Learning from the past...

...looking to the future.

The Health of Bolton.

The Director of Public Health's Annual Report 2013
(Reflections on our First Year)

Bolton Council

Acknowledgements

This report would not have been possible without the hard work of many people working in the Public Health Directorate with many colleagues in partner organisations. I would like to thank them all, particularly the people who have contributed to this report:

Lesley Jones
Billie Moores
Deb Malone
Nicki Lomax
Leesa Hellings-Lamb
Marie Bisset
Mark Cook
Michael Cook
Jayne Cook
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22nd April 2014

The Health of Bolton.
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Foreword

I'm delighted to present my first Public Health Annual Report which is also the first one to be produced since Bolton Council assumed its new leadership role for improving and protecting the public's health.

This report draws on the lessons from 1972 when public health was last a local government function, led by Dr. Alistair Ross, Medical Officer of Health. It also identifies the future opportunities which working in Bolton Council will bring to improve the health and well-being of the people of Bolton.

Good health and well-being is so much more than the absence of illness. Good work, decent homes, friends, the environment we live in, as well as the choices we make all have their part to play.

Bolton Council now has a clear stewardship role for the Bolton public's health. In the same way that the Council is working to create the conditions for economic development which benefits all so it now has the opportunity and responsibility to create the conditions for good health and flourishing communities.

Much has changed in the last 40 years since Dr. Ross's day. The NHS has experienced many further reorganisations. However, the transfer of public health responsibilities back to where they belong in local government offers the greatest opportunity to improve the health of Bolton people in the next 40 years – public health has come home.

Introduction

The return of public health to Bolton Council is a good opportunity for us to think and act differently in how we can achieve and sustain good health for all the people of Bolton. Whilst we have made good progress in tackling health inequalities over recent years, the gap in life expectancy is not closing fast enough both within the Borough and compared to the national average.

It is becoming increasingly clear that the focus on reducing disease through changing individual lifestyle behaviour – e.g. smoking, drinking and eating too much is not enough to bring about the improvements in health and well-being we aspire to. We have not paid enough attention to the root causes of unhealthy lifestyles and illnesses. For example the constant strain of poverty, low paid work, unemployment, poor housing, debt and insecure relationships, leads to a lack of control, poor physical environments, emotional distress, social isolation and physiological impacts such as reduced immune system. These wider determinants impact on unhealthy lifestyles and on susceptibility to mental and physical illness.

The Marmot Review: *Fair Society, Healthy Lives*[1] has provided a strong case for intervening at the 'root' causes of ill-health. We also need to focus on the presence of good health and well-being within the population. Being healthy is not just about living longer and being free from disease but it's about living better – having a life worth living. The root causes also address this – having a good job, a warm home, enough money to live on, good social networks and relationships, personal control, resilience and participating in society.

Unless we look at the 'causes of the causes' of illness, the gap in life expectancy will not close. For example, NHS Bolton developed the nationally acclaimed programme – the Big Bolton Health Check – to reduce the gap in life expectancy. The main causal diseases were identified as Coronary Heart Disease and Cancer and the programme was successful in reducing early deaths from these diseases. However, our successes in reducing Coronary Heart Disease and Cancer deaths were undermined by increases in alcohol related deaths – people died of other things instead. So new diseases and behaviours become leading causes of mortality unless the root causes are tackled and we make sure that what we do works for those whose health is worst. To quote Marmot, *"it's a matter of fairness and social justice*[2]*."* As health inequalities result from social inequalities then greater action is needed to tackle the social determinants of health – rather than individual biological determinants of disease. This is often referred to as 'working up-stream'.

The national financial context is also challenging the system, not just because of budget cuts but crucially because of the impact of recession on people's health – the toll of job loss and insecurity, debt, welfare cuts and reduced support services impact most and for longer on those who are most vulnerable and in poorest health.

[1] *Marmot M et al (2010) Fair Society, Healthy Lives: The Marmot Review. The Marmot Review* [2] *Ibid, p16*

The population is also changing – more older people and smaller families impact on the support people need and have. We're also becoming more mobile and more global – in work, relationships, knowledge and networks – we know more and have higher expectations. Climate change will also bring different diseases and worsening health conditions related to heat, shelter and food.

So, given these changes in our knowledge and in the wider context it is easy to appreciate the need to explore and adopt new approaches to improving health and well-being.

In order to create a healthier Bolton, an understanding of health as a positive sense of wellness is essential, rather than the traditional focus of health as illness and disease. A shift to wellness or well-being brings a broader, holistic focus. This recognises the physical, mental, social, environmental and spiritual dimensions of health as well as the social nature of health and the attention needed in addressing the social conditions. For example, some research has suggested that isolation may impact on life expectancy as much as smoking. Investing in wellness is a more sustainable approach – for people and our economy. Investing in treatment is unsustainable and inefficient in terms of improving health.

Well-being is about how we think, feel and function and, as demonstrated earlier, this is central to our physical health – our ability to be resilient to illness, to manage and recover from illness and our capability in staying healthy and making healthy choices. Linked to this is a shift from deficits to assets – a shift in people as passive recipients of services to active, informed and empowered consumers or indeed producers of health and health services. Services need to shift from being siloed and focussed on single issues to being more integrated and holistic – i.e. being about the whole person and their community.

Assets

Improving the public's health, reducing health inequalities and achieving other social goals have traditionally focused on the deficits and problems of individuals and communities. Understanding communities by their high mortality and morbidity rates, high hospital admissions, high crime rates, high worklessness etc. is only seeing part of the picture. The common response to such problems has been to provide more services, valuing professional intervention as the answer and a focus on the failure of individuals and local communities to avoid disease rather than their potential to create and sustain health and continued development.

The asset approach builds on wellness by valuing the positive factors that make us healthy rather than focusing on the deficit factors of illness and problems. An approach that values assets identifies the skills, strengths, capacity, knowledge and resources of people and places that contribute to good health and well-being. It paints a picture of a place that is positive, showing what being healthy looks like in that community and what is leading to good health and well-being (rather than creating a negative profile of an area with lots of problems). Community pride and spirit is therefore higher and people are engaged in solutions that are more sustainable for that community, with use of outside support where it is needed most.

By acknowledging how individuals and communities are currently contributing to health outcomes, their role as 'co-producers' of health and well-being is valued – agencies work alongside the community and are "on-tap" rather than "on top". Relationships between citizens and professionals are therefore more meaningful and equal rather than tokenistic and consultative. The provision of services is more integrated across and between agencies and communities. Solutions are generated locally and through collaborative approaches.

People identify their own assets and work collaboratively to develop them. The process itself leads to increased well-being through strengthening control, knowledge, self-esteem and social contacts – giving skills for life and work. Resilience is a key asset and is built through the asset approach – it creates stronger and more resilient individuals and communities. Psychological, biological and physical resilience are central to personal well-being, community empowerment and for responding and adapting to environmental and economic instability and vulnerability. Health and well-being itself is an asset for a thriving and sustainable economy and society.

Practical ways of using the asset approach include:

Health indicators

Monitoring and evaluation that uses measures of protective factors and outcomes – the presence of good health and well-being rather than only risk factors, illness and death rates. For example physical activity rates, use of green space, mental well-being, social connectedness, breastfeeding, school readiness, employment, job security.

Map community assets

Mapping what the community themselves say are the valuable resources and assets that improve their lives – the strengths, knowledge and skills of people and the value of places and facilities in the locality.

Joint Strategic Needs Assessment

Providing a balance of assets and deficits within the JSNA in order to describe the presence of health and well-being in the population and the assets of the local population that can be used to promote health, prevent illness, minimize the impact of illness and disability and promote recovery and care.

Community development

Empowering individuals and groups to use and build their knowledge and skills to bring about change through collective action.

Individual strengths based working

Services that assess individual strengths (not just problems and needs) and provide interventions that build on people's strengths and their personal and community resources that will enable them to recover from illness, manage their condition, care for themselves and their family and generally manage their future health and well-being.

Timebanking

Using time as a 'currency' of exchange within a community, where people use their skills and time undertaking practical help and support for someone else and receive equivalent support in time from someone else when they need it.

Digital and Social Media

The expansion of digital and social media is creating a more informed, engaged and connected public. It is transforming the way we learn, do business and have relationships. For public health it has potential to impact significantly on disease surveillance (monitoring patterns of disease across the world), on connecting with traditionally marginalised people, on improving health information and communication, on increasing service engagement and efficiency and crucially on increasing people's knowledge and engagement in improving their health and well-being.

Integrated wellness services

Our bodies function as one - our mental and physical health is inseparable. The traditional illness and service approach has been to separate out different conditions of the body and to treat them separately, often even ignoring their interactions. Patients move between different services, even though they have multiple needs and referrers equally find it confusing. Services that take a more holistic approach will be beneficial and more efficient to the patient and the service.

One example is an Integrated Wellness Service. This is where people can receive support in staying healthy and well. The focus is on building people's motivation, confidence and skill to make changes and their resilience to manage difficulties through working on personal goals. This could include stopping smoking, managing stress, losing weight but also finding work, managing debt or parenthood. Traditionally separate services work together and use more generic approaches to tackle the underlying factors of behaviour change and supported self-help.

Conclusion

In his 1972 report[3], Dr. Ross expressed his concern that the emergence of so-called "diseases of affluence" would store up problems for the future unless "balanced by advances in medicine allowing earlier detection and treatment of this condition (CHD)". Forty years later it is clear that whilst industrially scaled, early detection of risk factors can have a huge impact on rates of specific diseases, these problems will be replaced by other problems unless we tackle the "causes of the causes". Focusing on community assets, integrating well-being services and using digital and social media are promising areas where public health needs to focus activity to bring about the improvements in health and well-being for the people of Bolton to which we all aspire.

Recommendations

1. **Develop an integrated well-being service for Bolton residents.**

2. **Explore the opportunities to promote asset-based working to underpin the public service reform programme and the Joint Strategic Needs Assessment.**

3. **Further develop the health and well-being offer via digital and social media.**

[3] *Ross, A Annual Report of the Medical Officer of Health for the year Ended 1972 (alt title: The Health of Bolton 1972) County Borough of Bolton*

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Chapter 1

Demographics & Health Need

In this section:

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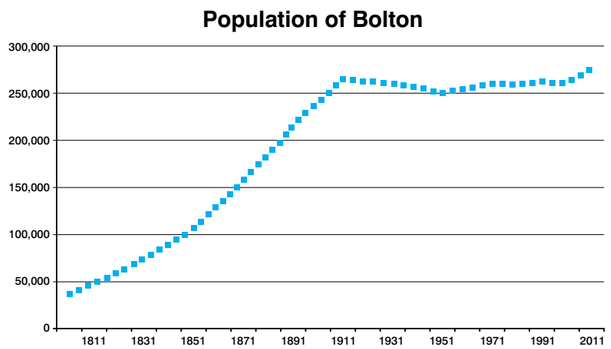
Demographics & Health Need

Dr. Ross in his 1972 report focused on particular aspects of the health of the people of Bolton; the falling birth rate, immigration, cardiovascular disease (CVD), lung cancer, mental health, and the health of older people. These remain relevant issues to Bolton today, while obesity and alcohol appear as more recent concerns.

Population

In 1972 the total population of Bolton stood at 259,993 people. The population of our Borough peaked in 1911 at 265,733 but 1972 saw a period of stability in terms of population size. The latest Census shows the current population of Bolton to have recently risen above the 1911 figure, with a resident population of 276,800 - there are more people in Bolton today than there has ever been in its history.



