

# Tameside and Glossop Joint Strategic Needs Assessment 2008-9

## Chapter 1: Executive Summary

### 1. Background

Since 1 April 2008, local authorities and PCTs have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA). The JSNA informs the Local Area Agreement and the Sustainable Communities Strategy.

The process of JSNA will establish the current and future health and wellbeing needs of a population, leading to improved outcomes and reductions in health inequalities. This is a partnership duty which involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services.<sup>1</sup> By identifying current needs and future trends PCTs will be able to ensure that current and future commissioned services address and respond to the needs of the whole population, especially those whose needs are the greatest.<sup>2</sup> Needs assessment is integral to the commissioning cycle. It offers a systematic approach to identifying the major threats to health and well-being of the local population, and the best evidence on how to tackle those threats effectively.

In 2007-8 the PCT, in close partnership with Tameside MBC, undertook a Joint Strategic Needs Assessment which established joint priorities for the PCT, council and partners. The PCT also contributed to the Derbyshire Joint Strategic Needs Assessment process. The priorities areas identified through these processes formed the basis for selecting the priority areas set out in the 2008-13 Strategic Commissioning Plan- those of improving life expectancy, addressing premature mortality from Cardio-Vascular Disease (CVD), improving mental health and well-being, addressing alcohol related harm and improving children's health including breast-feeding rates.

These strategic priorities formed the basis for the 2008-9 Joint Needs Assessment process. This focussed on four areas: tobacco control - fundamental to improving life expectancy as well as reducing premature CVD mortality; reducing alcohol harm reduction; adult mental health and well being, and CVD – coronary heart disease and stroke.

### 2. The 2007-8 JSNAs.

The 2007-8 JSNA was based on DH guidance<sup>3</sup> and analysed current inequalities by geography, ethnicity and gender. It used the core data set<sup>4</sup> and focussed on Level 1 outcomes, that is health outcomes.

The 2007-8 Tameside JSNA described Tameside as Borough where people die earlier and suffer more of the burden of disabling long-term illness and poor mental health

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<sup>1</sup> Joint strategic needs assessment. DH website. September 2009

<sup>2</sup> WCC competencies – refinement for Year 2. NHS 2009

<sup>3</sup> Guidance on joint strategic needs assessment. Gateway reference 8794. DH 2007

<sup>4</sup> Association of public health observatories. The JSNA core dataset. Gateway ref 10262. DH 2008.

than they should and highlighted preventable health inequalities between Tameside and England and within Tameside.

The report set out the principal causes of premature death and disabling illness in Tameside adults as heart disease, stroke, cancers and respiratory disease. Underlying these it described a number of lifestyle factors – smoking, poor diet, physical inactivity and harmful levels of alcohol consumption. It found that in Tameside there are large numbers of people with these risk factors and the consequences are clearly seen in local health experiences. The risk factors were also reflected in family life, so that Tameside children are less likely to be breast fed than in other parts of the country, but more likely to be obese or suffer tooth decay.

The Derbyshire Joint Strategic Needs Assessment found that generally people in Derbyshire had the same or better health than for England. There were however substantial health inequalities and an identified a need to target the health of the less affluent. Underlying these health inequalities were the same conditions as in Tameside – heart disease and stroke, cancer, chronic chest conditions, poor mental health and other causes of limiting long term illness. The rise in the number of older people living in Derbyshire was highlighted as leading to a large increase in future demand for health and social care.

Certain key issues emerge from both Tameside and Derbyshire JSNAs and offer a basis for strategic action to improve the health of the population of Tameside and Glossop. Key findings of both JSNAs are:

- Key underlying causes of inequalities are heart disease, stroke, cancers, respiratory disease and mental health
- The increase in the number of older people will lead to an increase in the demand for health and social care
- There is therefore a need for a far greater emphasis on prevention, self-care and supporting people to change lifestyle.
- This must be supported by strategic partnership initiatives to address the wider determinants of ill health particularly socio-economic deprivation.

## **2.1 Setting strategic priorities based on the 2007-8 JSNA**

The findings of the 2007-8 JSNAs have informed the priorities of key partnership strategies, in particular:

- The Tameside Community Strategy addresses the themes of supportive communities, a safe environment, a prosperous society, a learning community, a healthy population and an attractive borough. Good mental health and well-being is a cross-cutting theme, with other specific health issues addressed including tackling misuse of alcohol and its effects; tackling the underlying causes of ill health and health inequalities including poor quality housing, debt, obesity and promoting healthy lifestyles, reducing cancer and circulatory disease to improve life expectancy and promoting smoking cessation.
- The Tameside Local Area Agreement (LAA) which includes improving life expectancy, reducing premature deaths from CVD, reducing smoking, increasing participation in sport and physical activity, reducing alcohol related

hospital admissions, improving the emotional health of children and reducing childhood obesity.

- The Derbyshire LAA which includes improving life expectancy, alcohol related hospital admissions, prevalence of breastfeeding and adult participation in sport and physical activity and reducing childhood obesity.
- The NHS Tameside and Glossop Strategic Commissioning Plan 2008-13 priorities are:
  - Health inequalities and life expectancy
  - Reduction in premature death from circulatory disease
  - Improved mental health and well-being
  - A healthy start in life for children
  - Reduction in alcohol related harm

### **3. 2008-9 Joint strategic needs assessments**

#### **3.1 Priorities**

The 2008-9 JSNA has built on the partnership priorities identified in the 2007-8 JSNAs and focuses on four of the Community Strategy/ LAA/ Strategic Plan priority areas:

- Tobacco control (as the single most effective method of improving life expectancy and reducing premature deaths from CVD)
- Reducing alcohol related harm
- Cardiovascular disease – covering heart disease and stroke
- Adult mental health and well-being.

The data in each section covers both Tameside and Glossopdale in order to form the basis for joint action with Tameside Council and other partners, and with Derbyshire and High Peak Councils.

In addition to the needs assessments the JSNA includes chapters on the results of qualitative research carried out in 2008 focussing on issues for those living in areas of socio-economic deprivation in Tameside and their smoking and drinking.

#### **3.2 Partnership involvement in the 2008-9 JSNA**

- The tobacco needs assessment has been used as the basis for the Tameside tobacco control strategy and action plan produced by the partnership Tameside tobacco alliance which includes representation from Trading Standards, Environmental Health, Healthy Schools, Children Centre, Fire and Rescue, PCT commissioning and provider divisions, Licensing, Tameside Third Sector Coalition, Substance misuse services for Young People , adult services and Comms representatives from both PCT and Tameside Council.
- The alcohol needs assessment was jointly commissioned with Tameside Community Safety and will be used to form the basis for the refresh of the partnership Tameside Alcohol Strategy and Action Plan. The recommendations have been endorsed by Tameside Strategic Partnership, and by Crime and Disorder, Health, Children and Young People thematic partnership and will be taken to the Older People, Economic and Learning and Housing Partnership. It will also inform a total place pilot in Glossopdale focussed on reducing alcohol related harm.

- The mental health and well-being needs assessment covers the wider determinants of mental health and a full range of partners – including service users, Pennine Care, primary care mental health services, police, job centres, primary care and joint commissioning - have been involved in consultation and development of the recommendations.
- The CVD needs assessment covers population strategies for addressing key determinants of CVD as well as targeting at risk individuals. Effective population strategies to reduce CVD include tobacco control, promoting physical activity and improving the availability of a healthier diet throughout Tameside and Glossop and therefore consultation and development of the recommendations will actively involve Tameside, Derbyshire and High Peak councils and other partners.

### 3.3 Methodology

As stated above, needs assessment is a systematic approach to identifying and prioritising population health issues and inequalities, and for identifying effective strategies and interventions for tackling these.

In Tameside and Glossop the needs assessment process is based on validated protocols<sup>567</sup> which underpin the following local needs assessment framework, which was endorsed by PEC in December 2009.

#### *Scope*

- What is the purpose of this needs assessment?
- What will be included and what excluded?
- What questions will be answered by it?

#### *Context – overview of the health issue*

- What is the national picture in terms of prevalence and trends?
- How important is it as a Public Health issue is it for example in terms of the effect on mortality, morbidity, well-being, use of services, effects on attainment or the economy?
- Who are the particularly vulnerable or at-risk groups?

#### *The local situation in a national context*

- What is the picture in Tameside and Glossop relative to the rest of the country? What does this tell us about the potential for prevention?
- How are vulnerable groups represented in Tameside and Glossop and what effect will this have on inequalities?

#### *Policy drivers*

- Policy guidance on effective interventions to tackle the issue.
- Evidence on effective interventions to tackle the issue in the populations identified
- Consultation with groups of the public or patients including the findings of existing local or national consultations.
- Consultation with clinicians or front line staff – including the results of existing consultations.

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<sup>5</sup> Health needs assessment a practical guide: NICE 2005

<sup>6</sup> Stevens A, Raftery J, Health Care Needs Assessment. Radcliffe 2004

<sup>7</sup> Pencheon D, Oxford Book of Public Health Practice. Oxford University Press 2003

### *Services in Tameside and Glossop*

- A summary of what services exist at a universal, targeted, and specialist levels, e.g. universal prevention, targeted prevention, self care, primary care, secondary and tertiary care.
- Examples of good practice
- Targeting of services to meet need and address inequalities – prioritisation, targeting to at risk or vulnerable group.
- Existing care pathways.

### *Conclusions*

- Importance as a public health issue
- Tameside and Glossop benchmarked against national and regional figures – the potential for prevention.
- Particularly vulnerable groups in Tameside and Glossop
- What needs to be done to address the issue effectively?
- What gaps are there in existing services or pathways?

### *Consultation on the findings and conclusions*

- Involving stakeholders including key partners, public or patient reps, clinicians, commissioners in reviewing:
  - The plausibility and comprehensiveness of the findings and conclusions
  - What services need to do to address the findings and conclusions

### *Recommendations*

- Formulate recommendations based on the above
- Recommendations based on needs assessment findings and conclusions and stakeholder consultation form a highly credible basis for a strategy and action plan.

While needs assessments normally focus on particular health issues or lifestyle behaviours, a Joint Strategic Needs Assessment is an overarching assessment of health issues used to identify priorities. The 2008-9 uses the above methodology for the four priority areas, draws conclusions and makes recommendations for each area and then makes high level recommendations from the common findings from each of the needs assessments.

## **4 Findings from the 2008-9 Needs Assessment programme.**

### **4.1 Common findings from across the needs assessments**

Delivering a suite of needs assessments does highlight common findings which represent wider issues for Tameside and Glossop that should be tackled through cross-cutting strategies such as the Tameside Inequalities Strategy and by action across the Strategic Partnerships. Although these recommendations contain no surprises, the consistent findings from a systematic needs assessment process do present an authoritative basis for action.

- 4.1.1. For all the health issues examined in the 08-09 JSNA, - CVD, smoking, alcohol misuse and mental health, Tameside and Glossop is an outlier, with higher prevalence than would be expected even given its levels of socio-economic deprivation. These relatively high levels of poor health and health behaviours are increasingly understood and acted on by the Councils, PCT and partners. It is important that this commitment to improving key health indicators in Tameside and Glossop continues to be supported and built upon by policy makers, front line staff and the public.
- 4.1.2. A concentration of health issues in particular areas of Tameside and Glossop. Areas of multiple deprivation such as Ashton St Peters, Denton South and Gamesley in Glossopdale are the areas with the highest prevalence of all the lifestyle and health issues investigated by this suite of needs assessments. These areas are well recognised within the existing inequalities strategy and have the benefit of health outreach and other targeted services. However the strength of this finding does offer a basis for reviewing the provision of all mainstream services and their accessibility to those living in these areas.
- 4.1.3. Linked to the above is the consistent finding that a high proportion of those whose lifestyles place them at risk or who have already developed health problems have multiple problems and complex needs which go far beyond the individual health issues described in this suite of needs assessments. Again this has important implications for how services – not only health and social care but the whole range of support – are provided. Firstly there is a need to integrate services and to adopt a co-ordinated, cross-agency, integrated approach to care. Furthermore those with chaotic lifestyles or conflicting priorities often find it difficult to make best use of services and this means that to be effective services must be flexible in provision.
- 4.1.4. Each of the needs assessments has highlighted a lack of consistent, equitable evidence based provision to meet needs. Care pathways are not clear or well developed. There are examples of good practice but the care provided to individuals is not systematic and not based on the individuals' needs. There are numerous examples of good practice but the Tameside and Glossop population as a whole does not benefit from these, least of all those most vulnerable or at-risk. Often this is not a question of additional resource but of best use of available resource.
- 4.1.5. In all areas addressed by this suite of needs assessments it is clear that the most effective measures to improve health, well-being and quality of life in the longer term are through changes to the context in which people live – the availability of healthy choices – a good diet and physical activity, decent housing, education, training and employment, and limiting the supply as well as the demand for alcohol and tobacco. In many cases this requires no extra resource – simply a commitment to supporting health and well-being – on the part of all the partner agencies in Tameside and Glossop.

## **4.2. Tobacco control needs assessment**

### **4.2.1. Tobacco control context**

This needs assessment offers an evidence base for the first Tameside strategy and action plan to reduce harm caused by tobacco. It reviews tobacco related harm in Tameside and Glossop, and identifies particularly vulnerable groups through analysis of national and local data. It reviews the evidence of effective practice and highlights gaps in local practice. It recommends a programme of action which will effectively address the particular local issue caused by tobacco.

### **4.2.2. Tobacco control conclusions**

The needs assessment concludes that tobacco related harm is relatively high in Tameside and Glossop, reducing life expectancy, causing high levels of ill health and increasing health inequalities.

Local tobacco use is high, with specific groups particularly at risk, including those from lower socio-economic backgrounds, Bangladeshi adults and Pakistani men. Vulnerable groups include children and unborn babies, especially among families in areas of socio-economic deprivation and those with existing health conditions, including those with poor mental health and hospital in-patients. The picture of tobacco use in the Borough is one closely linked to multiple deprivation and other health and social care needs. Smoke-free legislation has aimed to de-normalise smoking, but it remains very much the norm in areas of socio-economic deprivation, further widening health inequalities.

The needs assessment further concludes that the services in Tameside and Glossop have not responded effectively to this health threat. Levels of recording of smoking status in primary care are low. Identification of smokers and brief advice – a simple and highly effective intervention – or referrals to local Stop Smoking Services are not consistent or systematic. It finds that a concerted, cross-agency strategy could result in both short and long term benefits, saving lives, improving quality of life and reducing the burden on health service resources

### **4.2.3. Tobacco control recommendations**

- There needs to be a wide scale recognition across Tameside and Glossop that tobacco related harm is the most significant cause of health inequalities and that we suffer higher levels of tobacco related harm than other, comparable areas.
- An effective response to reducing tobacco related harm across agencies will require high level commitment from all partner agencies to identifying and implementing basic and fundamental tobacco control measures, such as front line staff referring to smoking cessation services. All agencies should have systematic policies and procedures in place and should be trained in giving very brief advice to smokers. Barriers to this happening should be identified and dealt with (e.g. by including smoking in service specifications).
- Smoking cessation services need to be tailored to meet the needs of at-risk and vulnerable groups.

- Given the role of smoking in causing preventable ill health and exacerbating other conditions, health services should assess smoking status of all patients and advise smokers to quit. Primary care should routinely record smoking status and pro-actively target smokers. Hospital in-patients should have their smoking status recorded and smokers should receive advice and referrals before, during and after their stay.
- A consistent and integrated partnership approach is needed to reduce the supply of tobacco, especially under-age sales and illicit or counterfeit tobacco.

#### 4.2.4. Summary

The potential benefits to improving population health and reducing inequalities from reducing smoking across Tameside and Glossop justifies a consistent and systematic approach to effective tobacco control measures across services.

### 4.3. Alcohol needs assessment

#### 4.3.1. Alcohol needs assessment context

Partner agencies in Tameside and Glossop have recognised alcohol as an important issue affecting health and well being since the first Tameside Alcohol Strategy was agreed in 2003. Since then the National Alcohol Strategy has been published committing the Government to reducing alcohol related harm, and benchmarking data has been made available which shows that the Tameside population suffers high levels of alcohol related harm relative to England and the North West.

In 2008 the PCT included alcohol as one of five priority areas identified in its strategic plan as having the greatest impact on population health, well-being and inequalities. A partnership action plan was developed to reduce alcohol related harm. This included an evidence based programme of action aiming to reduce alcohol related hospital admissions.

The first step in the action plan was to produce a Needs Assessment to identify effective partnership action to reduce alcohol related harm in Tameside and Glossop. This needs assessment was jointly commissioned by Public Health at the PCT and by Community Safety at TMBC.

#### 4.3.2. Alcohol needs assessment conclusions

- Alcohol harm in Tameside and Glossop is extensive, is an important factor adversely affecting overall quality of life and in perpetuating inequalities. Tameside is in the "top ten" nationally for alcohol related harm in relation to health including admission to hospital, months of life lost, levels of consumption and levels of incapacity benefit linked to alcohol.
- Tameside and Glossop has significantly worse levels of harmful and binge drinking compared to the national average. Rates of alcohol specific and attributable hospital admissions and male alcohol specific mortality are also significantly worse.
- Alcohol misuse affects health and well-being in a number of ways – increasing liver and pancreatic disease, cardiovascular disease, life expectancy, mental health; crime and violence and public perception of violence, through its effects on the workplace and economy, on accidents, family and society.

- Alcohol related harm contributes significantly to premature death in Tameside and Glossop, especially through cardiovascular disease and cancers. In addition to NI 39 on reducing alcohol related hospital admissions, alcohol related harm will affect targets on all age all cause mortality, premature death through cancer and circulatory disease, healthy life expectancy, self reported health and well-being, and satisfaction with home and neighbourhood.
- Tameside and Glossop suffers particularly high levels of binge drinking especially by young men. This contributes to a wide range of social harm including alcohol related hospital admissions, crime, violence and disorder and teenage pregnancy. Efforts to tackle binge drinking will require action on tackling the supply and demand for alcohol, as well as front-line staff identifying and advising those who abuse alcohol.
- The Tameside and Glossop population also have high levels of harmful and dependent drinkers, many of whose drinking will contribute to premature CVD or cancer deaths. As well as developing the role of primary care, care pathways for acute and social care and mental health must deal effectively with alcohol as a contributing factor. Pathways for specialist alcohol services need development to ensure that they are effectively meeting the needs of all groups of harmful and dependent drinkers in Tameside and Glossop.
- Alcohol related harm from binge and chronic drinking is concentrated in areas of socio-economic deprivation, widening inequalities. Efforts to reduce alcohol related harm should be targeted to particular areas of socio-economic deprivation.
- A significant proportion of harmful drinkers suffer multiple and complex needs. Their needs will only be met through ensuring that pathways (e.g. mental health, criminal justice, social care) develop towards a co-ordinated multiagency case work approach to tackling alcohol related harm within a holistic approach to the individual or family's need.
- The underlying determinants of harmful drinking in Tameside and Glossop are wide ranging and deeply rooted in the local culture. Tackling alcohol related harm will therefore require concerted action on the part of the Strategic Partnerships and each thematic partnership.

#### **4.3.3. Alcohol needs assessment recommendations**

- That all partner agencies recognise the relatively high levels of alcohol as a threat to the health and well-being of the Tameside and Glossop population and act as advocates for tackling alcohol related harm through control of supply and demand as well as through service provision and social marketing.
- That partner agencies recognise the link between alcohol related harm and inequalities, and with multiple and complex needs. That they contribute to work in progress to ensure that all pathways for vulnerable groups – including those with mental health issues, with complex social needs or in contact with the criminal justice system include provision for the assessment and management of alcohol related harm, with referral to specialist alcohol services where appropriate. This will include training and support for front line staff in alcohol assessment and brief advice.

- That partner agencies give active support to partnership plans for tackling alcohol related harm. This will include identifying an alcohol champion, supporting pathway redesign, responding to consultations on the needs assessments and redrawn Tameside Alcohol Action plan and implementing the recommendations to Tameside of the alcohol and inequalities National Support Teams. Above all it requires each agency to commit to identifying the contribution they can make to tackling alcohol related harm in order to improve population health and well-being and address inequalities in Tameside and Glossop.

#### **4.3.4. Qualitative needs assessment work on alcohol.**

In September 2008 Dr Foster Intelligence delivered a report on home alcohol consumption in Tameside and Glossop. This was based a workshop carried out with 24 people in groups of eight. They were men and women from Tameside, all of whom came from areas of socio-economic deprivation and were drinking over the recommended limits. The findings were as follows:

##### *Overall findings*

- High levels of depression, loneliness, stress and mental health issues, contributing to smoking, drinking and unhealthy lifestyles
- Lack of awareness of government guidelines on alcohol and exercise
- Belief that guidelines are too low
- Some strong opposition to government interfering in lifestyle - need to be careful how to place health messages - avoid image of nanny state/interference
- Lack of immediate support when required
- People most likely to be influenced by:
  - People they trust (family, key workers, people who they have a close relationship with)
  - Experts, but people that they don't know (e.g. GP)

This work has formed the basis for proposals for a social marketing campaign to be led by Tameside Council.

### **4.4. Mental health and well-being**

#### **4.4.1. Mental health needs assessment context**

The strategic plan mental health priority emphasises mental health and well-being rather than severe mental illness. Following consultation with stakeholders it is intended that the findings form the basis for a strategy to promote mental and emotional resilience and reduce risk of common mental health issues.

#### **4.4.2. Mental health needs assessment conclusions**

- Common mental health issues are an important public health issue affecting about a fifth of the population and leading to health harming behaviours, and impact on attainment, employment, economic contribution and parenting, among other areas.
- Data consistently indicates a higher prevalence of common mental health issues in Tameside and Glossop compared to the national average. It also indicates a significant level of inequality within the population with areas of much higher prevalence and levels of need than the PCT average figures suggest. Prevalence will also increase as a result of the recession, also exacerbating inequalities.

- Particularly high levels of mental health issues are found among those living in areas of socio-economic deprivation, BME groups especially Bangladeshi and Pakistani populations, those with long term physical illness, those who are economically inactive and without qualifications, those who live in social housing (Local Authority or Housing Association).
- Policy guidance indicates that tackling basic needs (e.g. housing and finance) as well as employment issues, social exclusion, stigma and negative staff attitudes are key to addressing common mental illness. Supporting the development of emotional resilience, provision of appropriate access to support and community participation in decisions are also essential in addressing population need.
- The evidence for effective interventions advocates a stepped care approach to tackling common mental illness, starting with mental health promotion, followed by structured physical activity programmes, guided self help, CBT and leading up to psychological therapy and medication.
- A number of gaps have been identified in existing services and pathways:
  - There are examples of excellent practice in Tameside and Glossop, however these programmes are not always provided systematically across all areas, nor are they always provided equitably across the population.
  - Services are generally not targeted to areas or populations of greatest need
  - There are many good quality services available; however, they are not brought together in a coordinated, integrated way to enable joined up working and easy, comprehensive access
  - There is no consistent access for people with common mental illness. Referral and access triggers vary by point of access.
  - In addition to unclear access, there are no clear, mapped and agreed care pathways for people with common mental disorders
  - Entry to services is generally based on inclusion criteria, therefore there is potential for certain groups not to fit into these criteria, for example young people NEET (not in education, employment or training) and young families.
  - There is confusion regarding the care of people with complex needs, such as drug and alcohol related needs as well as mental health needs. Responsibility for care is often not clear or coordinated between services and therefore there is potential that need is unfulfilled in these groups.

#### 4.4.3. **Mental health needs assessment recommendations**

Recommendations were finalised following a stakeholder consultation workshop. They recognise:

- A need for all partner organisations to commit to tackling common mental health issues and promote mental health well-being through ensuring that all policies and strategies are inclusive and promote emotional resilience and resistance to risk.

- Use this needs assessment as a basis for a partnership, evidence based mental health and well-being promotion strategy
- Recognise the role that holistic support will play – and the key role of health, social care, education, housing and employment.
- Ensure systematic, equitable universal provision across Tameside and Glossop informed by equity audit. Ensure that this covers transitional groups including young people NEET (not in education, employment or training)
- Ensure that universal provision is built on to include targeted services to meet the needs of particularly vulnerable and at risk groups. Recognise that this may require a case work approach involving co-ordinated delivery of care across agencies for those with multiple and complex needs.
- Develop clear care pathways to ensure integrated services with consistent and appropriate access routes.

#### **4.5. Cardiovascular disease (CVD) (early findings)**

##### **4.5.1. CVD needs assessment context**

The CVD needs assessment covers both CHD and stroke. It explores both population and targeted high risk strategies and is intended to support the development of a strategic, partnership approach to the primary and secondary prevention of CVD in Tameside and Glossop. The following represent early findings.

##### **4.5.2. CVD needs assessment conclusions**

- Policy makers and frontline staff need be aware that CVD is a more important cause of premature death in Tameside and Glossop than in other areas, including other Spearhead areas, and to commit to population and targeted strategies to address these. The higher CVD levels in Tameside and Glossop demonstrate considerable potential for prevention.
- Although efforts are being directed towards developing a systematic approach to targeting those identified as being at risk from CVD, there is a need to complement this with an equally rigorous approach to promoting healthier lifestyles for the whole population of Tameside and Glossop. This is because the demographic trend towards an ageing population, combined with increases in the prevalence of obesity, hypertension and Type 2 Diabetes among younger people, will result in a steady increase in demand on both preventive and treatment services. A population-wide strategy to reduce the prevalence of lifestyle risk factors will be required in order to maintain the at-risk population at a manageable level.

##### **4.5.3. Recommendations**

###### *Population strategies –*

There is a need to tackle the following lifestyle issues in a systematic way across Tameside and Glossop, particularly targeting areas of socio-economic deprivation:

- Tackling the high prevalence of smoking across Tameside and Glossop must be an urgent partnership priority.
- Tackling the underlying causes of obesity to reduce Type 2 diabetes
- Improving diet across Tameside and Glossop
- Improving physical activity levels across Tameside and Glossop

#### *Targeting those at risk*

- There is currently no systematic implementation of the recording of smoking status, cholesterol status, blood pressure and diabetes and the management of these conditions
- There is an urgent need to ensure that smokers are referred to stop smoking services
- There are particular populations at high risk – those living in deprived communities, Pakistani and Indian populations and these should be recognised when targeting services.

