Bolton NHS
Primary Care Trust

Narrowing the Health Inequalities Gap

Tackling Exclusion and Disadvantage

Director of Public Health Annual Report 2007

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Foreword

Social exclusion is a relatively new concept, but in the context of reducing inequalities in health it is essential that we develop an understanding of what this means in our local circumstances. This year's Public Health Annual Report aims to share our understanding of the health issues faced by people in Bolton who are socially excluded, and describes some of the work we are doing to address these issues.

The Bolton Vision 2007 - 2017 sets out two very important aims for the people of Bolton - to narrow the gap between the most and the least well off, and to ensure economic prosperity. It is essential that we focus now on supporting the most socially excluded people in our community to ensure that they benefit from this new prosperity. If we fail to do this, we will fail to narrow the gap - and that means we will not reduce inequalities in health.

So, we need to find innovative ways to reach out to people and groups who may be socially excluded, and be pro-active in removing the barriers that prevent them from enjoying the good health that the rest of society expects to enjoy.

I am indebted to the many contributors to this year's report - a truly multi-agency effort! I am particularly grateful for Angela Hardman's skills as editor, Shenna Paynter for her administrative support and Julie Snell for her design skills.

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CHAPTER 1: Introduction

This year's annual report has grown out of the 2006 Director of Public Health Annual Report: Does Wealth Mean Health in Bolton which focused on inequalities in life expectancy between Bolton and the rest of England and between neighbourhoods within Bolton. The report highlighted geographical variations in life expectancy and explored the main causes (digestive disorders, cancers, circulatory disease and respiratory diseases) that contribute to reduced life expectancy across Bolton.

The Primary Care Trust (PCT), Bolton Council and all partners in the Local Strategic Partnership are committed to improving life expectancy across the borough by reducing our local life expectancy gap. It is well recognised that to deliver meaningful progress and tangible improvements in health and well-being, efforts need to focus on those that live in the most deprived areas and as a consequence are more likely to experience social exclusion.

Social exclusion is a term to describe what can happen when people or areas suffer from linked problems such as unemployment, poor skills, low incomes, poorly maintained housing, high crime, poor health and family breakdown. It results in an inability of people and some communities to exercise their social, economic and political rights as citizens and so they are excluded from society, experience disadvantage and are disempowered. This results in inequality and often discrimination, not only in accessing services but in a person's experience of ill health. Whilst social exclusion is in itself a determinant of poor health, poor health can influence exclusion.

Recognising that social exclusion is one of the factors at the root of health inequalities in life expectancy alongside poverty, employment, education, housing, social support, fear of crime and the quality of the local environment, this report is intended to develop a comprehensive understanding of a number of the key dimensions to social exclusion so that future efforts, across the health and social care community, are directed towards addressing the cause rather than the consequences of social exclusion. With this in mind, promoting social inclusion is fundamental to tackling exclusion and disadvantage and aims to enable each individual to have an equal opportunity to make decisions that affect their quality of life.

Progress has been and continues to be made in Bolton, but there are still many living a life of disadvantage, their problems are multiple, entrenched and often passed down through generations. A one size fits all approach will let down our most needy and hard to reach groups. We therefore need to deliver more personalised services, be more persistent and co-ordinated, and fit services around the needs of individuals if we are ever going to tackle the hardest complexities of peoples lives. This will mean finding new ways to work with and invest in our diverse community, ensuring that they are able to help us to identify and better understand barriers to inclusion. Furthermore we will contribute towards shaping interventions that will promote and deliver sustainable health improvement that will break the cycle of exclusion and disadvantage.

Social exclusion can not be addressed by any one single agency. Individuals and the wider community, in addition to the private and third sectors, all have a role to play. But most of all people who are suffering social exclusion must want progress for themselves and those around them. By working together we can ensure that even the most excluded have a stake in the society and economy of tomorrow by seizing the opportunities that life offers today[1].

This report is therefore about how the Bolton family works together to extend opportunity to the least disadvantaged so that they enjoy more of the chances and power that the rest of society takes for granted.

Understanding how social exclusion manifests itself in everyday life is central to determining how we can work with communities and individuals to improve the life chances of those who have experienced exclusion and disadvantage. Chapter 2 therefore shares a series of case studies which provide insight into the lives of people who experience exclusion. This helps to set the scene and context for the wider dimensions of social exclusion described in Chapter 3. Acknowledging the complexities of social exclusion, this chapter makes recommendations as to how we can promote inclusion and enable individuals to have an equal opportunity to make decisions that affect their quality of life not only for themselves but for future generations.

The main recommendations for action identified throughout the report are summarised in Chapter 4. And, finally, Chapter 5 shares progress against the recommendations for action in last year's report.

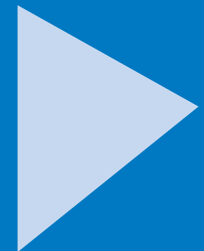
References

(1) DoH: *Reaching Out: An Action Plan on Social Exclusion*. September 2006.

CHAPTER 2:
Social Exclusion - What it's like for me

Understanding the impact of social exclusion on the way people live their life is a pre-requisite to acknowledging the many challenges socially excluded individuals and communities have to face from one day to the next.

The following case studies are intended to provide insight into the day-to-day life of individuals affected by social exclusion and in each case, illustrate how the individuals concerned have been enabled to overcome barriers to allow them to participate in community activities that have ultimately had a positive impact on their health and well-being. It is important to recognise however, that whilst there are many examples of individuals being supported who realise positive outcomes, there are many more who continue to experience exclusion.



Asylum Seekers and Refugees

(Due to the sensitive nature of the issues in this case study and to protect the identity of those involved, the following experiences are an amalgamation of more than one case)

Mary is a 17 year old refugee from Central Africa. Her family was forced to flee their village following an attack by local militia gangs during which she witnessed her mother being raped and tortured. Her father was murdered in the attack. Mary and her remaining family managed to get to a refugee camp in Uganda.

The family was offered resettlement to the UK as part of the Gateway Protection Programme (GPP). Whilst in the camp, Mary had met and married an older man who joined the family before leaving for the UK.

As part of the pre-arrival health screening in the refugee camp, Mary's mother was found to be HIV positive. During this check it was observed that Mary and her mother had both undergone female genital mutilation (FGM).

Mary felt very excited to arrive in England. She felt that she would be safe in the UK and that her mother would get help for the HIV, but as the days went by she realised that it was not going to be easy to get used to living in Bolton. Things were so very different. None of the family spoke English and had not had any formal education. Mary sometimes had nightmares about the violence she had witnessed in the past.

During the first few weeks in Bolton Mary and her family had many appointments to attend. None of the family could read English and they had to rely on their memory. Mary sometimes got confused and arrived very late for appointments.

Mary found that she was pregnant. She felt really nervous about going to see the doctor. The doctor had problems using the telephone interpreting service and they were unable to communicate. She was asked to bring a friend or family member to interpret, however none of Mary's family could speak English and she would feel embarrassed talking about her health issues in front of them. Mary felt shy about approaching the receptionist at the surgery; she felt the other patients were staring at her as she tried to communicate. She tended to avoid going to see the GP until problems became unbearable.

She was also worried about visiting the doctor because of the FGM she had undergone as a child; she knew that it was illegal in the UK and wondered how the doctor would react to her. She worried about the shame she would bring on her family if she did not arrange the procedure for her baby. However the doctor did not discuss the issue with Mary and she was too embarrassed to bring it up herself.

Mary and her mother were very happy with the service they received regarding HIV.

Mary and her mother were very happy with the service they received regarding HIV. She was seen very quickly after arriving in the UK because the health notes had been sent to the UK before the family arrived. The team arranged an independent interpreter for the appointment and this reassured Mary's mother

that her health issues would be kept confidential. Mary would like to see this happening for other health appointments.

Refugee Action supports the refugees arriving in Bolton through the Gateway Protection Programme. They allocated Mary a case worker who was able to help her to make some appointments and support her in learning to negotiate the health service in Bolton.

The nurse linked with the Gateway Programme and a nurse from sexual health had given talks to Mary and the other refugees about family planning and FGM. Following this Mary felt able to discuss the subject of FGM with her case worker who explained that if her baby was a girl she would be referred to a social worker get more advice.

Mary feels that she is integrating with the local community and beginning to build a new life for herself and her family in Bolton.

Mary feels nervous because the support from Refugee Action is coming to an end and she will need to be more independent in the future. Her English is improving because she is attending English as a Second Language to Overseas Learners (ESOL) classes. She got to know the staff at her GP surgery and now feels much more confident about making appointments and asking their advice, though she still struggles to discuss complex issues without an interpreter. Mary feels that she is integrating with the local community and beginning to build a new life for herself and her family in Bolton.

Older People

Chris is a 60 year old female, who has suffered from asthma since she was 9 years old. Her asthma worsened as she got older and at the age of 40 she also developed arthritis.

As time went by, Chris became increasingly isolated and her conditions limited her ability to socialise or even leave her house. Her arthritis pain was with her constantly. It affected her walking and she was prone to falling. Chris was very anxious about falling as any little graze or cut to her leg was likely to ulcerate due to the steroids that she was taking.

Chris used three inhalers to try to control her asthma. However, she was still in and out of hospital up to three times a week. The fear of her asthma was always on her mind and she was fearful that a bad asthma attack could kill her. Chris felt that suffering from asthma was very stressful and led her to feel isolated and 'trapped' at home. She was frightened to walk too far in case it set off an asthma attack or she fell. Also the weather had a great impact on her conditions.

Chris was unable to socialise as she was fearful of not being able to breathe and embarrassed at the thought of other people having to call ambulances for her. Mentally, Chris felt very low. During the winter months, she felt particularly isolated and housebound.

Chris lives in a deprived area, and reports that her neighbours are drug users and dealers. She has a constant worry of being broken in to if she leaves the house in the evening. Previously Chris had lived abroad. Not only had this helped her physical condition but she also felt much safer and felt supported by her neighbours. This experience had had a positive impact on her mental health. However living in a poor environment added to her stress and therefore worsened her condition.

Chris feels that public transport is quite good in her area. However she was unable to access it due to her fragility. She has to rely on taxis or her daughters to help her to get around.

Chris lives on limited resources due to her age and her conditions. Chris was forced to give up work when she was 50, due to ill health. She felt terrible about this as she had always worked and enjoyed her job in the caring profession. She feels envious of people who are older than her yet are still fit and active and able to live their lives to the full. Chris feels that if she was in a better financial position she would have had access to better housing and more choice in the area that she lives in. Chris feels that she would have had a better quality of life and that her arthritis would have been better if she had had more money. She feels she could have accessed a better life.

> "the classes have given me a new lease of life. I am now more confident and relaxed due to being able to control my breathing. I can now socialise more and am involved in my residents association. I have a life that I didn't think would ever be possible for me."

Chris started attending an Ageing Well Tai Chi class 3 years ago after her daughter told her about the sessions. Since joining the Tai Chi class she has learnt breathing techniques which have helped to stop asthma attacks. She now feels able to go out regardless of the weather and lead a more socially active life. Chris has learned how to cope with her arthritis and no longer gets frustrated if she can't do something because of it. She says "tai chi has enabled me to learn how to balance my mind and to relax. The classes have helped me improve my balance. As a result of this I have not had a fall for a few years. This has helped me to feel more confident".

The class that Chris attends is a community based class, although unfortunately it is not in Chris's community. She gets a taxi there and her daughter gives her a lift home. More classes in local communities, close to people's homes and where they feel safe and confident are essential.

Chris says "the classes have given me a new lease of life. I am now more confident and relaxed due to being able to control my breathing. I can now socialise more and am involved in my residents association. I have a life that I didn't think would ever be possible for me".

Whilst Chris's situation is not perfect, she still lives in a poor area and continues to feel unsupported by her neighbours, accessing one service has enabled her to live a more fulfiling life and engage with others.

Reaching in to communities where older people live (including sheltered housing and residential homes), and providing services which are appropriate, supportive, accessible and cheap would help to prevent older people becoming socially excluded and promote their engagement in the community.

Living with Disability

Tony is 62, and lives in Bolton. In November 2003 Tony's life was turned upside down. Over night he went from being a workaholic sales representative to a virtual recluse who requires the assistance of sheltered accommodation.
Tony tells his story …

"One morning as I was getting ready for work having just had my morning shave, I felt very dizzy and I must have then collapsed. My partner found me when she returned home from work. I had had a stroke.

I was immediately rushed to Bolton Royal Hospital. Twenty four hours later I was transferred to Hope Hospital. During all of this I was quite disorientated and had lost all sense of time. What seemed to me like three days was in fact only a few hours. In my mind I was convinced the nurses were trying to starve me to death, as they would not allow me food or drink. If only the nursing staff had realised that I had lost all sense of time and explained I had only been there a few hours and not days. If only they had explained that I was nil by mouth as they were arranging an MRI scan and they wanted to check my swallowing capabilities … perhaps then I would not have been so belligerent, difficult and rude.

I was eventually transferred back to Bolton Royal. The first ward was a good experience and the staff were friendly and helpful. But the second and third wards left a lot to be desired. I felt like a number and not a patient. I often felt that the nurses lacked basic understanding of individual needs.
After some time I was told I would have to go on the physiotherapy ward but that never came about.

When I returned home I was virtually bed bound and in a great deal of pain. Not only did this make daily living unbearable for myself but my partner and son had to watch me suffer and were helpless to do anything about it. There was a real lack of family support after my stroke and this put pressure on us as a family. In the end I decided to leave the family home and left to live in sheltered accommodation.

Independent living was difficult; I had never lived on my own. Getting used to the disability left me feeling socially excluded. I had no means of getting out and about. It took me six months before I even attempted to join the 'outside world'.

In February 2005 I purchased a motorised scooter. It was very expensive but has given me a great deal of independence. Up until this time I was room bound except to make tea and to go to the toilet.