Since 1911 Bolton's population has been ageing significantly. In 1972 approximately 13% of the population was aged 65 years and over. Today this proportion has increased to 15% and is expected to increase further into the future.

Immigrants from India and Pakistan began to arrive in the town in the 1960s and so 1972 would have been a period of changing demography in Bolton. By 1972 Bolton had increasingly become an ethnically diverse town.

Today, Bolton is an extremely ethnically diverse Borough with established communities of second and third generation South Asian communities. More recent changes to the local population have been a result of amendments to European employment law, the lowering of European borders, people seeking asylum from wars and prejudice, and from general migration trends. The main source countries of recent European migrants in Bolton are Poland, Hungary, Republic of Lithuania, Slovak Republic, and Czech Republic. People from Iraq and Palestine account for the majority of refugees in Bolton and people from Iran, Iraq and Afghanistan account for a significant proportion of the total asylum seeker population in Bolton. The largest numbers of migrants of African origin are from Nigeria. Bolton has also received a number of Ethiopian refugees under the Gateway programme in recent years alongside asylum seekers from Zimbabwe, Somalia, Congo, Eritrea, Malawi and, most recently, Syria.

Latest Census data (2011)[4] contains 17 separate categorisations for ethnicity with Bolton residents featuring heavily in each category. The largest BME community is described as Asian/Asian British Indian with 21,665 residents (or 7.8% of the total population). The smallest BME community is described as White or Irish Traveller with 214 residents or (0.1% of the total population). However, the Census categories are not sensitive enough to truly differentiate between more established and newer BME communities. Nevertheless, today in Bolton more than 20,000 people do not speak English as their first language and in total more than 80 different languages are spoken across the Borough.

The 1972 report makes several comments concerning the need for translators of Urdu and Guajarati in local health services to better meet the needs of immigrants. Today, as these communities are long established, the most common translations required in Bolton are Hungarian, followed by Arabic, Somali, Mandarin, Czech, and Slovak.

[4] *Office for National Statistics (2011), 2011 Census: bit.ly/1mZeIUT Accessed: 10th April 2014*

Births

In 1972 the birth rate in Bolton was declining, as was the number of home births. The birth rate in 1972 was 17.9 (per 1,000 population) and today this has fallen further to 13.9 (per 1,000 population). This continues the trend identified in the 1972 report as does the decrease in home births which had fallen to 2.5% in 1972 and is today only 1.7%. A decade prior to the 1972 report, up to 19% of all births occurred at home.

The stillbirth rate has reduced sharply in Bolton since 1972 from 16.3 (per 1,000 live and still births) to 8.0 (per 1,000 live and still births). However, in 1972 the stillbirth rate in Bolton was approximately 26% higher than the England average at that time. Though both rates have now reduced further, Bolton's stillbirth rate is almost 35% higher than England's – and so this inequality gap has widened.

The infant mortality rate (under one year) was 23.0 (per 1,000 live births) in 1972 and this has fallen considerably to 5.2 (per 1,000 live births) currently. Bolton's infant mortality rate in 1972 was around 26% higher than the England average whilst today this inequality gap has reduced to 15% higher.

Physical Health Needs

As the table below demonstrates, in 1972 Bolton had the same major killers as we do today – cardiovascular disease (CVD), cancers, and respiratory conditions.

However, today alcohol-related illnesses such as chronic liver disease and cirrhosis are increasing in prominence. More than this, recent analysis shows that alcohol-related deaths are having a disproportionate effect on health inequalities in our town. The 1972 report acknowledges that chronic conditions are more complex to deal with than illnesses of earlier years when infectious diseases were responsible for a higher proportion of the mortality rate.

Interestingly, these big killers in 1972 are said to be associated with a higher absolute standard of living i.e. an over-rich diet, cigarette smoking, and a lack of physical activity. Today, unhealthy lifestyles remain the main cause of chronic illnesses such as CVD, but nowadays these behaviours are strongly associated with deprivation rather than affluence.

Summary of the Principal Causes of Death, 1972

Causes of Death	No. of Deaths	Males	Females	0–	1–	5–	15–	25–	35–	45–	55–	65–	75–
Tuberculosis, Respiratory	9	8	1	–	–	–	–	–	2	1	3	3	–
„ Other	1	–	1	–	1	–	–	–	–	–	–	–	–
Syphilitic disease	–	–	–	–	–	–	–	–	–	–	–	–	–
Diphtheria	–	–	–	–	–	–	–	–	–	–	–	–	–
Whooping Cough	–	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal Infections	4	3	1	2	2	–	–	–	–	–	–	–	–
Acute Poliomyelitis	–	–	–	–	–	–	–	–	–	–	–	–	–
Measles	–	–	–	–	–	–	–	–	–	–	–	–	–
Other infective and parasitic diseases	2	1	1	–	–	–	–	–	–	1	–	1	–
Malignant Neoplasm:													
Stomach	50	25	25	–	–	–	–	–	–	4	8	26	12
Lung and Bronchus	115	97	18	–	–	–	–	1	4	17	30	46	17
Breast	34	1	33	–	–	–	–	–	1	3	7	12	11
Uterus	11	–	11	–	–	–	–	–	1	3	4	–	3
Other malignant and lymphatic neoplasms	206	104	102	–	1	1	–	2	2	21	45	69	65
Leukaemia and Aleukaemia	13	6	7	–	1	1	–	–	–	2	2	5	2
Diabetes	10	6	4	–	–	–	–	–	1	–	1	5	3
Vascular lesions of nervous system	355	147	208	–	–	–	–	4	2	11	37	102	199
Coronary Artery disease and angina	541	320	221	–	–	–	–	–	5	34	104	196	202
Hypertension with heart disease	40	12	28	–	–	–	1	–	1	2	5	8	23
Other heart disease	282	123	159	–	–	–	–	–	4	8	22	57	191
Influenza	11	3	8	–	–	–	1	–	1	1	–	3	5
Pneumonia	183	88	95	9	2	–	1	–	1	8	13	41	108
Bronchitis	115	83	32	–	–	–	–	–	–	4	18	41	52
Other diseases of respiratory system	27	12	15	3	–	–	1	1	–	1	5	5	11
Ulcers of stomach and duodenum	16	12	4	–	–	–	1	–	–	–	2	4	9
Gastritis, enteritis and diarrhoea	7	6	1	7	–	–	–	–	–	–	–	–	–
Nephritis and Nephrosis	12	7	5	–	1	–	–	–	1	2	1	4	3
Hyperplasia of Prostate	4	4	–	–	–	–	–	–	–	–	–	2	2
Pregnancy, childbirth and abortion	3	–	3	–	–	–	1	1	1	–	–	–	–
Congenital malformations	10	4	6	10	–	–	–	–	–	–	–	–	–
Other defined and ill-defined diseases	143	64	79	24	3	–	2	3	11	11	10	23	56
Motor vehicle accidents	24	12	12	–	1	3	4	1	1	1	–	4	9
Suicide	9	4	5	–	–	–	–	1	1	4	2	1	–
All other accidents	40	12	28	2	2	1	2	2	–	2	2	2	25
Homicide and Operations of War	–	–	–	–	–	–	–	–	–	–	–	–	–

People born between 1952 and 1972 who are today aged 40-60 years old are the key group at highest risk of CVD. This is now the target group for preventative interventions for CVD and the 1972 report anticipates this:

> ***"The outlook for people born in the last 20 years and who will experience this affluence for the whole of their lives must be a cause of great concern unless it is balanced by advances in medicine allowing earlier detection and treatment of this condition [CVD]".***

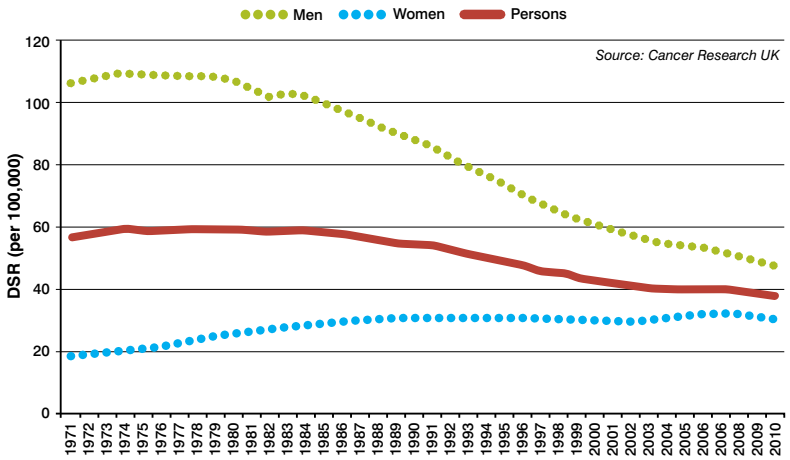
Dr. Ross was starting to think that the Big Bolton Health Check, which aims to reduce CVD risk in this cohort, needed to be implemented way back in 1972!

Dr. Ross advised that interventions to tackle this problem must focus on the adoption of healthier ways of living in addition to early detection and treatment. In Bolton today NHS Health Checks are aimed at early detection and the management of risk factors. This is complemented by statin prescribing for prevention and treatment of CVD, as well as a range of physical activity, diet and nutrition, and other lifestyle services to encourage the adoption of healthier lifestyles across the borough.

Deaths from lung cancer were also considered a key health problem in 1972.

Dr. Ross noted that just 18 people died from lung cancer in Bolton in 1943 and by 1972 this figure had increased to 115. The count today is around 160 per year in Bolton. Lung cancer incidence began to decrease for men in the 1990s but has been slowly yet consistently increasing for women since 1972. In actual fact, the latest annual figure shows more women than men are dying of lung cancer for the first time in the history of Bolton. If this continues, the local pattern of lung cancer will change significantly in the future.

Lung cancer mortality trend: UK



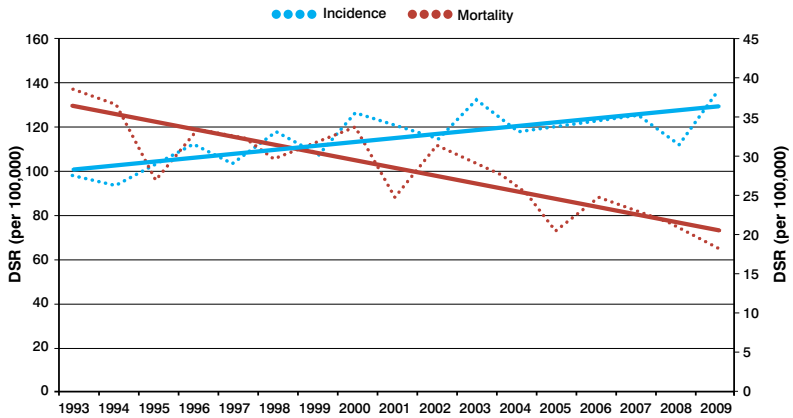
Smoking is the major cause of lung cancer. Nationally, 41% of women and over half of all men (52%) smoked in 1972, with a much greater proportion than today being heavy smokers (20+ cigarettes a day)[5]. Smoking prevalence has reduced gradually, but significantly, from the early 1970s to the present day. The reduction is not primarily due to established smokers giving up more rapidly, but is due in significant part to fewer young people starting to smoke and to smokers giving up at a younger age. Dr. Ross notes the importance of stopping local young people taking up the habit back in 1972:

"It is particularly desirable for children not to start smoking, but with a third to half [of] boys already smoking by the time they reach fifteen, to persuade children not to smoke is obviously a very difficult problem".