#### **5. Information sharing**

It is planned to make the results of the 2008-9 and future Needs Assessment programmes will be available to partner organisations through an electronic repository. This will include background documents and action plans. In Tameside this will be through the Partnership Information Portal (PIP).

## Chapter 2: Tobacco Control

### 1. Introduction

#### 1.1 Tobacco related harm

The level of mortality and morbidity caused by tobacco use is alarming, and smoking is the single greatest cause of avoidable illness and preventable death, reducing quality of life and life expectancy<sup>8</sup>. In addition, whilst many medical conditions associated with smoking may not be fatal, they may cause years of debilitating illness or other problems.<sup>9</sup> Indeed, following surgery smoking contributes to delayed wound healing and post operative respiratory complications<sup>10</sup>.

The Chief Medical Officer has also recognised the role that tobacco plays in perpetuating poverty, deprivation and health inequality<sup>11</sup>, and smoking has been identified as being responsible for over half the difference in the risk of premature death between social classes.<sup>12</sup>

#### Children and young people

Children and young people can also be affected by tobacco related morbidity, with those that smoke experiencing more respiratory symptoms than those who do not smoke and they are two to six times more susceptible to coughs, increased phlegm and wheezing. Smoking has been established as a cause of impaired lung growth in children and young people and can also cause asthma-related symptoms in childhood and adolescence.<sup>13</sup>

Children are less likely to give up smoking than those who start smoking later in life and are, therefore, also likely to consume more cigarettes and suffer from a greater addiction to tobacco. This, combined with a greater susceptibility of immature organs, results in an increased risk of suffering a smoking-related disease such as cancer, respiratory illness and cardiovascular disease and of dying early as a result<sup>14</sup>.

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<sup>8</sup> Department of Health, 1999. *Saving Lives: Our Healthier Nation*. <http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm>

<sup>9</sup> Action for Smoking and Health (ASH), 2008. *Smoking Statistics*. [http://www.ash.org.uk/files/documents/ASH\\_93.pdf](http://www.ash.org.uk/files/documents/ASH_93.pdf)

<sup>10</sup> The Information Centre, 2008. *Statistics on Smoking: England 2008*.

<sup>11</sup> Department of Health, 2008. *Excellence in Tobacco Control: 10 high impact changes to achieve tobacco control*. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084847](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847)

<sup>12</sup> Jarvis and Wardle, 2006. *Social patterning of individual health behaviours: the case of cigarette smoking*. In: M. Marmot & R.G. Wilkinson, eds. 2006. *Social Determinants of Health*. Oxford: Oxford University Press. Ch. 11.

<sup>13</sup> Information Centre, 2008. *Drug use, smoking and drinking among young people in England, 2007*.

<http://www.ic.nhs.uk/webfiles/publications/sdd07/SDD%20Main%20report%2007%20%2808%29-Standard.pdf>

<sup>14</sup> Information Centre, 2008. *Health Survey for England 2007*.

<http://www.ic.nhs.uk/webfiles/publications/HSE07/HSE%2007-Volume%201.pdf>

## Impact of second hand smoke

The Government's independent Scientific Committee on Tobacco And Health (SCOTH)<sup>15</sup> reported in 2004 that exposure to second-hand smoke can cause a number of serious medical conditions amongst adults and children: lung cancer, heart disease, asthma attacks, childhood respiratory disease and impaired lung growth and sudden infant death syndrome (SIDS or cot death).

The Tobacco Advisory Group Royal College of Physicians advise that passive smokers are typically exposed to about 1% of the tobacco smoke exposure sustained by a smoker and maternal smoking also results in foetal exposure to environmental tobacco smoke (ETS) products. In 2003, they estimated that second hand smoke exposure caused approximately 12,200 deaths in the UK, and that this estimate was likely to be conservative<sup>16</sup>.

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intra-uterine growth restrictions<sup>17</sup>.

## 1.2 What is tobacco control?

The Tobacco Control National Support Team has described tobacco control as those strategies which<sup>11</sup>:

- Reduce demand for tobacco with:
  - price measures including high rates of tax.
  - non-price measures such as advertising restrictions, smokefree laws, health warnings, information and advocacy, and stop smoking programmes.
- Reduce supply of tobacco by:
  - controlling illicit trade.
  - restricting access to minors

## 1.3 Tobacco Control within Tameside and Glossop

Tameside and Glossop has historical links with the tobacco industry. A tobacco factory, which closed in 1999, was situated in Hyde, employing over 900 people. As many local people were employed by the factory, local support for the industry was strong and this connection has been difficult to tackle over the years when trying to denormalise the use of tobacco within the local population.

To address tobacco control and the historical links with the industry, it was recognised that a comprehensive Tobacco Control Strategy was needed. However, there had

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<sup>15</sup> Scientific Committee on Tobacco and Health (SCOTH), 2004. *Secondhand Smoke: Review of evidence since 1998. Update of evidence on health effects of secondhand smoke.*

<sup>16</sup> Tobacco Advisory Group Royal College of Physicians, 2005. *Going smoke-free: The medical case for clean air in the home, at work and in public places.*

<sup>17</sup> Department of Health, 2009. *NHS Stop Smoking Services: Services and monitoring guidance 2009/10.*

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_096886](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096886)

not been a local systematic assessment of the scale of tobacco related harm, nor was there any existing opportunity for local agencies to come together and jointly plan how to tackle the problem.

The first step towards a Tobacco Control Strategy was to conduct a Tobacco Control Needs Assessment<sup>18</sup> to identify which population groups were most affected by tobacco related harm. The Needs Assessment would also review evidenced based best practice and guidance to highlight gaps in local tobacco control activity and services which are needed to meet the identified needs.

The National Support Teams for Health Inequalities and for Tobacco Control were also invited to visit Tameside and Glossop, review the local approach and make recommendations for further local action<sup>19</sup>. The newly convened Smokefree Tameside Tobacco Alliance, which involves membership from many partner agencies, used the recommendations from the Needs Assessment and the NST to create a Tobacco Control Strategy and Action Plan.

## **2. Tobacco related harm in Tameside & Glossop**

### **2.1 Scale of tobacco related harm**

#### **2.1.1 Smoking related mortality**

In 2005-07, the life expectancy in Tameside, which is a Spearhead local authority<sup>20</sup>, was 2.4 years for men and 2.2 years for women. This gap exists because there are higher levels of premature death than the population profile indicates should be expected. The London Health Observatory has developed the Health Inequalities Intervention Tool<sup>21</sup> to analyse these excess deaths and highlight the key issues that Spearhead areas should tackle to reduce the life expectancy gap.

The Tool shows that within Tameside, circulatory disease, cancer and respiratory disease were responsible for 87% of the excess male deaths and 89% of the excess female deaths (see

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<sup>18</sup> NHS Tameside and Glossop, 2009. Tameside and Glossop Tobacco Control Needs Assessment 2009.

<sup>19</sup> Department of Health, 2009. Tobacco Control NST visit to Tameside, June 2009, Feedback.

<sup>20</sup> As analysis was only provided for Spearhead local authorities, analysis that includes High Peak (which is not a spearhead area) is not available.

<sup>21</sup> Health Inequalities Intervention Tool for Spreaheads, updated 2009. London Health Observatory, 2009.

[http://www.lho.org.uk/LHO\\_Topics/Analytic\\_Tools/HealthInequalitiesSpearhead2007.aspx](http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesSpearhead2007.aspx)

Figure 2.1 and Figure 2.2). Note, these figures show the analysis of Tameside's life expectancy gap beside the analysis of the average Spearhead gap, and it can therefore be seen that these three diseases are responsible for around 20% less excess deaths in Spearhead areas than in Tameside.

It has been estimated that of all deaths in those aged 35 years and over from circulatory disease, 14% are attributable to smoking, as are 29% of cancer deaths and 35% of respiratory disease deaths<sup>22</sup>. Therefore a large proportion of excess deaths in Tameside are attributable to tobacco use.

These proportions of deaths attributable to smoking have previously been applied to local mortality rates. Males and females under the age of 35 years both experienced higher smoking related mortality in Tameside compared to Greater Manchester and the North West. (data for PCT populations were not published).

**Table 2.1:** Smoking related deaths and mortality rate, by gender, 2002.

Area	Smoking related deaths in 2002, all ages 35 and over			
	Male		Female	
	No. of deaths	Rate/ 100,000	No. of deaths	Rate/ 100,000
Tameside	291	527.7	212	346.9
Greater Manchester	3107	489.7	2267	323.8
North West region	8517	481.3	6191	312.9

*N.B As Glossopdale falls out with the North West region, it was not included in this analysis. Source: North West Tobacco Related Deaths 2002. Tobacco Control Research Bulletin.*

If the estimate for smoking related mortality (18% of all deaths) was applied to Tameside and Glossop deaths in 2007, then it could be estimated that around 450 people per year die as a result of tobacco use. However, as local smoking prevalence is higher than in England in general, then there might be more than 500 deaths per year attributable to tobacco.

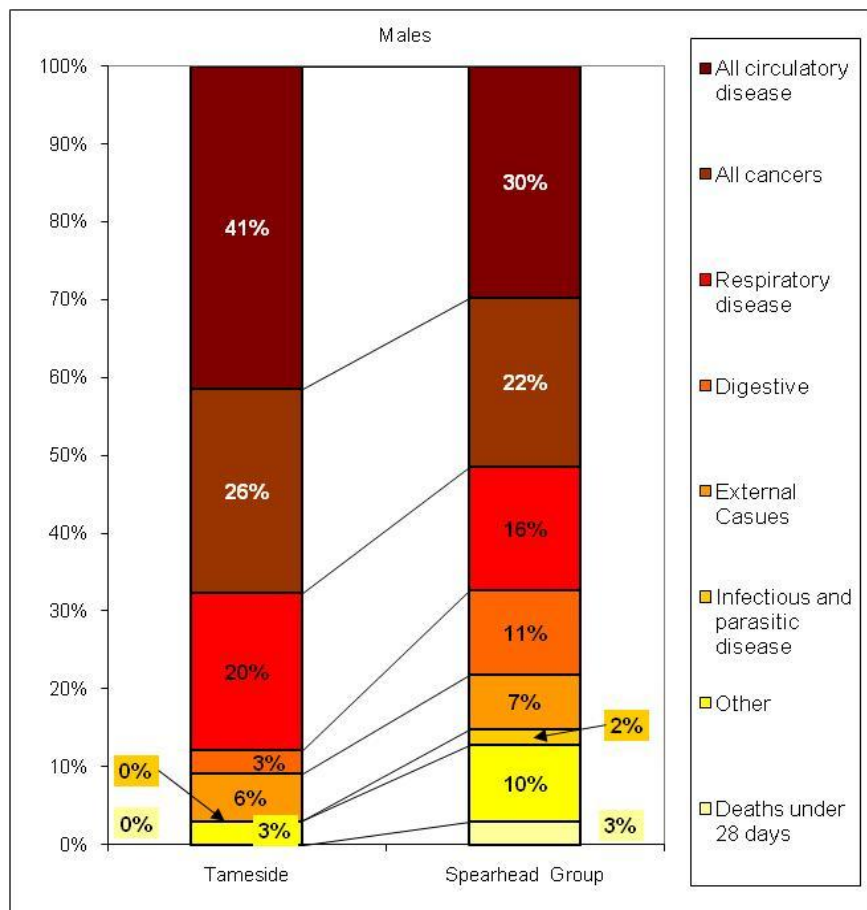
**Summary - Gaps towards achieving improvement targets**

It can be seen from Table 1 that males and females in Tameside experience a higher level of smoking attributable mortality than Greater Manchester or the North West.

Figures 1 and 2 demonstrate that the majority of excess male and female deaths in Tameside, which result in a lower life expectancy than England, are caused by smoking related diseases: circulatory and respiratory diseases and cancer. In addition, in Tameside these diseases have a larger proportional contribution to the life expectancy gap with England than in other Spearhead areas.

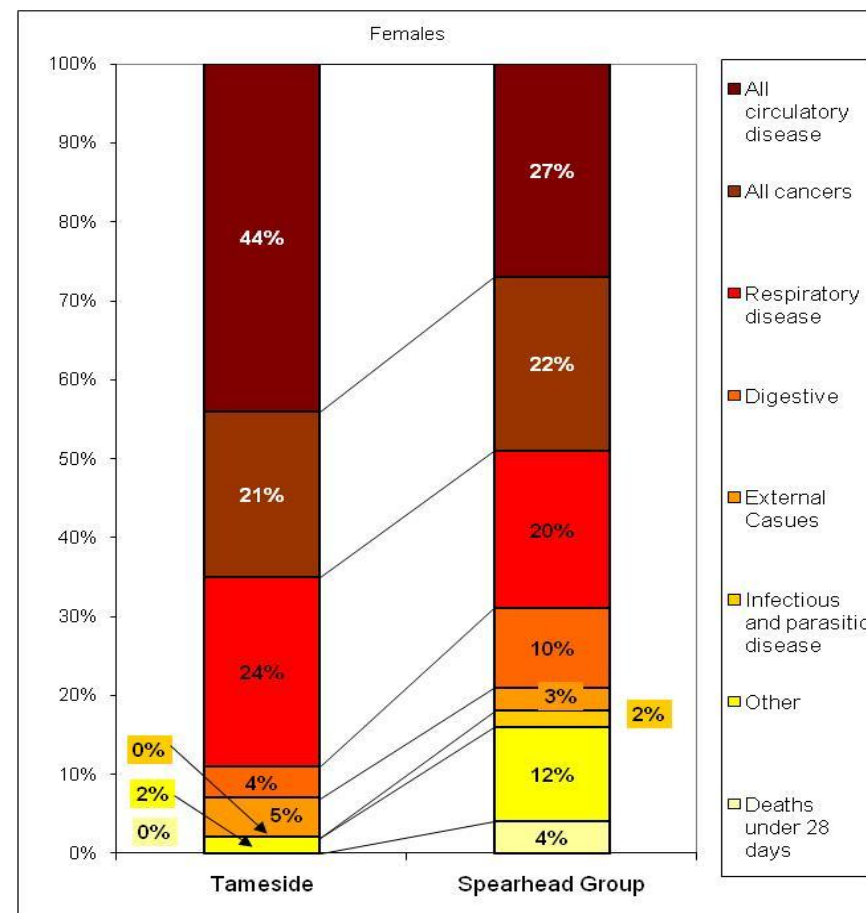
<http://www.ic.nhs.uk/webfiles/publications/Smoking%20bulletin/Smoking%202008/Statistics%20on%20Smoking%202008%20final%20format%20v9.pdf>

**Figure 2.1:** Breakdown of the life expectancy gap with England by disease, males, 2005-07.



Source: Association of Public Health Observatory, 2009. Health Inequalities Intervention Tool.

**Figure 2.2:** Breakdown of the life expectancy gap with England by disease, females, 2005-07.



Source: London health Observatory, 2009. Health Inequalities Intervention Tool.

## 2.2 Trends in tobacco related harm

Unfortunately, smoking attributable mortality and morbidity data is not available on an annual basis and so trends in smoking related harm are difficult to follow. One method is to analyse trends in lung cancer mortality, as it has been estimated that 90% of deaths in lung cancer are attributable to smoking<sup>23</sup>.

The rate of lung cancer deaths in Tameside (data is not available for Tameside and Glossop) are falling over time. However Figure 3 shows that this trend also exists throughout the North West and England, and therefore the level of mortality remains higher in Tameside than in the North West and England. This decline could be due to improve detection and treatment, but is thought to be due to falling smoking prevalence.

**Figure 2.3:** Directly Age Standardised Rates (DSR) for lung cancer mortality, persons, all ages, 1993 to 2007, Tameside, North West and England.



Source: NCHOD, 2008

### Summary - Progress toward reducing the gap in tobacco related mortality – benchmarks against England

Lung cancer mortality is falling in Tameside, and it can be assumed that other tobacco related mortality is also falling. However, this downwards trend also exists within the North West and England, resulting in levels of tobacco related mortality which remains persistently higher than in England.

<sup>23</sup> Action on Smoking (ASH) Facts at a glance: Smoking and Disease. November 2007. [http://www.ash.org.uk/files/documents/ASH\\_94.pdf](http://www.ash.org.uk/files/documents/ASH_94.pdf)

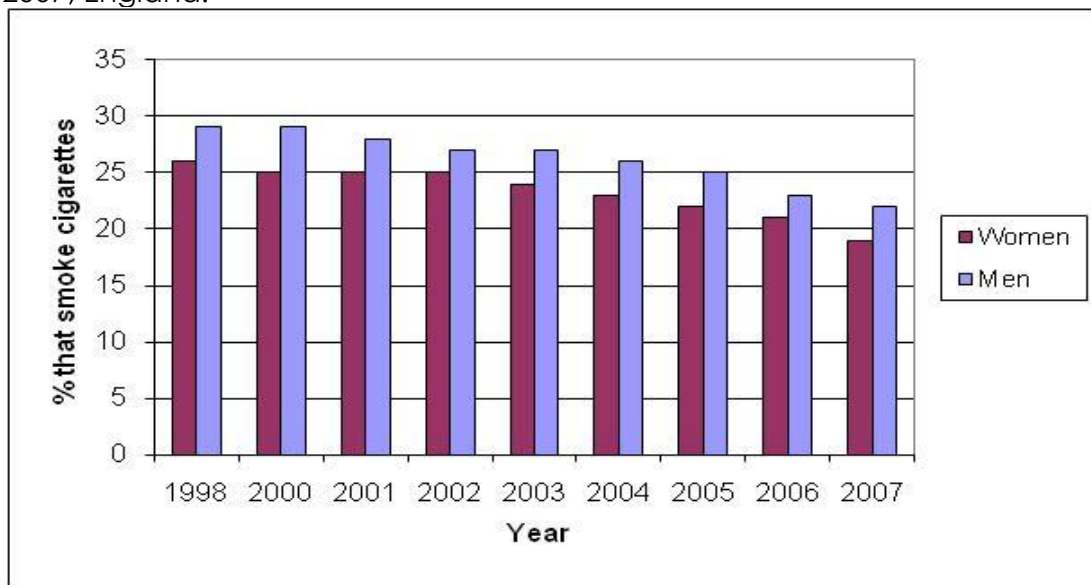
### 3. Patterns of smoking Prevalence

#### 3.1 Smoking prevalence in England

##### 3.1.1 Adults

Smoking prevalence has been falling: prevalence in England in 1998 was reported as 28% (29% among men and 26% among women) falling to 21% (22% of men and 19% of women) in 2007. However this rate in decline is reducing. It has been surmised that this is because the remaining smoking population are more entrenched in their habit, being less inclined to want to quit and being less successful in quitting.

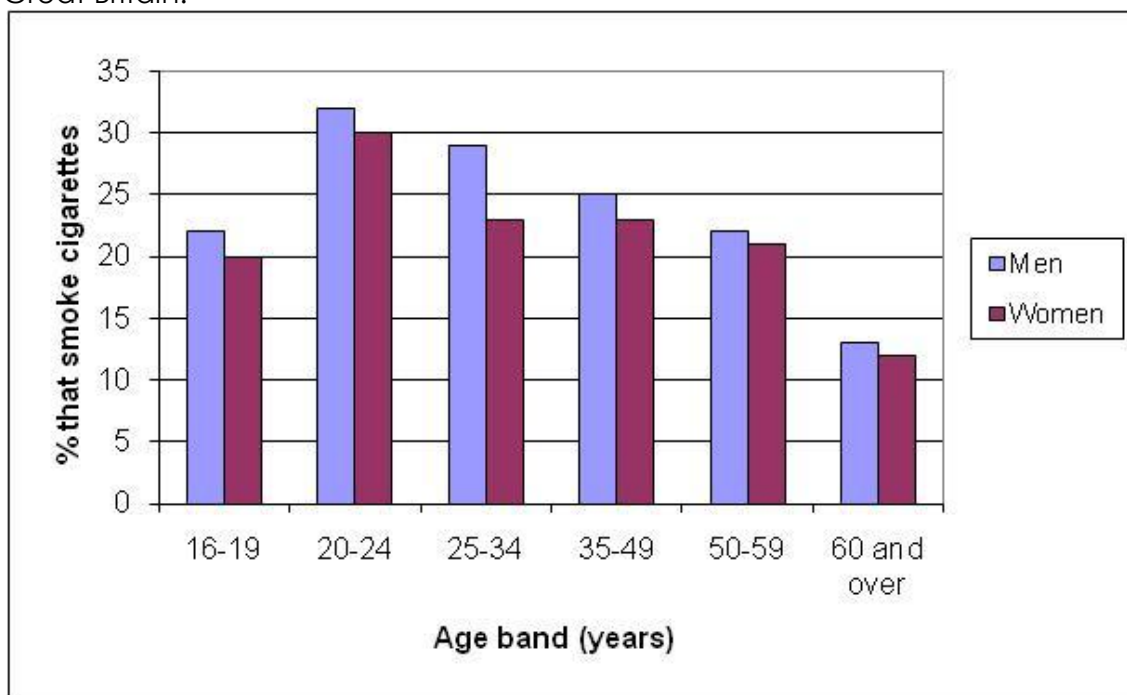
**Figure 2.4:** Prevalence of adult (16 years and over) cigarette smoking by sex, 1998 to 2007, England.



Source: ONS, 2009. General Household Survey, 2007.

Prevalence is higher amongst men than women, and is highest amongst those aged 20-24 years.

**Figure 2.5:** Prevalence of adult (16 years and over) cigarette smoking by age, 2007, Great Britain.



Source: ONS, 2009. General Household Survey, 2007.

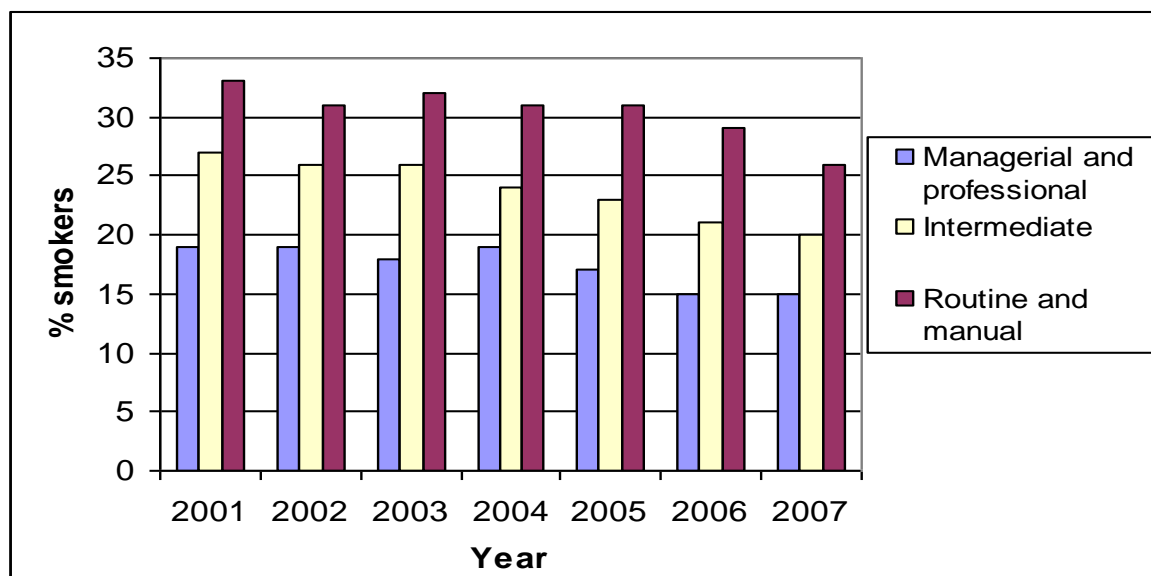
Nationally, there is a higher prevalence of smoking amongst the Routine and Manual (R&M) occupational group than the Managerial and Professional (M&P) occupation group. Amongst men, prevalence within M&P group is 16% compared to 28% R&M; amongst women, prevalence is 14% amongst M&P group compared to 24% R&M.

R&M smokers account for 50% of all smokers nationally. Within the R&M group, there is a higher proportion of younger people (who tend to smoke more than older people) than the general population, and they are also more likely to have children under five, compared to the general population. R&M smokers are more likely to have started smoking before the age of 16 years and are more likely to be more heavily addicted to smoking<sup>24</sup>.

<sup>24</sup> Department of Health, 2009. Tackling health inequalities: Targeting Routine and Manual smokers in support of the PSA agreement smoking prevalence and health inequalities targets.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_101224](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101224)

**Figure 2.6:** Prevalence of cigarette smoking by sex and socio-economic classification of the household reference person: England, 2001 to 2007



Source: ONS, 2009. General Household Survey 2007.

Amongst Black and Minority Ethnic (BME) communities, Bangladeshi, Pakistani and Irish men were much more likely to be current smokers than the general population, with Indian, Chinese and Black African men less likely.

Amongst women, only Irish women were more likely to be smokers than the general population. Women from other groups had low prevalence, with Bangladeshi women being the least likely to smoke.

**Table 2.2:** Prevalence (%) of cigarette smoking among adults, 16 years and over, by ethnic minority group and gender, England, 2004.

	General population (2004 rates)	Black Caribbean	Black African	Indian	Pakistani	Bangladeshi	Chinese	Irish
Men	24	25	21	20	29	40	21	30
Women	23	24	10	5	5	2	8	26

Source: Information Centre, 2006. Health Survey for England 2004: The health of minority ethnic groups.

