government Office North West in 2009, based on 2008 data showed our distance from the above 2010 target in terms of the additional lives needing to be saved to meet the 2010 targets.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>England and Wales</td>
<td>77.82</td>
<td>79.61</td>
<td>81.95</td>
<td></td>
<td>2.22</td>
</tr>
<tr>
<td>North West</td>
<td>76.3</td>
<td>78.5</td>
<td>80.6</td>
<td></td>
<td>2.22</td>
</tr>
<tr>
<td>Rochdale Borough</td>
<td>75.6</td>
<td>77.5</td>
<td>79.8</td>
<td></td>
<td>2.3</td>
</tr>
<tr>
<td>Gap</td>
<td>2.22</td>
<td>2.11</td>
<td>2.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Change in Gap</td>
<td>1.4%</td>
<td>1.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source of Data: Office for National Statistics

Healthy Lifestyles and Life Expectancy

We have long recognised the importance of promoting and enabling a healthy lifestyle and the contribution this makes to life expectancy and healthy life expectancy. Our key challenges remain the same and are:

- Reducing tobacco use
- Reducing levels of obesity
- Reducing harmful alcohol use
- Increasing levels of physical activity
- Increasing levels of healthy eating
- Reducing harmful sexual behaviour
- Improving mental well being

Future reports will document progress in these key areas.

Interventions highlighted as priorities were:

- CVD prevention and management
- Smoking cessation and reducing uptake
- Action on accidental overdoses
All Age All Cause Mortality (AAACM)

This indicator is used as a proxy measure for progress on Life Expectancy. It uses the same deaths data as life expectancy and includes infant deaths. As it is easier to calculate based on routinely collected data it makes it a more useful measure as it allows us to performance manage at a local level. It gives us an indication of progress on Life Expectancy and is a PCT vital sign and Local Area Agreement target but the life expectancy target remains the ultimate measure of success.

AAACM rates have fallen in each period since 1995-7. Analysis of progress in spearhead areas by the Department of Health in late 2009 has shown that the gap reduced for men in 2006-8 but not enough to meet the 2010 inequalities target for life expectancy. For women the gap has mainly stayed the same and is now on target to meet the life expectancy inequalities target.
Local progress and target - AAACM

A recent report shows that we are making good progress compared to other PCTs in North West.

Oct 2008 to Sept 2009 all-age all-cause mortality, compared to target trajectory

We have made steady progress in reducing AAAC mortality for men and women.

Using the Regional report as a measure of our progress for men and women, we can see that for men we are close to trajectory for the Borough and are on trajectory for women. To achieve our LE target projected to 2014 we would need to see an AAACM (Male) rate of around 600. The current figure is 795. To achieve our LE target projected to 2014 we would need to see an AAACM (Female) of around 490. The current figure is 574. This requires a greater rate of change than we have seen in the last three years.
Recent modelling by the Public Health Observatory has shown the impact of improvements that could be made by levelling up mortality rates to national averages.

Life expectancy years gained if the Most Deprived Quintile (MDQ) of Rochdale MCD had the same mortality rate as the local authority average for each cause of death.

The chart above shows the months that would be gained if all of our borough was at the borough average rates.
The chart below shows the impact if our population was at the national average rates.

*Life expectancy years gained if the Most Deprived Quintile (MDQ) of Rochdale MCD had the same mortality rate as the England average for each cause of death.*

<table>
<thead>
<tr>
<th>Intervention/therapy</th>
<th>Deaths averted male</th>
<th>Deaths averted female</th>
<th>Deaths averted Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD – treatment of pre existing CHD with four therapies; beta blocker, aspirin, ACE inhibitor, statin</td>
<td>56</td>
<td>39</td>
<td>95</td>
</tr>
<tr>
<td>CHD deaths averted Stroke deaths averted</td>
<td>24</td>
<td>37</td>
<td>61</td>
</tr>
<tr>
<td>Reducing blood sugars (HbA1c) over 7.5 by 1 unit</td>
<td>9</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>High risk/no CVD – management of hypertension</td>
<td>43</td>
<td>51</td>
<td>94</td>
</tr>
<tr>
<td>COPD – treating with inhaled corticosteroids</td>
<td>8</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>146</td>
<td>286</td>
</tr>
</tbody>
</table>

Work was undertaken for local spearhead areas by the Department of Health analytical team to look at which interventions could impact in the short term to narrow the health inequalities gap and save lives.