With my newly found independence I needed to find new interests that would get me out of the flat. So far, I have sat on a few council panels and am now an active member of BADGE, an action group for people with a wide range of disabilities.

I am much more active now but deep down I still get bored because of the inactivity and the inability to do what my head and heart still want to do.

My greatest barrier still remains one of access. My scooter is large and doesn't fit easily into some buildings. A motorised wheel chair would help to overcome some of these barriers but because I can now walk around my flat I am not entitled to one through the National Health Service. I might just have to save up and purchase one myself."

People with Long Term Conditions

Beryl lives in Bolton with her husband. She has four grown up children and five grandchildren. She has two cats that she dotes on.

Beryl has been a mental health service user for many years. She moved to Bolton several years ago after hearing how good Mental Health Services were here. She thought she would be happier here.

Beryl suffers from depression. Often, she spends days on end in bed with the curtains shut just crying and sleeping. Although she is desperate for someone to contact her to see how she is, she feels she does not want to inflict herself on other people. She wants to be left alone and copes by "battening down the hatches". She argues with herself and loses because at the same time she is hoping someone will phone her to see how she is. When no-one phones, she feel nobody cares and it reinforces her feelings of depression and isolation.

At other times Beryl feels she does want to talk and just needs someone to offload to but she doesn't know who to ring or where to go. She knows there are services available but does not feel they will give her the kind of support she needs. Beryl had been assigned a Psychiatric Social Worker when she came to Bolton but has had no contact with the service for seven years. She is confused about whether or not she has been discharged from the service. She wants to talk to someone who knows her and understands her and doesn't feel confident to contact the service and speak to somebody new and doesn't have the energy to explain her situation again and again.

Sometimes, although she may feel deeply distressed, she fears others will not take her crisis seriously. One of Beryl's cats went missing which made Beryl feel extremely depressed and upset. She lay awake crying all night; everything always feels worse at night. She thought about the Crisis Resolution service but thought 'I can't phone them about a missing cat, they would just think - stupid fool'

Beryl has attended local drop in services provided by the voluntary sector in the past but when she is feeling depressed she is less likely to have the energy to go out to the day centre or pick up the phone. When she has been along it has been good as long as her friends are there. If they are not there, Beryl feels intimidated and leaves. Beryl is concerned that there is no follow up from the drop in. If she hasn't been seen for a while, she wonders why nobody phones to check up on her and again this reinforces her negative feelings.

Beryl is therefore left to rely on others who have mental health problems but she is all too aware that they have their own problems and worries about phoning at the wrong time or adding to people's burdens.

In addition to her mental health problems, Beryl also suffers from arthritis, is at high risk of developing Cardio-Vascular Disease and has a long term bladder problem. As a result she is has to take a lot of different medications, some of which have side-effects of their own. These problems further exacerbate her isolation and her depression. Her mobility problems and bladder problems stop her going out. There is no upstairs toilet in her house so in the past she has had to use the bath at night. Her lack of physical activity due to the arthritis and depression increases her risk of cardio-vascular disease. Beryl is also a heavy smoker and knows it would benefit her health if she gave up but it is just too difficult for her due to her depression. Each of her problems compounds the others.

A friend has recently put Beryl in touch with Mhist (Mental Health Independent Support Team). Mhist is a voluntary organisation that offers support and advocacy to help people with mental health problems deal with a range of issues. As a result an advocate worker has recently helped Beryl get a commode and to apply for disability living allowance which has relieved some of her practical problems. Beryl is hopeful that the advocacy service will help her access other help in the future.

Low income families

Library Photo Posed by Model / www.JohnBirdsall.co.uk<http://www.JohnBirdsall.co.uk>

Sandra, Steve and their three children live on an income of £250 a week before tax plus working tax credit. Kristian aged two has asthma, and has three times been hospitalised with chest infections, and once with severe asthma. They have no car or family living nearby. This is Sandra's story:

"I have been depressed for a long time I guess. It's worse when I'm stuck in all day with the kids or if I'm worrying about money or about Kristian. The other two are OK but he always seems to be ill and then when he can't breathe properly I panic that he's going to die. I used to hate living here. The GP is miles away - it takes me about 30 minutes to walk with the kids or I have to get a bus and that's where the nearest chemist is as well, so when he's not well I call them out. Steve had a row with them at the surgery because they said we call them out too much, but it's not easy when you are on your own and he's not well to just go down there.

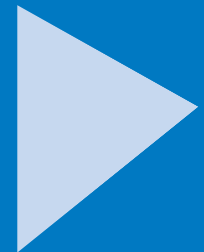
I didn't used to go out. I didn't really know people here and that made me more depressed. But then last year the health visitor rang. I'd missed taking the children for their injections, so she said just to call in to the neighbourhood centre. It's only a couple of hundred yards from my doorstep and I got given a cup of tea and everyone was really friendly. I got the injections done there and then. I've been going down every week since. I like it because there's somewhere for the children to play and I can just ask about things - things which I wouldn't drag 3 kids down to the doctor to ask because it's too far. And because the health visitor knows things, she can explain. The kids and I see her so often she is more like a friend now, and she knows the kids so she can just tell if they are a bit off colour.

> “Things are much better. I like living here now. I do still get depressed sometimes but because we've all got more friends we both feel we can cope better”

It's also helped Steve. He was having bad headaches but he wouldn't go to the doctor. I was telling the health visitor, so when he called in she asked him about it. She took his blood pressure and then she rang up the surgery and got him an appointment with one of the doctors that day. And now he's on tablets for high blood pressure. Things are much better. I like living here now. I do still get depressed sometimes but because we've all got more friends we both feel we can cope better - especially with Kristian - and we haven't had to call the doctor out for over a year."

CHAPTER 3:
Dimensions of Social Exclusion

This chapter shares insight into what we already know and understand about some of the dimensions that influence social exclusion. It explores the consequences of exclusion in terms of impact on health and highlights some of the existing work that is already being developed to promote inclusion. Importantly, recommendations are identified where further work is necessary to develop and enhance existing partnerships between the PCT, statutory agencies and the voluntary and community sector to ensure that even the hardest to reach, especially those who may not have been able to benefit from initiatives, programmes or services aimed at tackling exclusion and disadvantage, get the chance to turn their lives around.



Older People

Introduction

The experience of exclusion is not unique to older people. However, exclusion in later life can be particularly acute for three main reasons: first, those people who are excluded in mid-life are rarely able to break the cycle of exclusion in later life; secondly, the impact of key life events, such as bereavement, retirement and the onset of ill health, can lead people to become excluded in later life; and, thirdly, the impact of age discrimination on both the aspirations of individuals and the environment within which they operate.

Older people are not a homogeneous group and remain as diverse as the younger population. Older people range from the fit and active to the frail and dependant. They may be in prison, be homeless, have learning disabilities, not speak English or be gay, lesbian or bisexual for example. Older people are often described as 'older' from as young as 50. However it is recognised that many older people, much older than this, would not view themselves as old.

Older people in Bolton

There are approximately 86,500 people aged 50 and over living in Bolton. This equates to approximately 1/3 of the total population (this compares with Greater Manchester and England as a whole). This number is predicted to grow significantly in next 20 years from an estimated 87,000 in 2005 to 110,500 by 2025. This in turn will increase the share of the population for this age group from 33% to 40% during this period.

Culturally, Bolton is richly diverse. However only about 5% of Bolton's older population is from an ethnic minority community. With the population changes projected for Bolton and the country as a whole, the number of older people from ethnic minority communities is sure to increase.

Impact of social exclusion

Geographically, older people are spread throughout Bolton. Living centrally or more remotely presents benefits and challenges to older people in terms of exclusion. For example, those living in outlying districts may have difficulty with accessibility to some services, and those living centrally have a greater fear of walking alone in the daytime (Bolton Health Survey, 2007). Transportation and accessibility are important issues for older people in terms of exclusion. In Bolton approximately 70% of the general population have access to a car. However in the over 75-age range, this reduces to only 30% (Census, 2001). Therefore a significant number of older people rely on public transport to maintain their independence.

Research suggests that around a third of older people suffer from loneliness. Those most affected by loneliness are very old people and people isolated by a disability. About a third of carers report feeling lonely, at least sometimes.

The proportion of older people with a long-term illness that restricts their daily activities increases with age. Research has shown that two thirds of men and three quarters of women aged over 85 live with a long-term illness[2].

Being housebound (often as a result of living with a long term condition or disability), particularly when living alone can be very isolating and can lead to a lowering of self-esteem and confidence. Social support is very important in preventing mental health problems as are local befriending services.

How are we promoting inclusion?

The social exclusion of older people has long been recognised as an issue in Bolton and there are many strategic developments and practical initiatives in place to help to tackle the problem. Bolton has an older people's strategy 'A Better Bolton for Older People'. This also acts as the umbrella strategy for Bolton's Health Promotion Strategy for Older People, which is currently implementing work which looks to prevent the social exclusion of older people in Bolton. For example a DVD and training programme to tackle age discrimination is being developed and work is ongoing with older people from ethnic minority communities. Bolton's Ageing Well programme looks to engage with socially excluded older people and involve them in health improvement activities. For example Ageing Well run a men's group aimed at older Muslim men, and organises chair based exercises for a group of disabled older people at the Asian Elder's Initiative. Age Concern Bolton run lunch and leisure clubs (including transport) throughout the borough.

Bolton's first Active Ageing Centre is due to open early next year. This will involve older people through consultation and volunteering and will reach into and involve more isolated communities. Two further centres are due to follow.

What more needs to be done?

As with many other excluded groups it is recognised that those who suffer from the most severe exclusion are the people who do not, or are unable to, access services and initiatives that are aimed at prevention. More work is needed to support these individuals and communities to access the services that are available or by taking the services and support in to the communities.

Recommendations

- Continue efforts to strengthen community links with older people, and devise new ways to access those that are particularly hard to reach.
- Ensure that communication strategies are responsive to the needs of older people.
- Strategies to access hard to reach older people to be integrated into social marketing approaches.
- Ensure that all aspects of equality and diversity for older people are translated into business and service development plans and are reflected into organisational Equality Impact Assessment.

References

(2) Office for National Statistics 2005

People with Long-Term Conditions

Introduction

'Long-term conditions are those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies[3]. (DoH, 2007).

Long-term conditions include conditions such as diabetes, asthma, and chronic obstructive pulmonary disease and mental health problems.

Over 17 million people in this country report living with a long-term condition. Long-term conditions are the main contributors to reduced life expectancy and are to a large degree preventable. Lifestyle factors such as smoking, excessive alcohol consumption, unhealthy diets and physical inactivity are estimated to cause many of the long-term conditions.

Long-Term Conditions in Bolton

The Public Health Annual Report for Bolton 2006 shows that life expectancy for men and women is significantly below the national average for England and that early death from heart disease, stroke, respiratory conditions and alcohol related conditions are also significantly worse, compared to the rest of England. The health profile also noted that 9.8% of Bolton residents feel "in poor health".

Last year's Public Health report illustrated where the highest prevalence of long-term conditions is in Bolton and also the numbers of people admitted to hospital due to a long-term condition. This highlighted that people from deprived areas are more likely to be admitted to hospital for their condition, not only because more people suffer, but because they are more likely to delay in presenting to services for treatment. Fig. 1 illustrates hospitalised prevalence for chronic pulmonary disease. Long-term conditions tend to affect people as they get older and so as the population ages we can expect the prevalence of long-term conditions to continue to rise.

Impact of social exclusion

The relationship between long-term conditions and social exclusion is complex as each can reinforce the other.

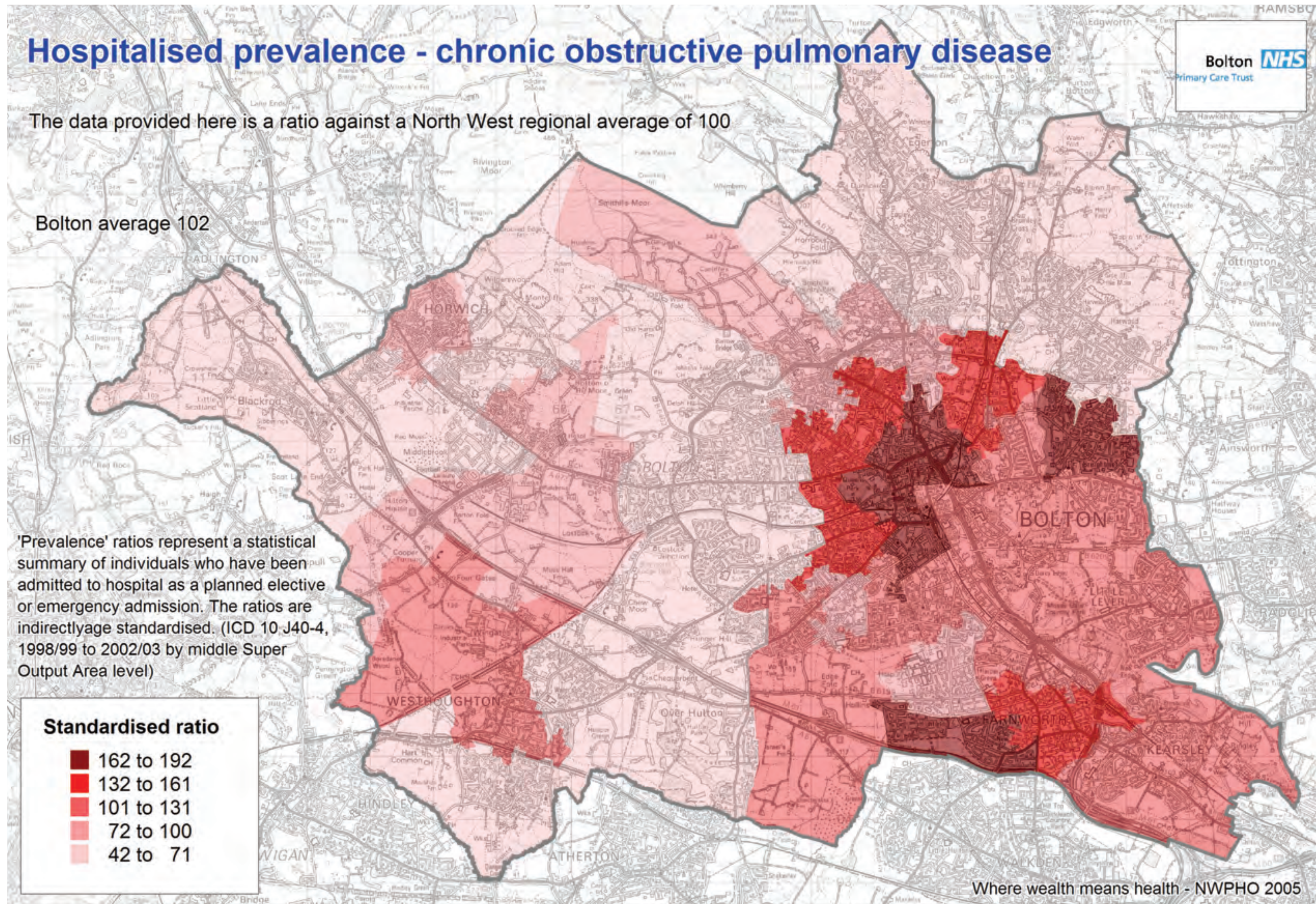
- People who experience social exclusion are more likely to develop a long-term condition because they are more likely to have adverse health risk behaviours such as smoking, poor diet, lack of physical activity and excess alcohol consumption.