The so-called 'cohort effect' (which shows fewer of each new generation taking up smoking) has now stopped and smoking habits have become more stable. This means that unlike the picture in 1972, the levels of cigarette consumption that we are observing today (particularly amongst men) will, in all likelihood, be maintained in future generations without significant new intervention. Thus, in the present day we are increasingly tackling a constant and in some ways entrenched proportion of our population who are smokers.

Considering other cancers, since 1972 both prostate and breast cancer have increased significantly in incidence while mortality rates for both have improved – prostate cancer incidence has increased more than fivefold and breast cancer has doubled over the period[6]. This is largely due to better and earlier diagnosis and particularly important for the latter is the breast cancer screening programme. The bowel cancer screening programme has also made a similar impact with incidence increasing and mortality reducing.

Breast cancer in Bolton



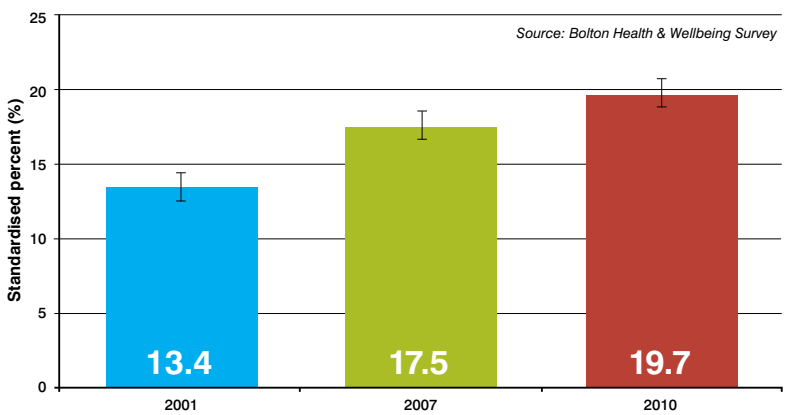
[5] *Davy, M. (2006) 'Time and generational trends in smoking among men and women in Great Britain, 1972-2004/05', Health Statistics Quarterly 32, 35–43.*

[6] *Office of National Statistics (2010) Social Trends 40: 2010 edition, ONS, Newport.*

Although major improvements have been made to smoking rates, obesity and alcohol are more serious issues today than they were in 1972. Lessons can be learnt from the tobacco control agenda when tackling these more recent problems, in particular the role of central government and big industry.

Very little concerning obesity is mentioned in the 1972 report. Dr. Ross does report on a community exhibition that focused on obesity and diet, but the unfortunate conclusion is that: *"the effect of this venture was doubtful as very little interest was generated"*. Today, obesity is one of our most significant public health concerns, both in Bolton and nationally. Obesity is known to be associated with a range of chronic conditions especially diabetes, but also CVD, hypertension, stroke, and certain types of cancer. Obesity has increased consistently over the past 20-30 years and today is at a level where the World Health Organisation (WHO) has referred to it as an epidemic of the developed world. So far, few interventions have been successful at reducing obesity levels across society and the main focus has been on halting its increase. New strategies are focused on planning (such as restrictions on local takeaways) and central government action such as standardised food labelling and the recent call for a tax on sugary soft-drinks. These are both reminiscent of tobacco control successes since the 1970s such as the ban on tobacco advertising, smoke-free legislation and age restrictions on tobacco sales.

Adult obesity in Bolton



Alcohol is also only briefly touched upon in the 1972 report, again around local health education projects. However today, alcohol is considered to be the second biggest cause of preventable death in the UK (after smoking). Alcohol-related illnesses and mortality have increased significantly in Bolton since 1972, with the number of 25-34 year olds dying due to cirrhosis increasing seven-fold over the past 30 years. In addition, alcohol-related harm is very strongly associated with deprivation and is a particular problem in the boroughs of the North West. The pressure to react to this increasing level of need has meant that both preventative and specialist services have struggled to keep pace and hospitals have been bearing the brunt of this increasing burden[7]. Furthermore, because of the strong association with deprivation, alcohol-related harm is a significant contributor to health inequalities in Bolton, as well as the UK as a whole. In fact, recent analyses show that the overall mortality gap between the most deprived areas of the country and the national average would have reduced considerably due to local work on CVD, cancer and other chronic diseases, were it not for the increasing impact of alcohol-related illness and mortality.

[7] *NHS Confederation (2010) Too much of the hard stuff: what alcohol costs the NHS, NHS Confederation, London.*

Mental Health

In 1972 Bolton was experiencing a major change in mental health services. A change in Government policy signalled the end of the old asylum model and a move towards community mental health – meaning that by the mid-1970s the population of mental hospitals was massively reduced. However, economic crises led to cuts in health expenditure, and whilst the Government reiterated its policy of community care, the financial situation meant little progress. Consequently it would take a lot longer for the community model of today to become established and the norm across the country.

If we consider incapacity benefits for mental illness, the increases in prevalence clearly began in the 1970s. The number of claims for the old Invalidity Benefit for mental illness went up 47% nationally in the 1970s and 57% in the 1980s. Increases continued into the 1990s with the Incapacity Benefit for mental illness. One reason for this increase may be that there is much less stigma attached to mental illness today than in the 1970s (though stigma remains an important issue today) as well as improved diagnosis, better treatment, and increased knowledge of symptoms in the general population. Whatever the reason, in Bolton today, one in four people will experience a mental health problem in their lifetime and 24,000 people have depression at any one time – much higher than reported back in 1972.

Older People

Bolton's population is ageing and with an older population comes illnesses and care needs specific to older age. In present day Bolton there are a range of community health services relevant to older people e.g. Community Stroke Service, Falls Service and Community Therapy Team, Parkinson's Disease Clinic, Podiatry, Continence Service, Diabetes Service. In addition, older people are the greatest users of secondary care services such as hospitals. The Council also directly provides and commissions a wide range of social care services including residential care, home care, equipment and adaptations, sensory services, day care and other forms of community support. There are around 7,000 older people supported by Adult Social Care in Bolton, accounting for 17% of the entire local 65+ population.

The 1972 report discusses the work of Geriatric nurses working to keep close ties between the hospital and the community:

"These two nurses visit patients on discharge from hospital giving them full support in an effort to decrease the possibility of the elderly person having to be readmitted to hospital and also to give them the confidence to continue to live in the community".

Today keeping people living healthy and in their own homes as long as possible is a key priority for both the quality of life of the individual and to ease the pressure on local services. In Bolton, as with the country as a whole, dementia is a growing concern. There are currently 1,400 people registered with dementia in Bolton; this is likely to be an underestimate. In fact, there are estimated to be 3,000 people in Bolton over the age of 65 with dementia. Numbers of people in need of care due to dementia will rise significantly in the coming years as the overall elderly population increases due to the disproportionate rise in the number of people aged 85 years and over. Looking ahead, this will mean an estimated total of 3,600 people with dementia in Bolton by 2020, increasing further to 4,800 by 2030. A significant proportion of this population will have very complex health and social care needs.

Conclusion

Much progress has been made concerning the health needs of a demographically shifting Bolton since 1972. However, the 1972 cohort of people are the first residents to be targeted at a population level by the Big Bolton Health Check (and other similar early diagnosis programmes) which aim to make a real impact on modern increases in complex chronic illnesses. In the future, the key challenges for the health of the Bolton population will almost certainly be those associated with alcohol and obesity. Finally, keeping older people well and in their own homes for longer must be a key strategic goal if we are to address the changing demography of the future Bolton.

Recommendations

1. **Ensure the Joint Strategic Needs Assessment (JSNA) develops as a vital resource to support health & social care and wider public service reform.**

2. **Engage with local commissioners to identify how Bolton's Health Matters can be improved to better meet their needs.**

3. **Enhance and develop the children and young people's element of the JSNA for example through the introduction of a local health survey to support the strategic focus on the early years agenda.**

4. **Build on the JSNA to include 'asset assessment' alongside 'needs assessment'.**

5. **Develop a systematic approach to the gathering, interpretation and presentation of qualitative data to match the high quality quantitative information provided in the JSNA.**

6. **Undertake needs and asset assessments which focus holistically on cohorts of the population.**

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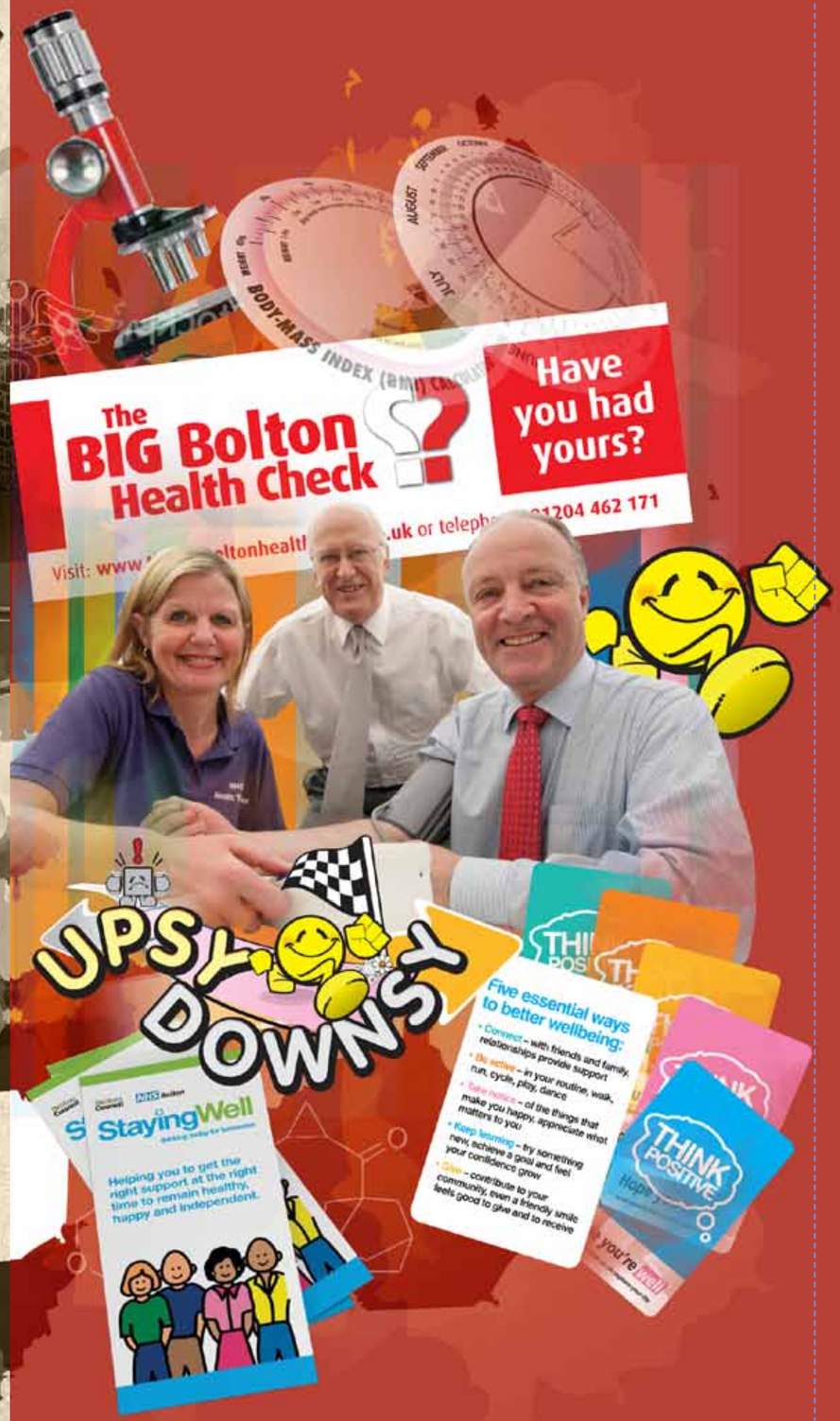
The Director of Public Health's Annual Report 2013

(Reflections on our First Year)



Chapter 2

Integrated Health and Well-being Services

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Chapter 2

Integrated Health and Well-being Services

In 1972 health services were organised very differently than they are today. In Bolton there were two hospitals (Bolton Royal Infirmary and Bolton General Hospital). GP practices, many of whom were single-handed or small practices that worked alongside community services such as health visiting and school nursing provided by the Council.