The estimates below show the number of deaths that might be averted in the short term and what might be possible if all the interventions were given to patients with that illness. These are not exact figures but are indicative figures to highlight priority areas. They are based on 100% compliance and analysis across areas different to ours, which need to be taken into account when looking at them. The rows below show those with the highest potential impact. Further local analysis is now needed to ensure that local plans are addressing the areas highlighted on the charts above.
PROGRESS AROUND MAIN CONTRIBUTORS TO OUR LIFE EXPECTANCY

Causes of our poor life Expectancy

The main causes of our poor life expectancy have not changed since our last report and continue to be: coronary heart disease, cancers, respiratory disease, infant mortality, suicide and digestive disorders. However the relative contribution has changed with the contribution of Vascular Disease decreasing slightly and the impact of digestive disorders which include alcohol related liver disease increasing.

The cross cutting priorities that significantly impact on our life expectancy and continue to be high priorities are: tobacco, obesity, healthy lifestyles, mental well being, alcohol and uptake of screening and immunisation programmes. The latest information is shown below to illustrate this.
The following diagrams show the analysis of months lost by disease area compared with the England average with changes over time.

**Months lost Females**

**Months lost Males**

**Infant Mortality**

In our last report we documented the good progress that has been made in the Borough to reduce infant mortality. Latest data shows that we have maintained that position with a small reduction on the previous data. We strive to drop below the North West as we did in 2004-6.

**Infant Mortality Rates (Age Under 1 Year) 1994 to 2008 - NHS HMR**

Source of Data: NWPHO

Source of Data: Office for National Statistics
Progress around main contributors to our Life Expectancy

**Cardio Vascular Disease**

We have seen excellent progress on reducing cardio vascular mortality both across the Borough and within our most deprived neighbourhoods (3% most deprived Super Output Areas). We are currently on our trajectory of reduction toward national rates.

The response to this information to date has been to:

- Raise awareness across partners of this fact, where these communities are and to encourage all to consider how their services are reaching out to these groups
- Practice based commissioning outreach events in Rochdale to engage more people to access primary care
- A major partnership across the Borough to prepare a bid to the British Heart Foundation to focus on our 3% most deprived communities which involved RMBC, Link4Life, Patient reps, PCT provider staff, Pennine Acute nursing and consultant staff, GPs, Practice Based Commissioners, PCT commissioners, CHD Collaborative, Cardiac network and GM Public Health Practice Unit. Although the team didn’t win the full bid the BHF did acknowledge the strength of the proposal and are funding the nursing element of the bid which will commence in the autumn. The Partnership also recognised the necessity to focus on these areas and have invested £200,000 to progress with the work to narrow this gap.
- Increased insight and marketing work within our most deprived communities
- Restructure of cardiovascular work and groups to improve the focus on tackling health inequalities

As the chart below shows our latest performance shows us dropping below the north west average for the first time in many years. The baseline year has also been added which was 1995-7. This sharp initial drop is over many more years.

**CVD Case Study - Reducing inequalities in Cardio Vascular Disease (CVD) outcomes**

Cardio vascular disease is the main contributor to our poor life expectancy. A recent local JSNA focused on our communities that live in the most deprived Super output areas nationally (Those in the worst 3% nationally). CVD rates were analysed to see if the rate of early deaths was different for these local populations. The graph above shows clearly that rates are far higher in these areas.
Progress around main contributors to our Life Expectancy

Cancer Chancer case study

Local analysis of ward data for early deaths due to cancers showed where premature death rates were above northwest averages and above England and Wales averages. We also established that rates were higher in our most deprived communities. Building on national and greater Manchester evidence that emphasised the importance of early presentation to improve cancer survival rates we agreed to implement the Cancer Chancer campaign within a defined number of local areas. Once again a wide ranging partnership worked across agencies and community groups to deliver the campaign. Full evaluation is underway and will be reported shortly.