- People who are socially excluded often present with symptoms later when the condition is more advanced, do not access health care when they have a long-term condition and can find it difficult to comply with treatment and self-care regimes. As a result, people's conditions can worsen more rapidly, they are more likely to experience complications and acute exacerbations and be high users of secondary and emergency health services.

- People who develop long-term conditions can become socially excluded for example by being unable to work. They therefore lose social contact and a sense of purpose as well as losing income, losing mobility and becoming housebound, being unable to participate in and maintain social networks and having difficulties accessing transport, services and buildings. Many people live with a condition that limits their ability to cope with day-to-day activities. For some people, especially older people and those who have more than one condition, discomfort and stress is an everyday reality. For those living in disadvantaged circumstances or for whom English is not their first language, the challenges are even greater.

- It is common for people to suffer from more than one long-term condition at the same time. There are for example strong links between mental health and wellbeing and serious physical illness and disability, both as a cause and consequence. For example people with heart disease are more likely to suffer from depression and people with depression are at greater risk of developing heart disease.

Fig. 1



How are we promoting inclusion?

Action to promote inclusion includes work to prevent long term conditions, to identify people with early symptoms of long-term conditions and to effectively support those with established long term conditions to maintain a good quality of life.

- A Workplace Health Programme is being rolled out which promotes healthy living at work but also aims to ensure people with long-term conditions are supported to remain in work.
- The 'Hope You're Well' Programme is working to identify people at high risk of developing cardio-vascular disease (and therefore many other long-term conditions) and supporting them to reduce their risk through lifestyle changes.
- The Ageing Well Programme supports older people within the Borough to adopt and maintain healthy lifestyles for example through Tai Chi and chair-based exercise programmes aimed at maintaining mobility.
- Community Ambassadors who engage with communities to identify people with long-term conditions and support them to access services.
- Expert Patient Programmes for patients with long-term conditions that support them to live as well as they can with their condition.
- Social Prescribing to ensure support on issues such as employment, education, healthy living, housing, income and welfare is made available to those who could benefit.
- Targeted interventions into areas where we know there are higher admissions to hospital and higher prevalence of long-term conditions. An example of this is the newly established chronic disease management team that supports GP practices in managing long-term conditions in targeted areas.
- The promotion of vocational rehabilitation in Bolton supporting all people with long-term conditions either back to employment or into educational establishments for training.
- Active Case Management for people with complex health and social care problems that allows a full health and social care assessment ensuring they have the opportunity to access all services.

What more needs to be done

Further work is required to:

- keep more people with long-term conditions in employment and to support people back into work
- further develop the capacity of the voluntary and community sector to support people with long-term conditions
- ensure services are pro-active in ensuring they are accessible to those who need them
- build opportunities for informal contact and pro-active outreach into service delivery
- develop a more holistic approach to addressing people's physical and mental health needs
- highlight the early warning signs of long-term conditions in the most deprived areas of the borough so that people will present earlier with their symptoms and therefore benefit from earlier treatment
- substantially expand the Expert Patient Programme
- develop more rehabilitation programmes for people with long-term conditions and promote these in the hard to reach groups

Recommendations

- To continue to target interventions for people with long-term conditions in the most deprived areas of Bolton.
- For all services to develop strategies to proactively engage with socially excluded people who are not currently benefiting from the service.
- Ensure that the strategies from the work with socially excluded groups on identifying barriers to accessing services are integrated into social marketing approaches and service design.
- To develop more rehabilitation programmes and self management strategies for people with long-term conditions.

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Black and Minority Ethnic Communities

Introduction

Bolton is home to 261,035 people (census 2001). The largest of Bolton's minority groups is that of Indian background which represents 15,884 people (6.1% of the Borough's population). This is the largest such community in the North West of England. People from a Pakistani background number 6487 (2.5% of the Borough's population). This makes it the sixth largest community in the North West England. None of the other minority ethnic groups exceed 1% of the Borough's population. Figure 2 illustrates the concentration of the black and minority ethnic (BME) population in Bolton at ward level at the time of 2001 census.

In terms of faith, Muslims (7% of Bolton's population) and Hindus (2%) are the next biggest religious groups in the Borough after Christianity, in both cases involving a higher proportion of the population than is the case nationally.

Impact Of Social Exclusion

The illness profiles of BME communities are distinctively different from that of the general UK population with variation occurring from birth to old age[4]. Although these profiles are drawn from national data, in a regional study, findings confirmed that people from BME communities were over-represented on almost all measures of social exclusion[5].

BME communities are more likely than others to live in deprived neighbourhoods; be poor; be unemployed compared with white people with similar qualifications; suffer ill health; and live in over-crowded and unpopular housing. People from BME communities experience widespread racial harassment and racist crime and are over-represented throughout the criminal justice system[6].

On top of socio-economic disadvantage, differences are also caused by discrimination. Higher levels of disadvantage and social exclusion means that minority ethnic communities are likely to be in greater need of quality public services[7].

Recording of ethnicity is an important factor in understanding inequalities. A report entitled a "Review of Local Data on Black and Minority Ethnic Health (2006)" undertaken by the PCT, highlighted the benefits of recording ethnicity but also found gaps in the way data was being captured. It is hoped that as the PCT becomes better at recording such information that it will be able to provide more robust data on local health needs of BME communities.

How Are We Promoting Inclusion?

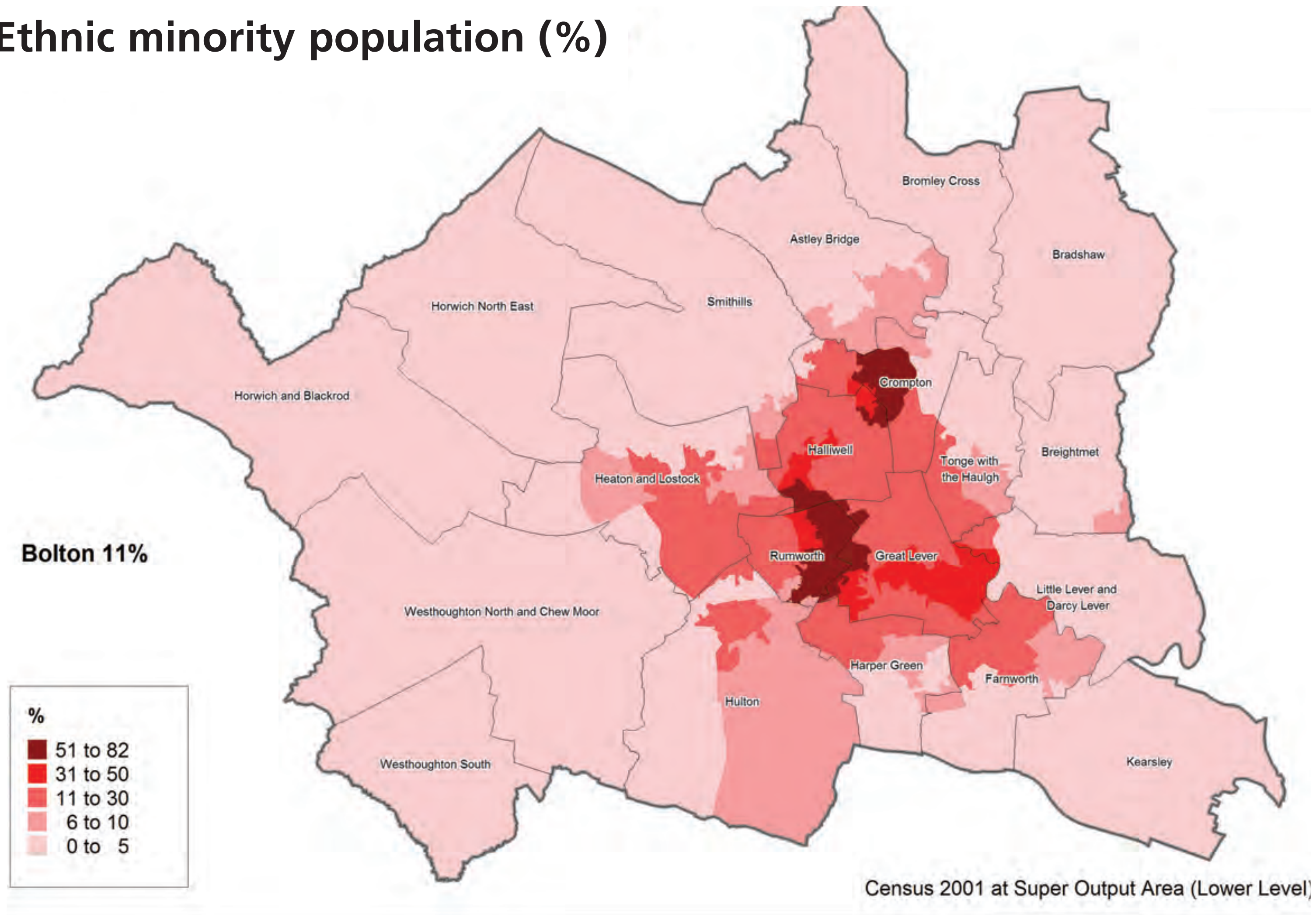
Bolton PCT is striving to make equality and diversity a part of everyone's business and is working to ensure that values underpinning this are a core part of policy and strategy development, service delivery and employment practice. The Race Equality Scheme is a vital part of this work. The scheme sets out aims and objectives and practical ways in which the PCT plans to meet its race duties. Implementation of the scheme is inextricably linked to wider work being facilitated in relation to promoting equality and diversity across the PCT core functions and services, for example:

- A strategy for improving organisational capability in relation to equality and diversity is being implemented by the PCT. This involves awareness raising amongst the PCT workforce about all dimensions of equality and diversity, including race.
- A framework to facilitate Equality Impact Assessment (EIA) has been implemented and is an integral part of all service development.

An extensive programme of (EIA) training has been and will continue to take place. Race will be included as a key component of that training. This training has been extended to include "Meeting, Treating, and Greeting Patients and Carers", for frontline staff including contractor services. It will help staff to increase their cultural awareness and provide insight on behaviours across specific cultures, including appropriate salutations, communications etiquette, preferred modes of communications, meeting styles and respect.

The PCT also recognises the importance of employing a diverse workforce that is representative of the population served in order to support the

Figure 2: Distribution of the BME community



delivery of culturally sensitive services. In this regard the PCT monitors and publishes the profile of the workforce to the PCT Board on a quarterly basis.

Language is one of the biggest barriers to accessing health services and in order to ensure that everyone is aware of the interpreting and translation service, details are posted on the PCT website and information is provided to staff and contractor services through regular news bulletins.

On a wider level, a piece of work is taking place to involve key partners and stakeholders to look at developing an integrated translation and interpretation service for the borough. Having one point of contact for the service will improve access to health and healthcare services for patients and carers as they will have more confidence in accessing services knowing that an interpreter is available; it will raise awareness of diverse communication requirements amongst service providers and will improve the quality of the service by ensuring that it delivers against certain standards, and moreover make better use of the limited resources that are available.

In order to ensure race equality and diversity is effectively mainstreamed, the PCT has established an Equality and Diversity Strategic Partnership. It is chaired by a Non-Executive Director and includes senior representation from the PCT and partner agencies. The fact that the partnership draws a wide membership facilitates sharing of information and good practice.

Local community involvement is fundamental to driving forward race equality and diversity and in this regard an Equality Target Action Group for Race is being established.

What More Needs To Be Done?

Efforts to promote inclusion of BME groups will be sustained as part of the organisational drive to integrate equality and diversity across the PCT's core functions and services. Central to this is the need to continue to work with BME communities and agencies to develop a strategic approach to addressing the wider health needs of our BME communities in the future.

Recommendations

- Develop a comprehensive multi-agency ethnic health strategy.
- Ensure the workforce is representative of the population/communities served.
- Mainstream ethnic monitoring as part of PCT systems and contractors services.
- Develop improved access to translation and interpretation service.
- Strategies to access hard to reach BME communities to be integrated into social marketing approaches.
- Ensure that all aspects of equality and diversity for BME communities are translated into business and service development plans and are reflected into organisational Equality Impact Assessment.