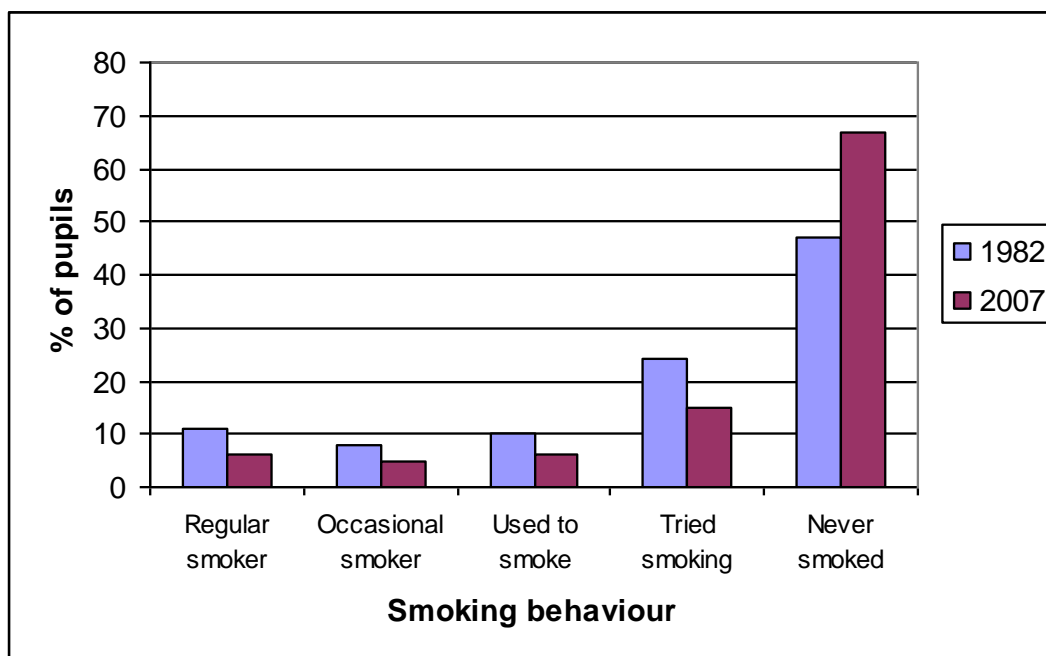
Smokers are also more likely than non smokers (as defined by the Odds Ratio) to:

- be living in deprived communities
- to have no qualifications
- to have bad or very bad health
- to eat no portions of fruit and vegetables per day
- drink more than 8 units of alcohol on their heaviest drinking day the previous week
- have started smoking at a young age
- have parents that smoke
- have poor mental health

### 3.1.2 Children and young people

The proportion of children and young people aged 11-15 years that smoke has reduced over recent decades. Prevalence of regular smoking (smoking at least one cigarette per week) fell from 11% in 1982 to 6% in 2007, and the prevalence of having 'never smoked' rose from 47% in 1982 to 67% in 2007.<sup>25</sup>

**Figure 2.7:** Smoking behaviour of pupils aged 11-15 years, 1982 and 2007, England.



Source: Information Centre, 2008. *Drug use, smoking and drinking among young people in England in 2007.*

Girls are more likely than boys to have ever smoked: 36% compared with 31%, and also to be a regular smoker: 8% compared with 5%. In addition, whereas girls were less likely than boys to have ever smoked at age 11 years (7% compared to 11%), they became more likely to have ever smoked at age 15 years (61% compared to 50%)<sup>26</sup>.

Young people with the following characteristics are more likely (as defined by the Odds Ratio) to be a smoker than a non smoker<sup>27</sup>:

- Female, older, white ethnicity, taken drugs in the previous year, drunk alcohol in the previous week, and have a history of truancy or exclusion from school, have poor mental health.

Since the introduction of the new smokefree legislation in 2007, there has been an overall reduction in the proportion of children (aged 0-15 years) being exposed to other people's smoke: 70% before compared to 62% after for boys; 69% before compared to 64% after for girls. The change was particularly noticeable in the younger age groups (0-12 years), 7% in 2007 compared to 18% in 2006. There was no significant difference for those aged 11-15 years.

<sup>25</sup> Information Centre, 2008. *Drug use, smoking and drinking among young people in England in 2007.*

<sup>26</sup> Information Centre, 2008. *Drug use, smoking and drinking among young people in England in 2007.*

<sup>27</sup> Information Centre, 2007. *Drug use, smoking and drinking among young people in England in 2006.*

Nevertheless, there was no significant difference in the mean number of hours children were exposed to smoke: 3.5 hours before and 3 hours after for boys; 4.2 hours before and 3.5 hours after for girls. There was no change in the small proportion being exposed to smoke for 15 hours or more per week, and a decrease in the proportion being exposed between 1 and 14 hours; 32% before compared to 25% after for boys; 29% before compared to 25% after for girls<sup>28</sup>.

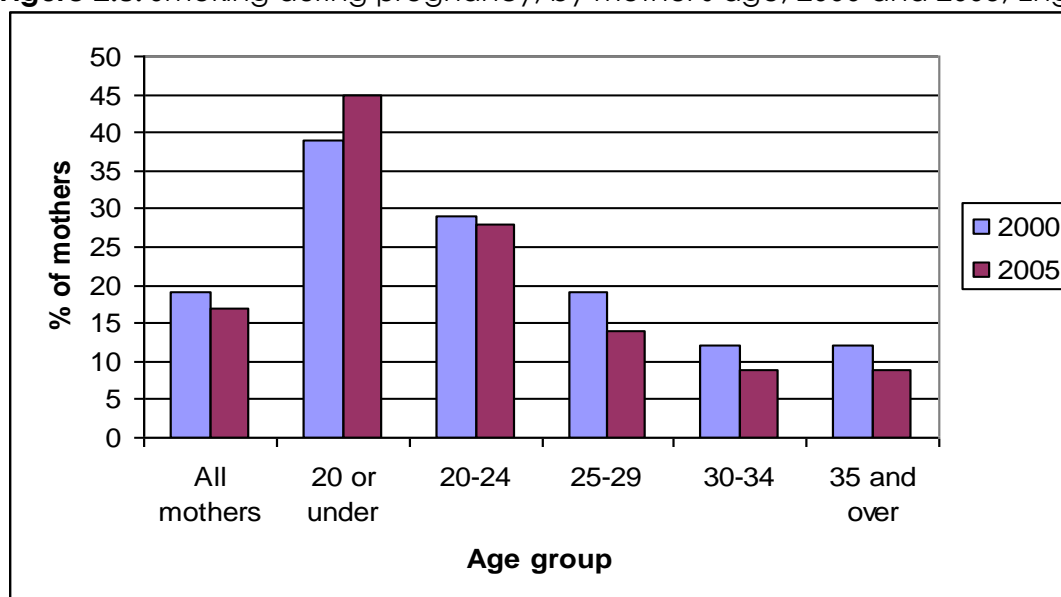
### 3.1.3 Smoking in pregnancy

In 2005, a third (17%) of mothers in England who had recently given birth reported smoking throughout their pregnancy. This proportion has fallen since 2000, when 19% of mothers smoked throughout their pregnancy. Recent figures report that in 2008/09 the proportion of all mothers that smoked at the time of delivery fell to 14.4%<sup>29</sup>.

Nationally, those most likely to smoke throughout their pregnancy include young mothers and those from R&M groups<sup>30</sup>.

- The proportion of mothers aged 20 years or under that smoked throughout their pregnancy increased from 39% to 45% between 2000 and 2005.
- Higher proportions of mothers from R&M class smoking at any stage of pregnancy compared, and a lower proportion quit before or during pregnancy, compared to mothers from M&P class.

**Figure 2.8:** Smoking during pregnancy, by mother's age, 2000 and 2005, England.



Source: Information Centre, 2007. Infant Feeding Survey 2005.

<sup>28</sup> Information Centre, 2008. Health Survey for England 2007.

<sup>29</sup> Department of Health, 2009. Smoking at time of delivery.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_102889.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_102889.pdf)

<sup>30</sup> Information Centre, 2007. Infant Feeding Survey 2005.

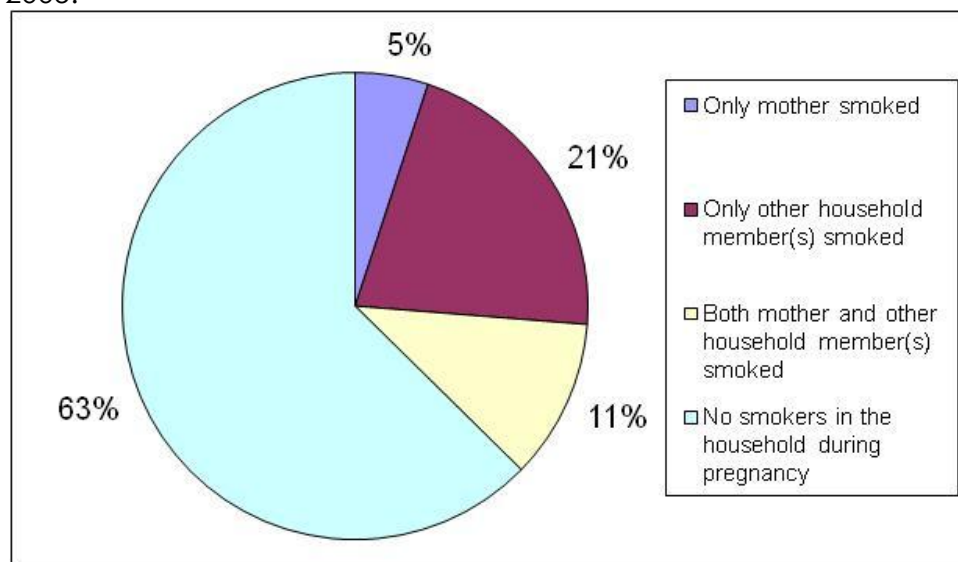
**Table 2.3:** Smoking status during pregnancy, by mother's socio-economic group, England, 2005.

	% who smoked before or during pregnancy	% who smoked throughout pregnancy	% of smokers who gave up before or during pregnancy
Managerial & Professional	19	7	64
Intermediate	30	12	61
Routine & Manual	48	29	40
All mothers	32	17	49

Source: Information Centre, 2007. Infant Feeding Survey 2005.

Overall, a third of mothers (33%) reported that they lived with at least one other person who smoked during their pregnancy. The smoking status of a mother seems to be associated with the smoking status of those around her. Amongst mothers who lived with at least one other smoker, 36% smoked throughout their pregnancy, compared to only 8% of mothers who did not live with another smoker.

**Figure 2.9:** Exposure of unborn baby to tobacco smoke during pregnancy, England, 2005.



Source: Information Centre, 2007. Infant Feeding Survey 2005.

### 3.1.4 Other forms of tobacco use

Non smoked tobacco use predominantly occurs within BME communities, however, even within these population groups, cigarette smoking accounts for the majority of tobacco use<sup>31</sup>.

Amongst men, cigar smoking was the next most popular form of tobacco use, with the exception of Bangladeshi men, for whom chewing tobacco was the second most popular use form of tobacco use (9%).

Amongst women, except Bangladeshi women, cigarette consumption accounted for virtually all tobacco use. Among Bangladeshi women, chewing tobacco was the most common use for tobacco (16%) rather than cigarettes (2%). Amongst women,

<sup>31</sup> Information Centre, 2006. Health Survey for England 2004: The health of minority ethnic groups.

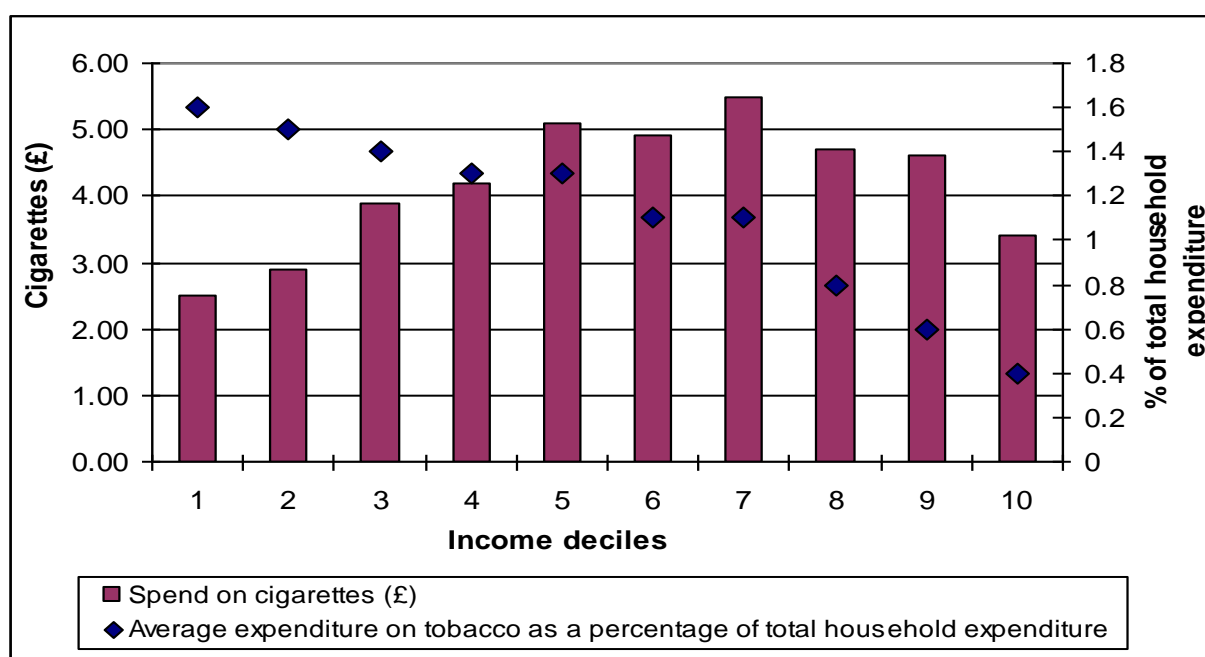
cotinine results were similar to self reported results, except amongst Bangladeshi women, with a high cotinine prevalence of 29%. This suggests an under self-reporting of tobacco use.

### 3.1.5 Economic impact

Household expenditure on tobacco products has more than trebled between 1980 and 2007, while expenditure on tobacco, as a proportion of total household expenditure, has decreased overall: 3.6% in 1980 to 2.0% in 2007<sup>32</sup>.

However, the relationship between actual spend and spend as a proportion of total income is not consistent throughout gross income deciles. Actual spend on cigarettes is lowest amongst those from the lowest income decile, but this translates to a higher proportion of their income when compared to those from the highest income decile. Thus spend on tobacco has a greater economic impact on those on the lowest income.

**Figure 2.10:** Cigarette expenditure and tobacco expenditure as percentage of total weekly household expenditure, Great Britain, 2006.



N.B. Those with the lowest income are in income decile 1.

Source: ONS, 2008. *Family Spending 2007* cited in *The Information Centre, 2008. Statistics on Smoking: England 2008*.

<sup>32</sup> The Information Centre, 2008. *Statistics on Smoking: England 2008*.

<http://www.ic.nhs.uk/webfiles/publications/Smoking%20bulletin/Smoking%202008/Statistics%20on%20Smoking%2008%20final%20format%20v9.pdf>

### 3.1.6 Summary

#### **Summary - Segmentation of population in relation to health need**

Those that suffer more from tobacco related harm than the general population are:

- Younger age groups
- Pakistani and Bangladeshi men; Bangladeshi women.
- Routine and Manual groups.
- Those with mental health problems.
- Those with existing health conditions, such as CVD, COPD and those receiving hospital treatments.

In addition, passive smoking harms particularly vulnerable sections of the population:

- Children.
- Unborn babies, particularly amongst Routine and Manual groups.

## 3.2 Smoking prevalence in Tameside & Glossop

### 3.2.1 Adults

It is difficult to determine local smoking prevalence accurately, therefore the NHS Information Centre produced a model in 2007 which applied prevalence information from the Health Surveys of England to local PCT population demographics (as of 2003-05) to produce an estimate of expected prevalence as opposed to actual prevalence<sup>33</sup>. The results show that there is a statistically significant higher estimated smoking prevalence in Tameside and Glossop than England: 29.7% compared to 24.1%, equating to around 60,000 smokers. This is the 8<sup>th</sup> highest estimated prevalence amongst the 10 Greater Manchester PCTs, and Tameside local authority's estimated prevalence is the 6<sup>th</sup> highest prevalence amongst the 43 North West local authorities.

The only prevalence model which produced estimates at ward level was the Action on Smoking and Health (ASH) model<sup>34</sup> that used data from the Twigg report<sup>35</sup> published in 2004, and deprivation scores (IMD2004). At that time the prevalence in Tameside and Glossop was estimated to be 32% compared to an average across all English PCTs of 28%. (See figure below). It can be seen that wards with higher deprivation scores are those with higher estimated prevalence.

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<sup>33</sup> The Information Centre, 2007. *Healthy Lifestyle Behaviours: Model Based Estimates*.

<http://www.ic.nhs.uk/pubs/healthylifestyles05>

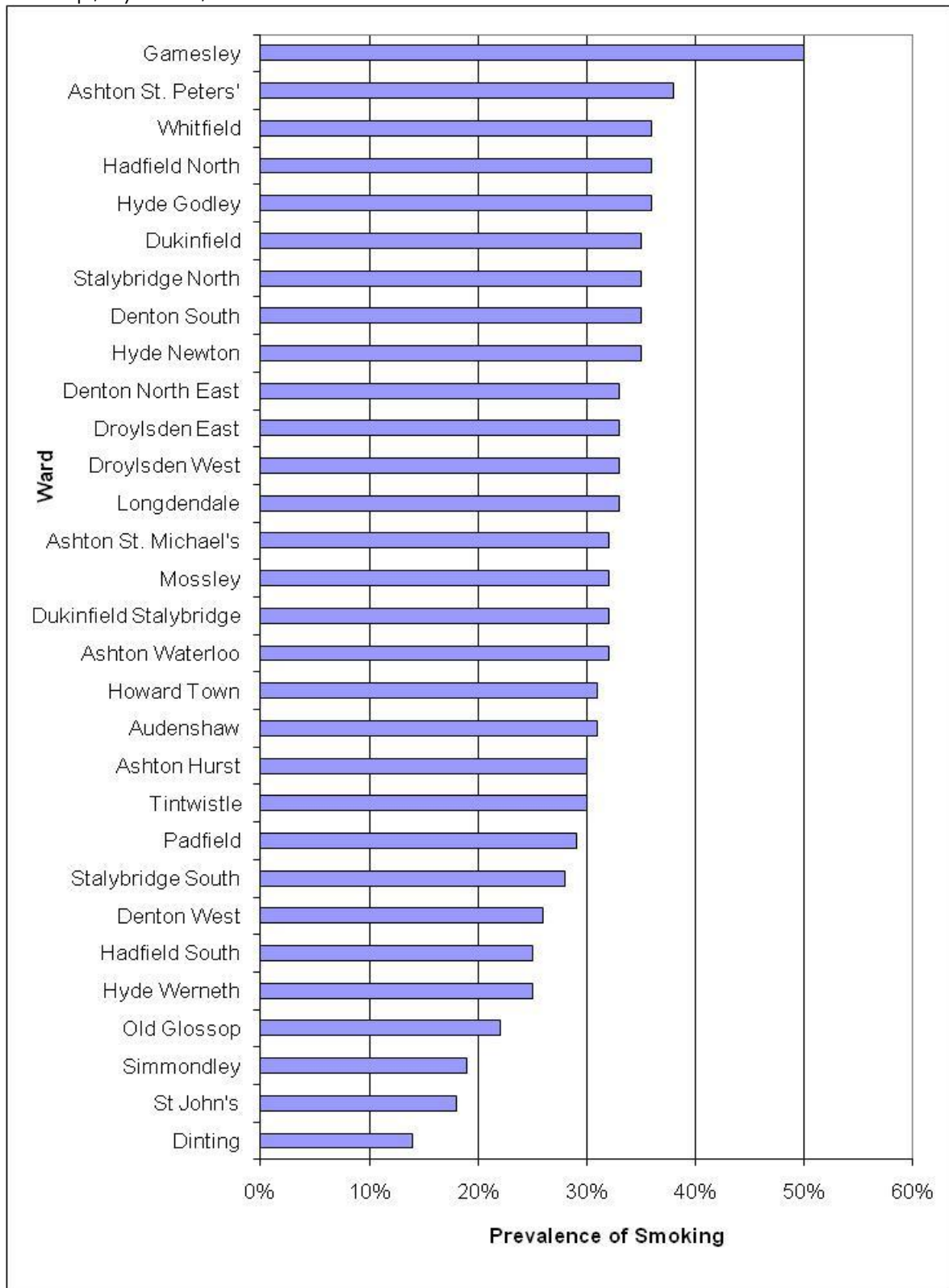
<sup>34</sup> ASH Mapping Project. Smoking prevalence and deprivation: A comparison of Smoking and Deprivation in England.

<http://old.ash.org.uk/html/mappingproject/mappingproject.html>

<sup>35</sup> Health Development Agency, 2004. *The Smoking Epidemic in England*. Twigg, L., Moon, G. and Walker, S.

[http://www.nice.org.uk/niceMedia/documents/smoking\\_epidemic.pdf](http://www.nice.org.uk/niceMedia/documents/smoking_epidemic.pdf)

**Figure 2.11:** Modelled estimates of adult smoking prevalence, Tameside and Glossop, by ward, 2004.



Source: ASH Mapping Project; Twigg, Moon and Walker, 2004.

## Summary - Unmet population need disaggregated to ward level.

Smoking prevalence has been estimated for each ward using a validated methodology based on socio-economic deprivation. Wards with higher deprivations cores are more likely to have a higher smoking prevalence.

### 3.2.2 Children and Young people

As in England, the proportion of children and young people that have never smoked is increasing. However, local survey results report a higher prevalence of regular smokers amongst Tameside Year 10 pupils compared to England. Similar to England, a higher proportion of girls in Tameside have tried smoking than boys.

**Table 2.4:** Comparison of pupil smoking prevalence, England and Tameside, 2006 to 2008.

	SDD, 2007 14 yr England	SDD, 2007 15 yr England	Tellus3 2008, Yr 10 England	SHRAB, 2006, Yr 10 Tameside	Youth Online 2008, Yr 10 Tameside
Never tried smoking	55%	45%	56%	40%	58%
All smokers+	17%	25%	9%	27%	-
Regular smokers*	9%	15%	8%	20%	15%

+ SDD – regular and occasional smokers; Tellus3 - sometimes, once per week, every day; SHRAB – “I smoke” and occasional smokers.

\* SDD – regular smokers; Tellus3 - every week, every day; SHRAB – “I smoke”; Youth online – current smokers.

N.B. Tellus3 survey does not provide Tameside results by individual age/year groups.

N.B. Year 10 pupils are aged 14 and 15 years.

Sources: Drug use, smoking and drinking among young people in England (SDD), 2007. Information Centre, 2008<sup>36</sup>; Ofsted, 2008. 2008 Tellus3 Tameside<sup>37</sup>; TMBC, 2006. SHRAB 2006<sup>38</sup>; TMBC, 2009. Tameside Youth Online Survey 08/09<sup>39</sup>

The average number of cigarettes smoked by Tameside pupils has increased in recent years. In addition, current/regular smokers in Tameside now smoke a third more cigarettes on average per day compared to pupils in England. Survey results also suggest that young people who smoke are possibly starting to smoke at a younger age than in England<sup>40</sup>.

The most common sources of cigarettes both nationally and locally is shops and also friends and family, with a slightly larger proportion of Tameside pupils obtaining their cigarettes from these sources compared to nationally. During 2008/09, just under half of Tameside Trading Standards' under age test purchasing attempts from shops and

<sup>36</sup> Information Centre, 2008. Drug use, smoking and drinking among young people in England, 2007.

<http://www.ic.nhs.uk/webfiles/publications/sdd07/SDD%20Main%20report%2007%20%2808%29-Standard.pdf>

<sup>37</sup> Ofsted, 2008. 2008 Tellus3 Tameside. <http://www.ofsted.gov.uk/Ofsted-home/Children-s-and-local-services-by-local-authority/Tameside>

<sup>38</sup> TMBC, 2006. Survey of Health and Related Attitudes and Behaviours 2006.

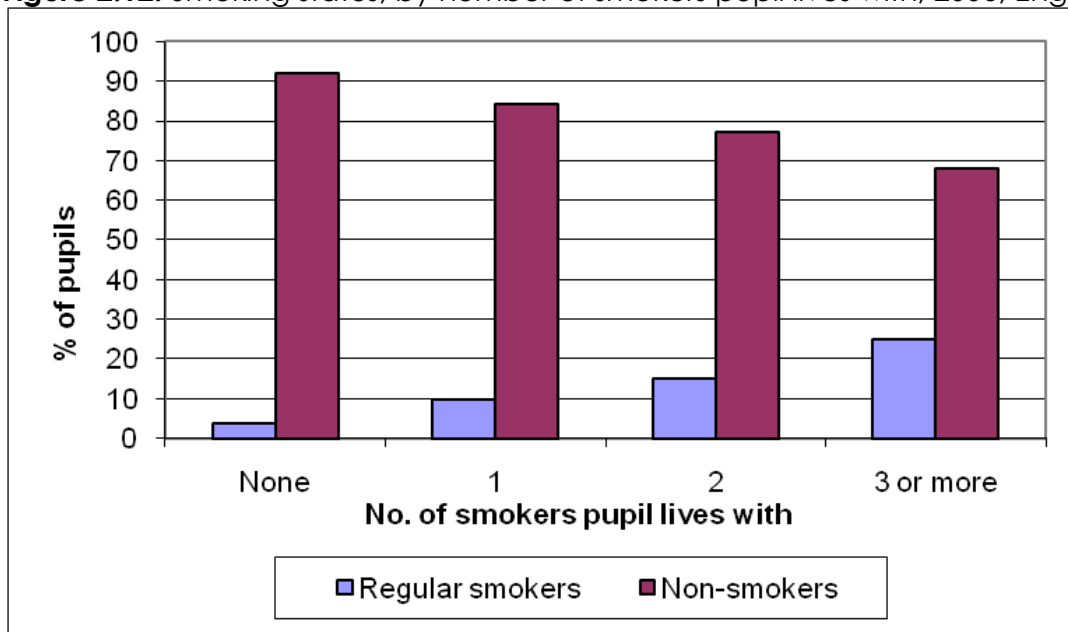
<sup>39</sup> Brahm Insight for TMBC, 2009. Tameside Youth Online Survey 08/09.

<sup>40</sup> TMBC, 2009. Tameside Youth Online Survey 08/09; TMBC, 2006. SHRAB 2006; Information Centre, 2008. Drug use, smoking and drinking among young people in England, 2007; Information Centre, 2008. Health Survey for England, 2007.

vending machines resulted in successful purchases, including 100% of vending machine attempts<sup>41</sup>.

National survey results show that young people are more likely to smoke if one or more of their parents smoke: 25% of pupils living with three or more smokers compared to 4% of those not living with any smokers. As there is a high prevalence amongst Tameside and Glossop adults, it follows that a high proportion of Tameside and Glossop young will also smoke.