Suicide and Injury Undetermined

The trend of reducing our rates of deaths in this area has continued and we are moving closer to the England and Wales rates. There is a national target to reduce suicide by 20% from the 1997 baseline to 2010. Similar to the national figures, suicide rates in the borough have fluctuated between 8 and 11 deaths per 100,000. We have on average, 60 deaths per year from suicide and undetermined injury in the borough, so if the National Service Framework target of reducing suicides by 20% by 2010 is met we want to see 12 fewer deaths per year.

Suicide prevention is the responsibility of a number of agencies. People with mental illness are at higher risk, so mental health services have a vital part to play. However, about three quarters of people who take their own lives are not in contact with any mental health services. A multi-agency suicide prevention strategy therefore needs to be developed for the borough, building upon and integrating the existing work on suicide prevention and audit.
Progress around main contributors to our Life Expectancy

Respiratory Disease

ASDR for Bronchitis, Emphysema and Other COPD All Ages Rochdale Borough

We are seeing an increased contribution to the life expectancy gap from digestive disease (including cirrhosis) this fits with the data we have on alcohol use in the Borough.

Rochdale Borough is significantly worse than the national average for:
- Alcohol related hospital admissions for males, females and the under 18s.
- Alcohol-related crime
- Claimants of incapacity benefits relating to alcoholism
- Harmful drinking (consumption of over 50 units a week for men and 39 for women)
- Binge drinking
- Alcohol related mortality

We are working towards reducing the impact of alcohol on health and our measure of progress is alcohol related admission.

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- Binge drinking
- Alcohol related mortality

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Admissions for Alcohol-Related Harm 2002 to 2009

The latest data for our Borough has shown a worrying increase whilst the North west and England rates have remained static. Our rates are also well above the North west rate. This area is a priority for the Borough and we need to accelerate action to reduce these rates.
INTERNAL INEQUALITIES

Deprivation

The Index of Multiple Deprivation (IMD) information has not changed since the production of the previous report/JSNA but this information has influenced our thinking and practice to ensure that the impact of deprivation on some of our key outcome areas is minimised. The latest Index of Multiple Deprivation showed that within the borough, deprivation is concentrated primarily within particular geographical areas. This area-based concentration is reflected in the IMD2007 which ranks Rochdale Borough as 10th most deprived nationally based on the Rank of Local Concentration. The Rank of Local Concentration indicates the severity of deprivation, or 'hot spots' within an area. Overall:

• 4 are in the 100 most deprived SOAs in England (compared with 2 in 2004)
• 16 are in the 3% most deprived SOAs in England (compared with 13 in 2004)
• 36 are in the 10% most deprived SOAs in England (compared with 35 in 2004)
• 57 are in the 20% most deprived SOAs in England (compared with 58 in 2004)

Heywood

Last year brought the Phoenix Centre – the first of our ‘joint service centres’ where you can access council and health services all in one place. This year brings Heywood’s Sports, Culture and Leisure Village, a £10 million centre due to open in the autumn.

Rochdale

After months of clearing a space next to the river, work will soon start on Rochdale’s new transport interchange and then the council’s new municipal offices.

Middleton

Last year brought the Middleton Arena, this year brings the new Tesco store.

Littleborough and Milnrow

Hollingsworth Lake remains an area of outstanding natural beauty and promotes physical activity.
In relative terms the concentration and extent of Rochdale Borough’s deprivation has become marginally worse, as shown in the table below. It must be noted, however, that changes made to the IMD mean that the data are not directly comparable. Despite the issues with data, comparatively, Rochdale Borough experiences a relatively high concentration of deprivation.

This table of the 2007 IMD shows a growth in the numbers of income deprived SOA’s in the borough. These are highlighted in red.