References

(4) DH (2005) Promoting Equality and Human Rights in the NHS. A Guide for Non-executive Directors of NHS Boards
(5) Improving the Health of Black and Ethnic Communities - a North West of England Perspective
(6) Beazley, M; Loftman, P. Race and regeneration: black and minority ethnic experience of the Single Regeneration Budget (LGIU 2001)
(7) Audit Commission (2004) Journey to Race Equality

Lesbian, Gay, Bi-sexual and Transsexual People

Introduction

Lesbian, gay, bisexual and transsexual (LGBT) people continue to face discrimination and exclusion across Europe in all spheres of life. Homophobic violence and abuse targeting LGBT people occurs on a regular basis.

Impact of social exclusion

Often same sex couples do not experience the same rights and protections as opposite sex couples and consequently suffer from discrimination and disadvantage in access to social protection schemes such as health care and pensions.

At work, many LGBT people hide their sexual orientation in order not to endure harassment or out of fear of losing their job.

Young people can be particularly vulnerable, especially if they are estranged from their family and friends. They may suffer from harassment at school and feel invisible which can lead to under achievement or dropping out of school. Mental illness and homelessness can also be issues for these young people.

This discrimination denies LGBT people equal access to social goods, such as employment, healthcare, education and housing and it also marginalises them in society and makes them one of the vulnerable groups who experience and are at risk of becoming socially excluded.

Sexual ill health is not equally distributed amongst the population. The highest burden is borne by women, gay men, teenagers, young adults and black and minority ethnic groups. Therefore it can be said that LBGT groups are often more at risk of sexual ill health.

There are also variations in the way sexual health services are provided, including health promotion and HIV prevention. The variations can be either in quality, range or access to services.

How are we promoting inclusion?

In Bolton there are a range of interventions in place to promote inclusion amongst LGBT people. These include the important work being undertaken with schools to prevent homophobic bullying. The Sex & Relationship education programme includes work on friendships, relationships and respect for others. The 'Living it' - prevention of homophobic bullying programme is a key part of this curriculum. A multi-agency homophobic bullying forum exists to help plan this programme. The Bolton Harmony forum has been developed to ensure that discrimination is tackled in a joined-up way, and has an important role in community cohesion.

The Sexual Health Strategy for Bolton aims to promote and improve the sexual health of the population. Prevention programmes specifically targeting LGBT groups have been implemented to improve access to services in this group. In addition:

- A local gay and bisexual men's community development worker to provide support and health promotion messages to this group. The service includes free condom provision, outreach work and support groups.
- Links are made to regional groups particularly in Manchester, where many gay and bisexual men and lesbian women from Bolton go to socialise.
- The multi agency sexual health training pool also provides training for staff on all sexual health issues, with an emphasis on young people and homophobic bullying.
- Joint working with the police supports the hate crime helpline.
- A sexual health website and newsletter has also been developed to support staff training and knowledge development.
- Secondary prevention work is commissioned through a number of voluntary agency providers.
- Provision of social care support for those individuals with HIV/AIDs.

Bolton has recently commissioned a study into the issues for LGBT people living and working in Bolton. This is being undertaken by Bolton University and is a joint project between the Bolton Harmony Forum in the local authority and the PCT. This piece of work will inform future services planning for LGBT people.

Recommendations

- To ensure the results of the study mentioned above are fed into the local business planning process in order that services are developed that respond to identified local needs.

- To continue to seek new ways of ensuring LGBT people are supported to be able to have equal access and be socially included in the Bolton family.

Disabled People

Introduction

The term "disability" is unhelpfully broad. It covers physical problems, learning disabilities, sensory impairments and mental health problems. The one term cannot adequately cover the scope of the difficulties and experiences of people with a disability. The experience of a person with a physical disability has many different dimensions to it and each physically disabled person's experience is unique. The same would be true for someone with a learning disability, and also for someone with a sensory impairment, or mental health problem. The complexity increases with age. It is realised that whilst there are commonalities across disabilities, there are also significant differences between each type of disability.

Disability in Bolton

There are approximately 270,000 people living in Bolton but 20.3% of the population have a long term limiting illness which is above the national average of 18.2%. In addition 7.4% of the working age population are permanently sick or disabled, compared to the national average of 5.5%[8].

In a recent report it was found that disabled people do less well than non-disabled people in many areas of life. Disabled people are also more likely to face discrimination and negative attitudes. The information below shows numbers of people affected by a range of disabilities[9]:

- There are approximately 11 million disabled adults in the UK (one in five of the total adult population) and 770,000 disabled children.
- The prevalence of disability increases rapidly with age, approximately 75 per cent of men and women aged 85 and over have a disability.
- 20% of those with a disability are aged under 45.
- 24% of deaf or hearing-impaired people miss appointments, and 19 per cent miss more than five appointments because of poor communication.
- Disabled people are four times more likely than the general population to find dentists' offices inaccessible or inadequate; twice as many find their doctors' surgery inaccessible.
- 40% cent of visually impaired people believe that their GPs are not fully aware of their needs, rising to 60 per cent for other surgery staff.
- One study has estimated that people with learning disabilities or long-term mental health problems are 58 per cent more likely to die before the age of 50 than non-disabled people

Impact of Social Exclusion

People can experience social exclusion for a number of reasons - some are born into exclusion, some enter into exclusion through their own actions. People do not choose to become disabled. People with a disability are either born into this situation of disadvantage, or enter it through circumstances beyond their control. They find themselves living within a culture that has developed using a social model of disability and that has made little response to their membership. Society is designed, and functions with, services and norms that are created by and for the able-bodied population - with little or no consultation with disabled people in this process. Consequently the implications for disabled people are far reaching and cover all aspects of life.

How are we Promoting Inclusion?

There has been an increasing gap between the experience of people with a disability accessing services and the experience of most people. But some good work has been undertaken, particularly with people with a learning disability. Below a number of initiatives are described to address the needs of disabled people and these include:

- Employment of a hospital based Learning Disability Nurse. The post has been created to support people when they are admitted and discharged from hospital.
- Primary Care Access Nurse employed to compile a register of patients with a learning disability. Each person on the register is then offered a health check.
- Health Action Plans focusing on person centred health and made available in appropriate formats.
- A Liaison Nurse in conjunction with an Assistant Practitioner employed to prioritise dental work with the dental clinic (hospital based).
- Early Onset Dementia Pathway project has been established to develop a care pathway for people who have Down's Syndrome and early onset dementia. Screening offered to those above 30 years of age and also identify people and their carers who may potentially be suffering from this condition.
- Information has become more accessible. Speech and Language Therapists together with Assistant Practitioners develop a range of information (photos, symbols, pictures and large text etc) to aid communications.
- Health Walks have started for people with learning disabilities and some members have undertaken training to become "walk leaders".

In order to reach out to disabled groups and organisations, as part of the development of the Disability Equality Scheme, Bolton PCT took the initiative together with partner agencies to hold a Better Bolton Café conference in July 2006. Following this event the Bolton Active Disability Group for Everyone (BADGE) was formed.

What more needs to be done?

Although there is lots of work happening to address needs of disabled people across health and social care settings, there are still gaps which exist and these are highlighted as follows:

- Basic awareness training on disabilities needed for hospital and community based staff.
- Care pathways need to be developed to ensure people, for example, with learning disabilities as well as for other associated conditions, such as autism and epilepsy, can access departments within the hospital.
- Strengthen links with GPs primary care to support the work of the Primary Care Access Nurse in identifying and offering health checks to patients with a learning disability.
- Information required in accessible formats for people with learning disabilities.

Recommendations

- Identify people with disabilities as a priority group and to improve and sustain healthcare for this client group.
- Ensure membership of, and commitment to, the new Disability Partnership by appropriate senior management representation across the healthcare sector. This will provide the opportunity to engage partner agencies in addressing the implications of the health agenda set by the Partnership.
- Establishment of a dedicated group (subgroup of the Disability Partnership) to implement the health agenda set by the Partnership and ensure inclusion of people with disabilities as partners.
- Undertake comprehensive annual health checks for all people with learning difficulties with follow up extended appointment times. This should be provided by the GP and Practice Nurse in partnership with Learning Disability Teams[10].
- Ensure training for health staff to increase knowledge and confidence in working with this client group including targeted health promotion campaigns.
- Ensure training of staff (hospital and community based) and appropriate provision of language and communication support.
- Utilise learning and good practice from work undertaken by the Learning Disability Practice Nurse and hospital-based Liaison Nurse .

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(8) ONS. Census 2001
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ONS. Census 2001
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Asylum Seekers and Refugees

www.JohnBirdsall.co.uk<http://www.JohnBirdsall.co.uk>

Introduction

Asylum seekers and refugees are not a homogeneous population having come from different backgrounds and cultures and having had a wide range of experiences which may affect their health.

To gain status as a refugee, an asylum seeker must be able to prove a well founded fear of persecution in their country of origin for reasons of race, religion, nationality, membership of a particular social group or political opinion, which may include torture, rape, imprisonment, discrimination and deprivation of rights, forced unemployment and prevention from working.

People arriving in Bolton have often had traumatic experiences because of war or torture in their own country and may have gone through an arduous journey to get here.

On the whole, people arriving are generally physically fit but may have specific issues due to their past experiences including; malnutrition; injuries sustained during war or torture; issues around sexual health due to rape, female genital mutilation, HIV; incomplete immunisations. It is often after spending some time in the UK that health begins to deteriorate due to stress associated with, going through the asylum process, living in poverty, suffering from discrimination and prejudice, and having difficulty in accessing health care.

People are often going through emotional turmoil, suffering from grief, isolation, loneliness, personal and cultural bereavement. Many people suffer from problems with mental health including symptoms of post traumatic stress and depression.

Asylum Seekers and Refugees in Bolton

In September 2007, Bolton had approximately 750 asylum seekers being supported: Africa 252; Pakistan; 116; Iraq 84; Iran 73; others 225.

Asylum seekers are housed mainly in areas where there are other ethnic minority residents, often in the more deprived areas of Bolton. Feedback from service users tells us that immigration issues and housing problems tend to take priority over health for this group.

There are also a significant number of people who have failed their asylum claim yet still feel unable to return to their country of origin and are therefore living in destitution with no recourse to public funds and very limited access to emergency health care. BRASS, who run a destitution project in Bolton have estimated that there are approximately 500 people living in this way in Bolton. However it is impossible to know exact numbers as by their very nature this group of people do not want to identify themselves to those in authority for fear of being detained and removed to their country of origin from where they are fleeing persecution. This group, often young single women and men may be very vulnerable as; they feel they can not approach authorities to report ill health, crime or squalid living conditions; they are unlikely to have family and may need to rely on people who they do not know very well to support them leaving them open to abuse; they may have emotional health problems due to past experiences of violence and torture and their present situation.

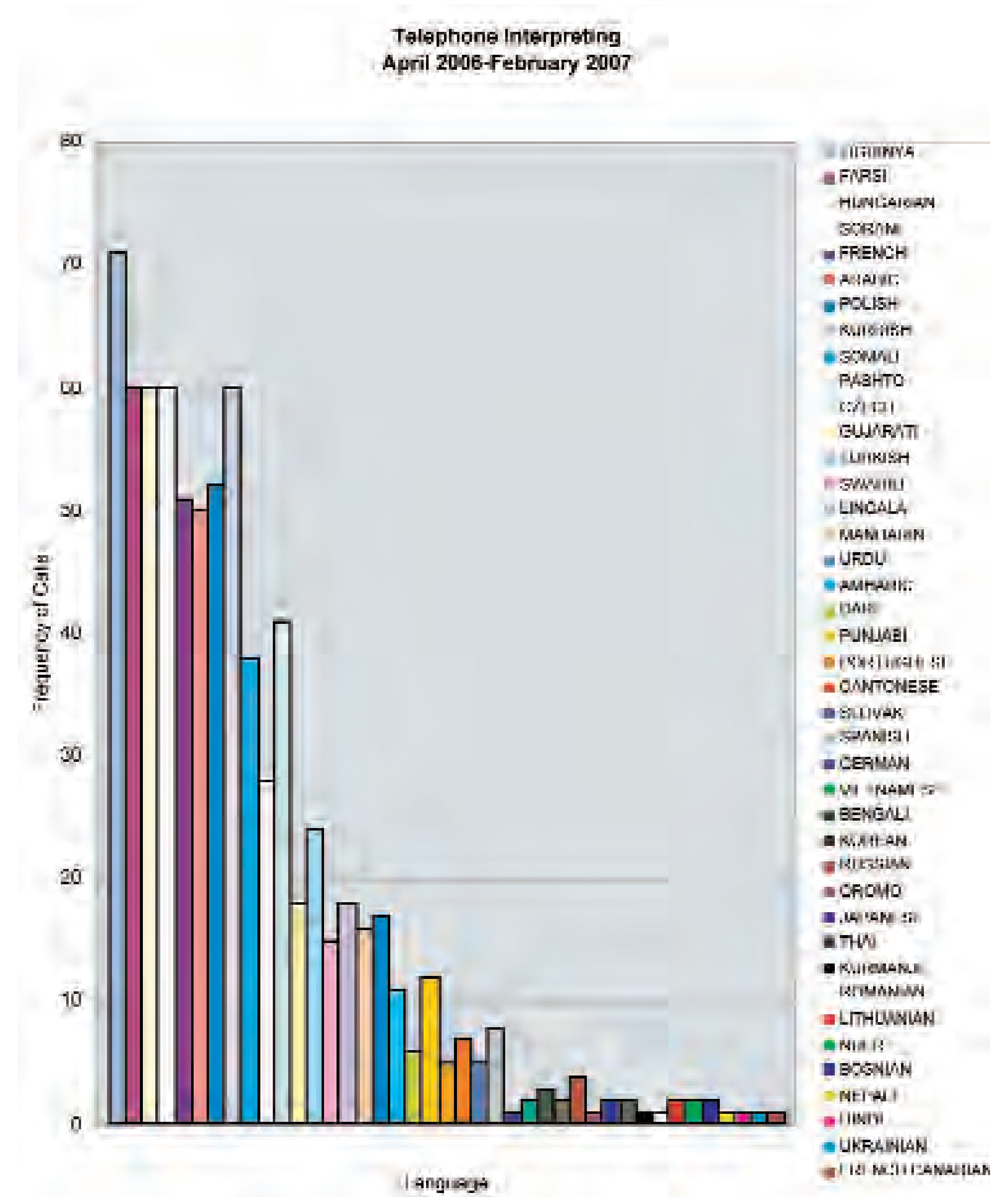
There are approximately 200 refugees who have arrived in Bolton through the Home Office Gateway Protection Programme. Since 2004, Bolton has welcomed Refugees from Liberia, Congo, Sudan, Mauritania and Ethiopia. The next group is from a Burmese community and will arrive from Thailand. This group of people have been given refugee status before arriving in the UK and do not have to go through the asylum process. The programme is managed and co-ordinated involving health, housing and education services working together to support the integration of individuals. In addition, the Refugee Action Agency in Bolton supports individuals in accessing services and in settling into the area helping them to overcome some of the barriers faced in accessing health care service.