There have been a number of important changes over the past 40 years which have implications for the way health care is provided, now and in the future. Services are faced with a growing and ageing population with more ethnic and cultural diversity. Whilst there has been a decline in the prevalence of many infectious diseases, there has been a corresponding increase in the number of people suffering from long term conditions such as diabetes and respiratory illness. Medical and technological advances have resulted in a better understanding of some conditions; improved diagnostics and treatment (e.g. less invasive surgery, organ transplantation); shorter hospital stays; and advances in preventive measures such as immunisation, screening and new medications such as statins. Conditions which once needed to be treated in hospital can now be managed by GPs or in a person's own home. New technology means access to information at the touch of a button which enables individuals to become active partners in their own care.

However some things remain as true today as they did in 1972; much ill-health is preventable and the demand for services continues to outstrip available resources. Positive outcomes and good patient experiences are dependent upon services working and co-ordinating effectively together. It is also still the case that a relatively large proportion of the health and social care budget is spent on a relatively small proportion of the population and inequalities in access to healthcare still exist.

It is now widely recognised that doing more of the same more efficiently will not be enough to meet these challenges. Completely new ways of working need to be found so that people can live longer, healthier lives.

Bolton's Health & Well-being Strategy takes a life course approach to the commissioning and development of services to ensure that the prevention agenda is embedded within the practice of all partners and providers at each life stage. Examples of this in action are outlined below.

Starting Well – improving life chances for children

In 1972 a new style of Child Health Clinic was being established in Bolton, offering mothers professional advice and counselling on child development. Access to developmental checks and baby clinics was limited by suitable accommodation, and greater availability was anticipated as new health centres were opened across the Borough. Health Visitors were increasing their number of home visits, taking support directly to families. Plans were also being made to integrate the work of medical officers and health visitors to ensure that every child had a least one developmental assessment, at around 9 months of age. Use of computers was being considered to generate appointments and keep records of child health service activity.

Today a comprehensive, preventative child health service is well established, through delivery of the universal Healthy Child Programme, offering developmental checks, immunisations, support and advice. This is offered across a range of settings including primary care, Children's Centres and through home visits. The national investment in Health Visitor numbers means that Bolton will be able to train and recruit 26.5 new health visitors by 2015. A new model of Health Visiting will also be implemented by 2015, strengthening the public health and community development role of the service, and ensuring that all families have access to a universal service and extra support if they have additional needs. Bolton Council will become the commissioner of early years health services from October 2015.

The Marmot Review identifies “Giving every child the best start in life” as its first priority as it is crucial to reducing health inequalities across the life course. The foundations for virtually all aspects of human development are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities it is necessary to address the social gradient in children’s access to positive early experiences. Later interventions although important, are considerably less effective where good early foundations are lacking.

Demand for maternity and early years’ provision has continued to grow, with a 22% increase in births since 2008. The introduction of a Greater Manchester Maternity Services specification and the ***Making It Better*** service re-configuration means that Bolton now hosts a centre of excellence for maternity and neo-natal provision at the Royal Bolton Hospital NHS Foundation Trust. Most women in Bolton have early access to maternity care and good progress has been made in implementing new standards for ante-natal and newborn screening, including Down’s Syndrome, Foetal Anomaly and Newborn Hearing screening. The provision of ante-natal care in local Children’s Centres provides a good starting point for integrated working across early years services.

Across Greater Manchester (GM) more than 40% of children are identified as not being “school ready” at the end of their first year at school. School readiness correlates closely to the risk of under achievement in school and subsequently in working life, and hence reinforcing the cycle of deprivation and poor health. Collaboration between GM authorities has developed the New Delivery Model for Early Years that features a core integrated set of assessment points to identify need at the earliest opportunity, ensure all agencies can track a child’s progress pre-birth to 5 years, and provide sequenced programmes of evidence-based interventions .The development of this model, which will be adopted early in the Oxford Grove area, is an exciting extension of children’s services. This will provide early identification, help and support for families of very young children to ensure that far more children are school ready by mobilising the early years’ workforce to work together using one model to produce the best outcomes for children.

Developing Well – The Link Between Health and Education

In 1972 the "general condition" of school children was deemed to be "satisfactory" following medical inspections of over 4,000 children in Bolton schools. There remained a focus on promoting improved hygiene and attempting to limit the spread of some communicable infections and infestations. Today however, standards of hygiene have moved on tremendously with almost all families having ready access to indoor bathroom facilities.

Dental health in children in 1972 was poor. At that point the link between sugary fizzy drinks and sweets and tooth decay was not as strongly established as it is today and toothpaste was not regularly used. Consequently both children and parents living in Bolton now are much more aware of the importance of maintaining good dental health. Nevertheless, Bolton still has a relatively poor dental and oral health, particularly in the most deprived areas of the town. As a result Health Visitors and Oral Health Promotion Specialists continue to promote healthy eating, tooth brushing from early childhood and the use of fluoride toothpaste.

Over the last 40 years the role of the School Nurse has changed dramatically. In 1972 the role was largely reactive; offering school children physical checks and examinations. The most pro-active interventions offered mainly focussed on preventing or limiting infectious diseases and thus School Nurses were key in providing vaccinations such as BCG to prevent tuberculosis (TB) transmission. School Nursing teams today continue to monitor physical health and development, via the National Child Measurement programme, for example and they also deliver a wide range of immunisation and vaccination programmes. It is, however, their health education, health promotion and safeguarding roles that have expanded since in 1972. During the 1970s School Nurses had little involvement in these programmes but today they are key to delivering sexual health promotion, health improvement training and tobacco control, healthy eating, exercise, substance misuse and mental well-being interventions for school communities. Bolton School Nurses work closely with the Healthy Schools Team to offer holistic health improvement programmes.

Healthy Schools Bolton

Healthier Living & Learning

One of the areas where School Nurses in Bolton have had a demonstrable positive impact is on teenage pregnancy. The number of young mothers aged under 16 years of age, in 1972 was almost the same as it is in Bolton today. In 1972 Dr. Ross noted an increase in "unmarried mothers" wishing to keep their babies. In current times the stigma of being an unmarried mother has all but disappeared. However unintended teenage conceptions remain a concern due to the poor sequelae that are associated with the health and well-being of teenage mothers and their children. Locally, the development of accessible contraception services, the delivery of multi-agency programmes such as Party Hard, Party Safe and Aspirations, and the implementation of Bolton's Teenage Pregnancy Strategy has seen teenage pregnancies reduce substantially in recent years.

Furthermore additional changes are afoot. In 2013 the Local Authority assumed commissioning responsibility for the Healthy Child programme (5-19 years). The challenge here will be to ensure that all school aged children and their families receive high quality health and well-being services, tailored and delivered in a co-ordinated manner.

Living Well – Tackling Long Term Conditions

Physical health

The main causes of premature death in 1972 were largely the same as they are today. The impact of respiratory illness, cancer, stroke and heart disease on death and disability in 1972 was somewhat greater than it is now due to poorer living and working conditions, fewer treatment options and a lack of understanding of the link between some lifestyle behaviours and disease (e.g. smoking and cancer and excess alcohol use and liver disease).

Dr. Ross and colleagues, had, by 1972 begun to develop greater awareness of the importance of changing unhealthy lifestyle behaviours in order to positively impact on preventable ill health. Almost 40 years later, in 2007, the Big Bolton Health Check was launched. For the first time all GP practices in Bolton worked on a large scale to identify patients on their practice lists, aged 45 and over, without diabetes or cardiovascular disease, and invite them for a health check. The programme aims to assess individuals' risk of developing heart and circulatory problems in the future and in 2013 became a mandatory commissioning requirement for Local Authorities. The Health Check programme in Bolton has had unparalleled success in terms of population coverage. By the end of the first year 82% of those targeted had received a health check and today the programme continues to systematically provide support and treatment to people over the age of 40 to enable them to reduce their risk of developing theses disease or better managing their conditions.

As a result the Health Check programme has been credited with reducing hospital admissions from heart attacks and premature deaths from cardiovascular disease (CVD). It has most recently been expanded to cover other long term conditions and causes of premature death such as respiratory problems, dementia, cancers and alcohol related conditions.

Lifestyle factors such as smoking, physical inactivity, poor nutrition, overweight/obesity and excess alcohol consumption are the main modifiable risk factors associated with the majority of long term conditions. In Bolton, the Health Trainer service, provided by Royal Bolton Hospitals Trust, and commissioned by the Council, provides support to people needing to make lifestyle changes. A recent evaluation of the Health Trainer service in Bolton has indicated that the majority of people taking up the offer of Health Trainer interventions, made significant changes to their unhealthy lifestyle behaviours and sustained these over a 6 month period.

Mental health

The stigma associated with mental ill health remains apparent today despite huge advances in diagnosis, treatment and management since the 1970s. Dr. Ross barely mentions the impact of mental health problems on Bolton residents and communities in his 1972 report. Meanwhile in Bolton today, mental well-being is increasingly recognised as being as important as physical health with more awareness of the relationship between the two. It is well documented that people with mental health problems are more likely to lead unhealthier lives and be more likely to suffer from physical long term conditions. Additionally it is now known that poor physical health can lead to a deterioration and mental well-being.

Following a mental health needs assessment and the development of Bolton's "It's My Life" Mental Health Strategy, a new model of service to support people with mild to moderate anxiety and depression was developed. The Think Positive service has been operational since September 2012 and has seen a growing number of individuals taking up the service offer. The service model focuses on early identification and intervention and aims to halt the progression of mental illness in its clients. Given a quarter of Bolton's population will be expected to experience mental health problems at some point in their life the Think Positive service is a welcome development in terms of both service delivery and stigma reduction. As the economic climate continues to challenge mental well-being, a co-ordinated approach to mental health promotion, linked to wider anti-poverty, regeneration and employment and training, intervention is essential to Bolton's future prosperity.

The current approach to long term conditions

Since the 1970s, the increased understanding of, and emphasis on, the positive benefits of healthy lifestyles had led to a range of national initiatives (e.g. Health for All 2000, The Health of the Nation and Choosing Health) to encourage health care commissioners and providers to focus on prevention and early intervention. Whilst these initiatives have most definitely resulted in the development of health promotion and improvement services, these have generally been implemented as separate services. Noting, today, that most people with unhealthy lifestyles have multiple problems (e.g. smoking, excess alcohol use and depression) Bolton Council's future ambition is to commission integrated wellness services that holistically respond to individuals' well-being needs. Wellness services provide support to people to live healthy lives. The wellness approach goes beyond looking at a single-issue, healthy lifestyle services and a focus on illness, and instead aims to take a whole-person and community approach to improving health. Wellness services are those that promote health and well-being rather than diagnose and treat illness. They aim to encompass and integrate both mental and physical health in order to improve a person's overall health and well-being. The outcomes of a wellness approach include better service integration and lack of duplication of services as well as the right combination of help properly tailored to meet individual needs.