Generally, the most deprived areas of the Borough remain the same locations as in previous years. Within Rochdale Borough, Langley is the one area that has demonstrated improvements in levels of deprivation in recent years.

The recent 2009 Rochdale Borough profile produced by the Association of Public Health Observatories and Department of Health showed the differences in life expectancy by deprivation quintile. All the lower super output areas in the country were ranked according to deprivation and then were split into five equal groupings (quintiles) 1 being the least deprived and 5 being the most deprived.
Internal Inequalities

The importance of targeting our evidence based interventions on our key causes within our most deprived lower super output areas is critical. For our Borough quintile 5 is also the one with the highest number of residents.

Another way of looking at in Borough inequalities is to look at ward based data. Recent analysis for 2006-8 shows the following ward information with men and women combined. Due to differing sizes of wards the confidence levels in the figures differ. The quintile information showed a 9 year difference and the ward data shows just less than 8 years of difference between wards. The ward information has shown a decrease in the gap since the last analysis.

Our local information was as follows based on 2005-7 figures.

<table>
<thead>
<tr>
<th>Quintile</th>
<th>% of borough residents in the quintile</th>
<th>Number of residents in the quintile (2005 figures)</th>
<th>Male life expectancy years</th>
<th>Female life expectancy years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (least deprived)</td>
<td>3</td>
<td>6228</td>
<td>80.3</td>
<td>85.9</td>
</tr>
<tr>
<td>2</td>
<td>14.9</td>
<td>30,741</td>
<td>80.5</td>
<td>83.7</td>
</tr>
<tr>
<td>3</td>
<td>13.4</td>
<td>27,726</td>
<td>77</td>
<td>80.7</td>
</tr>
<tr>
<td>4</td>
<td>26</td>
<td>53,685</td>
<td>75.1</td>
<td>79.6</td>
</tr>
<tr>
<td>5 (most deprived)</td>
<td>42.7</td>
<td>88,065</td>
<td>71.4</td>
<td>76.7</td>
</tr>
</tbody>
</table>

Difference between quintile 1 and 5

| Population | 100 | 206,445 | 75.1 | 79.6 |

Note: The confidence interval/accuracy of quintile 1 is greater than the other quintiles due to the effect of small numbers in quintile 1 in our Borough.

This information shows again the difference in Life expectancy between people living in our Borough is around 9 years for men and women, closely linked to deprivation.

The Life Expectancy at Birth for Electoral Wards in Rochdale Borough 2006-08

Source of Data: NHS HMR
Slope index of Inequality (SII)

A new measure has been introduced this year that has been included in the Strategic Commissioning Plans within Primary Care Trusts. This indicator has been developed because the Index of Multiple Deprivation is not routinely updated and we need a measure that we can compare with other areas that shows our borough health inequalities.

The indicator splits the population into deciles (roughly tenths) by Lower Super Output area and aggregates five years worth of Life Expectancy data. The life expectancy for each decile is based on that part of the populations mortality data for the five years 2003-7. The Slope of Inequality (SII) target is a single score reflecting the steepness of the slope between the best and worst off deciles that represents the gap in life expectancy of those groups. Thus the target is to reduce the gap between the bottom of the line and the top. The national target is to reduce the gap by approximately 1% per year. Each target is specific to each Borough and is not comparable between areas.

As this is a new measure we do not have any data with which to compare it to measure progress, this data is therefore the baseline for future use. This measure is a more accurate reflection of the absolute gap between our best and worst off residents.

Prior to this baseline being set we used the measure of the gap between the best and worst off super output areas. The above figure is more accurate as a Super Output Area may include people from a higher or lower income decile (Decile = roughly a tenth of the population). The increased difference over the previous measure mainly reflects the increased accuracy of the measure and may or may not show a worsening position.
Future targets

Our aim is to ‘flatten’ the slope by reducing the inequality between the first and tenth deciles. A single figure is given to represent that progress and is charted below. This is a challenging target as recent years have seen an increase in the slope.