Impact of social exclusion

One of the biggest barriers facing asylum seekers and refugees is communication. With over 40 different languages being used in Bolton (graph 1) this presents a significant challenge to health care workers in delivering high quality responsive services. Health workers find using telephone interpreters both difficult and time consuming. Outcomes from a workshop (held October 2007) to identify the health needs of migrant communities in Bolton emphasised this as one of the key challenges to effectively responding to health needs of individuals. Children or friends of the family are used inappropriately during some consultations. There are obvious implications around confidentiality when using friends or family to interpret at a medical appointment. People may want to disclose rape or torture which they may be unable to do without an independent interpreter. Friends and family often only speak basic English and interpretation could be inaccurate and therefore inappropriate treatment could be given. Some people decide not to seek medical attention for health problems as they find it so difficult to communicate, potentially leading to problems becoming more serious and needing more complex treatment. In addition, health promotion materials and information are very difficult to access in different formats and languages.

People often have to deal with discrimination and prejudice due to lack of awareness and misconceptions held by service providers and members of the community which can lead to isolation, which may in turn impact on their health and well-being.

Graph 1



Promoting social inclusion

In Bolton Health, Council Services, charities including Refugee Action, BRASS and community organisations work in partnership to promote the health and well-being of asylum seekers and refugees. The Council's Asylum Team has a multi agency approach with a nurse and a social worker based at the Asylum Office. It is important that agencies build on these networks to improve access to services for asylum seekers and refugees and to raise awareness amongst staff about this client group so that good practice can be shared.

A multi-agency Asylum Seeker and Refugee Health Development Group is in place to facilitate partnership work to promote health and well-being among asylum seekers and refugees. In October 2007, the group hosted a workshop to explore the health needs of asylum seekers and refugees. This was a multi-disciplinary event and was attended by people from across the health care community. Outcomes from the event have been translated into a plan for action that will drive forward change and improvement in access to health care.

Recommendations:

- Health & social care commissioners should ensure there is ready access to high quality translation and interpretation services.
- Health & social care providers should have routine access to regular cultural awareness sessions.
- Maintain and continue to strengthen links with new and emerging communities.
- New and emerging communities to be integrated into social marketing strategies.
- All aspects of equality and diversity for new and emerging communities should be translated into business and service development plans and be integrated in organisational Equality Impact Assessment.
- Recommendations arising from the Asylum Seeker and Refugee Workshop should be translated and acknowledged in wider business and development plans.

Low Income Families

Introduction

Since at least 1980, evidence has shown that those in the UK living on the lowest incomes also experience the worst health outcomes[11,12]. Bolton is a low wage economy. Median weekly pay is around £317.60, compared to the England average of £369.40 - even lower than the North West average of £344.20[13]. Worklessness in Bolton (calculated by counting people receiving job seekers allowance, incapacity benefit or severe disablement allowance) is high at 12.9% but reaches levels as high as 49% in the most deprived parts of the Borough. These economic facts mean that there is less money in the community to support people when they are ill, or to maintain a decent quality of life, and help to explain why the health gap between rich and poor in Bolton is marked, with the gap in life expectancy being approximately 15 years.

Low income as a risk factor for social exclusion

It is also a reality that resources for health are not equitable[14]. Some examples of this inequity are:

- The limited availability of low cost housing that concentrates low income families together creating a barrier to them accessing the personal and social capital (resources, knowledge, power and connections) available to those more affluent.
- That children in poorer areas are more likely to attend worse performing schools, and poor levels of educational attainment are linked to ill health, as well as unemployment and low income
- That most deprived areas have attracted the fewest GPs or pharmacists per head of population,
- That those families and individuals living on low incomes with the least access to private transport are disadvantaged by the difficulty of accessing town centre services, supermarkets and out of town shopping

Families on low income are therefore at a greater risk of social exclusion and its attendant problems of crime, antisocial behaviour and welfare dependency[15].

Not all of these factors lie within the control of the PCT. However, those that are their responsibility have influenced recent decision-making in a number of areas including:

- New buildings and services which have been placed in areas of disadvantage
- New investments in Primary Care services in areas of greatest inequity
- Extra investment in front line services to support the most vulnerable families
- New initiatives to remove barriers to access e.g drop in clinics; community based services; Food Access Bolton, (delivering fresh and affordable fruit and vegetables to the elderly, and other disadvantaged groups)

What more needs to be done?

Existing efforts and other similar investments have helped to improve the accessibility and affordability of health resources to families on low income, but more needs to be done to enable those families to secure their own health. At present decision making is based upon need measured in terms of health outcomes, or Government targets. However, those families who live on low incomes know most about what it is that affects their health and what is needed to bring about change. This may differ from professionals understandings of 'need'. Action to reduce the health gap must therefore start with the needs and concerns of low-income families, and the barriers that prevent them from accessing better health. It must then seek to enable those families and the communities in which they live to fully engage in improving their own health by finding and implementing their own solutions to those needs and barriers.

Recommendations

- That low income families be helped to voice their needs e.g. through citizens juries; social marketing etc
- That the PCT relinquish total power and control over resources, and empower those families and the communities in which they live the opportunity to be fully engaged and supported in decision making and improving their own health.
- That work with partner agencies be strengthened to include an agreed 'bottom - up' approach to the joint planning and delivery of services

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Offenders

Introduction

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Most offenders come from socially excluded groups, and offending itself exacerbates social exclusion, particularly if this leads to imprisonment. Offenders can find themselves in a downward spiral of offending and social exclusion, which makes access to health care more problematic. Access to good quality health care, both in prison and in the community, is therefore one key pathway in the National Reducing Reoffending Action Plan[16].

Offenders in Bolton

At any one time in Bolton, approximately 1,800 offenders (aged 18 and over) are supervised by the National Probation Service. Approximately 20% of all offenders in Bolton are women. In terms of ethnicity, offenders of Indian or Pakistani heritage are under-represented on probation caseloads, and within the prison system generally.

Impact of social exclusion

Offenders disproportionately suffer from mental and physical health problems, and tend to be over-represented in populations suffering from lack of emotional well being, self-harm, and substance misuse.

Imprisonment can be a very traumatic experience for the more vulnerable, and can lead to a heightened risk of self-harm, particularly amongst young offenders. Mental health problems can also undermine the chances of successful rehabilitation, as they can exacerbate significantly the difficulties many offenders find in coping with the demands that leaving prison places on them.

In the community, offenders are also disproportionately without GPs and access to psychiatric or psychological services is difficult to secure. Problems are also exacerbated where drug use and mental health problems co-exist.

Women offenders in particular tend to place greater demands on medical services, with high levels of depression and personality disorders, prevalence of self-harm, history of drug and alcohol abuse and physical ill health generally. In May 2005, the Youth Justice Board (YJB) commissioned researchers at Oxford University to carry out a health needs assessment for 17-year-old young women being held in the secure estate. The results showed that;

- 90% had left education by age 17
- according to General Health Questionnaire 12 (GHQ 12) scores, 71% of respondents had some level of psychiatric disturbance, which rose to 86% when factoring in long-standing disorders
- over one-third of respondents (36%) had self-harmed in the last month, of which

- the majority (92%) had cut themselves
- overall, 81% of respondents smoked, on average starting at age 12
- the majority drank alcohol prior to imprisonment (86%) and just under two-thirds (61%) exceeded the recommended weekly units for women
- most (82%) had used illegal drugs in the previous six months, 72% of whom used at least two substances

Promoting Social Inclusion

The Home Office is working closely with the Department of Health and the National Institute for Mental Health in England (NIMHE) to ensure the particular mental health needs of women offenders are met through implementation of the Women's Offending Reduction Programme[17] and the Women's Mental Health Strategy[18].

On 1 April 2006, funding responsibility for health care within the Prison Service transferred to the NHS, with Primary Care Trusts taking on full responsibility for commissioning prison health services for prisons in their catchment areas. New reception screening arrangements have been developed and phased in at local prisons. Tighter monitoring has been introduced to identify prisoners who have been waiting for transfer to hospital.

Court based mental health diversion/liaison schemes are key to the early identification of offenders' mental health needs and access to the appropriate services and support. The Home Office and Department of Health are, therefore, exploring what more could be done to improve the effectiveness of these schemes by identifying and building on areas of good practice. Funding has also been made available by the NHS to introduce multi-disciplinary teams to provide mental health services for prisoners, along the lines of the community mental health teams. In Bolton, we have now formed the Criminal Justice Mental Health team, working out of Park House, whose job it is to identify offenders with mental health issues, divert them from the criminal justice system into treatment where possible, or to manage the risk they pose in the community once sentenced.

In relation to substance misuse, approximately 40% of offenders assessed by the probation service in Bolton have recognised problems with drug misuse, and a similar proportion are considered to be problem drinkers. Whilst the former group have fast-track access into treatment through the Drug Intervention Programme, the latter group have greater problems in accessing treatment. In addition, the latter group are harder to reach, and more socially excluded. This is being addressed via our Alcohol strategy, in particular concentrating on those whose alcohol misuse leads to violent offending. This will ensure that at all points from arrest through to sentence, appropriate interventions are in place to work with alcohol misusing offenders.

All offenders who are subject to orders which bring them into treatment for drugs misuse attend health promotion groups, which aim to increase their knowledge of healthy life styles, and how to improve their health after giving up drugs. The Drugs Education And Learning group uses ex drug misusers to promote such messages within other agencies and hard to reach groups.

Recommendations

- There needs to be sufficient treatment capacity within alcohol misuse services to provide services to alcohol-dependent offenders, and to provide brief interventions to those whose drinking is hazardous.
- It is essential that all offenders have access to a GP and dental treatment.
- The work of the Criminal Justice Mental Health Team needs to be maintained.
- The work of self-help groups such as DEAL should be maintained and increased.

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Children in Care

Introduction

Children in care are one of the most vulnerable groups in society. They may be exposed to crime, as victims, or drawn into early offending. They may be faced with multiple problems, skip important stages of their education and face illiteracy and unemployment. Their long-term prospects may include homelessness, mental health problems and chronic debt. Any one of these problems can be difficult to overcome, but when adolescents suffer multiple disadvantages they need special help to break the vicious cycle. In later life, young people and adults who have been in care are more likely to be socially excluded than those from almost any other background[19].

Children and young people are predominately looked after following abuse or neglect by their primary carers and as a result their physical and emotional health can be impaired, requiring intensive remedial services.

Children in care in Bolton

In March 2007 there were 404 looked after children in Bolton. This is a rate of 64.3 per 10,000 children, which is higher than the national average of 55 per 10,000. There were also 63 young people receiving Short Break Care, and a total of 2669 short break care nights provided.

The health of looked after children is measured by a combination of health assessments for under 5's; the provision of dental care; and ensuring annual health assessments and immunisations are up to date. Bolton achieved 84.2% (very good banding) compared to the England average of 81% in 2006.

Impact of social exclusion

Research shows that looked after children are more likely to become teenage parents, many are looked after due to neglect by problem substance misusing parents and evidence shows that children in those circumstances are 7 or 8 times more likely to abuse substances themselves[20].

Research indicates that there are between 250,000 and 350,000 children in the UK who have a parent who is a problem drug user[21]; and there are up to 1.3 children in the UK living with parents who misuse alcohol[22]. Children of parental problem drug users are 7-8 times more likely to develop problematic substance misuse[23]. In Bolton, parental substance misuse was a factor in 37% of cases on the child protection register in 2006-2007, an increase of 2% on 2006 and 14% on 2004[24].

Looked after children (those in state-sponsored residential and foster care) have high levels of drug use compared to the general population, up to 30% of this population have been described as existing problematic users or potentially problematic users[25].

Local data on the estimated prevalence of drug use among looked after children is not currently available. Substance misuse among looked after children should be identified through Annual Reviews; data reported through

OC2 statutory returns for 2005-6 shows that of 285 children who had been looked after for at least 12 months, 6.3% were identified as having a substance misuse problem during the year.

Vulnerable children (including looked after children and those affected by parental substance misuse) are particularly susceptible to a range of negative outcomes, including poor educational attainment and economic disadvantage, poor health, drug use and offending[26].

Bolton Council provides training and tools to assess young people's substance misuse and deliver appropriate interventions, this is available to all practitioners working with children and young people in the Borough. The 360° Young People's Substance Misuse Service provides specialist treatment for under 19s.

Looked after children who are able to remain within the borough have continuity of education, health and social services. However their experiences have often lead to disrupted provision through exclusions from education and failure by carers to access universal health services. Looked after children can be reluctant to engage with services designed to assist and support them. They can experience frequent changes of placements which leads to disrupted provision, fragmented relationships, and can be stigmatised by their legal status.

Promoting social inclusion

It has been said that much of the under-achievement in looked after children could be addressed if these young people were subject to the same high expectations of success and the same parental drive and enthusiasm that any good parent would place on their own child.

In response to this, Bolton has a Corporate Children's Officer, and a Corporate Parents Panel. The rationale for the existence of the panel is that Children's Social Care are very efficient at safe-guarding vulnerable children, but to ensure an effective response to young people's developmental needs across all ages and services, a corporate and strategic response is required. The Panel seeks to ensure that the children for whom the Council provide care (looked after children) have their interests represented at the most senior level of the authority and consequently receive the best possible care and support.