**Figure 2.12:** Smoking status, by number of smokers pupil lives with, 2006, England.



Source: The Information Centre, 2007. *Smoking, Drinking and Drug Use among Young People in England in 2006*.

### 3.2.3 Smoking in pregnancy

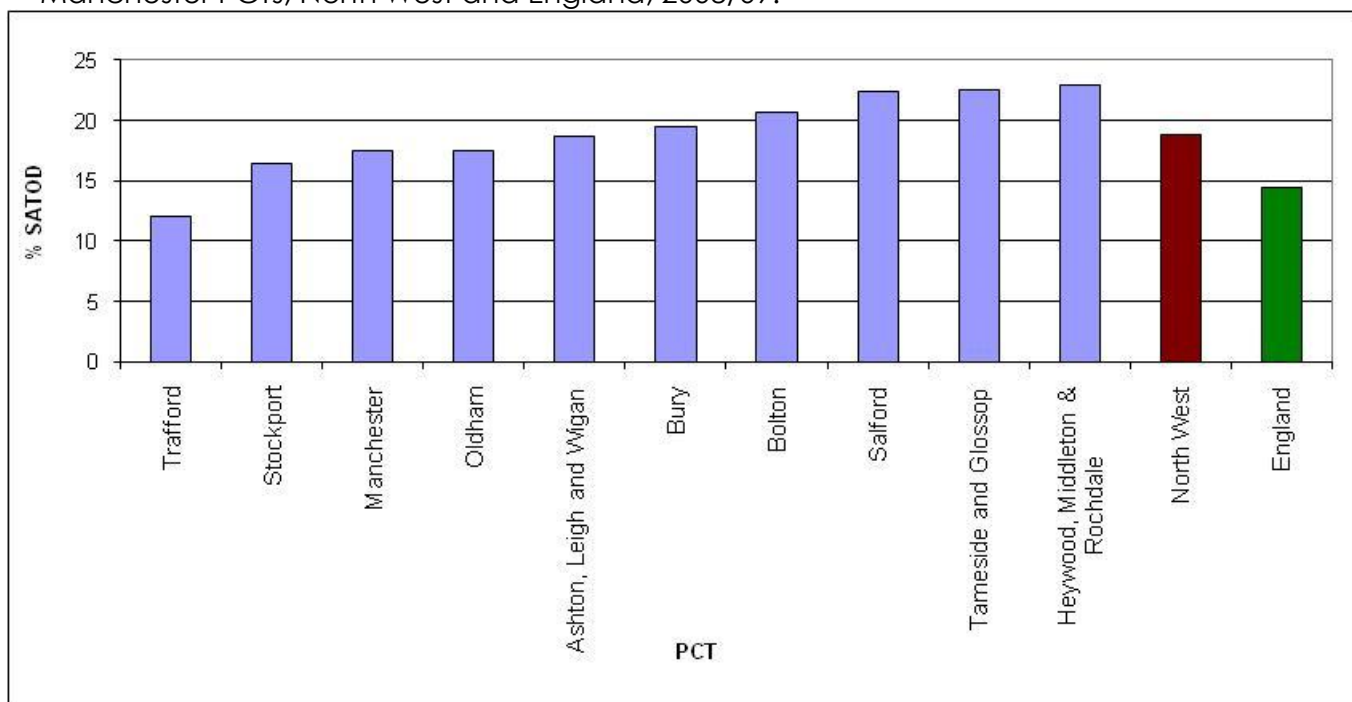
The proportion of mothers registered to Tameside and Glossop PCT GPs that smoke at the time of delivery (SATOD) has been falling in recent years to 22.5% in 2008/09. Nevertheless, this proportion is still higher than in the North West and England, where 18.8% and 14.4% of mothers respectively SATOD.

The nationally determined profile of mothers that SATOD indicate that they are more likely to be Routine and Manual (R&M), aged under 20 years and live with other smokers<sup>42</sup>. As these groups form a higher proportion of Tameside and Glossop's population than nationally, it is likely that the local profile of mothers that SATOD is similar to the national profile.

<sup>41</sup> TMBC, 2009. *Tameside Youth Online Survey 08/09*; Information Centre, 2008. *Drug use, smoking and drinking among young people in England, 2007*

<sup>42</sup> Information Centre, 2007. *Infant Feeding Survey 2005*.

**Figure 2.13:** Percentage of mothers not smoking at time of delivery, Greater Manchester PCTs, North West and England, 2008/09.



Source: Department of Health, 2009. Smoking at time of delivery<sup>43</sup>.

### 3.2.4 Other forms of tobacco use

No local data is available to determine local use of non smoked tobacco products. However, as there are large communities of Pakistani and Bangladeshi ethnic origin locally, it would be expected that there would be a high prevalence of smoking amongst men from these communities, and the use of chewing tobacco amongst Bangladeshi women in particular.

The wards with the largest populations of these specific communities are<sup>44</sup>:

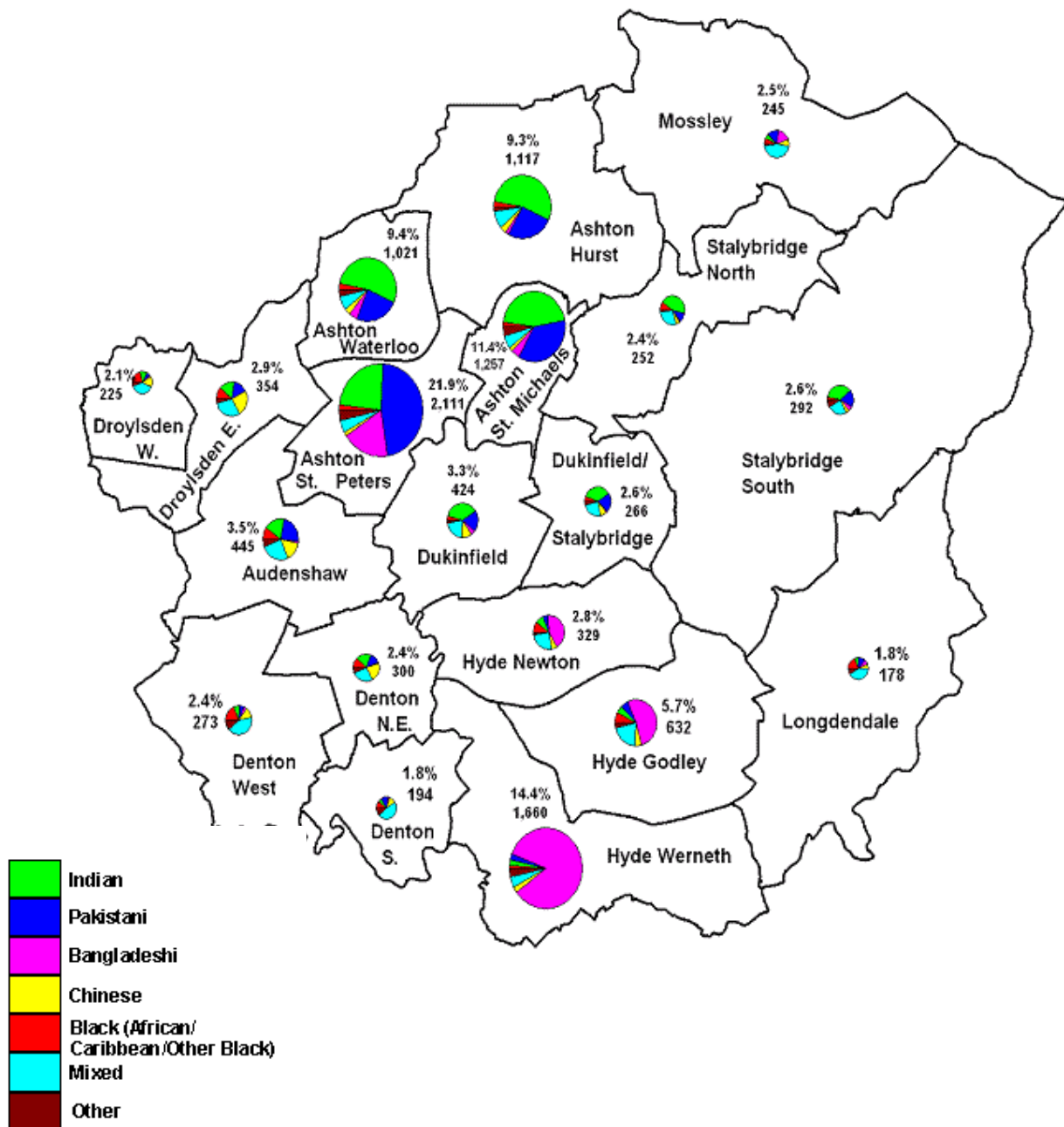
- Pakistani - Ashton St Peter's, Ashton St Michael's, Ashton Hurst and Ashton Waterloo.
- Bangladeshi – Hyde Werneth, Ashton St Peter's, Hyde Godley, Hyde Newton.

<sup>43</sup> Department of Health, 2009. Smoking at time of delivery.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_102889.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_102889.pdf)

<sup>44</sup> Office for National Statistics, Census 2001. <http://www.statistics.gov.uk/census2001/census2001.asp>

**Figure 2.14:** Minority ethnic communities in Tameside (Numbers and percentages are total non-white population of ward), 2001.



Source: Census 2001.

### 3.2.5 Qualitative needs assessment

During 2007, Dr Foster Intelligence carried out research for the Association of Greater Manchester PCTs, involving manual smokers (across C, D and E social classification groups) who wanted to quit. A range of workshops were held with smokers aged 18 years and older from across the Greater Manchester area, including representation from BME groups. Ten group members came from Tameside and Glossop. In addition, discussions groups were also held with Tameside and Glossop smokers, aged 18-50 years.

The results showed that many smokers also have other health and social concerns: poor mental health, poor diet and lack of exercise, criminal activity, poor social capital i.e. isolation and estrangement from family and friends. Quitting smoking has a low priority as their daily life gets in the way and any quit attempt is unplanned and short lived.

They also:

- Perceive quitting to be hard with limited chance of success,
- Wondering how they will fill their time afterwards,
- Are concerned that they will feel isolated and alone and
- Feel they will start smoking again because everyone else does it.

The main motivations for quitting are:

- To be around for their kids and grandkids.
- To have more money for their kids and to be a better role model.
- To protect the health of their children from 2<sup>nd</sup> hand smoke.

What does not motivate them to quit is:

- Cost – don't pay tax on their cigarettes
- Smell – everyone smokes, so everyone smells
- Impact on skin – everyone smokes, so age at a similar rate

### 3.2.6 Summary of smoking prevalence in Tameside and Glossop

Those that suffer more from tobacco related harm in Tameside and Glossop are:

- those from low socio-economic/ R&M groups.
- Bangladeshi adults and Pakistani men.
- those with existing health conditions, including poor mental health and those receiving treatment in hospital.
- those exposed to passive smoking – children and unborn babies, particularly amongst R&M families.

In addition, pregnant women are more likely to smoke if they are younger, live with other smokers and come from R&M groups; and children are also more likely to smoke if they live with others that smoke.

The population of Tameside and Glossop includes a higher proportion of R&M classes and lower socio economic groups than the general population. These are groups that experience higher smoking prevalence than the general population, resulting in an overall smoking prevalence within Tameside and Glossop that is higher than in England, with an estimated 60,000 adult smokers locally.

Within Tameside and Glossop wards with the highest adult smoking prevalence according to the ASH model are:

- Gamesley (ranked highest).
- Ashton St Peter's (ranked 2<sup>nd</sup> highest).
- Hyde Godley, Hadfield North and Whitfield (ranked equal 3<sup>rd</sup> highest).
- Denton South, Stalybridge North, Dukinfield, Hyde Newton (ranked equal 6<sup>th</sup> highest).

Wards with the largest Pakistani and Bangladeshi communities are Ashton St Peter's and Hyde Werneth respectively.

## **Summary –**

### **Unmet need within Tameside and Glossop**

Amongst adults, children and young people and pregnant women, there is higher prevalence of smoking compared to the North West and England.

The groups within the population of Tameside and Glossop that already experience health inequalities, are the groups which also have high smoking prevalence, thereby further increasing health inequalities, for example: those from R&M/low socio-economic groups; those from certain BME populations and those within existing health conditions. The wards with the highest smoking prevalence are Gamesley and Ashton St Peter's, and wards with high deprivation scores also tend to have a high smoking prevalence. The wards with high Bangladeshi populations, and therefore possibly high levels of smoking and chewing tobacco, are: Hyde Werneth, Ashton St Peter's, Hyde Godley, Hyde Newton

The impact tobacco use has on our population is disproportionate and services should be effectively commissioned and redesigned to reduce this harm, with the aim of reducing premature mortality and health inequalities within Tameside and Glossop.

Qualitative research has shown that amongst those who do smoke quitting is a low priority as they are coping with other health and social concerns. Smoking provides a social bond with others and even though the usual information offer to help smokers quit is not motivating, they are concerned over the health of their children and want to be able to provide materially and emotionally for them.

## **3.3 Analysis of progress in achieving smoking related targets in Tameside and Glossop**

### **3.3.1 National prevalence targets**

Two PSA targets have been reaffirmed as part of PSA 18 for the period 2008/09 to 2010/11<sup>45</sup>. Indicator 3, which are also national and local vital signs (VSB05):

- Reducing adult (16+) smoking rates to 21% or less by 2010.
- Reduce prevalence among routine and manual groups to 26% or less by 2010.

There are also two targets necessary to achieve the Smoking Kills' targets<sup>46</sup>:

- Reduction in smoking amongst 11 to 15 year olds from 13% (in 1996) to 9% or less by 2010.
- Reduction in the percentage of women who smoke during pregnancy from 23% to 15% by 2010 focussing on smokers from disadvantaged groups.

As mentioned earlier, local prevalence is difficult to determine, and figures for small areas tend to be unreliable. The most recent estimate for Tameside and Glossop was 29.7% and was published in 2007 using data from the 2003 to 2005 Health Surveys for England. This would indicate that Tameside and Glossop are not likely to achieve the target of 21%, but as there is a high proportion of adults from Routine and Manual groups, the target of 26% may be more relevant to aim for. If prevalence in

<sup>45</sup> Her Majesty's Treasury, 2007. PSA Delivery Agreement 18: Promote better health and wellbeing for all, 2008-11.

<sup>46</sup> Department of Health, 1998. Smoking Kills: A White Paper of Tobacco. <http://www.archive.official-documents.co.uk/document/cm41/4177/4177.htm>

Tameside and Glossop falls at the same rate as in England, around 1% per year, then local prevalence may meet the target for Routine and Manual groups by 2010.

Amongst children, we also do not have consistent prevalence data. The local Survey of Health Related Attitudes and Behaviour (SHRAB) surveys have had the highest response rate of all local surveys, and amongst 15 years olds prevalence of regular smoking was 15% and amongst 14 year olds 9%. The survey did not include younger pupils, but as fewer younger pupils tend to smoke, it seems possible that the target of 9% prevalence may be possible. The only results we have which include year 6, 8 and 10 pupils is from the national TellUs3 survey. Prevalence amongst this age group in Tameside was 9%.

With regard to women smoking at time of delivery (SATOD), prevalence in Tameside and Glossop remains high (22.5%) and achievement of the national target seems unlikely.

### 3.3.2 Local smoking cessation targets

As smoking prevalence at a local level can be difficult to determine accurately, the number of 4 week quitters achieved by local Stop Smoking Services (SSS) have been used as a proxy for local smoking prevalence.

NHS Tameside and Glossop have consistently met their 4 week quit targets, see below, and were only one of a few within the North West region who surpassed their 2008/09 target, achieving 1,837 quits against a target of 1,781.

**Table 2.5:** Vital Sign VSB05: The numbers of smokers setting a quit date who have successfully stopped smoking at the 4 week follow up.

Vital sign	Smoking Prevalence (Smoking Quitters)	2008/09	2009/10	2010/11
VSB05_01	Number of 4 week smoking quitters who attended NHS Stop Smoking Services	1,781	1,870	2,000

Source: NHS Tameside and Glossop Stop Smoking Service, 2009.

### **Summary - Progress and gaps towards improvement targets**

A range of available data suggests that although Tameside and Glossop will struggle to meet the overarching prevalence target for adults of 21% by 2010, it may be possible that overall prevalence in Tameside and Glossop will fall below that set for Routine and Manual groups: 26%.

Amongst children, surveys suggest that prevalence amongst Tameside young people will fall below the national target of 9% by 2010.

Tameside and Glossop has a high prevalence for women (SOTOD) and is unlikely to meet the national target of 15% by 2010.

NHS Tameside and Glossop have been successful in consistently meeting their 4 week quit target, which increases year on year.

Systems are being implemented to effectively monitoring more specific targets relating to population subgroups, which have recently been introduced. This will also build capacity to respond to prevalence targets which are expected within the forthcoming year.

## **4. Comparison with Peer PCTs**

For benchmarking purposes, Tameside and Glossop PCT is usually compared to other Greater Manchester PCTs as it is thought the population experience similar determinants of health and many health promoting initiatives are delivered across the Greater Manchester area. However, in 2001 the Office for National Statistics (ONS) produced the Area Classification<sup>47</sup> to group together areas according to key characteristics, derived using census data, common to the population in that grouping. Tameside and Glossop PCT was defined as Industrial Hinterlands A along with 14 other PCTs.

These two methods of benchmarking Tameside and Glossop PCT have been used to highlight smoking related performance measures.

### **4.1 Smoking prevalence**

The NHS Information Centre produced a smoking prevalence model in 2007<sup>48</sup>. The results show that there is a statistically significant higher estimated smoking prevalence in Tameside and Glossop than England: 29.7% compared to 24.1%. This is the 8<sup>th</sup> highest estimated prevalence amongst the 10 Greater Manchester PCTs. However, it's only the 7<sup>th</sup> highest of the 15 peer Hinterlands A PCTs.

### **4.2 Smoking at time of delivery**

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<sup>47</sup> ONS 2001 Area Classification.

[http://www.statistics.gov.uk/about/methodology\\_by\\_theme/area\\_classification/default.asp](http://www.statistics.gov.uk/about/methodology_by_theme/area_classification/default.asp)

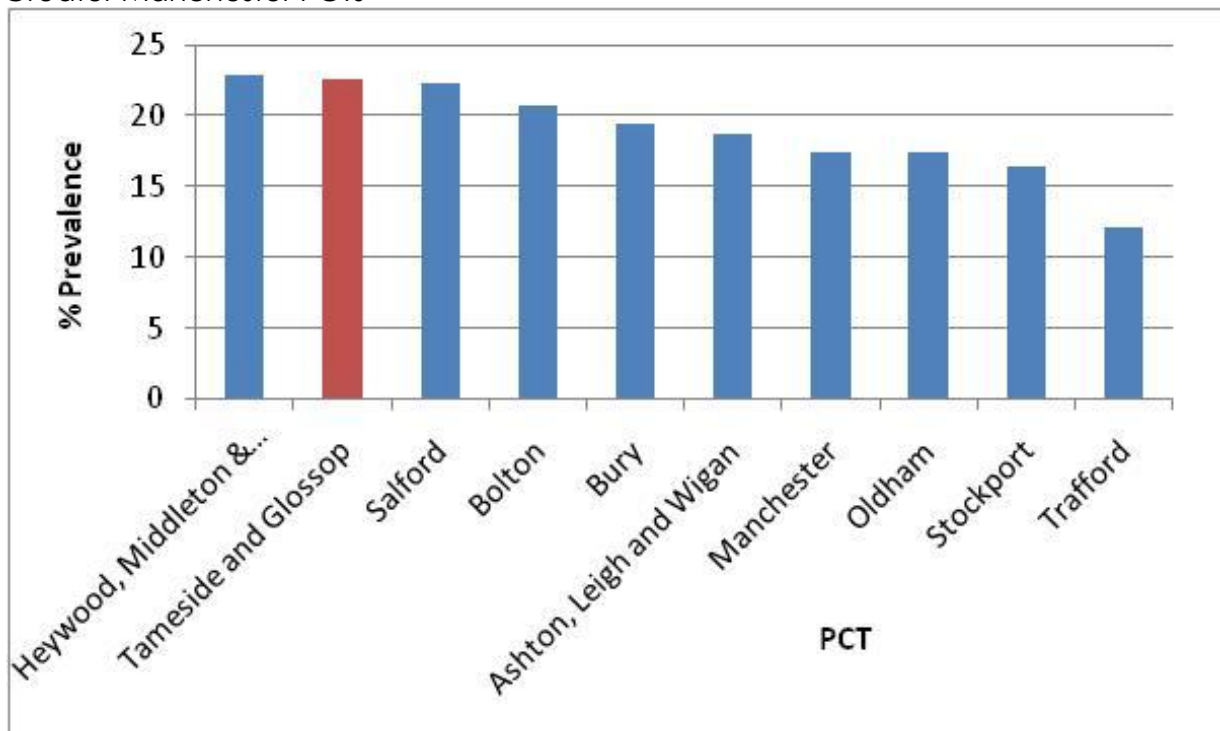
<sup>48</sup> The Information Centre, 2007. Healthy Lifestyle Behaviours: Model Based Estimates.

<http://www.ic.nhs.uk/pubs/healthylifestyles05>

The proportion of mothers registered to Tameside and Glossop PCT GPs that smoke at the time of delivery (SATOD) has been falling in recent years to 22.5% in 2008/09. Nevertheless, this proportion is still higher than England, where 14.4% of mothers SATOD.

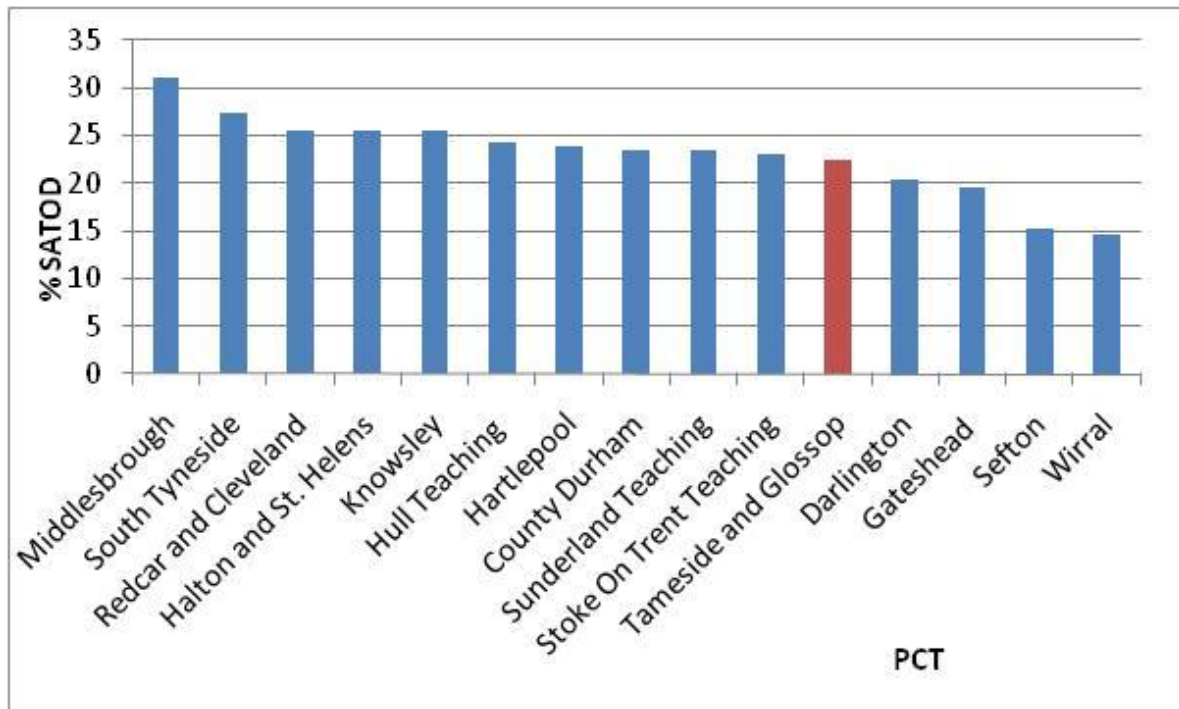
Amongst the 10 Greater Manchester PCT's, Tameside and Glossop has the 9<sup>th</sup> highest prevalence, but only the 5<sup>th</sup> highest amongst 15 Peer PCTs.

**Figure 2.15:** Percentage of women smoking at time of delivery (SATOD), 2008-09, Greater Manchester PCTs



Source: Department of Health, 2009. Smoking at time of delivery.

**Figure 2.16:** Percentage of women smoking at time of delivery (SATOD), 2008-09, Industrial Hnterlands A PCTs.

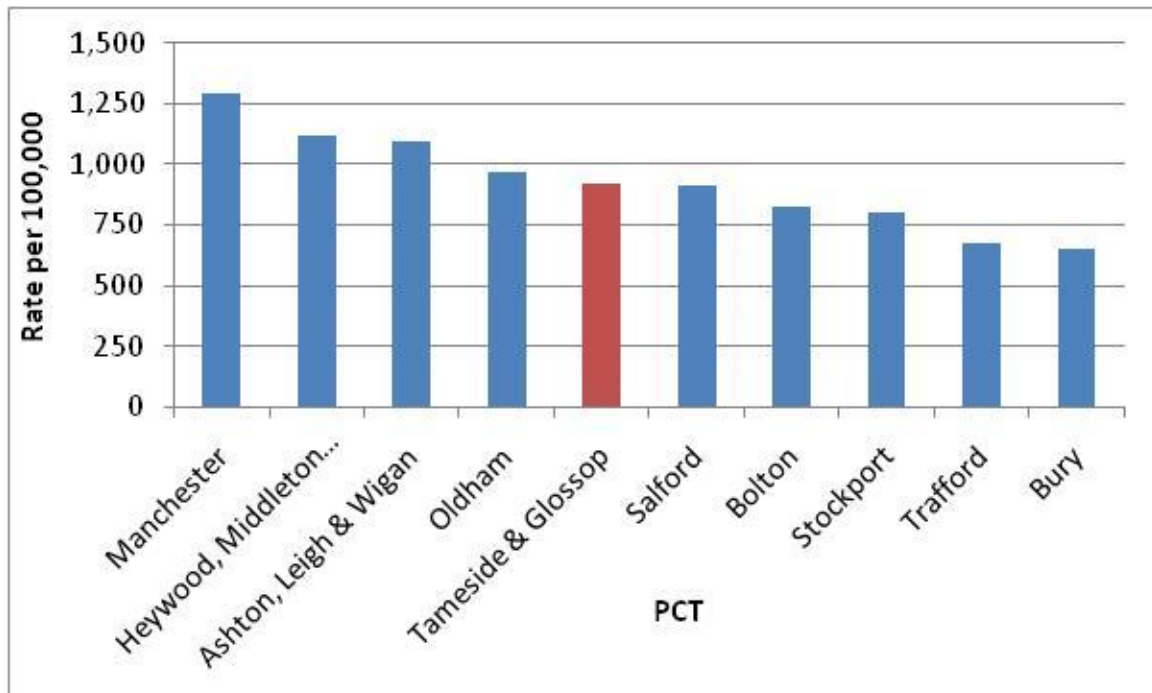


Source: Department of Health, 2009. Smoking at time of delivery.