The above data reinforces what we know about inequality between male and female life expectancy and between the best and the worst off in the borough.
Internal Inequalities

Our local targets going forward are:

<table>
<thead>
<tr>
<th>Year</th>
<th>Male years</th>
<th>Female years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 to 2005</td>
<td>11.00</td>
<td>7.90</td>
</tr>
<tr>
<td>2002 to 2006</td>
<td>11.20</td>
<td>8.60</td>
</tr>
<tr>
<td>2003 to 2007</td>
<td>12.00</td>
<td>9.20</td>
</tr>
<tr>
<td>2004 to 2008</td>
<td>11.88</td>
<td>9.11</td>
</tr>
<tr>
<td>2005 to 2009</td>
<td>11.76</td>
<td>9.02</td>
</tr>
<tr>
<td>2006 to 2010</td>
<td>11.64</td>
<td>8.93</td>
</tr>
<tr>
<td>2007 to 2011</td>
<td>11.53</td>
<td>8.84</td>
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<tr>
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<td>2011 to 2015</td>
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<td>2012 to 2016</td>
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<td>2013 to 2017</td>
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</tr>
</tbody>
</table>

Source of Data: Association of Public Health Observatories
THE RECESSION AND HEALTH

Last year the Joint Health Unit undertook a Health Impact Assessment of the recession and their key findings were as follows:

**For Residents**
- Our already most deprived individuals, groups and communities are likely to be the worst affected
- The impact on the local economy will bring increased redundancies which will have far reaching implications, not just financially but also for health and wellbeing

**For the local Economy**
- Firm closures
- Doubts over business sustainability
- Viability of some regeneration or physical development schemes may need to be revisited

In addition we are now seeing the effects of surviving businesses and the public sector having to make cost savings

**For the Public Sector (LA and NHS)**
- Loss of revenue
- Increase or change in service demand
- Business continuity risks
- Medium / longer term impacts
- Possible of reduced financial settlement
- Planning for zero growth in investment even where there are no planned budget cuts
For Employment:

Unemployment is expected to increase by about 2500 people in the Borough over the next 2 years and the 2007 rates of employment are unlikely to be seen again until 2018. It is anticipated that the recession will increase unemployment to 6500.

A shrinking local economy with reduced levels of employment will impact negatively on a number of the main determinants of health, which in turn could contribute to poorer life expectancy and increased health inequalities locally. This will occur at the same time as those funds available to the NHS and its partners to address these issues will see no growth.

All partners working to improve health will need to maximise what they do with existing funding to ensure value for money, effectiveness and increased productivity. Improving quality and innovation will be crucial if the ability to invest in prevention and other “upstream” activities is to be retained and future health improved.

Unmet needs in a harsh economic climate

Last year the Young Foundation published their interim findings from a mapping study of unmet need. Their focus was on unmet needs which were multiple (interconnected, mutually reinforcing and complex); persistent (over the life course an intergenerational) and severe (causing high levels of socially recognisable harm or suffering). These are the kind of unmet needs often seen in the Borough of Rochdale. They identified the following major areas of unmet needs:

- Unmet psychological needs
- Unmet needs for care and support
- Unmet needs relating to financial strain or indebtedness
- Unmet consumer and legal needs

Whilst the researchers didn’t undertake a direct study of health needs they have addressed unmet needs over a number of the key determinants of health which will be acting on the population of the Borough of Rochdale. The following section looks at the first three of these needs in a bit more detail as they are likely to have the biggest local impact on the determinants of health.

Unmet Psychological needs

The most common unmet psychological needs they uncovered were:

1. Self Esteem
2. Competence
3. Autonomy
4. Relatedness
5. Physical Thriving
6. Pleasure and stimulation
7. Meaning or self-actualisation
8. Security
9. Popularity and influence
10. Comfort and reward

Of these the first four emerged as the most important.