In Bolton, a multi-disciplinary team, including a Clinical Psychologist, an Educational Psychologist and a Senior Social Worker (Emotional Health) work to ensure the holistic assessment of looked after children and appropriate intervention.

Recommendations

- Support for parents to enable them to adequately care for their children within the family unit is vital to reduce the numbers of children requiring substitute care.
- Ensuring that children receive the universal health services and support of health professionals who are trained to assess and have the capacity to provide additional support for parents who have additional needs.
- Quick access to flexible, specialist emotional health services for looked after children who have complex conduct disorders or mental health needs who live in Bolton or are placed out of borough especially through transition to adulthood.
- Improve responses to looked after children with substance misuse problems through better education, information and interventions which respond to the changing nature of problematic drug misuse in Bolton.
- Develop responses to children affected by parental substance misuse through implementation of a multi-agency Hidden Harm Strategy, lead by the Safeguarding Board.

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People who are Unemployed

Introduction

Unemployment is an important dimension of social exclusion and as such can have a significant affect on people's health.

Impact of social exclusion

Research indicates that unemployment causes social exclusion for two main reasons. Firstly, unemployment and subsequent reliance on state benefits leads to material deprivation which means there is less money in the household to pay for a safe, warm comfortable home, a nutritious diet, adequate clothing, leisure activities and breaks/ holidays. In this situation it is also extremely difficult to find the money for unexpected items. Not being able to afford the same lifestyle as that which we see as 'normal' in society is clearly a cause of social exclusion. Because society is generally more affluent than in the past, there is a significant contrast between those not working and the employed[23].

In addition, being out of work also has psychological impacts which cause social exclusion. Typically work provides a way for us to contribute to society. Work provides us with a role and function and through this makes us feel valued[24]. Work also provides us with contact with other people and social support. Because working is a societal norm, without work we can feel isolated, unvalued and without a purpose[27]. This can be reinforced by social attitudes to those who do not work. Unemployed people are often perceived to be lazy and to blame for being out of work.[28]

When we consider the effect that being out of work has on social exclusion, it is not surprising that unemployment has a negative impact on health. Unemployed people and their families have an increased risk of premature death, even after allowing for other factors.[29] This is most likely to be caused by a combination of three factors: lack of resources affecting living conditions (such as housing); the physical impact of living with low levels of stress for long periods of time caused by social exclusion; and unhealthy behaviours (such as smoking to help cope with stress, poor diet caused by reduced income and low levels of physical activity caused by changes to the structure of day to day life). These factors contribute to coronary heart disease, diabetes, some types of cancer, respiratory disease and mental health problems, many of which are more prevalent in unemployed people[30].

Promoting social inclusion

In Bolton, local partners are working to support people into employment. This work particularly prioritises unemployed people, those claiming incapacity benefit, single parents and people from black and minority ethnic communities. This support can be very practical such as helping with searching and applying for jobs, help with the cost of buying appropriate clothes for an interview or travel costs. In order to encourage employers to recruit people who have been out of work for some time, working interviews or job trials are supported by Bolton Council and Jobcentre Plus. This enables people to have a try at doing a job on a trial basis to show an employer whether they are suitable. Other support focuses more on the development of 'life skills' such as language and maths skills, assertiveness and building the

confidence of people who have been out of work for some time. A new Government initiative called Pathways to work beginning in Bolton in January 2008 will also provide people on incapacity benefit with support to manage the health problem that has prevented them from working. Health professionals potentially have a role in helping to target these employment support programmes to those whose health is most affected by their worklessness. Bolton's social prescribing programme enables health professionals to refer to employment support, however there may be more that could be done to make the links between health professionals and employment support.

There are a number of initiatives in Bolton which aim to reduce the social exclusion faced by people who do not work. These include 'Quids in' Bolton's credit union which can provide low interest small loans to help people have the funds for crises. 'Quids in' also runs courses to help people develop their money management skills. Partners in Bolton are also working to develop opportunities for volunteering, so that people with time available can feel that they are making a contribution to society while at the same time developing their skills.

There is evidence that low levels of activity among people who don't work is associated with psychological stress. Being involved in community or social activities and participating in decisions that affect our lives can mitigate the psychological impacts of worklessness.

It is important to also be aware that there is a direct relationship between health services and employment policy. GPs are a 'gatekeeper' to the health related benefits system, as they are responsible for signing people off work and repeating this process at regular intervals. Primary care could therefore be an important way of accessing this group of workless people.

As people move into employment, the management of health conditions may need to change in order to support them to stay in employment. Although there are schemes in place locally to provide employment support to vulnerable groups even when they have returned to employment, there is not support for these individuals to help manage their health problem within the workplace.

There is a myriad of employment support available in Bolton through training providers, jobcentre plus, Bolton council and other regional and national agencies. The challenge is to make this activity meaningful and understandable for those providing routine care and support to vulnerable groups to enable them to refer on to support.

Recommendations

- Local agencies such as Bolton Council and Bolton PCT should provide opportunities for people to be involved in decision making and should support the local community and voluntary sector.
- Bolton Council and Primary Care Trust should be an exemplar in encouraging people from socially excluded groups into employment.
- The feasibility of providing employment support and occupational health services within general practices to reach those who do not work due to health reasons, should therefore be explored.
- The feasibility of establishing condition management within employment support should be considered.
- Encourage employers to provide healthy working conditions and occupational health services to prevent ill health retirement, through the development and roll out of a local healthy workplace programme.
- A single point of access to employment support needs to be established to make referral easier.

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People who are Carers

www.JohnBirdsall.co.uk<http://www.JohnBirdsall.co.uk>

Introduction

Carers come from all walks of life, all cultures and can be any age, and in fact many people at some stage in their lives find themselves looking after someone, whether that be their partner, child, relative or friend, who may need support because of their age and frailty, physical disability, mental illness, addiction or disability.

Carers in Bolton

In Bolton it is estimated that there are over 28,000 people who undertake a caring role, with 6,000 of these looking after someone for over 50 hours per week; while there are estimated to be 1,250 young carers under the age of 18.

Impact of social exclusion

There is a direct link between maintaining a carer's health and well-being and their ability to support the person they look after; and both the carer and the person who they look after are themselves from one of the many socially excluded groups. If a carer is unable to care because of poor health then the person they look after is also affected which means it is essential that a preventative approach is taken to support both the carer and the person they look after.

Carers may be at greater risk of poor health because of back strain caused by lifting, stress related conditions, the frequency of not enough sleep or rest and the fact that many carers are elderly themselves.

Carers are a socially excluded group in themselves and the social exclusion is greater in young carers, carers of people with a mental health illness or disability, and older carers.

There is a direct link between deprivation and a carer's health and well-being, with those people who live in areas of greater social deprivation and factors such as low income, low educational attainment, inadequate housing, and social isolation having a greater risk of poor health and wellbeing. Carers face being caught in a poverty trap and for these reasons alone are regarded as a disadvantaged and high priority group in terms of health care need.

Bolton has a higher percentage rate of total number of carers not in good health, as represented in table 1, when compared to the North West of England and England as a whole, and the difference increases further for those carers from Bolton who provide 50 or more hours a week and in poor health when compared to the North West of England and England as a whole.

Table 1 The number and percentages of carers aged 16+ in poor health by number of hours cared compared with non-carers in poor health.

	Total number of carers	Total number of carers not in good health	Percentage of all carers not in good health	Number of carers providing 50+ hrs of care a week in poor health	Percentage of carers providing 50+ hrs a week in poor health	Percentage of non-carer population in poor health
Bolton	27,813	3,903	14.03	1,450	23.00	13.26
North West	707,580	96,545	13.64	36,925	22.69	13.14
England	4,764,300	563,855	11.84	203,528	20.58	10.63

Source: In Poor Health: The impact of caring on health - Carers UK (2004), taken from the Census 2001.

Table 2 The number and percentages of carers aged 16 plus who provide 50 or more hours a week within each Ward area of Bolton

Area in Bolton	Total number of people	Total number of carers	Number of carers providing 50+ hrs of care a week	Percentage of carers providing 50+ hrs a week
Astley Bridge	13,979	1,541	283	18.36%
Blackrod	13,098	1,415	299	21.13%
Bradshaw	13,177	1,640	296	18.05%
Breightmet	13,595	1,569	414	26.39%
Bromley Cross	13,837	1,534	259	16.88%
Burnden	12,969	1,298	348	26.81%
Central	10,713	1,023	309	30.21%
Daubhill	11,813	1,221	290	23.75%
Deane-Cum-Heaton	16,987	2,071	409	19.75%
Derby	13,152	1,290	365	28.29%
Farnworth	12,993	1,263	388	30.72%
Halliwell	12,026	1,220	311	25.49%
Harper Green	13,768	1,553	409	26.34%
Horwich	14,343	1,555	253	16.27%
Hulton Park	16,370	1,953	310	15.87%
Kearsley	13,248	1,356	313	23.08%
Little Lever	11,505	1,291	247	19.13%
Smithills	10,881	1,253	257	20.51%
Tonge	10,153	1,076	325	30.20%
Westhoughton	12,430	1,263	272	21.54%
Bolton	261,037	28,385*	6,357	22.40%

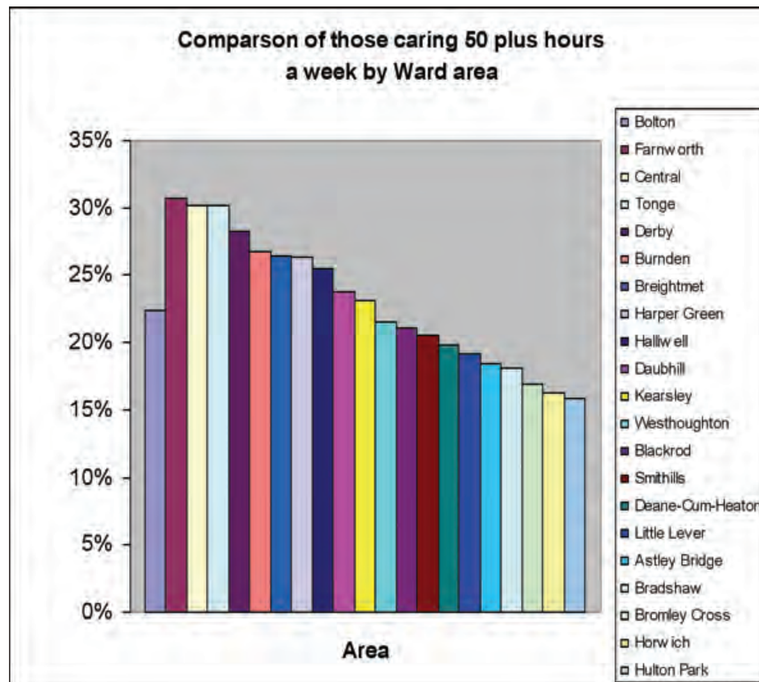
**Total number of carers differs from Table 1 marginally because of the answered question in relation to poor health*
Source: Census 2001

When comparing the percentage of carers providing 50 or more hours a week in poor health to the percentage of the non-carer population in poor health the difference is dramatic - with the figures almost doubling in number across the board, while Bolton represents the largest percentage of carers providing 50 or more hours a week in poor health with a figure of 23% when compared to the North West of England and England as a whole.

Table 2 shows the number and percentages of carers aged 16 plus who provide 50 or more hours a week within each electoral Ward area in Bolton from the Census 2001.

Graph 2

Comparison of those caring 50 plus hours a week by Ward area



Graph 2 shows a percentage comparison of those caring for 50 hours a week within each Ward area in Bolton. The evidence clearly demonstrates a correlation between those represented in Graph 2 with the most deprived Wards in Bolton such as Central, Derby, Farnworth, Burnden, Halliwell, Tonge, Harper Green and Breightmet - with all eight wards appearing in Graph 1 above the Bolton total, which in turn is greater than the North West of England and England total as a whole.

The evidence clearly demonstrates a need to support those carers who live in the most disadvantaged areas in Bolton. However, there are pockets of social deprivation existing in areas such as Johnson Fold, Hall i'th' wood, Oldhams, Platt Hill, Hindleys, Clough Farm, Dove Bank and Springfield Road making it just as important to have a consistent approach to all areas within Bolton that face greater deprivation than in other areas. Tackling inequalities is a direct priority when supporting carers across the Borough.

Promoting social inclusion

Carers' health is a public health issue. Maintaining a carer's health and wellbeing not only means the carer stays healthy, it also means the person who needs looking after is able to maximise their health through the person who knows them best and can be supported in their own home for as long as possible.

To aid carers in maintaining and improving their health and wellbeing a number of services are being delivered and developed through key partners in health and social care that includes

- Increasing Carers Assessments so carers are recognised and supported
- An information website for carers to access
- GP information notice boards in practices across the borough
- A Supporting Carers Programme to assist carers to care through learning and training courses
- Carers health checks to look at their own health and wellbeing
- Further opportunities for carers to access breaks

Recommendations

- Provide information that is joined-up and consistent through the development of a multi-agency information strategy that targets those carers who are normally hard to reach.
- Ensure Primary Care and Hospital discharge staff identify and signpost carers to the appropriate services.
- Training and support to all health and social care staff needs to be delivered to raise the awareness carers' needs and proactively find hidden carers.
- Develop stronger but simple referral systems and care pathways for all agencies in supporting carers.
- Work with those communities that are socially deprived in finding and supporting carers who are hidden and may not be in touch with services.
- Improve identification to hard to reach carers such as Young carers, carers of people with a mental health illness or disability and older carers.
- To ensure carers who are hard to reach have a voice in what services and support is delivered locally to them.