### 4.3 Quit rates

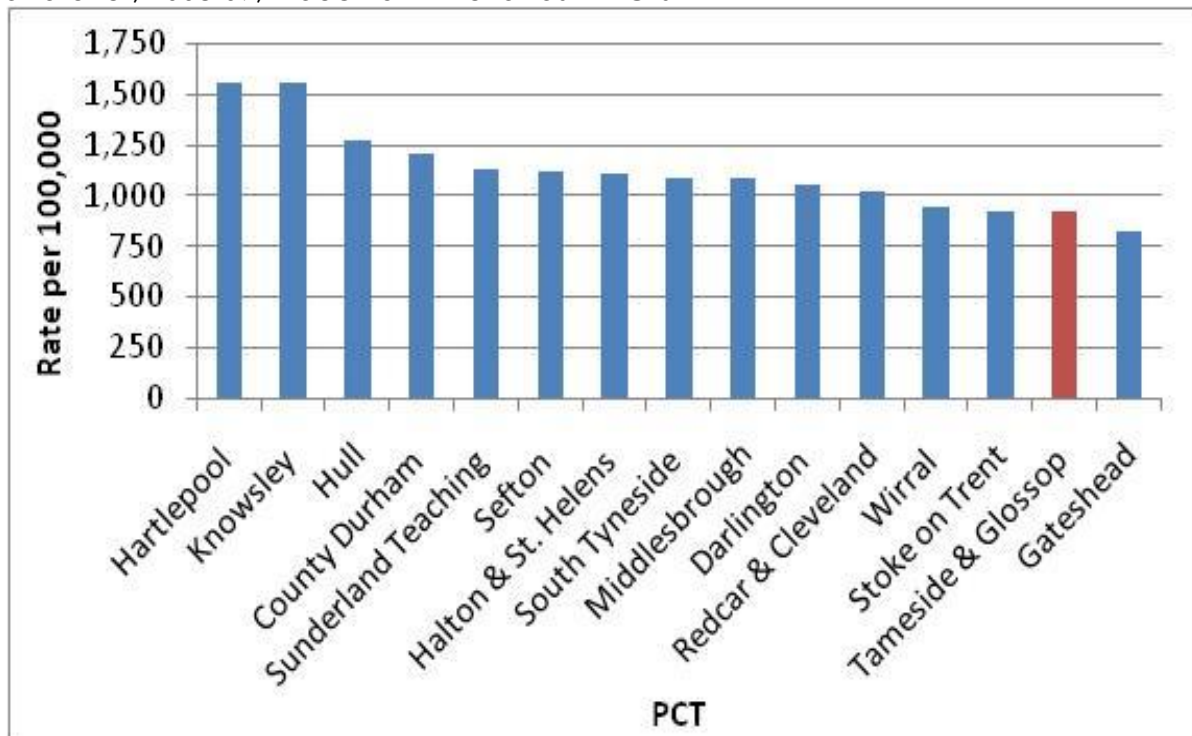
When considering how effective local Stop Smoking Services are, one of the performance measures used is the rate of successful 4 week quitters per 100,000 population. The national rate for England is 813 successful self reported 4 week quits per 100,000 population aged 16 years and over compared to the rate in Tameside and Glossop of 920, which is the 5<sup>th</sup> lowest amongst the 10 Manchester PCTs and 14 lowest amongst the 15 Industrial Hinterland A PCTs.

**Figure 2.17:** Rate of self reported 4 week quits per 100,000 population aged 16 years and over, 2008-09, Greater Manchester PCTs.



Source: The NHS Information Centre, 2009. Lifestyle Statistics.

**Figure 2.18:** Rate of self reported 4 week quits per 100,000 population aged 16 years and over, 2008-09, Industrial Hinterlands A PCTs



Source: The NHS Information Centre, 2009. Lifestyle Statistics.

## Summary - Health need benchmarked against peer PCTS

Smoking prevalence in Tameside and Glossop is 8<sup>th</sup> highest of 10 Greater Manchester PCTS, but 7<sup>th</sup> highest of the 15 peer Hinterlands A PCTS. Amongst the 10 Greater Manchester PCT's, Tameside and Glossop has the 9<sup>th</sup> highest prevalence of smoking at time of delivery (SATOD), but only the 5<sup>th</sup> highest amongst Peer PCTS.

The rate in Tameside and Glossop of successful self reported 4 week quits per 100,000 population aged 16 years and over, is 920, which is the 5<sup>th</sup> lowest amongst the 10 Manchester PCTs and 14 lowest amongst the 15 Industrial Hinterland A PCTS. Therefore when compared to Greater Manchester PCTs, Tameside and Glossop's smoking prevalence amongst adults and pregnant women is high, and the quit rate is middling. On the other hand, amongst peer PCTS, the adult and pregnant women prevalence is middling, and the quit rate is low.

## 5. Plans to improve performance and meet smoking related targets

The newly convened Smokefree Tameside Tobacco Alliance, which involves membership from many partner agencies, used the recommendations from the Needs Assessment and the NST (see section 1.3) to create a Tobacco Control Strategy. The strategy includes an action plan which gives responsibility for action across the Smokefree Tameside Tobacco Alliance membership.

The aims of the strategy are to:

- To reduce the level of tobacco related harm within Tameside by
  - Reducing the prevalence of adult and child smoking
  - Reduce passive smoking
- To reduce the tobacco related health inequalities by
  - Focussing on reducing tobacco related harm amongst routine and manual groups

The strategy<sup>49</sup> focuses on actions which aim to improve local performance to meet targets, as well as reducing smoking prevalence and the wider harm that tobacco causes the local population. The action plan is structured to reflect the format of the NST feedback:

- Vision, Strategy and Partnership working
- Strategic planning and Commissioning
- Interventions and Treatment
- Criminal Justice, Licensing and Availability
- Culture change – being healthy and staying safe
- Communication

Although Glossopdale residents are supported by the Tameside and Glossop Stop Smoking Service, links have also been established with Derbyshire Smokefree Alliance. This will ensure that a wide range of activities are delivered to reduce tobacco related harm within Glossopdale.

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<sup>49</sup> Tameside Tobacco Control Strategy: Tameside Strategic Partnership December 2009

**Summary - Plans to improve performance to meet health outcome aspirations and benchmarks.**

The newly convened Smokefree Tameside Tobacco Alliance, which involves membership from many partner agencies, has developed a Tameside Tobacco Control Strategy. The strategy includes an action plan which focuses on improving local performance to meet targets, as well as reducing the harm that tobacco causes the local population. Responsibility for action is held across the Smokefree Tameside Tobacco Alliance membership.

## Chapter 3: Reducing Alcohol Related Harm

### 1. Introduction

Nationally and locally there is a growing recognition of the damage done to population health and well-being, the threat to safety of children and adults, the effects on the economy and on attainment, by the misuse of alcohol.

Alcohol was identified as a priority in the 2008-13 NHS Tameside and Glossop Strategic Plan. The metric for the priority was a reduction in alcohol related hospital admissions, also a Tameside LAA priority and a Vital Sign. To support the achievement of the target, the key agencies worked to develop an evidence based action plan.

The first step in the action plan was to carry out two needs assessments – an assessment of population level need jointly commissioned by Tameside MBC Community Safety Department and the PCT, and an assessment of need for specialist alcohol services. This chapter is based on the findings of those needs assessments backed by some more recent data from the North West Public Health Observatory's (NWPHO) Local Alcohol Profiles (LAPE).

### 2. Prevalence and trends in alcohol related harm in Tameside and Glossop – inequalities between Tameside and Glossop and England and the North West.

#### 2.1 Local alcohol profiles for England – benchmarking alcohol related harm

Local alcohol profiles<sup>50</sup> provide data on the effects of alcohol related harm on life expectancy, on mortality rates, hospital admissions, crime, the economy, accidents and levels and styles of consumption. It enables comparison with the North West Region and with other PCTs nationally.

**Table 3.1:** Alcohol Related Indicators – Tameside & Glossop

ID	Indicator	Measure (a)	National Rank (b)	Regional Average
1	Months of life lost – males (an estimate of the increase in life expectancy at birth that would be expected if all alcohol-attributable deaths among males were prevented)	12.3	132	12.0
2	Months of life lost – female (as above for females)	5.0	116	6.0
3	Alcohol-specific mortality – males (Deaths from alcohol-specific conditions (all ages male) directly standardised rate per 100,000 population.)	19.3	130	18.1
4	Alcohol-specific mortality – females (as above for females)	6.5	97	9.6

<sup>50</sup> Local alcohol profiles. NWPHO 2009

5	Mortality from chronic liver disease – males (Deaths from chronic liver disease including cirrhosis (all aged male) directly standardised per 100,000 population)	17.1	95	19.8
6	Mortality from chronic liver disease – females (As above for females)	9.1	114	11.1
7	Alcohol-attributable mortality – males (Deaths from alcohol attributable conditions (all ages, male) directly standardises per 100,000 of the population.	44.8	118	47.3
8	Alcohol-attributable mortality – female (As above for females)	16.7	96	20.1
9	Alcohol-specific hospital admission – under 18s (Person admitted to hospital due to alcohol specific conditions (under 18s, persons) crude rate per 100,000 population).	133.2	139	122.1
10	Alcohol-specific hospital admission – males (Persons admitted to hospital due to alcohol specific conditions (all ages male), directly standardised rate per 100,000 population.)	613.7	130	596.1
11	Alcohol-specific hospital admission – females (Persons admitted to hospital due to alcohol specific conditions (all ages female), directly standardised rate per 100,000 population.)	291.1	131	312.1
12	Alcohol-attributable hospital admission – males (Persons admitted to hospital due to alcohol attributable conditions (all ages male), directly standardised rate per 100,000 population.)	1699.3	134	1591.4
13	Alcohol-attributable hospital admission - females (Persons admitted to hospital due to alcohol attributable conditions (all ages female), directly standardised rate per 100,000 population.)	998.4	139	923.3
14	Hospital admissions for alcohol-related harm (NI39)(directly age and sex standardised per 100,000 population).	1996.10	130	1943.8
15	Alcohol related recorded crimes (crude rate per 1000 population)	9.9	101	8.6
16	Alcohol –related violent crimes (crude rate per 1000 population)	6.4	95	5.9
17	Alcohol-related sexual offences (crude rate per 1000 population)	0.1	110	0.1
18	Claimants of incapacity benefits – working ages	220.5	127	214.7
19	Mortality from land transport accidents (all ages and persons, directly standardised per 100,000 population.)	1.3	45	1.7
20	Hazardous drinking (synthetic estimate)	23.0	133	22.1
21	Harmful drinking (synthetic estimate)	6.8	138	6.3
22	Binge drinking (synthetic estimate)	22.3	124	23.0

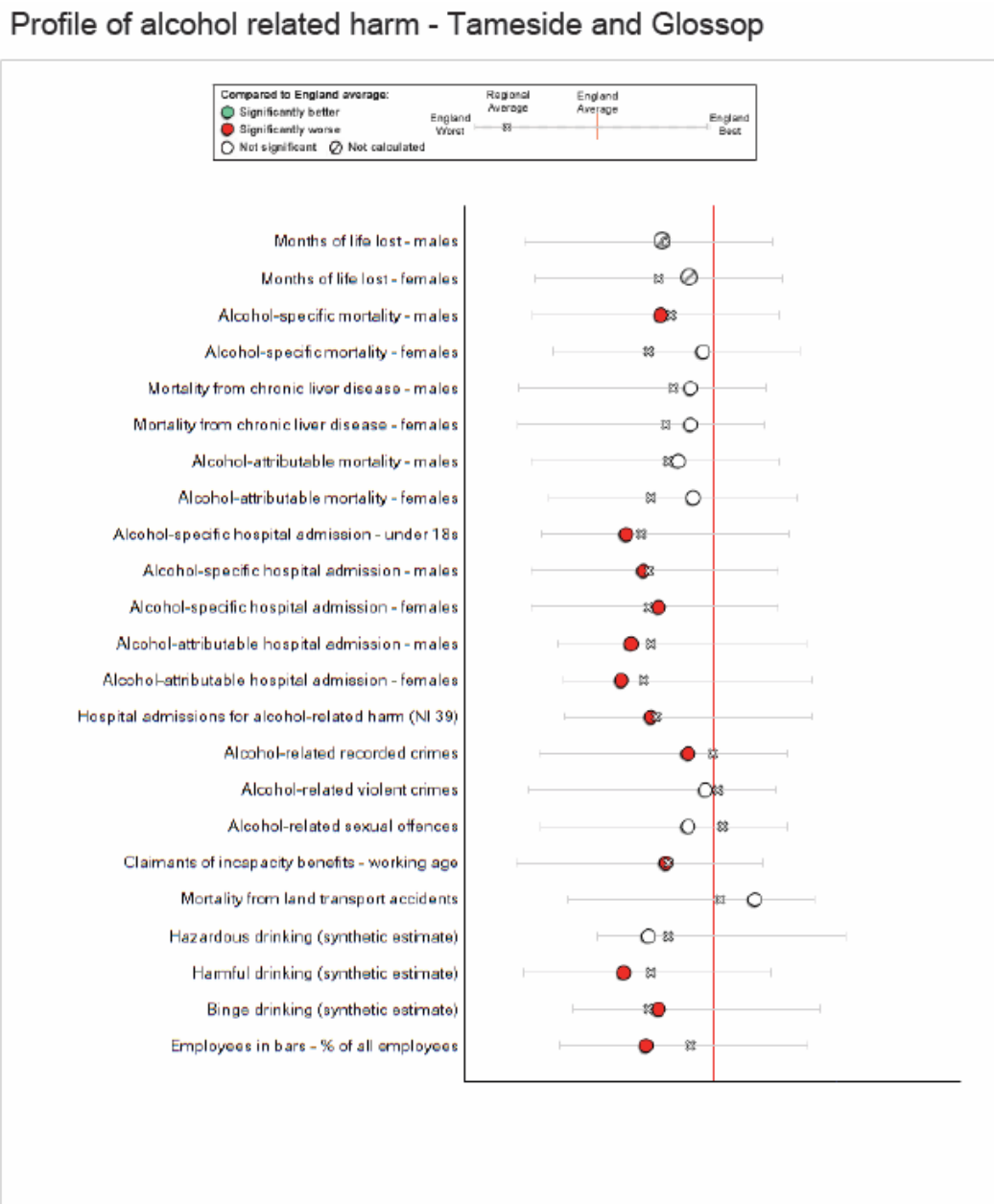
23	Employees in bars - % of all employees	2.9	138	2.3
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Source: Local alcohol profiles (NWPHO 2009)

Footnotes	Definition
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Alcohol-Specific	Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-specific conditions with their ICD-10 codes and associated attributable fractions can be found at: <a href="http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf">http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf</a>
Alcohol - Attributable	Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For those latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: <a href="http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf">http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf</a>
a)	The actual indicator value for the primary care organisations as calculated in the definitions below. For some indicators PCT values were estimated as a population weighted average of component local authority values – indicators: 15, 16, 17 – Alcohol-related recorded crimes: 18 – Claimants of incapacity benefits: 20, 21 – Hazardous and Harmful drinking.
b)	The rank of the of the local indicator value among all 152 primary care organisations in England. A rank of 1 is the best local authority in England and a rank of 152 is the worst. For indicator 23, a rank of 1 is the highest and a rank of 152 is the lowest value, as the desirability of the value (what is better or worse) has not been determined.

**Figure 3.1:** Profile of alcohol related harm Tameside and Glossop.



Source: Local alcohol profiles for England NWPFO 2009

## **Summary – Alcohol related harm in Tameside and Glossop benchmarked against England and the North West**

Table 1 and Figure 1 show that Tameside and Glossop rank above the national average for all of the measures of alcohol related harm used (apart from mortality in road transport accidents.)The population suffer significantly higher levels of the following types of alcohol related harm relative to the England average:

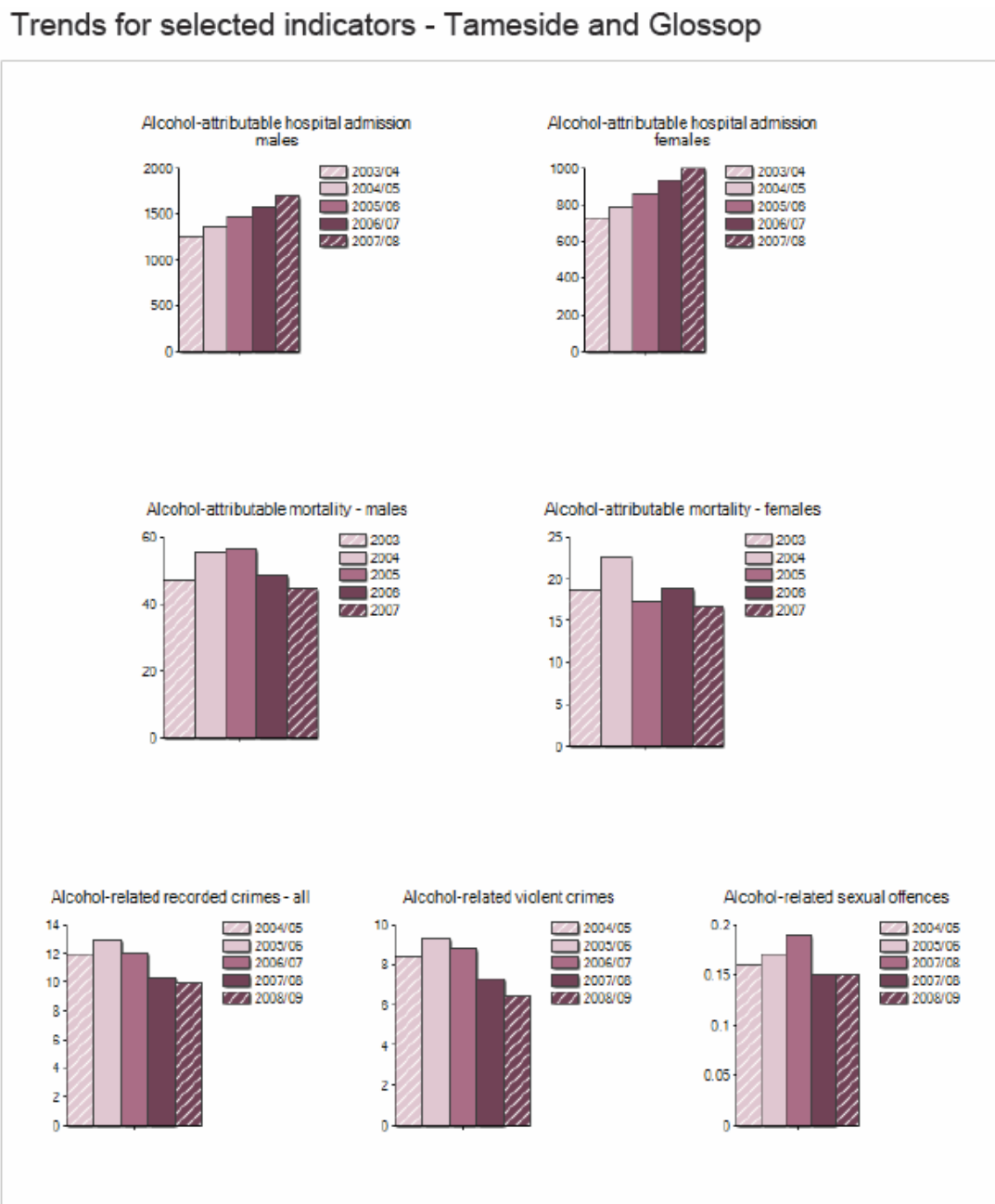
- Alcohol specific mortality for males
- Alcohol specific hospital admissions for males and females and for under 18s
- Alcohol attributable hospital admissions (also higher than regional average)
- Hospital admissions for alcohol related harm (NI 39)
- Alcohol related crimes
- Incapacity benefit claimants (alcoholism)
- Estimates of harmful drinking (also higher than regional average) and binge drinking

In general (exceptions are noted above) the Tameside and Glossop population ranks around the North West regional average.

## **2.2 Trends in alcohol related harm in Tameside and Glossop**

Figure 2 shows trends in selected indicators of alcohol related harm for Tameside and Glossop .

**Figure 3.2:** Trends for selected indicators – Tameside and Glossop



### Summary – trends in alcohol related harm

Levels of alcohol attributable hospital admissions seem to be rising steadily in Tameside and Glossop , whereas trends for the other indicators for which data is available (alcohol attributable mortality, alcohol related crimes, violence and sexual offences) do not show a rise. There are indications of a sustained fall in the level of these indicators.

## 2.3 Benchmarking against national targets

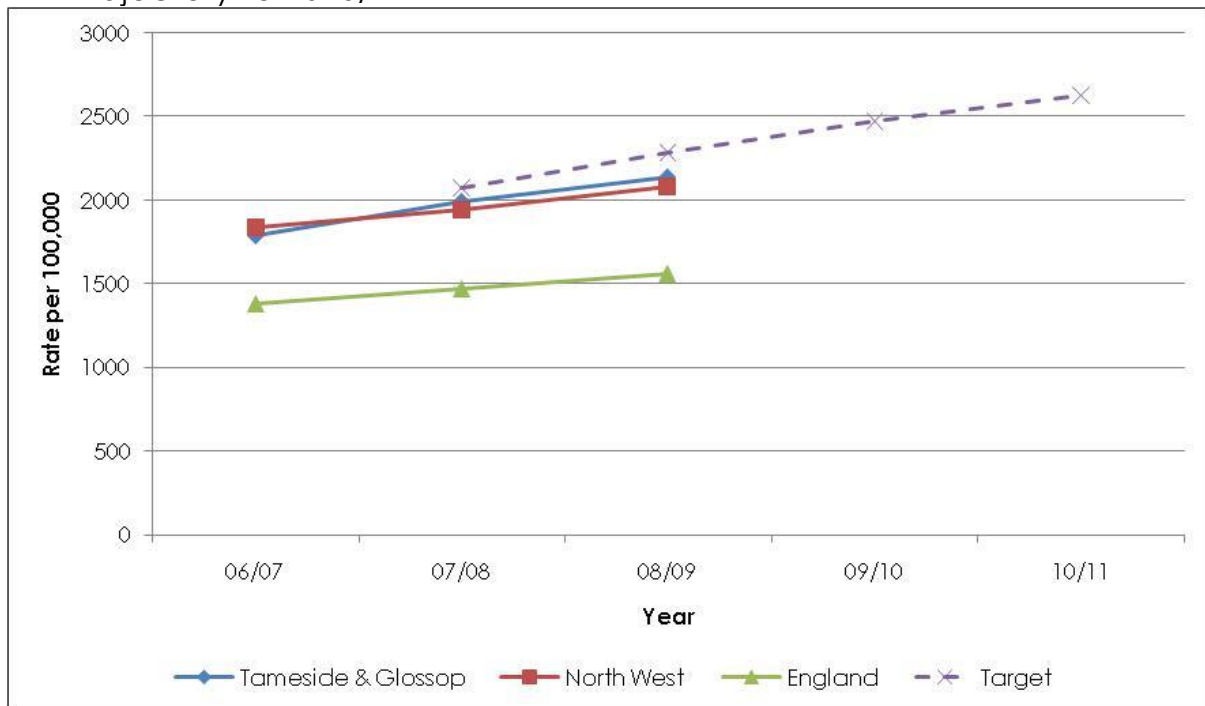
2.3.1. The targets for reducing alcohol related harm are set through the alcohol trajectory for VSC 26 Rate of hospital admissions per 100,000 population for alcohol related harm and the complementary Tameside and Derbyshire LAA targets for NI 39.

**TABLE 3.2:** Alcohol related admissions for Tameside and Glossop benchmarked against England and the North West. Tameside and Glossop Target admissions.