Ageing Well – Integrating Health and Social Care

Too often, people, particularly older people and those with long term conditions, suffer the consequences of services that are fragmented and/or poorly co-ordinated. They are often faced with dealing with multiple professionals working in silos and have to tell their story many times. Nationally and locally today this can be the case for a large number of residents. In many ways this can be explained by the rise of health and social care specialists. Since the 1970s health and social care providers have increasingly specialised in understanding and responding to single conditions. Whilst this has had positive impacts in terms of improved treatments, technology and support, it has meant that people with multiple needs are potentially faced with a plethora of professionals and interventions.

The need for better co-ordination of services is not new. In 1972 social care assessments were carried out, supporting the early discharge from hospital of some patients, and avoiding the admission of others. However, with increasing pressure on resources and rising demand for health and social care a transformational approach to integrated health and social care service delivery needs to be adopted.

No single part of the health and social care system can successfully tackle these challenges alone. To ensure people receive the right support at the right time, incentives must be aligned to ensure finite resources are targeted in the most effective way. Preventing illness and empowering people to stay well is not something health and care professionals can do in isolation; broader action from across society is required, involving a large number of partner agencies.

In Bolton today multi-disciplinary health and social care teams comprising community nurses, social workers, physiotherapists, occupational therapists, mental health workers, GPs, generic workers and third sector agencies are being developed, centred around clusters of GP practices. The teams will work beyond normal working hours and will take a holistic approach to service delivery.

Whilst similar approaches are being taken across most health and social care economies, a unique element of the Bolton Model is the inclusion of an additional preventive focus on those at risk of needing intensive health and social care in the future. Interestingly, in 1972, Dr. Ross reported on a Geriatric Advisory clinic for people aged 60 years and over which aimed to keep older people well longer. It seems that over the last 40 years this approach has somewhat diminished but with an ageing population facing multiple needs the prevention orientated approach has been revived.

The Staying Well project for Bolton has been a successful feasibility study which has systematically identified older people aged 65 years plus at high risk of requiring future health and social care support. Staying Well is a partnership between Public Health, Adult Services, the Strategic Housing Department and the Clinical Commissioning Group. The results have been so encouraging to date that Staying Well will become a cornerstone of Bolton Health and Social Care Integration programme. The approach addresses the wider determinants of health such as poverty, isolation and poor housing alongside more traditional health and social care needs.

Conclusions

Health care needs have changed over the last 40 years and there have been significant advances in preventative healthcare, screening and treatment, leading to improved health outcomes for many. However, the challenge of managing demand remains at the forefront of Bolton's health and social care economy's priorities. Continuing the approach of simply trying to provide better treatments to those who are unwell will not be enough to address this challenge. A more radical approach is required which pays much more attention to those with the greatest needs and which focuses on the underlying causes of poor health and inequality, whilst also focusing on prevention and keeping people well.

Giving every child the best start in life is the first recommendation of the Marmot review into health inequalities. Action to reduce inequalities and poor outcomes must start before birth and follow the life path of children through to adolescence and adulthood to break the cycle of disadvantage. Bolton Council is working collaboratively with Greater Manchester Councils to find new ways of sharing this investment.

Likewise into adulthood and older age, the population of Bolton needs to stay as healthy and as independent as possible in order to have improved quality of life. Healthier adults and older people are more able to actively contribute to their communities, to the local economy and to the prosperity of the town. This approach needs to be complemented by improved integrated health and social care delivery which is more flexible and responsive to individual need.

Recommendations

1. **Ensure the effective delivery of the Early Years model from pregnancy to five years of age and prepare for the implementation of the new model for Health Visiting and the Council's new commissioning responsibilities.**

2. **Re-design the Healthy Child Programme for school age children focusing on the most vulnerable groups and with reference to the new (national) model for School Nursing.**

3. **Further strengthen and expand the provision of services to improve mental health and well-being and ensure that key cohorts in the population such as Work Programme leavers get the service they need. Further develop opportunities within primary care to help people stay well by systematically addressing individuals' health and social care needs.**

4. **Further develop and implement the Bolton Integrated Health and Social Care model to expand and improve multi-disciplinary care across the Borough.**

The Health of Bolton.
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Chapter 3
Health Protection

In this section:

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Health Protection

Back in 1972 the role of the then Medical Officer of Health was primarily to protect the public's health and a key focus was on preventing deaths or illnesses resulting from infectious diseases. Over the years the role of the Director of Public Health has broadened considerably and in 2013 health protection encompasses a wide range of public health topics including immunisation, screening, infection control, communicable disease control and emergency planning. This chapter looks some of the similarities and differences in health protection issues over the past 40 years.

Measles

Of the notifiable diseases, measles stands out in 1972 as the most prevalent in Bolton. In 1972 there were 1,050 cases notified; Dr. Ross comments:

"It is extremely disappointing that a potentially preventable condition could appear in such numbers in the community".

Today, there are around 3,000 measles notifications a year in the whole of the UK, with approximately 300 cases notified in the North West region, of which just 50 are confirmed cases. In 1972, 29 people died nationally of measles, whereas now virtually no one dies of the disease. However, complications arising from the disease, the most severe of which are blindness and encephalitis, mean that immunisation against the infection remains important. Recent reductions in both measles prevalence and mortality are primarily due to increased immunisation uptake. In 1972, 52% of the population were immunised against measles compared to 90% today. Bolton's measles vaccine coverage exceeds the national average uptake and stands at 94% overall. Locally, however, challenges remain as vaccine uptake in some areas of the borough are lower that the Bolton average (e.g. in parts of Halliwell, Farnworth and Kearsley). In addition, 2008 and 2009 saw an increase in measles following several years of low immunisation. Subsequently in 2012 and into 2013 small outbreaks of measles have been observed in both children and young people across the Borough.

Meningitis

Bolton experienced an outbreak of acute meningitis in 1972. After several years of no notifiable cases, 44 cases occurred locally in 1971, followed by another 39 in 1972. These 83 cases in a two year period compare to a total of 13 over the 20 years prior to 1972. Dr. Ross stated that the outbreak in Bolton was not replicated on the same scale in any other part of the country. Nearly all of the 83 cases in Bolton were found to be due to meningococcal Group B. This was unusual for the time, and pointed to the outbreak occurring within a relatively small section of the population. Indeed, Dr. Ross later confirmed a high carrier rate amongst local family contacts had been discovered.

Prior to the introduction of the Meningitis C (Men C) vaccine in 1999, around 60% of all meningitis cases nationally and locally were Group B strains, whilst 40% were Group C strains. The Men C vaccination had an immediate impact on reducing mortality from Group C infections and today Group B strains account for 90% of all cases. Overall meningitis has reduced substantially since 1972, primarily as a result of Men C immunisation, but also due to the introduction of the pneumococcal meningitis vaccination. Whilst this is exceedingly positive, meningococcal Group B is now the most prevalent form of the infection and has not reduced to the same extent as Group C. On average around 800 cases of Meningitis B are recorded nationally per year with an average of 2-3 deaths occurring in Bolton residents annually.

Diphtheria

Diphtheria is a vaccine preventable disease for which there is a national immunisation programme in the UK. Since the 1950s Diphtheria cases and deaths have been rare. In 1972 there were no notifications of Diphtheria in Bolton; however Dr. Ross shows concern about the level of immunisation locally at the time:

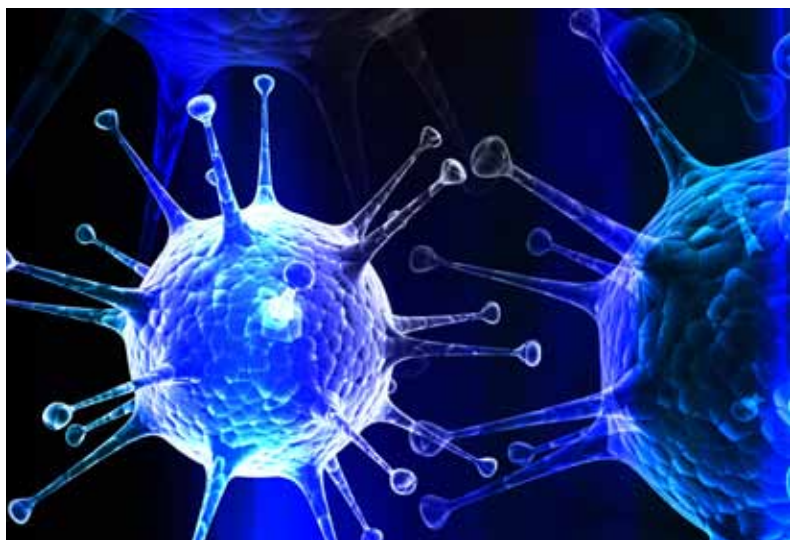
"The present level of immunisation cannot guarantee that the disease will not reappear for nearly a third of Bolton's children have not been immunised against the condition. These children are concentrated in particular areas of the town and the presence of a carrier of the disease in these communities would constitute a potentially serious situation".

Today in Bolton, 95.5% of children are vaccinated against the disease by their 1st birthday and 97.5% by their 2nd birthday. In 1972 Dr. Ross lamented the poor progress in improving the level of immunisation, comparing the town's performance to other local authorities who were doing better. Today the reverse is true with Bolton's childhood immunisation rates being higher than average for the North West and England as a whole.

Influenza

Seasonal influenza occurs in winter and prevalence peaks between December and March with new strains of flu constantly emerging. This means that there is potential for epidemics to occur, as seen most recently with the H1N1 strain of the virus. Flu vaccine is now offered each autumn to key groups who are most at risk of the disease and its consequences, especially those aged 65 years and over. Around 72% of Bolton's 65+ populations have the flu vaccine each year exceeding the national target of 70%. However, average flu vaccine uptake for over 65's across England is higher than this suggesting that it is possible to further improve local flu immunisation rates in this cohort.

More positively, however, Bolton has a higher than average uptake of flu vaccination in people with long term conditions such as Coronary Heart Disease, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease. Nevertheless, locally as well as nationally, there is still more work to be done to encourage pregnant women and frontline health care staff to take up the offer of the vaccine in order to protect themselves and prevent onward transmission of the disease to the wider population.



Tuberculosis

In 1972 Tuberculosis (TB) was deemed a major health concern so much so that there is a separate section of the 1972 report devoted to the disease. In 1972 there were 121 new cases of TB diagnosed in Bolton (76 respiratory and 45 non-respiratory). In 2012/13, TB is regarded as a re-emerging infectious disease, with Bolton experiencing comparatively high levels of TB (circa 70 new cases per year). Now, as in 1972, a significant proportion of TB cases occur in people born outside the UK or born to families of BME origin. In 2012 around 70% of TB cases were confirmed in Bolton's BME communities, which is much the same as in 1972 when 77% of cases were from these populations.

The BCG vaccination programme has changed significantly since 1972, when 387 vaccinations were delivered across the Bolton population to protect against TB. Today the immunisation is only offered to babies deemed to be most at risk of the disease and to people who have come into contact with a case of TB. In 2012 approximately 900 vaccinations were administered to at risk children and contacts of TB cases across the borough.

Though mortality from TB has generally been low over the past four decades, seven people from Bolton died from TB in 1972. Today the TB mortality rate in the town has improved to approximately one death per year. However, TB deaths are entirely preventable as TB is a curable condition providing that the antibiotic treatment regime is completed. In 2012, 84% of Bolton cases completed TB treatment which is a cause for concern given that failure to complete treatment is contributing to the rise in multi-drug resistant TB cases across the country.

Sexually Transmitted Infections

1972 also saw an epidemic of Gonorrhoea in Bolton. The total number of venereal diseases diagnosed at that time was 876, with Gonorrhoea accounting for 207 of these. The introduction of new technology in the form of an Answerphone service was established in April 1972 to increase clinic attendances. Dr. Ross reflected that having received 21,800 calls, the Answerphone service was "fulfilling a much needed service in the town".