Drugs

Introduction

The growth of drug problems during the mid-to-late 1990s in Bolton has had a profound impact on individuals, communities and the Borough as a whole. Many people have taken drugs experimentally. However, a smaller number have developed a myriad of health, social and legal problems as a result of their drug misuse or dependency on heroin and/or crack. The impact of their drug problems has spread to local communities who have faced a rise in anti-social behaviour, family breakdown and higher levels of crime. The poorest and most deprived areas have been damaged the most. They have become a focus for drug dealing which has fuelled further decline, undermined community cohesion and led to heightened levels of fear and intimidation among local people.

Some groups of young people are particularly vulnerable to becoming problem drug users, namely: those in the looked after system; the sexually exploited; those with disabilities; truants and excludees; those with mental health problems; the homeless; those with families with a history of substance misuse; those in families with a long history of unemployment; and young offenders.

Impact of social exclusion

Many drug misusers experience major health problems as a result of their addiction. Injecting heroin users face an increased risk of overdose and premature death, respiratory failure and deep vein

thrombosis, and in addition are in danger of acquiring Hepatitis B and C and HIV (related directly to risky behaviours such as needle sharing and unsafe sex). Mental health problems, including anxiety and depressive disorders, are also common among heavy users. Heavy crack use can lead to problems such as paranoia, weight loss and breathing difficulties, with many experiencing suicidal thoughts.

As the severity of drug misuse increases, many people struggle to hold down jobs. They experience poverty and family breakdown and face legal and financial problems. The high cost of consumption on a regular basis means that some users rely on criminal activity to fund their habit. Although shoplifting is the most commonly reported offence in Bolton, crimes such as burglary and robbery are also reported. Increasing numbers have housing/accommodation problems or are homeless.

Promoting social inclusion

International and national evidence shows that high-quality drug treatment can be effective in improving physical and mental health, and reducing illegal drug use, offending behaviour and the risk of death due to overdose or blood-borne virus infections.

In Bolton changes in the level and quality of treatment have made a difference. Numbers in treatment at the Substance Misuse Service (Bentley House) have increased and waiting times for treatment are low. Offenders are referred into treatment through the Drugs Interventions Programme (DIP), and this has led to reductions in drug-related crime. Services are also in place which target young people and sex workers. We have tried to achieve a balance between treatment services which are able to maintain drug users on opiate substitute prescribing and services which help people remain abstinent. Structured Day care programmes are available, as well as in-patient and community detoxification and residential rehabilitation. Information on treatment services has been made accessible on a website (www.boltondrugsinfo.co.uk) and a directory of services is also available.

Harm reduction services have an important role to play in reducing harms existing users are causing to their health. There is an increasing number of needle exchanges available through pharmacies in addition to the Central Needle Exchange at Bentley House. Needle Exchange will also be available from the newly commissioned open-access drop in service, due to open in the spring of 2008. In partnership with the Ambulance Service, drug users have been targeted with overdose prevention. Users and carers play a vital role in the planning of services.

However, effective care also requires adequate access to “wraparound” provision. This includes housing, education, training and employment support. Wraparound provision which supports drug misusers' reintegration into the Bolton community has not been achieved. Some progress has been made through programmes such as Supporting People (Floating Support services have been commissioned for both drug and alcohol misusers). Nevertheless, more could be done to improve housing, employment, educational and training opportunities.

Whilst the range and accessibility of treatment services in Bolton is good, services are heroin and crack focused. It would appear that younger problematic drug misusers are choosing a different combination of drugs - namely alcohol, cocaine, cannabis, ecstasy and prescribed drugs. Some younger people are using all four of these drugs (and in some cases including some prescribed drugs) to achieve specific effects including self-medication. A new post heroin/crack problem drug user population is being created which will probably increase in size. This poses additional challenges in relation to the performance of harm reduction services and drug treatment services against national targets and in the effectiveness of services available.

Recommendations

- Improve the quality and effectiveness of drug treatment services in order to achieve better outcomes for clients, including improved retention of clients in treatment, and a higher percentage of successful completions and planned discharges from treatment services.
- Improve access to drug information and advice through the commissioning of an open-access drop in facility.
- Maintain provision for heroin/crack users whilst at the same time consider how services can be provided for the new profile of drug misusers who use and misuse different substances via a complex repertoire - namely Alcohol, Cocaine, Cannabis, Ecstasy and other prescribed drugs.
- Improve the response to young people through better education, information and interventions which respond to the changing nature of problematic drug misuse in Bolton, particularly to those vulnerable to developing substance misuse problems.

Homeless

Introduction

www.JohnBirdsall.co.uk<http://www.JohnBirdsall.co.uk>

Every year, more than 200,000 households nationally experience homelessness or the threat of homelessness. A small but significant number end up sleeping rough, others live in hostels and other insecure accommodation. The most visible and extreme form of homelessness is that of people sleeping on the streets[31].

Each September the Department of Communities and Local Government publishes a national rough sleeping estimate to establish the current position against the 1998 baseline. As with the baseline figure the annual estimate is based on a combination of recent street counts and estimates. In the first 6 months of 2007 the estimate for Bolton identified that between 0-10 people were rough sleeping[32].

Homelessness in Bolton

From 2002 to 2006 in Bolton the number of households recorded as eligible, unintentionally homeless and in priority need has followed a general downward trend from 762 to 549. (see chart 1)

Some of the key reasons for homelessness in Bolton include:

- Violent relationship breakdown
- Parents no longer willing or able to accommodate
- Other relatives or friends no longer willing or able to accommodate
- Termination of tenancy, rent / mortgage arrears, access to the housing market

Other important reasons include:

- Harassment, violence, intimidation
- Leaving institutional care
- Leaving the National Asylum Seeker Service

Finally, there are also some other groups in Bolton, which are vulnerable and are homeless, including people from black and minority ethnic communities and people who misuse substances[33].

Impact of social exclusion

A powerful relationship exists between homelessness and poor mental and physical health. Homeless individuals suffer in greater numbers from mental health problems with estimates as high as 30% - 50%. Moreover these figures are likely to underestimate the problem, given that many homeless people are out of contact with health care providers and so may be suffering with undiagnosed conditions, including psychological trauma related to the experience of homelessness itself. Physical health problems also remain under diagnosed. What we do know is that rates of severe health infections like Tuberculosis, HIV and Hepatitis C continue to escalate, often going untreated. Some GPs may be unwilling to register individuals who are homeless as permanent, or even temporary patients, instead offering isolated or episodic care. This may leave some homeless people with few health care options, and force them to rely upon accident and emergency departments for primary care services, if any. At the same time those registered with GPs may not use them. Stigma and discrimination are powerful deterrents to service use. Negative experiences with health services can leave a lasting impression. Moreover, people are often faced with urgent, competing needs or interests, which may make health issues less of a priority[34].

Promoting social inclusion

Services have been shaped to meet the needs of households in order to sustain settled accommodation as part of a wider objective of improving Health & Well Being and achieving the goals of sustainable, settled & diverse communities.

In terms of homelessness related services and those services aimed at preventing homelessness, considerable effort has been focussed on identifying and targeting key vulnerable groups and types of situations and

Chart 1

circumstances that arise. This has led to the ongoing development of approaches, and in particular multi-agency responses to, the discreet needs of households & individuals in order to prevent homelessness or where it does occur, ensure sustainable positive outcomes with those interventions.
The development of this increasingly integrated approach can be seen not only across those services providing interventions in situations of the most acute & pressing need, but are reflected across the approaches adopted by mainstream services. There is a commitment and belief of all the partners to an approach that has a demonstrable longevity, and rebalances interventions away from quick fixes to ones which can be sustained.

There are inevitably many challenges that present when tackling homelessness and it is Bolton's belief that this integrated approach is best suited to and fit for purpose to meet the challenges ahead. This approach is reflected within strategic and operational contexts.

A number of areas of service development in particular have contributed to these achievements, including:

- Delivery and embedding of domestic violence strategy, including Safe Haven & Safe As Houses projects and multi-agency case management;
- Community Legal Services Partnership, widening access to advice including County Court project;
- Interventions for offenders and prison leavers, targeting high risk & prolific acquisitive offenders in particular, and development of prison release / NFA - No Fixed Abode, interventions;
- Anti-social behaviour interventions, including the development of the Family Project core unit and multi-agency approaches to tackle anti-social behaviour and reduce evictions;
- Refugee & Asylum planned move-on, support & integration projects;
- Implementation of intensive housing management for vulnerable households, roll-out of furnished tenancies and remodelling of decommissioned housing schemes;
- Landlord accreditation, extension of lease management and family bond schemes increasing access to private rented sector;
- Young Runaways project, school presentations, mainstreaming work to prevent & divert those at risk of exploitation and Time2Talk family mediation for young people at risk of homelessness.

What more needs to be done

A key thread which runs through all the above areas is the challenge presented by households whose circumstances, lifestyle and behaviour present barriers to engagement and whose needs often outstrip the thresholds of service provision.

The most needy households and individuals experiencing homelessness are often typified by chaotic lifestyles and inter-generational impacts that readily leads to non-engagement and withdrawal & exclusion from services.

There is a timely opportunity within Bolton to focus attention upon some of the most needy households and individuals exhibiting the most unsettled and at times chaotic of lifestyles. Current service review and operational process in particular in relation to:

- Single homelessness review;
- Offender resettlement;
- Domestic violence and the multi-agency casework approach;
- Child concern and current Joint Area Review of services to children; and
- Substance Misuse / Hidden Harm;

of which accommodation is a key pathway intervention, provides an opportunity to co-ordinate and effectively target multi-disciplinary interventions to positively impact upon a core of households who often draw disproportionately upon a wide range of services.

Recommendations

- Homelessness Prevention & sustainability requires a continued emphasis towards prevention approaches
  Ensuring access to quality advice and affordable & appropriate housing
- Accessing temporary/emergency & supported accommodation to reduce inappropriate use of temporary accommodation
- Ensure an adequate and varied supply of accommodation within social & private rented as well as ownership and shared-ownership options
- Focus attention upon some of the most needy households and individuals exhibiting the most unsettled and at times chaotic of lifestyles
- Co-ordinate and effectively target multi-disciplinary interventions to positively impact upon a core of households who often draw disproportionately upon a wide range of services
- Ensure better access to Primary Care Services for homeless people

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Gypsies and Travellers

Introduction

Due to their nature and way of life, gypsies and travellers have been socially excluded throughout the years from lots of main stream services as well as from the majority community. This is due mainly to cultural differences and suspicions from both this community and the wider community, some real and some perceived. Prejudice still remains in England. A MORI poll in 2003 showed that over 1/3 of respondents were more prejudiced towards gypsies and travellers than other minority groups. A lack of authorised sites and transit sites is seen as a large part of the problem, creating illegal encampments and the adverse media coverage that follows.

Gypsies and Travellers in Bolton

Within Bolton there are a number of gypsies and travellers. Some reside on sites whilst others reside in houses. The influx of migrant Roma families from the EEC e.g. Romania, has increased these numbers.

There were approximately 250 gypsy/traveller and Roma gypsies families identified as residing within the Borough during a survey undertaken in 2006, being split between houses and caravans. This is likely to have increased slightly since then. In relation to the Roma Gypsies there is an additional barrier in relation to language.

There are also those families who live a nomadic life travelling throughout the country and stopping at various places.

Impact of Social Exclusion

Gypsies and Travellers are known to have poorer health and have a life expectancy which is shorter than the national average. Research shows that traveller women lived 12 years less, and traveller men lived 10 years less than the national average[35].

Due to their nomadic way of life, continuity of care can also be a problem resulting in missed appointments and immunisations.

There is a risk to their health because of low take-up of child immunisations and cancer screening initiatives. Low literacy levels are also a bar to good health education and the perception that they are a "hard to reach" group.

Promoting Social Inclusion

Inclusion is definitely improved with authorised sites. In Bolton, access to services via the Gypsy Liaison Officer, Traveller Education, Health Visitors and Midwife is excellent. Health visitors attend sites on a regular, pre-arranged basis and deal with a wide range of health issues, the midwife also attends when required. To promote inclusion a bid has been tendered to the Department of Communities and Local Government for the provision of a community centre on site, which will allow even greater access to service and enable those services to more readily reach this community.

Access to doctors' surgeries is excellent for those residents on site but illegal encampments fare less well. Illegal encampments are visited by the Gypsy Liaison Officer who carries out an assessment of need and informs the necessary agencies of their whereabouts and circumstances. If necessary the Health Visitor for that particular area is asked to attend, for other medical needs people will be directed to the NHS Walk-in Centre.

Access to dental treatment is difficult.

The Gypsy and Traveller Strategy for Bolton sets out our ongoing commitment to promote inclusion and sets out an action plan for 2006-2008, its aims and objectives are as follows:-

Aims

- To increase access and up take of customer orientated services and so achieve greater involvement.
- To reduce exclusion, and health and economic inequalities, prejudice and support.
- To encourage engagement and interaction with the wider population; and
- Facilitate the maintenance and promotion of Gypsies and Travellers cultural distinctiveness.

Partnership working with AGMA (Association of Greater Manchester Authorities) is also taking place with a view to producing a Regional Strategy. This will follow consultation with gypsies and travellers as part of the Accommodation Needs Assessment.

What more needs to be done?

Due to the isolation of this group ongoing work is required. Bolton's Gypsy and Travellers Strategy, a "live" document has been created, allowing us to evolve and adapt to changes in guidance, legislation and local needs. Work is ongoing at regional level. Joint working across the North West and Nationally is crucial to the success of reducing inequalities and addressing the needs of gypsies and travellers.