	06/07	07/08	08/09	09/10	10/11
Tameside & Glossop	1791	1996	2140		
<i>T&amp;G Target</i>		2070	2,286	2474	2630
North West	1835	1944	2080		
England	1384	1473	1562		

**Source:** NWPFO, 2009

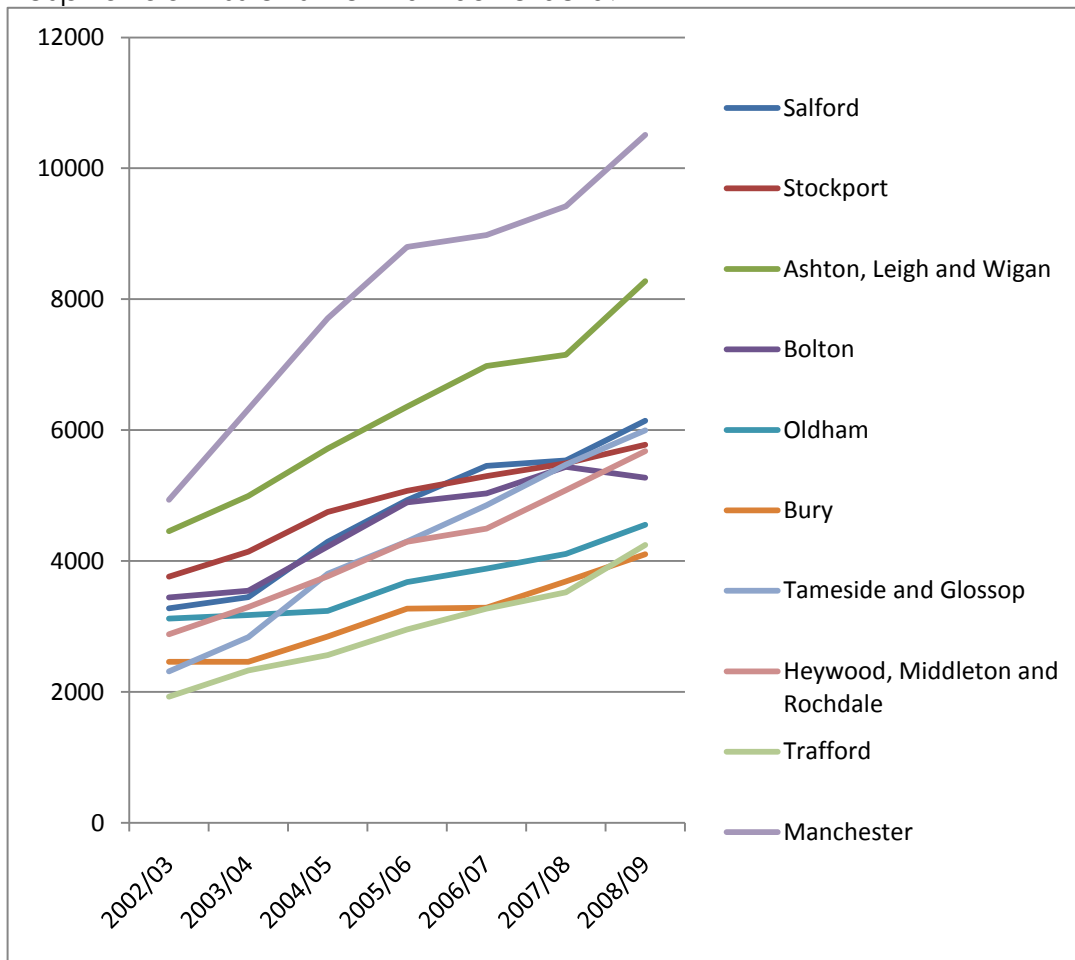
**Figure 3.3:** Alcohol related hospital admissions per 100,000 2006/7-2008/9 with trajectory to 2010/11



Source: NWPFO, 2009

Table 2 and Figure 3 show alcohol related hospital admissions have risen more slowly than the VSC 36 trajectory. However this leaves no room for complacency as the rate continues to rise and is significantly above the England figure.

**Figure 3.4:** Comparison by PCT of increase in numbers of alcohol related hospital admissions from 02-03 to 08-09

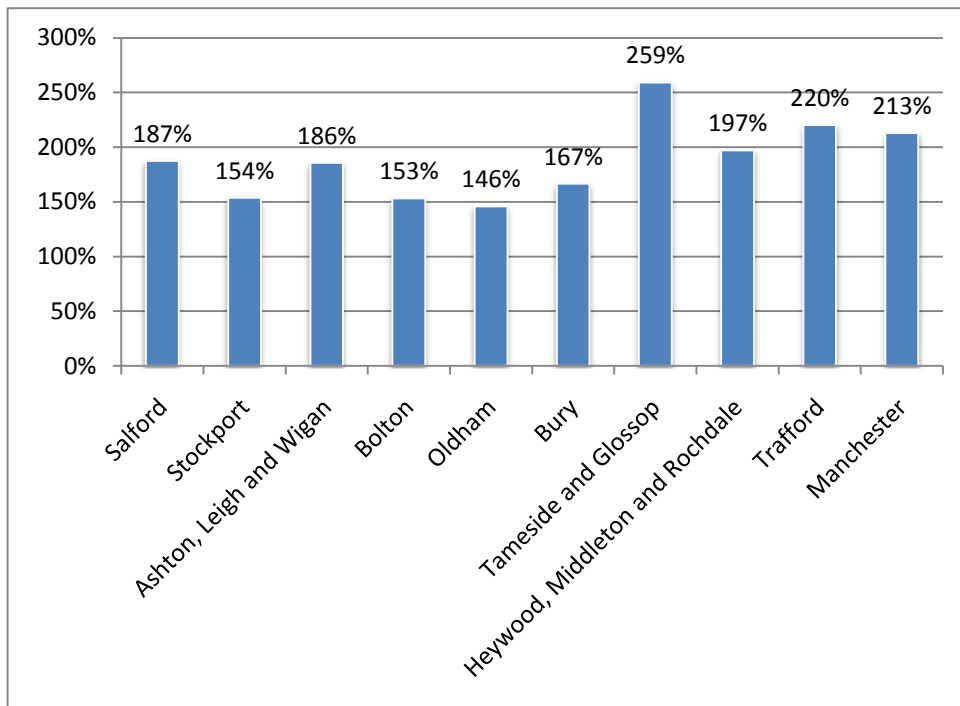


Source: based on NWPHO data (2009)

Figure 4 benchmarks the rise in alcohol related admissions for Tameside and Glossop relative to other Greater Manchester PCTs since 2002-3 and shows that the rate of rise in Tameside and Glossop is steep relative to other PCTs.

Figure 5 shows that the % rise in alcohol related hospital admissions in Tameside and Glossop between 2002-3 and 2008-9 has been the greatest of all the Greater Manchester PCTs at 259%.

**FIGURE 3.5: % INCREASE IN ALCOHOL RELATED HOSPITAL ADMISSIONS 2002/3-2008/9**



SOURCE: NWP HO DATA 2009

Figure 6 shows the component diagnoses of the alcohol related hospital admissions for 07-08

**Summary – Benchmarking health need against National Targets : progress and gaps towards achieving improvement targets**

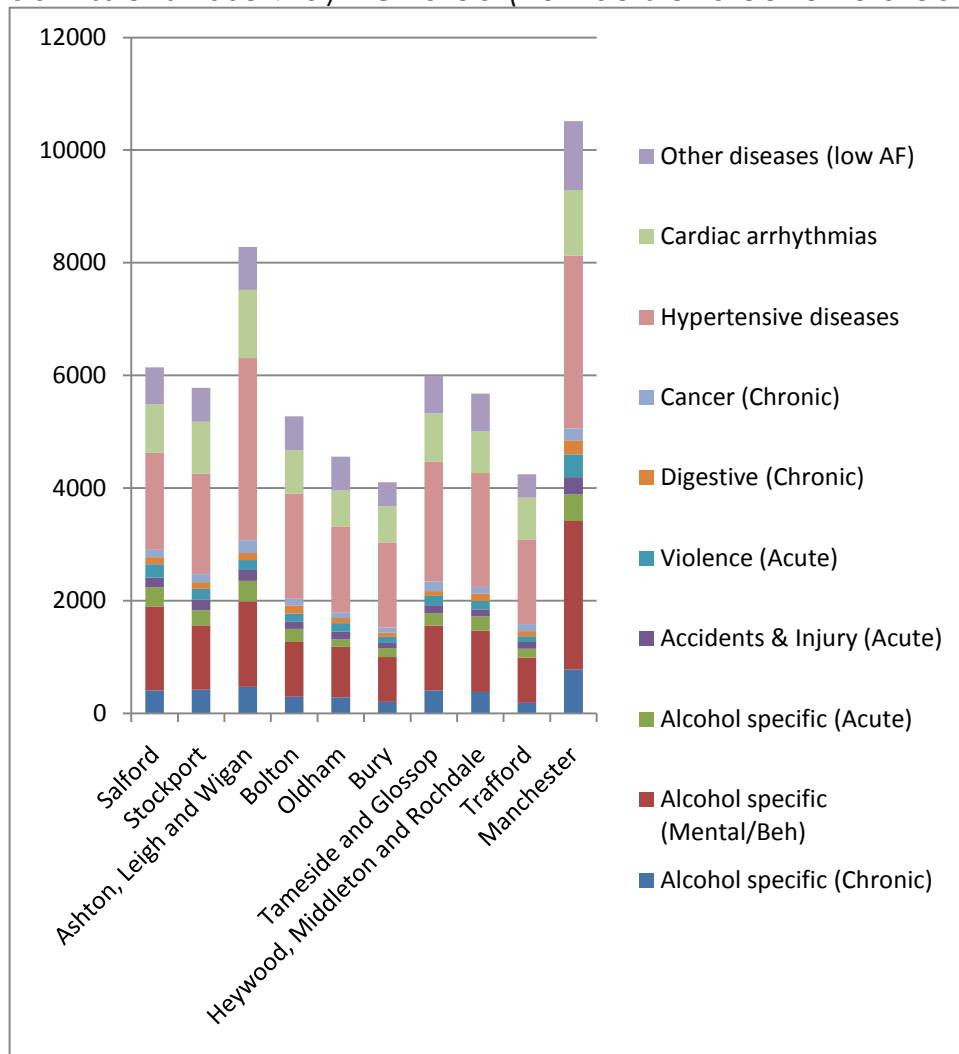
Although Tameside and Glossop did achieve its target of reducing the rise in the increase in alcohol related hospital admissions in 08-09:

- Rates remain above the NW average
- Rates remain significantly above the England average
- Tameside and Glossop has shown a higher rate of rise than other areas in Greater Manchester over the six years since the indicator was first developed.

**2.4 Causes of variance – the underlying causes of alcohol related hospital admissions**

Figure 6 shows that hypertensive disease, alcohol specific (mental behavioural) (ie acute intoxication) and cardiac arrhythmias are the three main underlying causes of alcohol related hospital admissions across all the PCTs.

**Figure 3.6:** Breakdown of underlying causes of alcohol related hospital admissions 2008-9 by PCT area (numbers of alcohol related admissions)

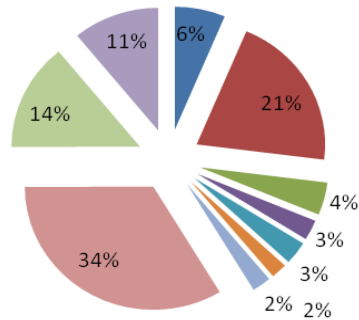


Source NWPFO DATA 2009

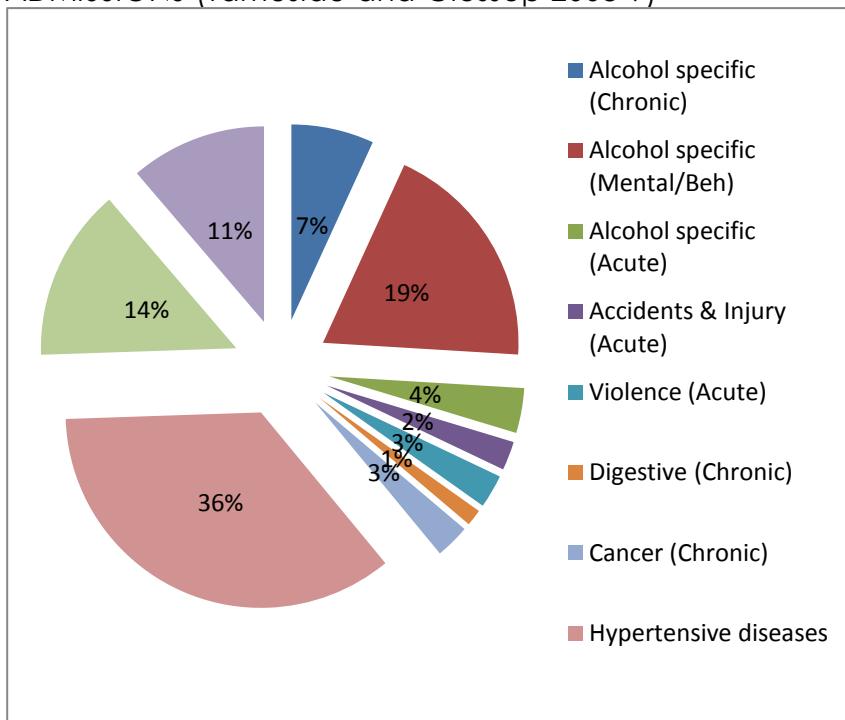
Figures 7 and 8 show the contribution that each of the causes makes to the total. For both Greater Manchester and Tameside and Glossop, hypertension is the cause of just over one third of attributable admissions, acute intoxication about one fifth and cardiac arrhythmias a sixth.

**FIGURE 3.7: CONTRIBUTION OF EACH DIAGNOSIS TO ALCOHOL RELATED HOSPITAL ADMISSIONS (Greater Manchester PCTs 2008-9)**

- Alcohol specific (Chronic)
- Alcohol specific (Acute)
- Violence (Acute)
- Cancer (Chronic)
- Cardiac arrhythmias
- Alcohol specific (Mental/Beh)
- Accidents & Injury (Acute)
- Digestive (Chronic)
- Hypertensive diseases
- Other diseases (low AF)



**FIGURE 3.8: CONTRIBUTION OF EACH DIAGNOSIS TO ALCOHOL RELATED HOSPITAL ADMISSIONS (Tameside and Glossop 2008-9)**



Hypertension is the most frequent cause of alcohol related hospital admissions – 35% for Tameside and Glossop

## **Summary – Analysing causes of variance: the contribution of different causes of admission to alcohol related hospital admissions**

One third of alcohol related hospital admissions in Tameside and Glossop are attributable to hypertension. These can be tackled through assessing those on GP hypertension registers and encouraging those who are drinking at harmful levels to cut down or abstain.

One fifth of admissions relate to acute intoxication. This can be tackled through identification and brief advice in a range of settings including young people's services; crime and disorder and town centre safety and A and E. Key too to reducing this group of admissions are measures relating to enforcement, licensing and town centre safety.

Arrhythmias may arise as a result of binge drinking (tackled as for acute intoxication), or as a result of chronic drinking at harmful levels. Most of those drinking to this extent will be already known to services and there is no evidence for the effectiveness of brief advice with this group.

### **3. Alcohol related harm within Tameside – segmentation of the population**

Comparing the Local Alcohol Profiles for England as described above demonstrates that the population of Tameside and Glossop suffers higher rates of alcohol related harm than the England average, although generally Tameside and Glossop is around the NW Regional Average.

Using Hospital Episode Statistics (HES) admissions can be linked to ward of residence. This involves linking ICD codes to causes of admission linked to binge drinking, chronic drinking and dependent drinking. The ICD codes used are all alcohol specific rather than alcohol attributable (ie alcohol is the principal underlying cause in all cases admitted with these codes).

#### **3. 1 Binge drinking**

The literature shows that binge drinkers are associated with high levels of crime and disorder and 'risky' behaviour e.g. unprotected sex. 'Synthetic estimates' of alcohol consumption patterns for mid 2005, produced by the Centre for Public Health<sup>51</sup>, show approximately 22% of Tameside's 16 years and over population are binge drinkers (around 37,000 people). The ICD codes most directly related to binge drinking are those relating to acute intoxication (F10.0 and T51.0). As figures 3 and 4 below show:

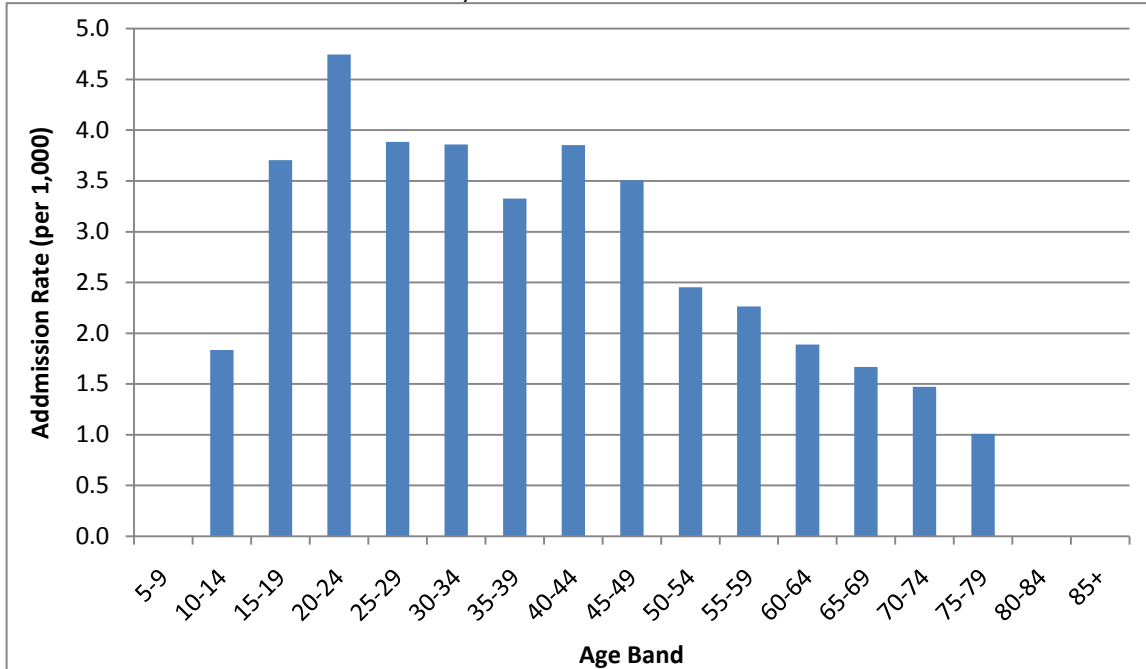
- Twenty to twenty five is the peak age for acute intoxication. However there are high rates of admissions for a band of age groups from 15-49 years old. Rates tend to decline after the age of 49.
- From the age of 15 onwards, men account for by far the majority of admissions for acute intoxication. However, quite different patterns of admission apply to men and to women. Male admissions peak at 20—24 and then tend to reduce. Female admissions have two peaks – at 15-19 and again at 40-44. For the age bands 15-19, 35-39 and 40-44 there is less difference between male and female admissions than at other ages.

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<sup>51</sup> The impact of alcohol in Greater Manchester: quarterly report November 2008. Centre for Public Health, Liverpool John Moores University

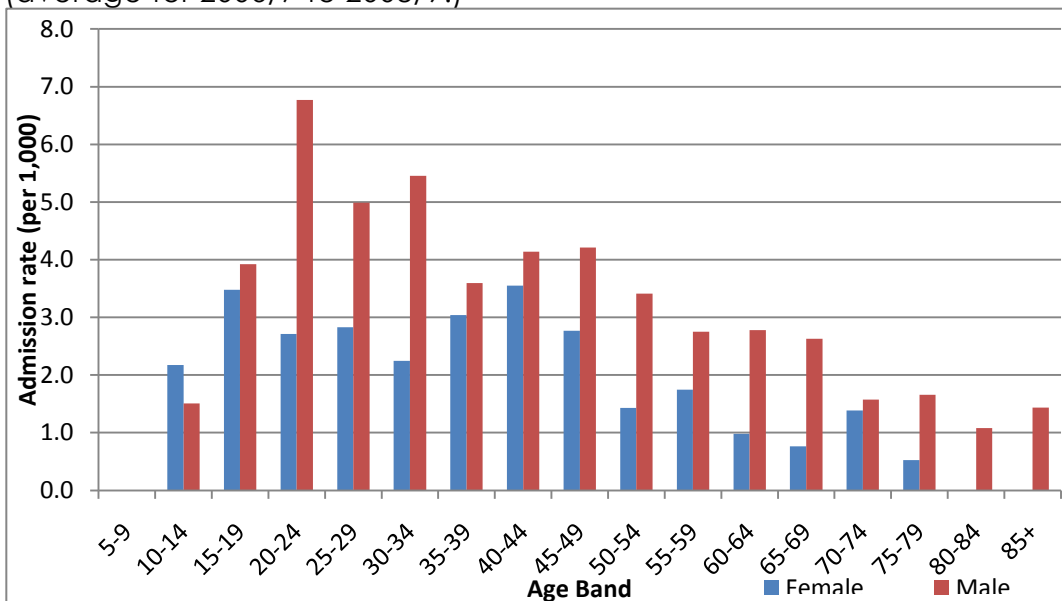
- In the 10-14 age group, young women outnumber young men with a total of 83 10-14 year olds being admitted with acute intoxication symptoms in the years 2006-8.

**Figure 3.3** Tameside and Glossop admissions with acute intoxication symptoms (ICD Codes F10.0 and T51.0) by age band, rate per 1,000 population (average for 2006/7 to 2008/9 admissions).



Source: Secondary Uses Service, 2009  
 Total N=1828  
 NB: Rates based on data values under 5 are not shown.

**Figure 3.4:** Gender differences in Tameside and Glossop admissions with acute intoxication symptoms (ICD Codes F10.0 and T51.0), - by age band rate per 1,000 (average for 2006/7 to 2008/9.)



Source: Secondary Uses Service, 2009  
 Total N=1828 NB: Rates based on data values under 5 are not shown.



**Figure 3.6:** Indices of Deprivation 2007 for Tameside and Glossop PCT, Super Out Put Areas in the 5, 10 and 20% most deprived nationally.

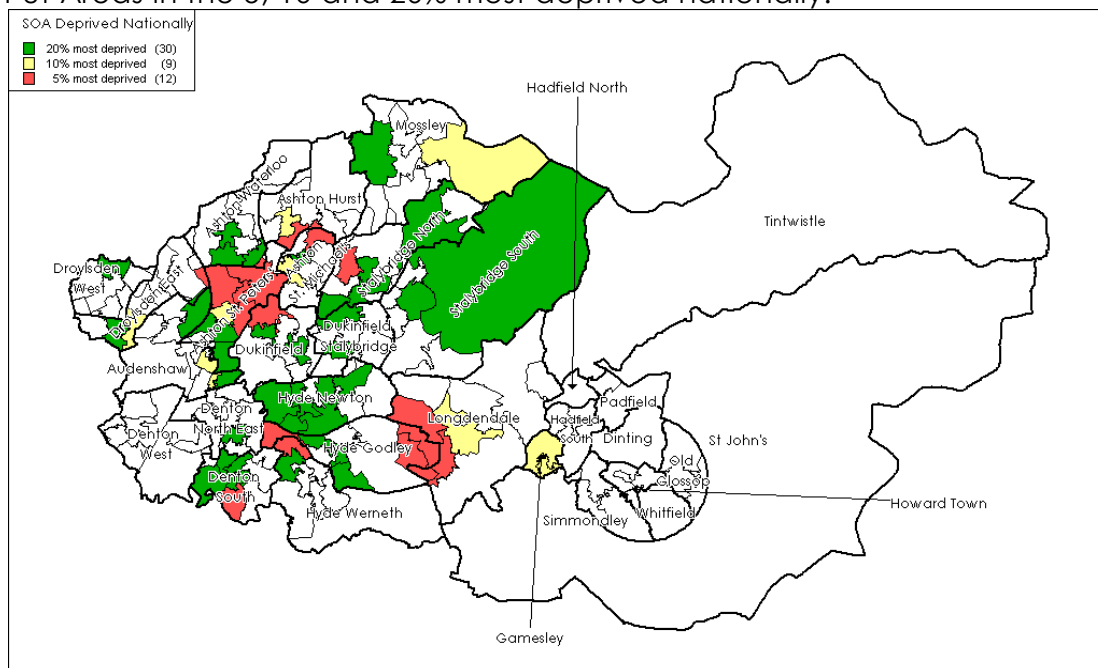
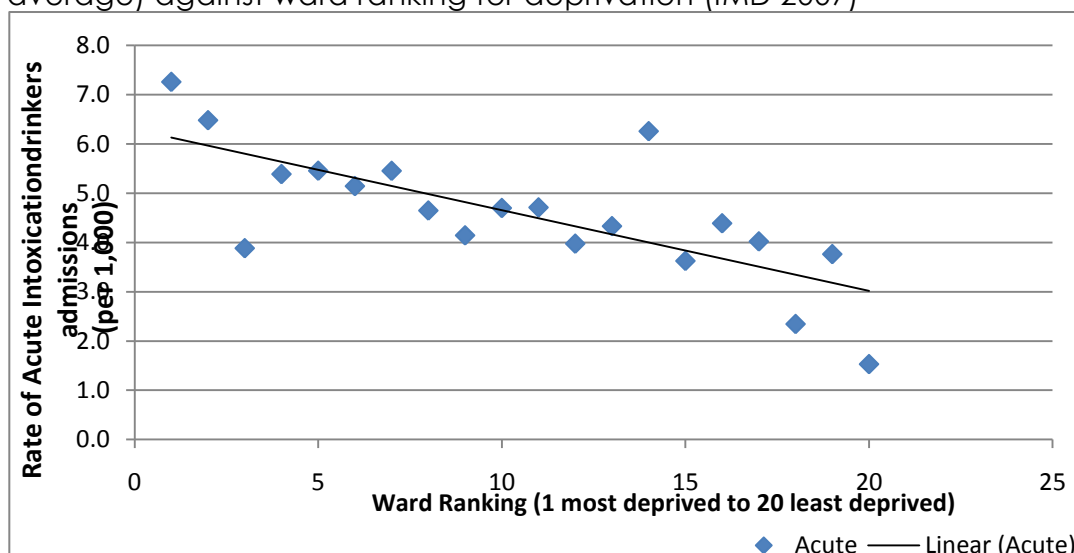


Figure 6. shows the concentrations of socio-economic deprivation in Tameside and Glossop. Comparison with Figure 5 confirms the close relationship between socio-economic deprivation and high rates of admissions for acute intoxication. This is further confirmed by Figure 7 which plots admission rates for acute intoxication against ward rankings for deprivation and that rates rise with increases in socio-economic deprivation.

**Figure 3.7:** Acute Intoxication Ward rate for admissions (2006/7 to 2008/9 average) against ward ranking for deprivation (IMD 2007)



Source: Secondary Uses Service, 2008

The ward ranking indicates 1 (most deprived) to 20 (least deprived) and is based upon the IMD 2007 data retrieved from <http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>

Table 2 below shows rates and actual numbers of admissions by ward to provide information on what practical action needs to put into place as well as to identify which population groups are at highest 'risk'. The table is ranked by numbers of admissions.