<table>
<thead>
<tr>
<th>Self Esteem:</th>
<th>Competence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to say or feel “I am worthy”</td>
<td>The ability to say or feel “I am capable”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Autonomy:</th>
<th>Relatedness:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to say or feel “I am in control”</td>
<td>The ability to say or feel “I matter to others”</td>
</tr>
</tbody>
</table>

The cause of these unmet needs is complex but there are two sets of factors that influence them. Firstly the Intrinsic factors of mental health or emotional problems and secondly the extrinsic factors of lack of relationships or social capital.
The Recession and Health

There have been a number of studies and assessments done in Rochdale looking at these factors and we have a good understanding of how the determinants of health affect local people. It is important that we continue to cross reference these as we develop innovative ways to re-invest and realign the core budgets of members of the LSP in order to meet the requirements of financial probity, retain current services that address local needs and work to address unmet needs.

The local JSNA process supported by the LSP partnerships is one of the vehicles available to deliver this. Not all areas will require a detailed new JSNA to be undertaken. In many cases existing information pulled together based on the principles of a JSNA will inform the changes we need to see.

Whilst the Young foundation reported that individual characteristics often explain more of the unmet needs than neighbourhood measures of social support and interaction it is important that the LSP maximise the impact its partners have on psychological wellbeing on a daily basis. In particular:

- Maximising income
- Supporting the development of social networks and capital
- Building self esteem
- Shaping attitudes and beliefs
- Improving the wider economic, social and political environment

For Health and Social care partners informing and empowering clients will be essential to achieving future improvements,

Unmet financial needs

Income is increasingly unevenly distributed in the UK with around 25% of the population living in poverty. The index of multiple deprivation for the Borough suggests that the situation is even worse here.

In addition to low income there is also the impact of indebtedness. The Young report describes four forms of indebtedness.

1) Aspirational: Borrowing to acquire the products and services which represent “the good life”
2) Amelioration: Borrowing by the motivation to better one’s situation
3) Situational: This is less planned and represents a response to unforeseen circumstances. The need for this type of indebtedness does not tend to reduce in times of economic difficulty
4) Desperational: Borrowing usually by those who are already over indebted often to sub prime lenders. This is the use of credit to “borrow the way out of trouble”. The need for this type of borrowing is even higher in times of recession.

All staff in contact with local people need to be aware of these financial risks and their likely prevalence at a time of recession and be able to signpost individuals, groups and families to the services who can support and help them.
The Recession and Health

Having looked at these areas of unmet needs in the context of a recession the Young Foundation researchers went on to look at those areas likely to change most in a time of financial recession. Their analysis showed the following:

- Areas will probably see increases in the informal care load:
  This will be partly due to increasing restrictions on access to formal care in response to financial recovery. The local partnerships need to be aware of this and the current burden of care managed in this way. In looking to get cost effective care support to informal carers and their networks will be critical to ensuring that all needs are met with the appropriate needs being managed by the formal system.

- Increased convergence and connectivity i.e. sharing problems and solutions:
  This brings with it innovative ways to meet needs e.g. the use of internet shopping to deliver to the elderly to ensure subsistence and nutrition needs are met.

- A particular impact on the ageing population:
  Services need to be aware of the potential for self-destructive behaviour in this group leading to an even greater burden of unmet needs.

- Increase in leisure time at a time of decreased means to spend on it:
  This needs to be channelled into the satisfaction of needs without increased opportunities for self destructive behaviour.

- Increase in access and to information sources:
  This brings more self identification of need and more awareness of formal service availability which may not be equally available to those in the greatest need.

- Increased diversity in the available labour market:
  Need to ensure that this does not act to widen the inequalities gap by reducing aspirations and access to employment in currently disaffected groups – this potential needs to be reversed with these groups and appropriately targeted to encourage them to take up new opportunities.

- Increased concentration of people and services in urban areas:
  With increased ageing and needs seen in rural populations.

- Increased preparedness for disaster, terrorism, climate change, security and economic shock:
  Will intensify at societal and therefore individual level. Need to make sure that this doesn’t happen at the expense of those already vulnerable.

- Increased globalisation and ecological awareness:
  This will bring new needs but also new priorities and opportunities.