Since that time Gonorrhoea rates in Bolton have decreased substantially but in 2012 Gonorrhoea is still the second most common sexually transmitted infection (STI), after Chlamydia. This is in line with national trends and a recent increase in diagnoses of both these two STIs is partly due to the introduction of the Greater Manchester RU Clear Chlamydia and Gonorrhoea screening programme. This programme specifically targets 15-24 year olds as younger people are more likely to contract STIs. Nevertheless, generally, STI diagnoses rates continue to rise across all age groups and currently an average of 80 cases of Gonorrhoea are diagnosed in Bolton each year.

There is no mention of Chlamydia in the 1972 report but today Chlamydia is a substantial public health challenge as it far outweighs the incidence of all other STIs with around 1,200 cases diagnosed each year in Bolton. Chlamydia is primarily a disease of the young and is often asymptomatic. In order to detect undiagnosed infection, instigate treatment and positively impact on onward transmission, localities need to achieve a diagnosis rate of at least 2,400 per 100,000 resident 15-24 year olds per year. This is the level which is expected to produce falls in Chlamydia prevalence in the future.

Annually, in Bolton, over 10,000 Chlamydia tests are carried out resulting in an above average diagnosis rate of 2,820 per 100,000 resident 15-24 year olds. Therefore, as in 1972, public health action is resulting in a major STI problem being addressed in a systematic way.

The most notable change in the field of Genito-urinary Medicine has been the emergence of HIV/AIDS in the 1980s. AIDS was not clinically observed until almost a decade after the 1972 public health report was published. Across the North West region the number of people living with HIV/AIDS has been increasing over the past 20 years. This is largely due to improvements in the diagnosis, treatment and management of the disease. Today, the prevalence of HIV in Bolton stands at around 210 cases. This is almost certainly an underestimate as national studies indicate that around a third of people with HIV are unaware that they have the disease.

Whilst effective treatments for most STIs have been further developed over the past couple of decades, the sexual health promotion advice in 2012 remains exactly the same as in 1972 - always use a condom with each new sexual partner.

Deaths from Infectious Diseases

In 1972 in Bolton, 6 children under the age of 2 years died from diarrhoea and enteritis and 187 children and adults died from pneumonia. Today mortality from diarrhoea and enteritis (more latterly identified as E.Coli) is exceedingly rare but approximately 150 people each year die from pneumonia across the Borough. In 1972 the majority of pneumococcal deaths occurred in older people and the very few that occurred in previously healthy people were mainly resulted from a complication of another serious disease. This remains the case today. However, Bolton currently has a significantly higher mortality rate from pneumonia than average, with the rate being particularly high in women. This is a serious issue which needs to be addressed by further increasing the uptake of pneumococcal immunisation in at risk groups as well as reinforcing the message that death from pneumonia may be a consequence of flu.

Other Infections

Hepatitis C represents a growing concern with the burden of disease increasing in conjunction with a significant level of undiagnosed cases, especially in the injecting drug user population and in some Black and Minority Ethnic communities. The North West has the highest prevalence of Hepatitis C in the country and drug services are striving to reduce onward transmission by delivering harm reduction messages and promoting Needle Exchange Schemes. However, with around only half of drug users aware they have the disease, the risk of transmission remains substantial.

Hepatitis B is a vaccine preventable disease and in 2012 immunisation continued to target the most at risk groups, including injecting drug users, sex workers, and certain occupational groups. Hospital admissions and laboratory test data suggest Hep B prevalence may be reducing both nationally and locally. Bolton residents diagnosed with the disease now benefit from established referral pathways into treatment.

Finally, with the relatively recent increases in MRSA and C. Difficile, healthcare acquired infections (HCAI) have become a key feature of infectious disease surveillance and control. Rates of these infections have been falling sharply since 2007/08 and, in general, Bolton had lower than average rates for both MRSA and C. Difficile than other Greater Manchester areas in 2012. Infection control is still a major public health concern with appropriate antibiotic prescribing and simple hand washing being the key tools in reducing HCAI incidence.

Immunisation and Screening

Running parallel to preventive interventions and early diagnosis of infectious diseases has been an increase in the range, consistency and uptake of immunisation and screening programmes. Immunisation does more than just protect an individual; it protects entire communities. Sufficient vaccination (to achieve "herd immunity") levels can provide protection against disease for members of the community who would otherwise be left vulnerable.

Although back in 1972 screening was undertaken for both breast and cervical cancer, it was not as part of a co-ordinated programme, and so uptake was patchy (only 15 women in 1972 underwent breast examinations) and outcomes were difficult to assess. Since then, a wide range of adult screening programmes have been established, both for cancer and non-cancer, all of which use robust call and recall systems, and evidence-based screening tests. Uptake does vary across Bolton, with people living in more deprived areas usually less likely to take up the offer of screening.

Bowel Cancer Screening is one of the most recently introduced screening programmes with full roll out across the North West achieved by 2009. Bowel cancer is a major public health problem. In Bolton, it is the third most common cancer (Cancer Research 2011)[8] therefore a substantial programme of community awareness raising and engagement has been undertaken across the Borough to improve equity of uptake.

Systematic immunisation and screening programmes have resulted in a reduction of the incidence and severity of once common diseases. Early identification and treatment of potentially life altering or fatal diseases has led to enhanced quality of life for more of the population.

[8] *PHIT Bolton (2012) Bowel Cancer Screening in Bolton. PHIT Reports Issue 10 http://www.boltonshealthmatters.org/knowledgehub/phit-report-issue-10-bowel-cancer-screening-bolton Accessed: 10th April 2014*

Food Safety

The 1972 Medical Director's Annual Report focused significantly on the inspection and supervision of food and also premises (including abattoirs) reflecting the role of Public Health at the time. Following the reorganisation of the health service in 1974, food hygiene responsibilities remained with the Council as part of Environmental Health Services. Comparison of the figures below highlights the continued need for action on food safety. Whilst awareness of the importance of hand hygiene and the safe storage of food is increasing it is clear that food safety remains a key issue for the safety of the public.

Salmonella	Cases 1972: 5,664	Cases 2011: 9,956
Campylobacter	Cases 2000: 58,236	Cases 2011: 64,608
Listeria	Cases 1983: 111	Cases 2011: 147
Escherichia coli O157:H7 (E-coli)	Cases 1991: 361	Cases 2011: 1,182

The Future of Health Protection

In terms of health protection, the changes to the NHS that became statute in 2013 were some of the most radical ever implemented. The 1972 report looks ahead to public health moving into the NHS and out of the Local Authority. In 2013 the Local Authority re-gained some, but not all, of the public health functions it once held.

2013 saw the development of a new national organisation, Public Health England, which assumed responsibility for the majority of health protection functions from 1st April 2013. Emergency Planning continues to require local health and social care agencies to take a collaborative approach to issues such as winter planning, flood risk, chemical or biological incidents and large scale outbreaks of infectious diseases (e.g. pandemic flu). This activity is commissioned by another new national organisation - NHS England.

Whilst Directors of Public Health are no longer at the forefront of health protection, they retain strategic oversight and responsibility for ensuring that the local population remains protected from threats to good health. To this end, Directors of Public Health must be assured that partner agencies have robust plans and programmes in place to achieve this key objective.

Conclusions

Deaths from infectious diseases in Bolton residents have reduced dramatically since 1972, as have morbidity rates. Effective immunisation coverage remains the key to ensuring that rates of vaccine preventable diseases continue to fall, with the aim of achieving a 95% uptake rate for childhood immunisations.

In terms of flu vaccination uptake, Bolton performs well overall. However there are certain groups where vaccination uptake needs to be increased. It is particularly important that vulnerable individuals are protected from flu, and its consequences, (e.g. pneumonia) as it is highly infectious and easily spreadable.

Whilst BCG vaccination can provide some protection from TB and is offered to children considered to be most at risk of contracting the disease, in line with national guidance, key public health interventions to reverse increasing TB rates need to focus on treatment completion and symptom awareness.

Sexually transmitted infections (STIs) remain a major challenge to maintaining good health and well-being. Whilst most STIs are curable, HIV is not and it is a matter of concern that STI rates across all age ranges continue to increase year on year. No single approach will result in a reduction in STI rates but individuals need to have the necessary understanding of STI transmission as well as the ability to negotiate safer sex on a consistent basis if rates are to fall.

In very general terms the old adage of "coughs and sneezes spread diseases" remains as pertinent today as it did in the late 20th century. Good hygiene, particularly good hand hygiene, is a simple but effective tool in preventing and controlling the spread of infection. It is equally important that individuals in both health care and non-health care settings wash their hands regularly as this will assist in reducing Health Care Acquired Infections.

Recommendations

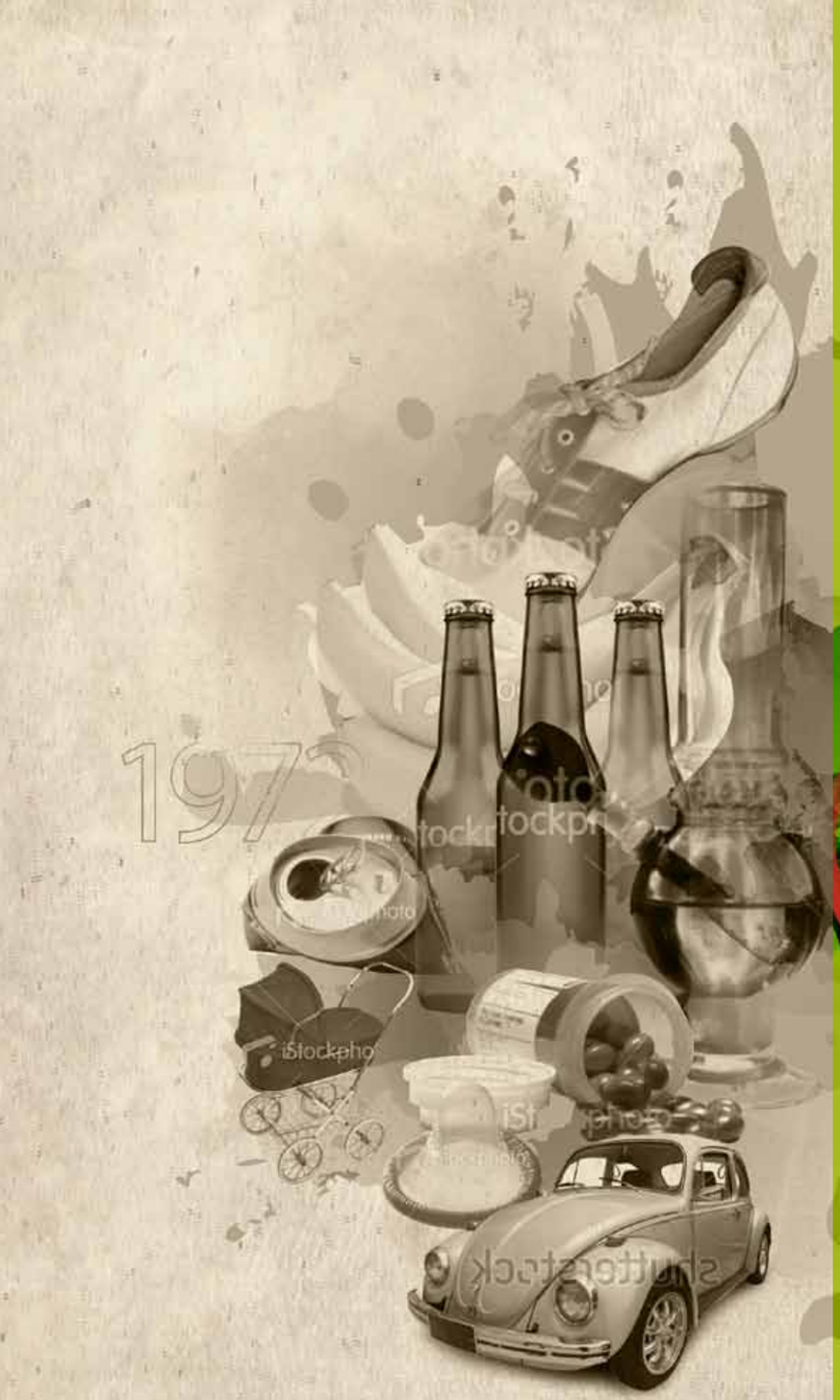
1. **Improve engagement with communities to increase vaccination uptake rates where these are substantially below the national 95% uptake target.**