**Table 3.2:** Acute intoxication admissions (F10.0 and T51.0) 3 year average numbers and rates by ward per resident 1,000 population (Average of 2006/7 to 2008/9 admissions) ranked by average numbers (actual)

<b>Ward name</b>	<b>3 yr av number admissions per year (2006-9).</b>	<b>Ward Population</b>	<b>Rate (Av) per 1,000</b>
Hyde Newton	119	6340	6.3
Ashton St. Peters'	114	5865	6.5
Ashton Hurst	97	5928	5.5
Denton South	95	5808	5.5
Ashton St. Michael's	93	5755	5.4
Hyde Godley	88	5704	5.1
Droylsden East	83	5874	4.7
Audenshaw	80	5676	4.7
Dukinfield	80	6158	4.3
Stalybridge North	77	6195	4.1
Stalybridge South	72	5469	4.4
Mossley	70	5021	4.6
Hyde Werneth	69	5787	4
Dukinfield Stalybridge	66	5472	4
Denton North East	63	5581	3.8
Ashton Waterloo	62	5701	3.6
Longdendale	60	5151	3.9
Droylsden West	43	6112	2.3
Gamesley	29	1332	7.3
Denton West	28	6096	1.5
Howard Town	9	2062	1.5
Whitfield	8	1117	2.4
Simmondley	7	2523	0.9
Hadfield North	6	1070	1.9
Hadfield South	6	2305	0.9
St John's	5	985	1.7
Tintwistle	5	1129	1.5
Old Glossop	<5	2397	-
Padfield	<5	1431	-
Dinting	<5	937	-

### Summary – Unmet need for the local population disaggregated to ward level – binge drinking

The figures on admissions for acute intoxications do point to a need to target efforts to reduce binge drinking to three separate groups:

- Young men, particularly those aged 20-34
- Young people of both sexes especially those aged 15-19
- Adults of both sexes especially those aged 35-49
- Those living in areas of socio-economic deprivation especially Ashton St Peters, Hyde Newton, Ashton St Michael's , Ashton Hurst, Denton South, Hyde Godley (including Hattersley) and Gamesley.

### 3.2.Chronic drinking

'Synthetic estimates' of alcohol consumption patterns for Tameside mid 2005, produced by the Centre for Public Health<sup>25</sup> show approximately 23% of the population are hazardous drinkers and approximately 7% are harmful drinkers. Centre for Public Health data also show that alcohol specific mortality for Tameside was higher than that nationally.

The ICD-10 codes used for Hazardous and Harmful drinking are:

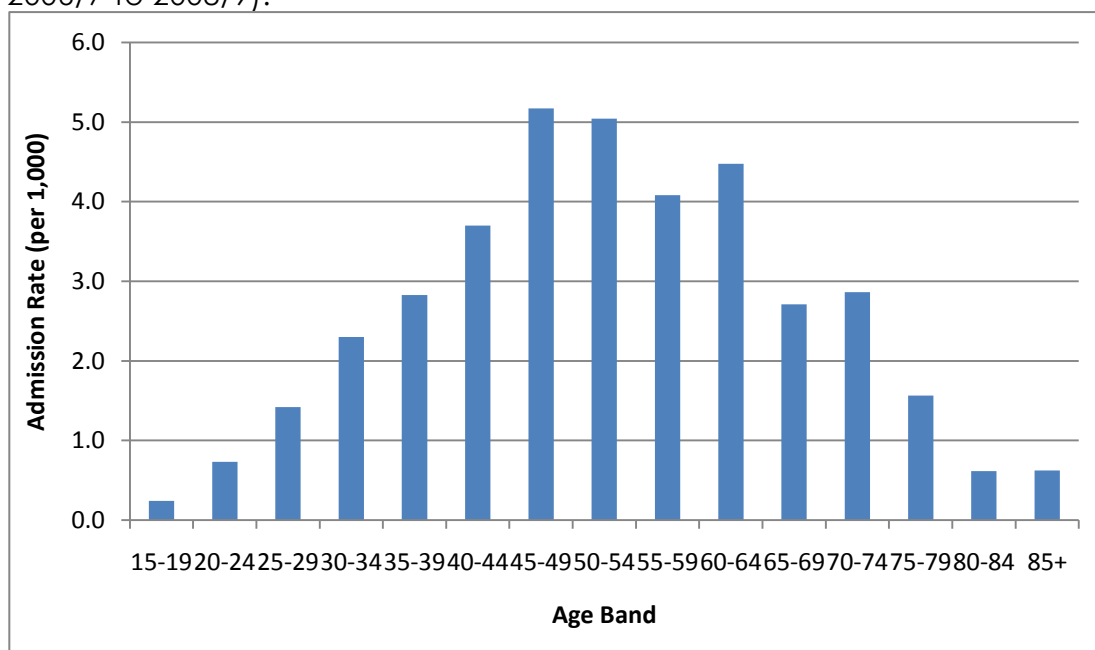
F10.1	Harmful use
F10.5-9	Psychotic disorder, Amnesic syndrome, residual and late-onset psychotic disorder, Other and unspecified mental and behavioural disorders
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
K70.0-8	Alcoholic Liver disease
K70.9	Alcoholic Liver disease, unspecified
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis

Figures 8 and 9 show admissions related to alcohol specific conditions caused by harmful and hazardous drinking. It should be noted that these only cover alcohol *specific* conditions such as liver disease and degeneration of the nervous system. They do not cover alcohol *attributable* admissions such as hypertension and arrhythmias. The figures show:

- Admissions for harmful and hazardous drinking peak at the 45-54 age band
- Females admissions peak at the 45-49 age band
- Males admissions peak at the 50-54 and 60-64 age groups
- For all age groups rates of admissions are higher for males than for females. However this difference is more marked in older (50+) rather than younger age bands and may indicate a new cohort of younger women who drink more heavily than previous generations.

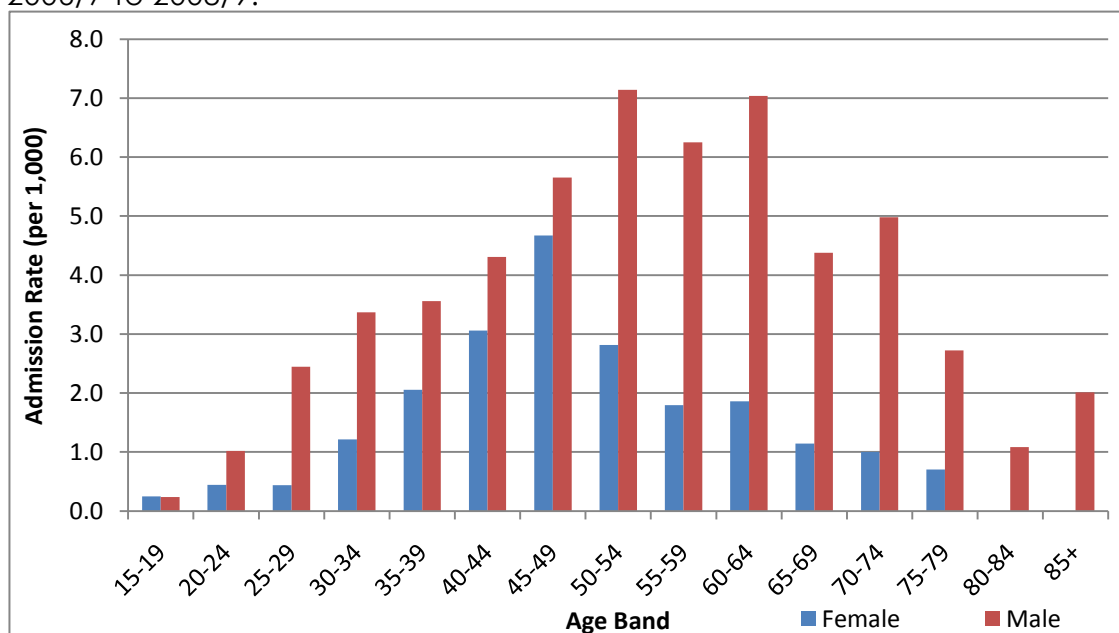
**Figure 3.8:** Tameside & Glossop Admissions for alcohol specific conditions related Hazardous and Harmful Drinkers (ICD codes F10.1, F10.5-9,G31.2, G62.1, I42.6,

K29.2, K70.0-9), rate per 1,000 registered population by age band, (average for 2006/7 to 2008/9).



Source: Secondary Uses Service, 2009.  
Total N = 1640

**Figure 3.9:** Gender differences: Tameside & Glossop Admissions for Alcohol Specific Hazardous and Harmful Drinkers (ICD codes F10.1, F10.5-9, G31.2, G62.1, I42.6, K29.2, K70.0-9), by gender and age band, average of financial years 2006/7 to 2008/9.

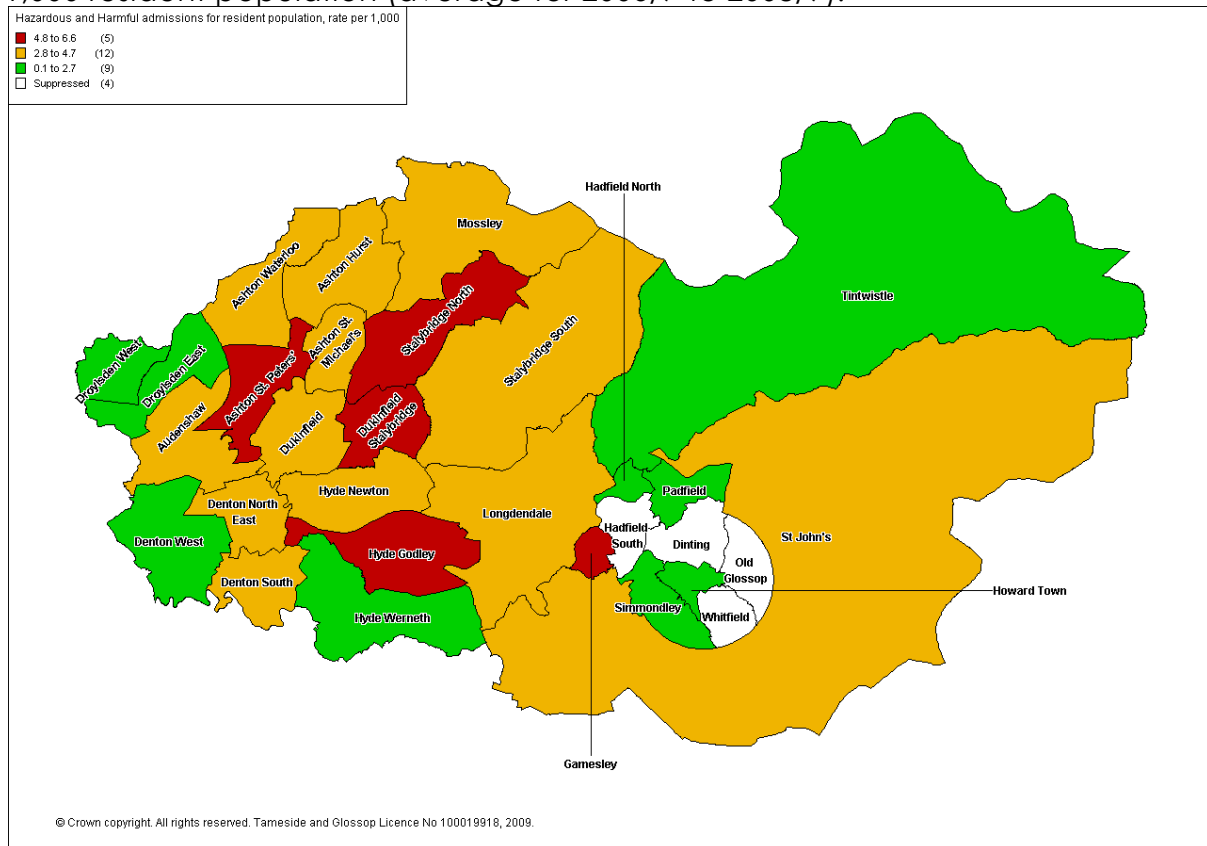


Source: Secondary Uses Service, 2009. Total N = 1640 NB: Data values under 5 have been suppressed.

Figure 10 and Table 3 show the admissions for alcohol specific admissions related to hazardous and harmful drinking by ward of residence. The areas with particularly high rates and numbers of admissions are Ashton St Peters, Dukinfield Stalybridge, Stalybridge North, Hyde Godley. Gamesley has very high rates but relatively small numbers as its population is lower. Comparison with Figure 4.5.4 does show an association with socio-economic deprivation. Figure 11 confirms the positive

association between admissions for alcohol specific conditions relating to harmful and hazardous drinking and residence in areas of socio-economic deprivation.

**Figure 3.10:** Tameside & Glossop Admissions for Alcohol Specific Hazardous and Harmful Drinkers (ICD codes F10.1, F10.5-9, G31.2, G62.1, I42.6, K29.2, K70.0-9), per 1,000 resident population (average for 2006/7 to 2008/9).

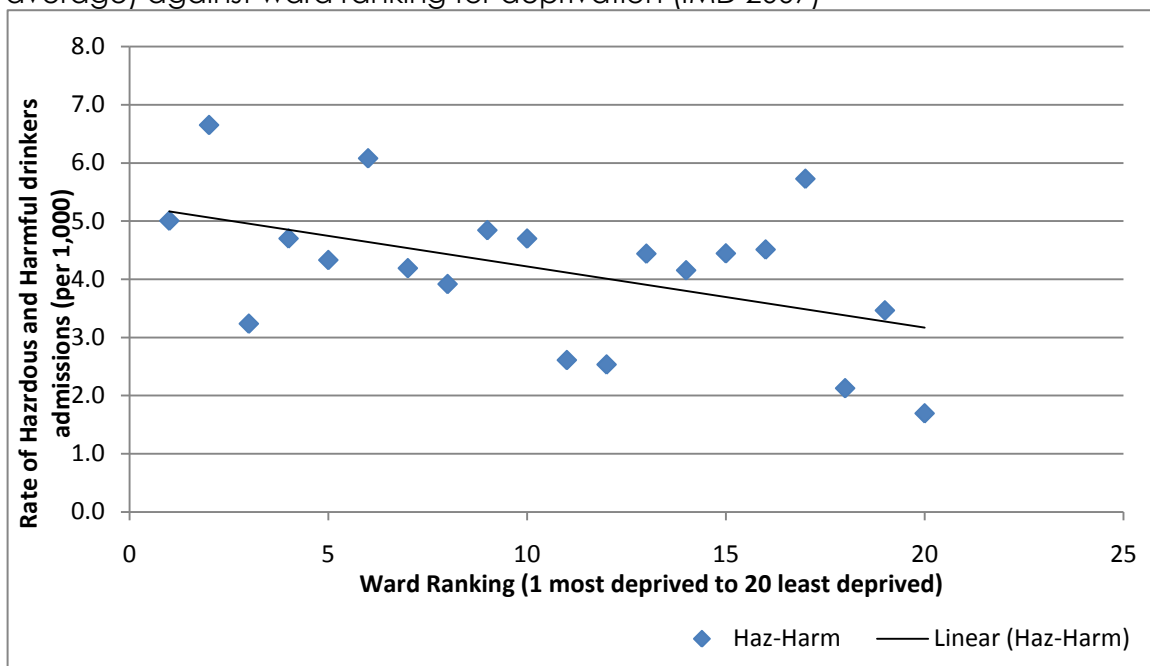


**Source:** Public Health Intelligence Team, NHS Tameside and Glossop  
277 records excluded due to out of area postcode

**Table 3.3:** Tameside & Glossop Admissions for Alcohol Specific Hazardous and Harmful Drinkers (ICD codes F10.1, F10.5-9,G31.2, G62.1, I42.6, K29.2, K70.0-9), by ward per resident 1,000 population (Average of 2006/7 to 2008/9 admissions) ranked by average number of admissions. (Actual)

Wardname	Count	Population	Rate (Ave) per 1,000
Ashton St. Peters'	117	5865	6.6
Hyde Godley	104	5704	6.1
Dukinfield Stalybridge	94	5472	5.7
Stalybridge North	90	6195	4.8
Ashton St. Michael's	82	5755	4.7
Dukinfield	82	6158	4.4
Audenshaw	80	5676	4.7
Hyde Newton	79	6340	4.2
Ashton Hurst	77	5928	4.3
Ashton Waterloo	76	5701	4.4
Stalybridge South	74	5469	4.5
Denton South	73	5808	4.2
Mossley	59	5021	3.9
Denton North East	58	5581	3.5
Longdendale	50	5151	3.2
Droylsden East	46	5874	2.6
Hyde Werneth	44	5787	2.5
Droylsden West	39	6112	2.1
Denton West	31	6096	1.7
Gamesley	20	1332	5
St John's	12	985	4.1
Howard Town	10	2062	1.6
Tintwistle	9	1129	2.7
Simmondley	9	2523	1.2
Padfield	7	1431	1.6
Hadfield North	6	1070	1.9
Old Glossop	<5	2397	-
Hadfield South	<5	2305	-
Dinting	<5	937	-
Whitfield	<5	1117	-

**Figure 3.11:** Hazardous and Harmful Ward rate for admissions (2006/7 to 2008/9 average) against ward ranking for deprivation (IMD 2007)



Source: Secondary Uses Service, 2008

**Summary – Unmet need for the local population disaggregated to ward level – chronic drinking**

Men consistently drink more than women in all age groups.

Although drinking levels have been shown to decline with age, the cumulative effects of hazardous and harmful drinking are evidenced in Tameside’s high levels of hospitalisation and premature mortality from alcohol associated conditions. These peak between the ages of 40-64. Female admissions peak earlier, at ages 45-49, than males, where peak levels are from 40-64. This may reflect the development of harmful drinking patterns among a younger cohort of women.

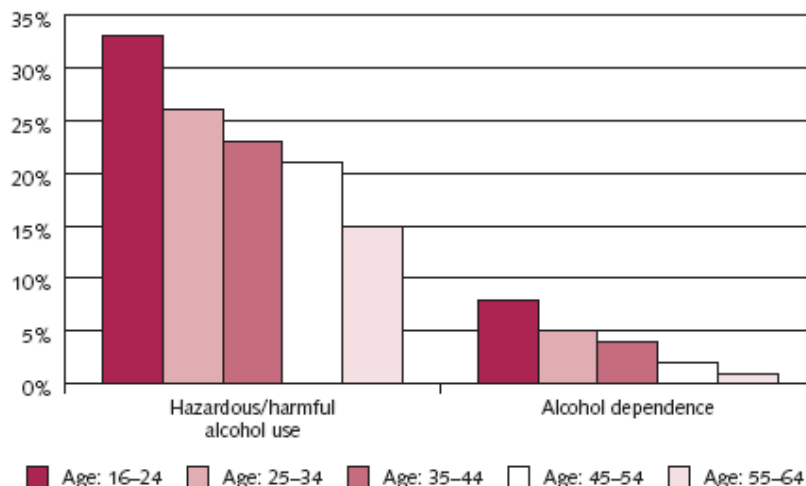
Again, there is a positive association between high levels of alcohol consumption and high levels of socio-economic deprivation, with highest admission rates in some of the most deprived wards in Tameside and Glossop. Ashton St Peters, Stalybridge North, Dukinfield Stalybridge, Hyde Godley and Gamesley all show the highest rates of admissions.

### 3.3. Dependent drinkers

As figure 12 below, shows, information from the national alcohol needs assessment<sup>53</sup> indicates that the pattern of increased percentages in the younger age groups holds true even for dependent drinkers with percentages of people in England in the 16-24 age group (8%) twice as high as in the 35-44 age group (4%).

**Figure 3.12:** Reproduced from the National Alcohol Needs Assessment

**Figure 2: Percentage of people in England with an alcohol use disorder by age**



They found that black and minority ethnic groups had considerably lower prevalence of hazardous/harmful alcohol use, but a similar prevalence of alcohol dependence when compared with the white population.

Data on hospital admissions of Tameside and Glossop dependent drinkers are shown in figure 13 and 14 below, Here, as can be seen

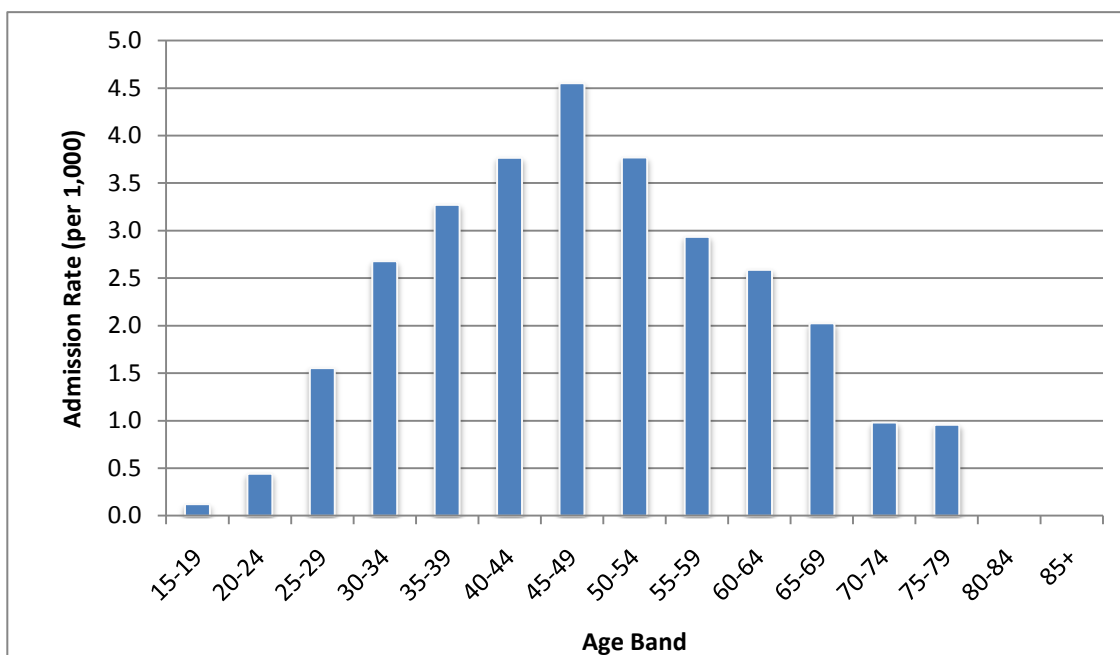
- Men still far outnumber women but the peak ages are older, from 40-54.
- The data show a quite different age pattern than that for admissions coded as being for 'acute intoxication' and also a different age pattern to that indicated in national figures.

The ICD-10 codes used for patients dependent on alcohol are:

- F10.2 Dependence syndrome
- F10.3 Withdrawal state
- F10.4 Withdrawal state with delirium

**Figure 3.13:** All Tameside and Glossop admissions with alcohol dependence symptoms (ICD Codes F10.2, F10.3 and F10.4) by age band, rate per 1,000 registered population (average for 2006/7 to 2008/9).

<sup>53</sup> Alcohol Needs Assessment Research Project (ANARP) The 2004 national alcohol needs assessment for England. Department of Health 2005.

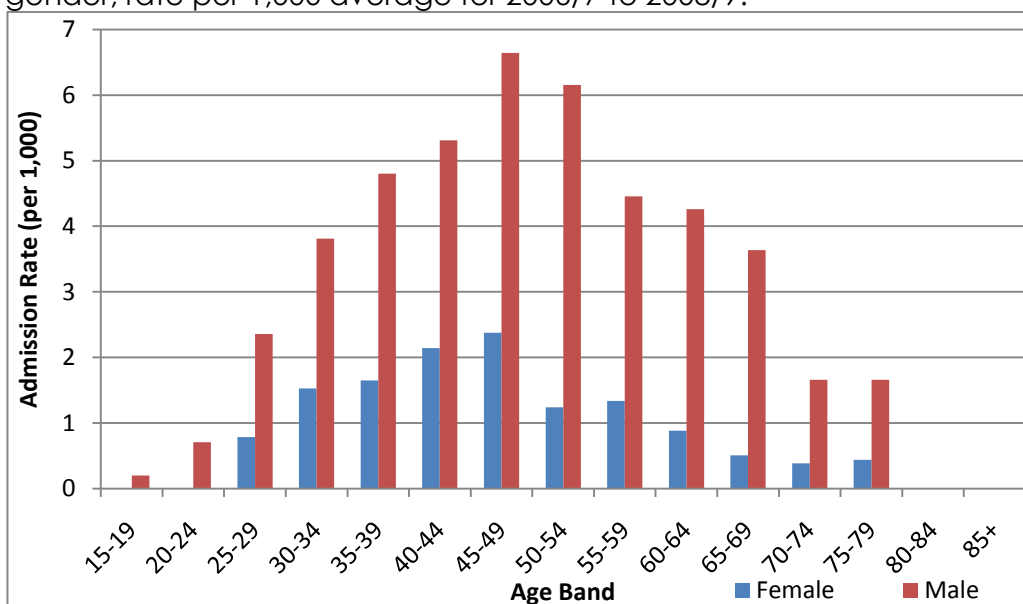


Source: Secondary Uses Service, 2009.  
Total N = 1365

Source: Hospital Episode Statistics, 2008. N = 795

**N.B.** The data relate to people with a Tameside and Glossop address and include all hospitals.

**Figure 3.14:** Gender differences: Tameside and Glossop admissions with alcohol dependence symptoms (ICD Codes F10.2, F10.3 and F10.4) by age band and gender, rate per 1,000 average for 2006/7 to 2008/9.