- A continuing trend toward individualisation:
  This is likely to have the biggest impact on communities where there are traditionally stronger family and societal bonds. The impact of this will need to be addressed given the expected increasing need for informal care across all communities.

- Changing norms and views on what is a need or right:
  Services need to be aware of the potential impact of raising aspirations and self esteem on the potential demand for further support and work with individuals, groups and communities so their role in meeting their own needs is acknowledged and happens at the required level.

- Increasingly evidence will inform policy:
  Understanding the factors that have the biggest impact on the community should lead to innovative service developments aimed at addressing these.

- By meeting psychological needs the perceptions of need will change:
  Ideally this should bring with it a move away from targeting single needs to innovative service delivery that takes a holistic approach to the individual or groups served.
Recommendations

• That the Borough and Public Sector Organisations retain their commitment to promotion and prevention

• That NHS Heywood, Middleton and Rochdale and Rochdale Metropolitan Borough Council at the very least maintain current levels of investment in promotion and prevention

• That we ensure we make the most effective and efficient use of that investment

• That NHS HMR and RMBC is careful to balance high impact short term priorities with addressing long term challenges

• Collectively we ensure that a systematic approach is taken to implementing high impact evidence based initiatives

• That the principles of quality and health improvement supported by efficiency, effectiveness, and value for money are applied to priority areas starting with long term conditions, healthy lifestyles and people with multiple needs

• That productivity is underpinned by quality so that services are not just efficient without being effective

• Evaluation should be applied in a local context to support the realignment of expenditure

• We need to drive out variation in access, impact and outcomes to achieve equity and tackle inequalities

• That we build on the good progress made in key outcome areas and engage more with local people to improve further
Appendix 1:

Young Foundation twelve hypothesis of unmet need

1. Places of unmet need
   Unmet need will be concentrated where there is high vulnerability and the visibility of need / suffering is low. These range from custodial institutions to strong micro-communities.

   Custodial institutions include both the care and the justice system and often extend to those who have recently left such an institution. Nursing and care homes are included here as their remit is to provide protection and safety which could be at the expense of wellbeing, quality of life and psychological need.

   A micro-community is one with:
   - High levels of internal bonding and low levels of bridging (social) capital
   - Significant stigmatisation of social problems
   - Mistrust of statutory services and authorities
   - A culture of resolving problems and finding solutions internally

2. Women and positive deviance
   There is significant unmet need where women’s roles are absent or impaired

3. Service readiness
   Unmet need will cluster around individuals who are not “service ready” – this includes: lack of a postal address; timing of the offer of care; barriers of language or intellect

4. Optimal contact with services
   Unmet needs clusters with those who have suboptimal contact with services. This can present as either no contact or frequent repeated contact with different services

5. Life events and transitions

6. Need clusters
   If there is an unmet need in one aspect then there are likely to be related unmet needs

7. Debt and financial strain

8. Mental Health Needs

9. Polarised infrastructure
   If agencies delivering services polarise then an increase in unmet need is likely

10. Availability of Information, Knowledge and Advice
    These inoculate against avoidable need

11. Articulation of need
    Significant unmet need will be found where the barriers to articulating those needs are the greatest

12. Self reporting of need versus other reporting
    Individuals underestimate their own needs

Anyone wanting to know more about the mapping needs programme can contact the research time via the following web link www.youngfoundation.org

It is now more important than ever that the principles of prevention, equity and value for money are applied to everything that we do and that all service change and development is carried out with those most in need at the centre of those changes.

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i ‘Planning to achieve targets modelling for health inequalities workshop report July 2009’

ii The Health Impact of the Economic Recession in Rochdale Borough. JHU January 2009

iii The receding tide: Understanding unmet needs in a Harsher economic climate. DanVale, Beth Watts and Jane Franklin. The Young Foundation

iv JSNA Older People
### Appendix 2:

<table>
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<tr>
<th>Ward Code</th>
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Life expectancy based on deaths from All Causes registered from 2006 to 2008 using the Chiang methodology

Source of Data: ONS Death Extracts