2. **Target work to increase flu vaccination uptake in pregnant women and front line health and social care staff. Linked to this is the need to increase pneumococcal immunisation uptake, especially in women.**

3. **Increase activity to ensure that those communities most at risk of developing tuberculosis have improved information about its symptoms. In addition work needs to continue to reduce the stigma associated with the disease and to better enable individuals who have tuberculosis to successfully complete treatment.**

4. **Continue to focus on sexual health improvement, good sex and relationships education and improved access to sexual health services in order to reduce sexually transmitted infection (STI) transmission.**

5. **Increase awareness of infection prevention and control interventions in order to continually improve communities' understanding of how the spread of infectious diseases may be ameliorated.**



The Health of Bolton.
The Director of Public Health's Annual Report 2013
(Reflections on our First Year)

Chapter 4

Health Improvement

In this section:

Chapter 4

Health Improvement

In 1972, the concept of behaviour change as part of the Public Health agenda was just emerging in response to the recognition of 'lifestyle' factors as key causes of ill-health and disease. This followed the successful implementation of infection prevention and control and public policy measures to improve living standards e.g. slum clearance and the Clean Air Act.

In these early days approaches to behaviour change focused on health education in the form of talks and exhibitions with the prime audience being school children and mother and baby groups supplemented by in-service training for staff.

However, the limitations of such methods were also starting to emerge. Reporting on Mothercraft and Parentcraft classes, in his 1972 report Dr. Ross says:

> *"It is still sadly true that these classes miss a certain needy proportion of the community and whilst Mothercraft teaching in schools plays a very important part in bridging this gap, constant attention must be given to ways of reaching those mothers who do not attend".*

The 1972 report also refers to a public meeting at the Octagon Theatre on the problems of drugs but turnout was very low.

The initial response was to develop ever more sophisticated and targeted methods of 'getting the message across' e.g. through the development of audio-visual aids such as video, leaflets in different community languages.

The underlying assumption in these education based approaches to behaviour change was that if people had the 'right' knowledge they would then act in an 'appropriate' way to maintain or improve their health. These approaches also assumed that individuals, once 'educated' on health matters, had the ability and/or resources to be able to adopt health messages. However over time it became clear that more affluent people were much more likely to adopt 'healthier lifestyles' as a result of health education interventions than people from more deprived communities leading to growing inequalities in health.

Much has been learnt since then. We now recognise that an individual's behaviour is influenced by much more than knowledge. Individual attitudes, motivation, confidence and skills play a large role in how people behave which are in turn influenced by norms within peer groups and wider society. External physical factors also considerably influence the degree to which individuals can adopt healthier lifestyles such as income levels, living conditions, access to affordable transport, the availability of goods and services. For example the availability of high fat, high sugar food and drink is plentiful, usually requires little or no preparation and is affordable whilst healthier foods tend to be less accessible, require more preparation and are sometimes more expensive. It is clear that tackling obesity in this context requires much more than simply educating people about healthy eating. It requires us to create the conditions which support people to live healthier lives such as easy access to fresh fruit and vegetables.

Our approach today

Today we take a more sophisticated approach to influencing health-related behaviour by working simultaneously at the level of the whole population, the community and the individual.

As we know from Chapter 1, tobacco, alcohol and obesity are major health challenges for Bolton people as they are across the UK. This Chapter sets out how we work at population, community and individual levels to address these challenges.

Population level – these are interventions that can be put in place that will impact on whole populations. They usually involve policy or legislative action for example smoke free workplaces in 2007 which prohibited smoking in public places and work places.

Community level – this is action taken within neighbourhoods or local organisations such as schools, workplaces and healthcare settings which connect with significant numbers of people.

This work involves identifying and supporting the development of community based assets which make a positive contribution to health. Asset based approaches value the capacity, skills, local knowledge and connections within a community. Examples include the extended use of community based buildings, the identification and involvement of community champions, maximising the contribution of local community groups and voluntary organisations.

Individual level – these are interventions focused directly towards individuals either singularly or in groups. Examples include social marketing activity which goes beyond the previous "one size fits all" promotional campaigns of the past. Social marketing uses an approach which seeks to differentiate between groups within populations by a deep understanding of behaviours, drivers, attitudes and beliefs. The result should be the development of a mix of approaches which are likely to have an impact on the wide range of individuals.

There is significant potential to develop the use of social media as part of a community engagement for health strategy however it will be important to learn lessons from the past and consider how this can be achieved without further widening health inequalities. Social media interventions must take account of the potential for a ready response from some sections of the population versus a lack of engagement from others as a result of digital exclusion.

Tobacco

Whilst smoking prevalence has decreased significantly in recent years approximately 20% of Bolton's adult population are smokers. Bolton has a rate of 1,469 per 100,000 smoking attributable hospital admissions, higher than the national average but lower than average for our region, and 10 people a week die in Bolton as a result of smoking related illness.

Half of all long-term smokers die early from smoking-related diseases, including heart disease, lung cancer and chronic bronchitis. Men who quit smoking by 30 add 10 years to their life. People who kick the habit at 60 add three years to their life. In other words, it's never too late to benefit from stopping. Quitting not only adds years to your life, but it also greatly improves the chance of a disease-free, mobile, happier old age.

Population

Seven years have now passed since the introduction of the legislation to make workplaces and public places smokefree in England. Research shows that the law has had a significant impact. Results from studies conducted in England show benefits for health, changes in attitudes and behaviour and no clear adverse impact on the hospitality industry. Second hand smoke exposure in children fell, continuing a positive trend observed since the mid 1990's. Analysis of Hospital Episode Statistic in England shows a significant drop in hospital admissions for heart attacks as a result of smokefree legislation.

Community

Bump the habit

Smoke Free Homes is a Bolton initiative which aims to raise awareness of tobacco related harm with families and communities. Families are asked to pledge to make their houses totally smoke free in order to protect the health of family members, particularly children, from second hand smoke. Community members become advocates for a smoke free environment by encouraging others to join the scheme. Those signing up receive a support pack of resources, the opportunity to receive Stop Smoking support and a home fire risk assessment. To date 2,657 families (which include over 3,400 children) in areas of high smoking prevalence have made the pledge to keep their homes smoke free for the sake of their families.

Individual

Since 2003 Bolton NHS Stop Smoking Service has helped **14,000** people to quit smoking. Community quit groups, seven week intensive quit groups, and one-to-one therapy sessions are available as are services based at the maternity unit, in local pharmacies and in GP practices.

Alcohol

The current recommendations for weekly alcohol intake advise that men should not regularly drink more than 3-4 units of alcohol a day and women should not regularly drink more than 2-3 units a day *('Regularly' means drinking this amount every day or most days of the week).* A pint of average strength beer or a large glass of wine is about 3 units.

Drinking more than the amount suggested by the guidelines can damage a person's health and is one of the biggest behavioural risks for disease and death. This isn't only a burden on individuals and families but also a drain on hospital resources and public money: every year, alcohol-related harm such as domestic abuse, crime and anti-social behaviour costs society £21 billion.

There are an estimated 60,000 people in Bolton who regularly drink over the recommended safe levels.

Population

The current focus in addressing the issues associated with alcohol related harm is to make it easier for people who do drink to do so responsibly and so reduce alcohol related harm

Decreasing the availability and increasing the price of alcohol are key interventions in reducing alcohol harm. Taxation and Minimum Unit pricing (MUP) are mechanisms for doing this. Evidence supports a minimum unit price for alcohol to reduce rates of hazardous drinking and alcohol related problems[9]. It is estimated that a minimum unit price of 45 pence would prevent 344 deaths, 13,900 hospital admissions and 24,100 crimes in England each year.

Canada is one of six countries where a minimum unit price has been introduced and resultant data suggests the Sheffield estimates are conservative and that a 10% rise in alcohol pricing would lead to an 8% reduction in consumption, a 9% decrease in hospital admissions and a 32% reduction in alcohol related deaths per year.

Individual

Identification and Brief Intervention Advice (IBA)
AUDIT C is an alcohol screening test designed to identify people who are drinking harmful or hazardous amounts of alcohol. It can also be used to identify people who need further diagnostic tests for alcohol dependence.

Brief intervention is a short session of structured brief advice to help someone reduce their alcohol consumption and can be carried out by non-alcohol specialists.

Primary care services in Bolton have implemented IBA across all GP practices, some pharmacies and Council services in the past 3 years. Over 100,000 people have completed an alcohol audit and/or received brief intervention advice from trained staff on managing their drinking.

[9] *Holmes J et al (2014) Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study The Lancet http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2962417-4/abstract*

Good Nutrition and Healthy Weight

Population

Around 1 in 5 of all reception aged children, 1 in 3 year 6 children and 60% of adults in Bolton are overweight or obese. Although a very complex issue, one of the main contributing factors to our high and rising overweight and obesity levels is the widespread accessibility of high calorific foods with high fat and sugar content, often served in large portions.

Issues of food quality are also of increasing public concern today as depicted by the recent 'horse meat scandal'. Whilst the consumption of horse meat does not in itself have public health implications, recent events have highlighted the nature of the globalised food industry. The need to maximise profit margins along the long processing chain and the high number of miles food travels before it reaches our plates has a negative impact on nutritional quality as well as safety of our food the UK, 40% of the food we eat is imported including up to 90% of fruit and 60% of vegetables. This is a changing picture from 1972 when a larger percentage was produced in the UK.

British consumers eat far more pre-packaged processed food now than in 1972. These foods tend to be higher in calories, fat, saturated fat, sugar and salt making a significant contribution to the obesity epidemic and the development of other long term chronic conditions.

Community

The Farnworth Childhood Obesity Project. Based on the successful French EPODE programme, is a multi-agency approach to tackling childhood obesity. It includes action to create a supportive environment e.g. by restricting the number of new take-aways and promoting a healthy catering award; working with schools, agencies and families in the area to promote healthy eating, enhance cooking skills and develop opportunities for children and their families to be more active and the delivery of weight management programmes. A large investment of resources from a number of agencies into 12 Farnworth/Little Lever primary schools has taken place. Annual measurement of all children in each year group at each school is taking place to monitor the impact of the programme. After just one year of the project there are already promising signs of a reduction in obesity in some year groups.

Individual

The Food Action Bolton programme engages with local people to stimulate interest and support local food growing projects, has a demonstration 'healthy eating' café 'The Kitchen on Great Moor Street' run by a cooperative of refugees and operates a fruit and vegetable van delivery scheme, 'the FAB Van', to increase accessibility to affordable fruit and vegetables.

The Market Well-being project has achieved national acclaim. A food and nutrition worker delivers healthy cooking skills courses and demonstrations from within Bolton Market and helps people source affordable ingredients from the market stalls.