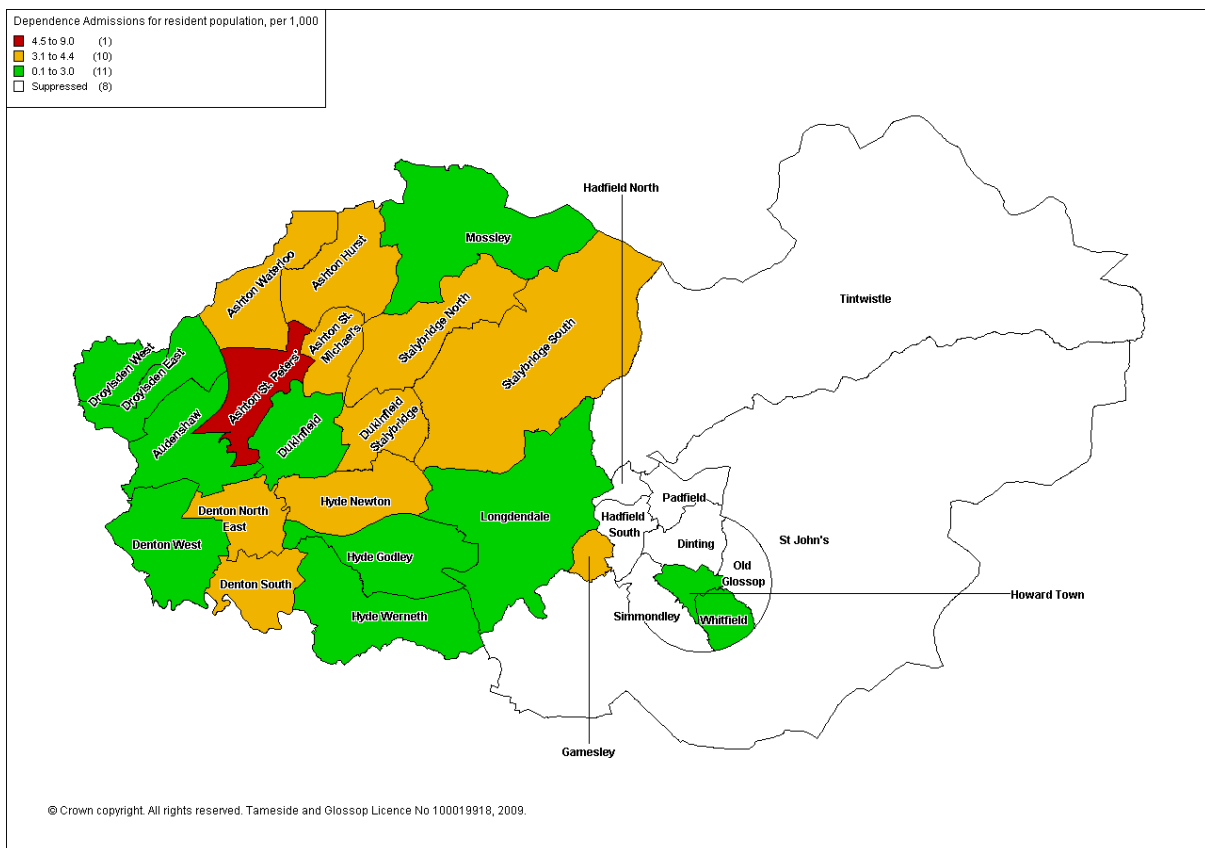
Source: Secondary Uses Service, 2009.  
Total N = 1365 NB: Rates based on values under 5 have not been shown

It may be the case that young people are less likely to be identified as dependent drinkers if they have not developed physical symptoms of harm. Also younger patients are likely to be under identified in primary care as:

- men, and young men especially, do not contact their GPs as often as women and consequently there will be less opportunity for GPs to detect alcohol dependency
- GPs tend to under-identify younger patients even when they present at surgeries<sup>54</sup>.

Figure 15 below shows the number of admissions for dependent drinkers by ward. The graph shows links to socio-economic deprivation, with particularly high levels of dependent drinking in St Peters and higher levels in other areas of socio-economic deprivation.

**Figure 3.15:** Tameside and Glossop admissions with alcohol dependence symptoms (ICD Codes F10.2, F10.3 and F10.4) per 1,000 resident population, (average for 2006/7 to 2008/9).



**Source:** Public Health Intelligence Team, NHS Tameside and Glossop  
 Rates based on average numbers <5 gave not been calculated.  
 236 records excluded due to out of area postcode  
**Source Hospital Episode Statistics 2008**

<sup>54</sup> Alcohol Needs Assessment Research Project (ANARP). The 2004 national alcohol needs assessment for England. Department of Health 2005. Gateway ref. 5650

### **Summary – Unmet need for the local population disaggregated to ward level – dependent drinking**

While national data shows that the highest levels of dependence are among the older age groups, those Tameside and Glossop residents admitted for conditions related to dependent drinking are most likely to be male, to be aged between 40-59 and to be resident in an area of socio-economic deprivation. Ashton St Peters – among the 5% most deprived wards in England – has the highest rates of admissions related to dependent drinking in Tameside and Glossop.

## **4. Qualitative needs assessment work on alcohol and tobacco.**

In September 2008 Dr Foster Intelligence delivered a report on home alcohol consumption in Tameside and Glossop. This was based a workshop carried out with 24 people in groups of eight. They were men and women from Tameside, all of whom came from areas of socio-economic deprivation and were drinking over the recommended limits. The findings were as follows:

### *Overall findings*

- High levels of depression, loneliness, stress and mental health issues, contributing to smoking, drinking and unhealthy lifestyles
- Lack of awareness of government guidelines on alcohol and exercise
- Belief that guidelines are too low
- Some strong opposition to government interfering in lifestyle - need to be careful how place health messages - avoid image of nanny state/interference
- Lack of immediate support when required
- People most likely to be influenced by:
  - People they trust (family, key workers, people who they have a close relationship with)
  - Experts, but people that they don't know (e.g. GP)

This work has formed the basis for proposals for a social marketing campaign to be led by Tameside Council.

### **Summary – Understanding causes of variance: the underlying causes for harmful drinking in Tameside – using qualitative data**

Qualitative research shows that in Tameside drinking alcohol to harmful levels may be linked to low level mental health issues such as depression, stress and loneliness.

Those who drink are not clear on government guidance, but even so there is a belief that recommended limits are too low and that the government should not interfere in lifestyle issues.

People who can influence them to reduce their drinking are those close to them, people they trust, key workers and also those who are perceived as experts such as GPs.

## **5. Segmentation of the population by need for alcohol treatment in Tameside and Glossop**

### **5.1. Prevalence of alcohol use disorders**

The Local Alcohol Profile for England (LAPE) tool developed by the North West Public Health Observatory estimates, for the population aged 16 and over, the number and percent prevalence of hazardous – defined as consumption of between 22 and 50 units of alcohol a week for males and between 15 and 35 units for females - and harmful drinkers - defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.

The data is based upon Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001. Table 4 and Table 5 show the estimates for numbers and percentage prevalence of hazardous and harmful drinking.

**Table 3.4:** Hazardous drinkers: mid 2005 estimate, North West Public Health Observatory

	Persons	Prevalence
Tameside and Glossop	45,266	23%
North West	1,211,231	22.1%
England	8,027,474	20.1%

**Table 3.5:** Harmful drinkers: mid 2005 estimate, North West Public Health Observatory

	Persons	Prevalence
Tameside and Glossop	13,347	6.8%
North West	342,477	6.25%
England	2,010,856	5%

Table 2 Estimates of harmful drinkers

Source: [http://www.nwph.net/alcohol/lape/NWPHO\\_PCT\\_HH.xls](http://www.nwph.net/alcohol/lape/NWPHO_PCT_HH.xls).

As already described, ANARP gives figures for hazardous and harmful drinkers as one category. These are based on the findings of the Psychiatric Morbidity Survey which in turn are primary based on the Alcohol Use Disorder Identification Test (AUDIT) questionnaires. This has a high degree of specificity and sensitivity in detecting hazardous drinking in a UK population.

**Table 3.6:** estimates of prevalence of harmful and hazardous drinking in the population

	National (ANARP) 2000-2002 data	%	National (NWPHO) 2005	NW(ANARP) 2000-2002 data %	NW (NWPHO) 2005
Harmful/hazardous(all)	23%		25.1%	29%	28.35%
Harmful/hazardous(M)	32%				
Harmful/hazardous (F)	15%				
Dependent (all)	3.6%			3%	
Dependent (M)	6%				
Dependent (F)	2%				

Source: ANARP/NWPHO

Although using slightly different definitions, the NWPHO observatory figures for prevalence of harmful and hazardous drinking in the population are close to the ANARP estimates and would imply that about 30% of the Tameside and Glossop population drink to hazardous (23% or 46,000) or harmful (7%, 14,000 people) levels.

Estimates of rates of dependent drinkers in the NW population are 3% (ANARP) which would give an estimated number of 6,000 dependent drinkers in Tameside and Glossop.

## **5.2. At risk and vulnerable groups within the population.**

The alcohol needs assessment on population level harm recommends targeting the following groups:

- Young people (those aged between 15 and 19). Men over this age are also 'significantly' associated with admissions for 'acute intoxication'. Girls aged between 10 and 14 outnumber boys.
- Binge drinkers aged between 20-49. Predominantly male and particularly those aged 20-24. Associated with crime, violence and disorder.
- People living in the 'hot spots' identified both by data showing offenders at 'high risk of reconviction through alcohol misuse' and hospital admission data for 'conditions wholly related to alcohol which show a high degree of congruence. People living in 'deprived' circumstances generally are at higher risk of all kinds of alcohol misuse.
- Offenders and their families who have issues with alcohol use
- Those who are dependent drinkers
- Black and minority ethnic groups whose representation in those who have addictions is frequently overlooked
- Young (under 25s particularly men) dependent drinkers who are unlikely to be identified in primary care settings
- Hazardous and harmful drinkers who are overwhelmingly male and aged between 35 and 74. Men aged between 25 and 29 appear to represent a new cohort of younger men who are hazardous and harmful drinkers
- Those with multiple admissions for alcohol related problems
- Those who have 2 or more CVD health risk factors (such as diabetes, obesity, smoking, hypertension or cholesterol) whose hazardous and harmful drinking put them at increased health risk
- People with multiple needs/problems especially those who have child care/family responsibilities

### **Summary – Population segmentation by health care need: quantifying the need for alcohol services in Tameside and Glossop**

There are an estimated 46,000 hazardous drinkers in Tameside and Glossop. The evidence is that these would benefit from a systematic programme of Identification and Brief Advice (IBA) delivered through front-line staff including primary care, acute hospital services, young peoples, criminal justice and other services in contact with vulnerable groups.

The findings of the population based needs assessment, confirmed by National Support Team (NST) recommendations are that priority should be given to those:

- Those involved in binge drinking including young people and younger adults especially men.
- Under 15s including girls
- Chronic drinkers at risk of developing alcohol related ill health
- Those in areas of high deprivation.
- Children and families with multiple needs
- Adults with multiple needs including those involved with the criminal justice system.

The use of a recognised assessment tool (such as AUDIT or FAST, developed for use in primary care or the Paddington tool for use in A and E ) is supported by the evidence of effectiveness and could be prioritised for these groups.

There are an estimated 14,000 hazardous drinkers in Tameside and Glossop. The evidence is that many of these would benefit from a systematic approach to IBA as described above. Others would benefit from evidence based specialist treatment interventions. There are an estimated 6,000 dependent drinkers in Tameside and Glossop who would benefit from evidence based specialist alcohol treatment interventions.

### **5.3. Estimates of demand for alcohol services**

Estimates are based on the Rush model<sup>55</sup>. The proportions passing from one stage to another are based on Rush, amended to fit the Tameside and Glossop pathway with assumptions on % assessed receiving services based on actual service data.

What the model offers is a quantitative planning model which aims to give an indication of how much of each type of treatment is required to meet the estimated need in the population. The model was developed in order to project uptake for services based on expected rather than historical demand ie what should be rather than what historically has been.

The stages in the model are:

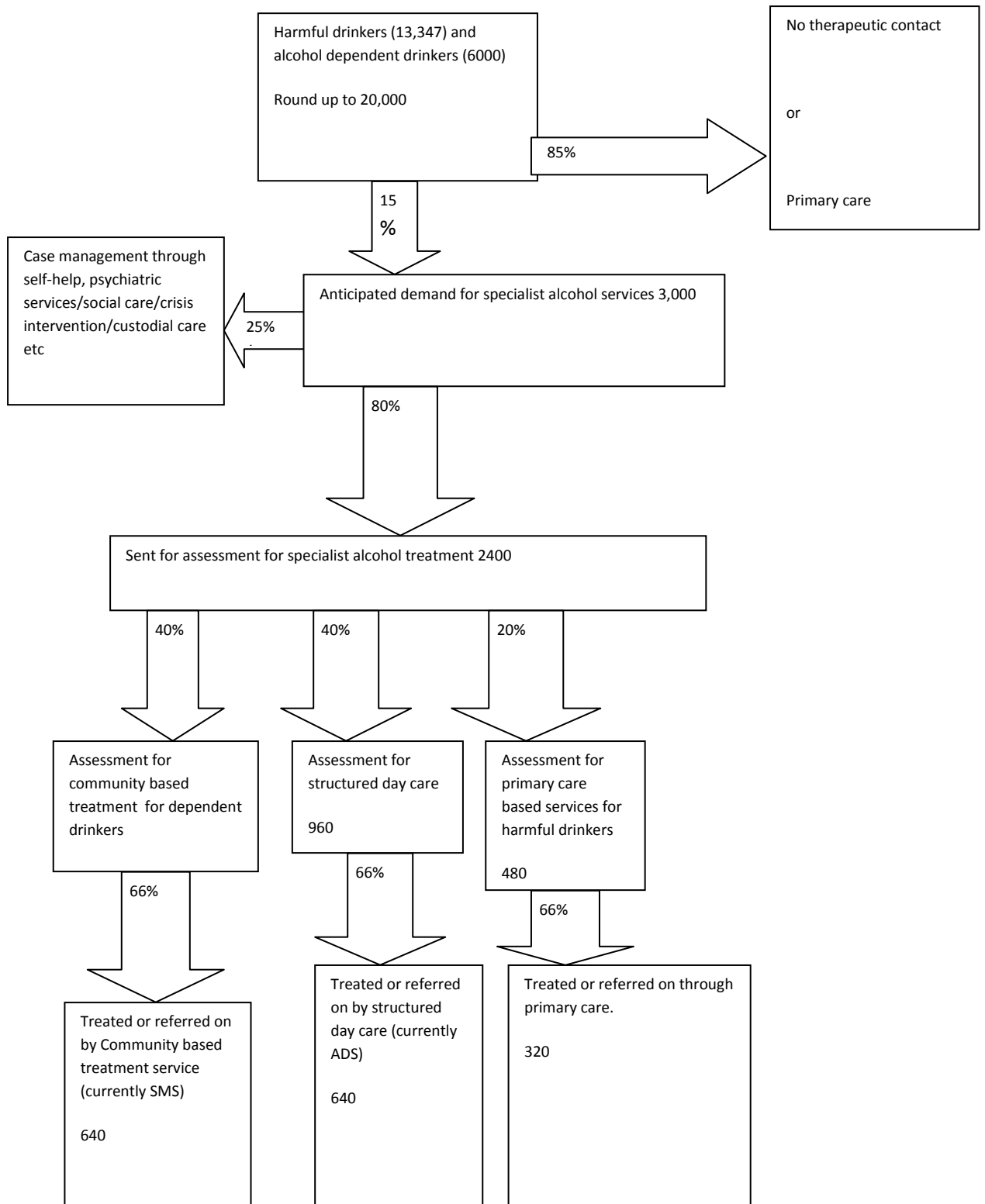
1. Determine the population
2. Determine the numbers of hazardous and dependent drinkers

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<sup>55</sup> Rush B, 1990. British Journal of Addiction, A systems approach to estimating the required capacity of treatment services

3. Determine the number to be treated each year. This depends on a number of assumptions which include:
  - Percentage of dependent drinkers relapsing annually
  - Annual increase in dependent drinkers
  - Numbers harmful drinkers
4. Estimate number requiring each level of service based on:
  - Published literature
  - Established monitoring and reporting systems
  - Informed opinion
  - System based forecasting models

**Figure 3.15:** An estimate of demand for different aspects of treatment services based on Rush.



## Summary – Segmentation of population by health care need: estimating the demand for specialist alcohol services

Use of a recognised predictive model estimates that annually about 3,000 of Tameside and Glossop's hazardous and dependent drinkers should demand specialist alcohol services annually. Of these an estimated 1600 (following triage, drop-outs etc) should actually enter services, against existing capacity of approximately 1000.

### 5.4 Planning alcohol services to meet health outcome aspirations and benchmarks

NHS Tameside and Glossop Strategic Commissioning Plan identifies the reduction of alcohol related harm as a PCT priority and sets out, as an appendix, a robust evidence based approach to the reduction in alcohol related hospital admissions which is reproduced below. The principles of the plan remain current while the detail of the plan has been refined and developed in line with:

- The findings of the Needs Assessments
- The recommendations of the National Service Teams (Inequalities and Oral Health)
- The realities of public sector finance.

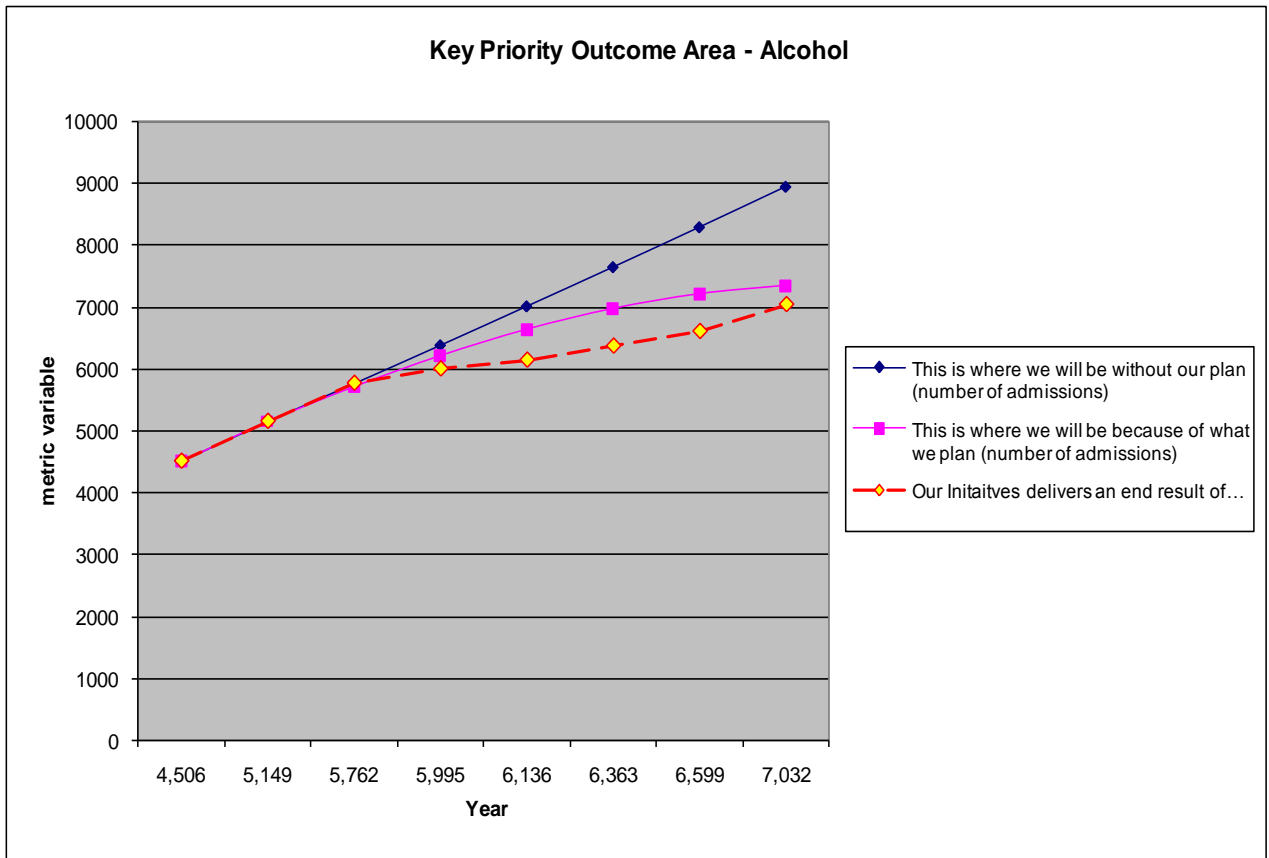
The Key outcome we plan to bring about is:	Prevent 3,967 hospital admissions for alcohol related harm between 2006/07 and 2013/14 (reducing expected admissions by 1% per year)
--	--

The reason we are doing this is because:	Alcohol is an underlying risk factor for the principal causes of premature death in Tameside and Glossop
--	--

To monitor our success, we will measure:	The rate of hospital admissions for alcohol related harm per 100,000 population.
--	--

In terms of how this will look over time:	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
This is where we will be without our plan (rates per 100,000 population)	1824.00	2070.3	2306.52	2542.78	2779.04	3015.5	3251.8	3488.1
This is where we will be because of what we plan (rate per 100,000 population)	1824.00	2070.3	2285.81	2474.24	2629.91	2748.48	2826.43	2862.23
This is where we will be without our plan (number of admissions)	4506	5149	5762	6382	7012	7647	8292	8947
This is where we will be because of what we plan (number of admissions)	4506	5149	5710	6210	6635	6970	7207	7342
Number of admissions to prevent each year	0	0	52	172	376	677	1085	1605
Cumulative number of admissions to prevent	0	0	52	224	600	1277	2362	3967

We will do several things to influence this. In summary, the initiatives we plan are:	The evidence for doing this is/says...	We therefore predict that by doing this the outcome for <b>local people</b> is that:	We also predict that by doing this, the impact on <b>current services</b> is that:	...and this is how far each initiative moves the dial toward our overall improvement target
Initiative 1) To develop a programme of training in targeted screening and brief interventions for primary care including DES, health improvement and A and E staff and support implementation	8 hazardous or harmful drinkers need to receive brief interventions in order for one to reduce their drinking to low risk levels (DH /NTA 2005).	Increase in uptake of specialist alcohol services. Reduction in numbers drinking at harmful levels. Delivery of interventions to 5000 people per year when fully implemented.	Opportunity costs for primary care teams and A and E staff. Increased demands on specialist alcohol services. Reduction in alcohol related admissions.	Assuming 1 in 8 reduce admissions by 625 annually when fully implemented
Further increase capacity for brief interventions through fire and rescue, police, social care staff and other front line staff.	8 hazardous or harmful drinkers need to receive brief interventions in order for one to reduce their drinking to low risk levels (DH /NTA 2005).	Increase in uptake of specialist alcohol services. Reduction in numbers drinking at harmful levels. Delivery of interventions to 1800 people per year when fully implemented.	Opportunity costs for front line staff. Increased demands on specialist alcohol services. Reduction in alcohol related admissions.	Assuming 1 in 8 reduce admissions by 240 annually when fully implemented
Integrate alcohol within the roll out of Connect 4 Life and the work of the health outreach team	Connect 4 Life pilot showed 37% reduction in alcohol consumption in harmful drinkers.	Assume Connect 4 Life coaches reach 100 harmful drinkers per year and 1 in 8 succeed in reducing drinking levels to non risky levels. Assume health outreach contact 600 people through campaigns know your unit campaigns and 1 in 100 reduce consumption from risky to non risky.	Opportunity costs for front line staff. Increased demands on specialist alcohol services. Reduction in alcohol related admissions. Requires additional worker to support.	Using stated assumptions reduce admissions by 20 annually when fully implemented
Initiative 2) To increase capacity in the specialist alcohol services in order to reach hazardous as well as harmful drinkers. (Adult Tier 2&3, Young peoples and family support plus those from Criminal Justice system) linked to monitoring and outcome evaluation	The provision of alcohol treatment to 10% of the dependent drinking population within the UK would reduce public sector resource costs including long term health costs.	Specialist alcohol services will be provided to an additional 2500 hazardous/harmful drinkers. Assume that 1 in 4 of those receiving services will reduce their drinking from hazardous or harmful to non-risky levels.	Requires increased investment at Tiers 2 and 3 including primary care NES, young peoples and family services and criminal justice, plus some service redesign. Total of 16 additional workers across services.	Reduce admissions by 600 annually when fully implemented
Further increase in capacity in specialist alcohol services including increased capacity to meet needs of Glossopdale residents	See above	Specialist alcohol services to be delivered to a further 600 people.	See above. Requires another 4 additional workers.	Using assumptions above to reduce admissions by 150 per year
Initiative3) To develop a care pathway between the hospital and alcohol services, including young people's services	Development of identification and brief intervention in A and E is a high impact interervention in reducing admissions.	Specialist alcohol services will be provided to an additional 300 hazardous/harmful drinkers. Many of these account for repeat admissions. Therefore assume that 1 in 4 of those receiving services will reduce their drinking from hazardous or harmful to non-risky levels, and that this	Reduced burden on A and E and ward staff. Reduced alcohol related admissions. Requires increased capacity in alcohol services plus some service redesign.	Based on above assumptions this will reduce admissions by 80 per year.
Initiative 4) Social marketing campaigns targeted at at risk groups eg young people binge drinking or home drinkers	High impact changes: develop health promotion campaigns to disseminate and amplify messages of national social marketing campaigns.	If campaigns reach 20,000 at risk drinkers and their social networks assume 0.55% reduce drinking to low risk levels	Will increase demand on specialist alcohol services . Reduction in alcohol related hospital admissions.	Using assumptions reduce admissions by 100 annually
Initiative 5) Partnership working to address harmful drinking through sharpened criminal justice for drunken behaviour, toughened enforcement of underage sales, action on irresponsible pricing promotions	Measures to reduce consumption associated with binge drinking will reduce alcohol related accidents, injury, poisoning.	Reduction in binge drinking, home drinking, underage drinking. Assume affects 5000 at risk drinkers saving 1 in 20 admission.	Requires significant PH commitment to partnership working. Will reduce alcohol related hospital admissions.	Using assumptions above to reduce admissions by 100 per year



**Summary – Plans to improve performance to meet health outcome aspirations and benchmarks**

NHS Tameside and Glossop Strategic Commissioning Plan set out evidence based plans to tackle alcohol related hospital admissions. These were developed in partnership with key agencies including Tameside Council, Tameside Foundation Trust, Third Sector, Police, Probation, Alcohol Provider Services, Primary Care and with service user involvement.

The plans have evolved and been refined in the light of two alcohol needs assessments – population level and specialist services, invited visits from the National Support Teams for alcohol and inequalities and in light of adjustments to public sector finance.

The principle remain unchanged – working through frontline staff to identify and advise on alcohol related harm, ensuring the effective delivery of specialist alcohol services to meet need, work with the Hospital to ensure that care pathways ensure that alcohol related harm is identified and managed, working with the Council, police and other agencies to limit the supply of and demand for alcohol and getting appropriate messages on limiting alcohol related harm to targeted groups of the population in appropriate ways.

In summary it is planned to reduce the high levels of alcohol related harm in Tameside and Glossop through a programme of evidence based interventions based on a sophisticated understanding of the needs of its citizens and communities.