Vulnerable Groups and Complex Needs

Tackling Exclusion

Individual level support is vital for those with more complex needs. Indeed this was recognised in 1972 when families with longstanding and deep rooted problems were identified as needing intensive case work. To support co-operation between different workers these families were referred to a monthly co-ordinating committee which decided on which professionals were best placed to offer support to the entire family.

Family First in Bolton is the local response to the national Troubled Families programme.

The programme aims to work with over 800 families identified as having complex needs over a two year time period. This group of families are faced with a myriad of issues that impact upon their quality of life and the communities they live in. Some of the challenges families face include: being workless, caught up in the criminal justice system and/or have vulnerable children with poor school attendance and/or behaviour issues. The Family First programme has developed a more integrated approach to service delivery, providing tailor made packages of support to families and using whole family assessments and interventions in order to change behaviour and reduce dependency on public services.

Responding to Diversity

Chapter 1 of this report compares the recent migration trends in Bolton with those in 1972 and points to the challenges associated with multi-lingual societies. Cultural differences and communication difficulties add to the challenges of ensuring that people from BME communities are able to access health care services and adopt healthier lifestyles. In 1972 Dr. Ross commented on the need for translation and interpretation services. Today it is recognised that it is not possible to take such an approach given the increasing diversity of the Borough. To this end community and individual approaches are taken in order to directly target health improvement messages to people who find it difficult to understand written or spoken English.

Whilst a small amount of health improvement literature has been translated into some community languages (e.g. the Don't be a Cancer Chancer campaign) there has recently been a stronger emphasis on exploiting new technologies (e.g. via the development of Smart Phone Apps) to support and engage individuals and communities who may be excluded due to language barriers.

Settings Based Approaches

Working with schools: from talks to whole school approaches

In 1972, a Health Education Officer was employed to give talks in schools and delivered 165 sessions directly to school children. The Medical Officer observed that

> *"Many teachers, whilst prepared to give simple factual health education talks, have felt anxious about dealing with more personal topics in the field of sex education, relationships and the abuse of drugs".*

Today, 125 Schools in Bolton have achieved the National Healthy Schools Award which requires the achievement of 41 standards across 10 health themes such as healthy eating, sex and relationships and emotional well-being. The standards cover the curriculum, the school environment and links with the wider community. It is a systematic approach to developing health-related culture and practice in schools to maintain and improve children's health. The Healthy Schools team, rather than engage in direct delivery to children, focus on supporting schools to maximise their role in improving the health of children. In the school year 2012/13 the team had more than 10,000 contacts with schools with every school in Bolton receiving at least 10 contacts including support visits and staff training events.

However, the anxiety amongst some teachers when talking about Sex and Relationships and Substance Misuse remains.

This organisational development type approach has also been adopted within Primary Care through the 'Health Improvement in Primary Care Programme', Royal Bolton Hospital Foundation Trust via the 'Health Promoting Hospitals' programme and in Workplaces via the 'Clock on 2 Health' programme.

Well-being

Building community resilience and well-being is essential to improving health. Well-being is about how we think and feel about ourselves, others and the world around us. The degree to which people think and feel positively influences their ability to cope with difficulties, make the most of opportunities and contribute to society. Research undertaken by the Public Health Team in collaboration with Bolton's Neighbourhood Management Teams ***'Concerning Health Matters: Voices from 3 Neighbourhood Renewal Areas (2012)'***[10] demonstrates quite clearly that despite knowing health messages and having a desire to be healthy, many people lack the self-belief that they can take the necessary steps to adopt healthier lifestyles. It also highlights that whilst most people value their health and seek to be healthy, their concept of health was very much defined as what was needed for daily living rather than an abstract goal.

"If These Walls Could Talk" project

Those who are disadvantaged by health inequalities are the people with the knowledge and insight into the barriers that prevent health in their community and what might work to overcome them. Such individuals should therefore be equal contributors to planning, designing and implementing interventions to improve health. As a result of the above research, work was initiated in Breightmet to develop the self-confidence of women in the area, empowering them to speak up, challenge the status quo, take control of their lives and access entitlements such as free child care. Through the project 40 women from Breightmet have found a voice. They are growing in confidence, feeling positive, making decisions and addressing issues and discussing them with knowledge and assertiveness.

[10] Griffiths B (2012) Concerning Health Matters: Voices from 3 Neighbourhood Renewal Strategy areas in Bolton: bit.ly/1eKcjFQ Accessed 15th April 2014

Wider Determinants of Health

The health and well-being of individuals and local communities across all age groups is influenced by a range of factors both within and outside the individual's control, and not just by lifestyle choices. These influencing factors include housing, education, financial security and the built environment as well as the health systems that determine the health of our local populations. The interrelationships between these factors are represented in the Dahlgren and Whitehead (1991) 'Policy Rainbow' (below), which identify the layers of influence on an individual's potential for health. This model has been useful in providing a framework for enabling the contribution of each of the layers to health to be recognised.

A Social Model of Health (Dahlgren & Whitehead, 1991)[11]

Health and Housing

The origins of modern public health lay in an understanding of the impact of living conditions on people's health and led to major improvements in sanitation and housing conditions and the resulting reduction in the prevalence of communicable diseases such as typhoid and cholera.

In 1972, Slum Clearance and clean air were major priorities which led to big improvements in standards of living.

Quality Housing

The Slum Clearance programme in Bolton began in November 1955 with 7,582 houses being cleared by way of compulsory purchase order leading to the re-housing of 5,763 families. During 1972, 322 houses were demolished and 46 families were re-housed in the areas of Washington Street, Venture Street, Grecian Street and Kay Street.

Today, the link between housing and health and happiness remains as strong as ever however, challenges remain in ensuring everyone in Bolton has a decent home.

Despite significant investment in both public and private sector housing to ensure that homes are brought up to decent standards, the worst living conditions continue to be found within the private rental sector. It is estimated that there are nearly 9,500 vulnerable households living in non-decent private sector housing in the Borough. It would cost around £58.5m to bring these properties up to a decent standard.

[11] *Dahlgren G & Whitehead M (1991) Policies and strategies to promote social equity in health. Institute for Future Studies*

The Council has recently allocated £6m to tackle the issue of decency in private sector housing stock. The new approach aims to bring the properties in the worst condition and those lived in by vulnerable homeowners to a decent standard i.e. safe, warm and dry.

There continues to be a significant demand for social and affordable housing in the borough with over 18,000 households on the Council's Housing Register. Through the Bolton Community Homes Board, Bolton Council is able to secure national funds to develop new homes. In addition, work is underway to develop alternative delivery models in order to bring empty properties back into use and to make better use of the private rented sector.

As the number of older people in our community grows, there are more vulnerable people living in non-decent private sector accommodation and increasing numbers of people with disabilities living alone. Vulnerable people commonly struggle to manage all areas of their homes and often have to choose between "heating or eating". This can lead to poor health and increase the likelihood of them needing additional care potentially within a care home.

Recognising that most people's preferred choice is to remain living independently, the Council's Home Solutions project focuses on providing joined up housing related services to assist older and vulnerable people to live more independently. Based around the existing Bolton Care and Repair service, which assists older or disabled people with home improvements and repairs. Home Solutions is working to enhance this current service model to provide a more joined up referral mechanism. It is developing both a universal and targeted advice and information offer to all customers and a casework function for those with more complex needs. Services provided include energy efficiency measures, a handyperson scheme and support to access the Disabled Facilities Grant.

Homelessness is on the increase in the Borough believed to result from the impact of Welfare Reforms. There are increasing numbers of people being declared homeless as well as living in temporary accommodation including Bed and Breakfast.
The Council is preventing homelessness by improving the range and quality of the housing options available. This has been addressed through the provision of appropriate housing and support; enabling people to maintain their accommodation or secure more suitable accommodation where possible. In addition appropriate services and interventions have been provided to those people experiencing homelessness to ensure that they are supported to play a full and positive role within the community in which they live.

Clean Air

Air pollution was a significant problem in 1972 with the main sources being from industrial and domestic chimneys. The first Clean Air Act was introduced in 1956 although smoke control began in Bolton in 1954 with the introduction of a Town Centre Smokeless Zone leading to a reduction of smoke pollution of 1/3 by 1972. Regulations to control the height of chimneys were also introduced but perhaps the biggest factor in reducing pollution from domestic coal fires was the conversion to gas heating.

Despite significant reductions in emissions of many pollutants since the 1970s, air pollution still causes harm to both public health and the natural environment. Air pollutants are largely the products of combustion and are emitted from various sources including power generation, industry, transport and agriculture. Air pollution from transport is the most significant source in Bolton. Petrol and diesel motor vehicles emit a wide variety of pollutants including Carbon Monoxide, Nitrogen Oxides, Volatile organic Compounds (VOCs) and particulates (PM10).

The Environment Act 1995 places a responsibility on Local Authorities to review and assess air quality within their boundaries. The Greater Manchester Authorities work together to improve local air quality and have developed a regional Air Quality Action Plan. This plan is incorporated into the Local Transport Plan due to the recognised local importance of emissions from road traffic.

The main actions include improvements to the transport network e.g. improved traffic control systems at junctions and priority to passenger transport and cycling; regulation and enforcement e.g. poorly tuned engines or through 'idling' and preventing bonfires; promotion of personalised travel arrangements using public and active travel modes; encouraging uptake of cleaner technology, fuels and practices.

Conclusion

If improving health and reducing health inequalities was easy we would have done it by now. To achieve improvements in health outcomes across the population requires co-ordinated action across all the levels of intervention i.e. population, community and individual. Improvements can also only be achieved with the input of a wide range of stakeholders across the public, private, voluntary and community sectors in order to develop shared goals and ambitions. Currently this approach is at the heart of public health strategy to influence positive behaviour change and improve overall health outcomes.

Given that so many of the drivers of good health and well-being lie beyond the scope of the NHS itself, the opportunity to more directly influence these factors from within the Council is a tremendous and exciting opportunity.

Between 1972 and 2013, whilst public health was the responsibility of the NHS, there was a shift in focus towards a more medical model of health in response to the emergence of chronic diseases and associated lifestyle risk factors. Actions taken in that time have addressed and improved some of the physical and environmental factors affecting disease; but challenges still remain for example in respect of ensuring decent housing and improving air quality. Publication of the Marmot Report on Health Inequalities and a return of public health to Bolton Council set the scene for a stronger focus on the wider determinants of health.

Dr. Ross must have foreseen the development of this aspect of public health when he said in 1972:

> *"Health education covers such a diverse field, that it sometimes becomes difficult to draw all the threads together in a profitable way. Obviously a multi-disciplinary approach is needed, but it is growing too fast to enable one person to act as a co-ordinator for any length of time".*

In addition, Dr. Ross also foresaw the need to invest in upstream health education and health improvement interventions in order to realise savings many years into the future. He said:

> *"The saving in the cost of services and gain in personal happiness through health education over a number of years, has proved to repay the resources that are made available to this service".*

Prevention pays. There is also a growing acceptance of the importance of investing in prevention among key stakeholders otherwise we will continue to "spend on failure".

Recommendations

1. **Explore further the potential of social media in supporting the achievement of health improvement outcomes (whilst being aware that not everyone has digital access).**

2. **Evaluate and learn from pilot programmes and initiatives such as Farnworth Healthy Weight in order to ensure best use of limited resources.**

3. **Continue to identify and improve health outcomes for vulnerable groups including Black and Minority Ethnic and new and emerging communities.**

4. **Continue to target and develop actions to improve the quality of private sector housing particularly the private rented sector.**

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