Recommendations

As set out in Bolton's Gypsy and Traveller Strategy Action Plan 2006-2008

- Establish/amend ethnic monitoring systems to ensure that gypsies and traveller are included.
- Establish/develop existing regular approaches for updating need.
- Develop a better and shared understanding of the need of gypsies and travellers.
- Develop a consistent approach to consultation/engagement for all service providers including unofficial sites.
- Develop mechanisms for providing feedback to agencies and gypsies and travellers in order to influence service improvements.
- Develop the local multi-agency partnership group to enable joint approaches and processes to be developed to address gypsy and traveller needs and issues..
- Update the Strategy and Action Plan.
- Engage with relevant sub-regional and regional bodies to influence and support the development of robust approaches.
- Increase awareness of how to access services amongst the gypsy and traveller community.
- Review ways to improve ease of access to services, eg. Primary care.
- All LA & PCT services and agencies to review gaps highlighted in the research and develop a Project Plan to address them.
- All services to identify actions to improve community cohesion/reduce social exclusion of gypsies and travellers.

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Young Parents/ Teenagers at Risk From Pregnancy

www.JohnBirdsall.co.uk<http://www.JohnBirdsall.co.uk>

Introduction

Teenage pregnancy can be said to be both a cause and a consequence of social exclusion. Teenage pregnancy is strongly associated with the most deprived and socially excluded young people. Difficulties in young people's lives such as poor family relationships, low self esteem and unhappiness at school put them at greater risk.

Young people who become parents can also become socially excluded, because they can be isolated, have difficulty obtaining employment and may have little support.

Young parents & teenagers at risk from pregnancy in Bolton

In Bolton the rates of under 18s conceptions are significantly higher than the national average. The rates have changed little since the 1998 baseline and currently is at 51.9 per 1000 females 15 - 17 years. There has been a reduction of 3% from 2004 to 2005 (the latest statistic available) and the first quarter of 2006 also showed a slight decrease.

Impact of social exclusion

Teenage parenthood continues to be a marker for social disadvantage. Amongst mothers, individual attributes measured in childhood, such as having a conduct disorder, poor reading ability and having a mother with low education aspirations, increases the likelihood of teenage motherhood[36].

Outcomes for teenage mothers and their children can be poor.

- At the age of 30 years teenage mothers are 22% more likely to be living in poverty than mothers giving birth age 24 or over and are much less likely to be employed or living with a partner.
- Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth aged 24 or over.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.
- Teenage mothers have 3 times the rate of post natal depression than older mothers and a higher risk of poor mental health for 3 years after the birth.
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers.
- Teenage mothers are 3 times more likely to smoke in pregnancy and 50% less likely to breast feed than other mothers, which has negative health consequences for the child.
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their 20s,

have higher mortality rates under 8 and are more likely to have accidents and behavioural problems.
- Amongst the most vulnerable girls the risk of becoming a teenage mother before the age of 20 is nearly 1 in 3[37].

Promoting social inclusion

The local Teenage Pregnancy Strategy is delivered via annual multi agency, borough wide action plans, with the aims of preventing teenage conceptions and supporting those who do become teenage parents.

The work streams include:

- Engagement of key partners, social care, health, education.
- Data and Performance Management.
- Provision of Young People focused Contraception/Sexual Health services.
- Strong delivery of Personal Health and Social Education including Sex and Relationships Education by schools.
- Targeted work with at risk groups of young people.
- Workforce training on sex and relationship issues within mainstream partner agencies.
- A well resourced Youth Service with a clear remit to tackle issues such as teenage pregnancy and young people's sexual health.
- Raising aspirations.
- Work with parents of teenagers
- Support for teenage parents, including improving self esteem, raising aspirations, encouraging and supporting access to education, training and employment. Individual and group support - tackling issues such as domestic violence, safe guarding, parenting, housing and finances.

The support available for young parents is good and Bolton has the fourth highest percentage of teenage mothers in further education (FE) in the country. Those who attend FE are less likely to have a second teenage conception, with rates of only 3%. Bolton as a whole has a second teenage conception rate of 9.4% against a national average of 20%. Support services aim to remove barriers to education and good parenting in order that young mothers can improve the life chances for themselves and their babies. Those gaining confidence, accessing services and gaining qualifications can then move on to more skilled employment, and improve their financial situation.

Although the support given to young parents is improving outcomes, the prevention of teenage pregnancies remains a priority for Bolton. Current action plans are strong and should impact on rates in future years.

Recommendations

- To continue to support the improvement of Sex and Relationships Education in schools.
- To improve support available to teenage parents by ensuring all partner agencies provide appropriate services. Eg. Children's Centres supporting teenage parents to access their local provision.
- To continue to influence partners to provide 'Young People Friendly' services, meeting the You're Welcome Quality Criteria.

References

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People who misuse Alcohol

Introduction

Alcohol is an important part of our social and cultural life. However, alcohol is also related to a range of serious problems for some individuals their families and the wider community, with alcohol being identified as an exacerbating factor in many of the causes of social exclusion[39].

Alcohol misuse is known to cause a range of health problems. Alcohol related digestive disorders make a significant contribution to reduced life expectancy in Bolton. For females between 2003-2005 digestive diseases including cirrhosis of the liver was the primary cause of reduced life expectancy. For males this was the second most common cause. Alcohol related conditions include cirrhosis of the liver, some cardiovascular diseases, increased risk of developing certain cancers, and heightened risk of injury and violence.

There is a close association between alcohol dependency and mental health problems, with heavy drinking being linked with psychiatric morbidity including clinical depression. It is estimated 65% of suicide attempts are linked with excessive drinking.

Impact of social exclusion

Whilst alcohol misuse is more prevalent amongst socially excluded groups it is also a key cause of social exclusion.

Families

Alcohol misuse has a significant impact on families. Up to 1.3 million children in the UK are affected by parental alcohol problems[38]. Alcohol misuse in families contributes to financial difficulties, problems in relationships between family members, conflicts and disputes and the quality of parenting. Around one third (360,000) of all domestic violence incidents are linked to alcohol misuse[39] and alcohol misuse by parents was identified as a factor in over 50% of child protection cases[40]. Between 50% and 90% of families on social workers child care caseloads have parents with drug, alcohol, or mental health problems[41]. Marriages are twice as likely to end in divorce where there are alcohol problems[42].

"Mum keeps hitting me. She drinks. She won't understand I love her." Gillian, 15[43]

"Mum and Dad … spend all their money on drink. There's no soap in the house and all my clothes are too small. I lost a girlfriend because she said I smell." Paul, 14[43]

Parent alcohol misuse can therefore significantly contribute to the social exclusion of children, who can become emotionally isolated from their parents, take on 'advanced' responsibilities and see or experience violence, which in turn can lead to long term physiological impacts and feelings of guilt among children affected[43].

Young people

Young people's own consumption of alcohol can also lead to social exclusion, as it is an important risk factor in teenage pregnancy. Young people who have been drinking alcohol are more likely to lose their inhibitions and participate in risky behaviour such as having unprotected sex. Young people with alcohol problems also have a higher rate of mental health problems, are at risk of being excluded from school and further education opportunities and are more likely to be involved in crime .

Unemployment

Problem drinking can make it difficult for people to work productively and hold down a job, making alcohol miusers particularly vulnerable to unemployment and therefore to further social exclusion. A census of alcohol services found that, of the 10,000 people receiving help for their drinking problems each day, 36% were unemployed44.

Crime and the criminal justice system

People who misuse alcohol are also more likely to be involved in criminal activity and therefore to be offenders. Up to 50% of violent crime and 70% of domestic violence is associated with alcohol misuse. Among male prisoners, 58% of remand and 63% of sentenced prisoners were drinking at hazardous levels in the year before they entered prison.

Homelessness

Alcohol misuse is also an important risk factor for homelessness as family break down, offending, unemployment and associated poverty make problem drinkers more likely to lose their home. Up to 50% of rough sleepers are estimated to be alcohol dependent[43].

Promoting social inclusion

A wide range of initiatives have been developed to address the growing problem of alcohol misuse and the social exclusion that it can cause. These include:

- A programme to deliver alcohol brief interventions in primary care. These have been shown to be effective in reducing the amount of alcohol that 'hazardous' and 'harmful drinkers' drink[44].
- The implementation of behavioural counselling interventions in primary care to reduce risky/harmful alcohol use by adults[45].
- Open access, and specialist structured alcohol treatment services;
- The provision of a floating support service to help people with alcohol misuse problems sustain their tenancies and prevent homelessness;
- A variety of specialist treatment options including prescribing and detox provided by the 360 Young peoples substance misuse service.
- Support for carers and concerned others provided by the new tier two alcohol service based with the Alcohol and Drug Service within the voluntary sector

Recommendations

- An increased emphasis on improving employment, training, and housing for people with an alcohol misuse problem.
- Additional support for people affected by alcohol misuse.
- Expand the provision of Brief Interventions to all Primary Care settings.
- Develop sustained and focused campaigns to provide clear information and promote a positive image of a 'responsible drinking culture' combined with targeted programmes of support for people who have problems with their drinking.

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CHAPTER 4: Conclusion

Promoting social inclusion presents a challenging agenda to all those agencies both statutory and non-statutory and the voluntary sector who strive towards improving the health and well-being of the Bolton community.

The canvass is not blank. Chapter 3 of this report described for some of the dimensions of exclusion, existing work being implemented to promote inclusion and detailed a number of recommendations to be taken forward. Some of the recommendations have already been integrated into existing strategy documents, others have not and therefore need to be prioritised into appropriate development plans for action.

Whilst the journey towards delivering sustainable change and improvement has already commenced, there is a considerable way to go. The Bolton family is committed to working in partnership to respond to the challenge of narrowing the gap in health experience.

In working together, the PCT and partner agencies need to become fully engaged with the community and work hard to understand the many complexities and interrelated issues that affect individuals abilities, attitudes and motivation to improve their life chances and break the cycle of exclusion and disadvantage. A key priority must therefore be to work directly with the community to develop innovative ways to engage with hard to reach groups so as to improve their ability to engage with services. This will be essential to facilitating community ownership and participation in the wider programme of work to promote inclusion.

At the heart of this, and to avoid unnecessary duplication of effort, is the need to develop and agree a comprehensive agency wide approach to social marketing and communication. This will be the lynchpin to delivering successful interventions. Working proactively and creatively to support and enable hard to reach groups to identify solutions to 'their' problems that fuel exclusion is of paramount importance. Fundamental to this will be the need to enable the community to become a key player in decision making processes.

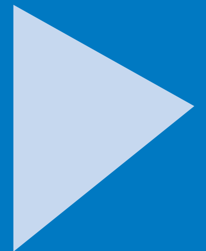
Bolton is already involved in a cross-Government initiative led by the Social Exclusion Task Force, with the aim of improving service delivery for people with multiple problems and complex needs. Connected Care is a new model of health and social care service delivery that will focus on three areas of the borough including Farnworth East, Oxford Grove and Lower Deane. Connected Care will bring together housing, health and social care services as well as wider support, education and employment to provide a wide range of support that is more responsive to local communities and will provide an important framework for future borough wide developmental work to support and guide efforts to tackle social exclusion in the long term.

Opportunities to tackle social exclusion and promote inclusion must be maximised through the equality and diversity work programme. Understanding and valuing the richness of diversity in the community and ensuring that needs based interventions are developed will be key to future change and improvement. To do this and to do it well, robust systems and structures must be in place and implemented to ensure that Equality Impact Assessment and evaluation is integral to all that we do.

To successfully tackle social exclusion it is essential that the PCT and partner organisations continue to work together to agree a robust strategic approach that will promote inclusion and will deliver sustained progress towards reducing health inequalities in Bolton now and into the future.

CHAPTER 5:
Public Health Annual Report 2006:

Progress Report



Chapter 1 - Overview of Life Expectancy

Recommendation	Progress
Undertake health impact assessment of the different Local Area Agreement Blocks to ensure that the health impact of the LAA is maximised	A new Local Authority Agreement (LAA) is now being developed to run from 2008 to 2011. The health impact of the new LAA will be assessed during its development to ensure that its contribution to improving health and reducing inequalities in health is maximised. High impact cross cutting interventions are being identified and their impact on health will be assessed as part of the decision to include them in the LAA.
Ensure that the PCT and local primary care services are engaged in the delivery of the Neighbourhood Renewal Strategy	The Neighbourhood Renewal Strategy includes the development of Neighbourhood Action Plans (NAPs) for each of the priority areas. In each area local networks are being established, which are made up of those delivering services in the area. These networks oversee the delivery and development of the NAPs. The PCT is represented in these area networks. Links to general practice are made through Health Trainers, who are based within practices in the most deprived areas of the borough.
Ensure that the PCT develops a sustainable approach to improving access to high quality primary care, particularly in deprived areas	**1. Procurement of a New Innovative Practice** A key contributor to improved access will be improved by our work with the Department of Health to procure a new innovative practice in Bolton. This will be sited in or close to the town centre to serve targeted areas that are under-provided. These targeted areas have high proportions of BME patients. It is envisaged that this tendering process will re-energise the existing market and raise standards related to improved access across existing practices. To ensure a more responsive service the provider will be required to recruit staff from the local community. The contract model for this new practice is APMS (Alternative Provider of Medical Services) and this will allow the PCT to specify service key performance indicators related to delivery standards including access and responsiveness. The new practice is expected to be operational by Spring 2008 **2. GP Workforce Growth Initiative** In addition to the above development, a scheme has been developed for existing practices (in targeted areas of under-provision) to bid for workforce growth. Bidders will be required to introduce more flexibility and responsiveness for patient access. This will incentivise change in areas of high need (areas of high proportion of ethnic minority communities; deprivation and associated poor health) and improved access will be designed around the needs/preferences of the population. Bids have been received and are currently being evaluated.

Chapter 2 - Alcohol related disease

Recommendation	Progress
Establish a Local Enhanced Service focusing on hazardous drinkers,	A Local Enhanced Service specification has been developed and will be piloted with practices in 2008.

that includes establishing practice registers of hazardous drinkers	
Train a wide range of individuals in the identification of hazardous drinkers and the delivery of effective brief interventions	A programme of training on Brief Interventions has been commissioned. The first training sessions took place in September 2007. The training is designed to develop core skills for staff around health related behaviour change and motivational skills. Subsequent sessions will cover various health topics including alcohol. The Alcohol Brief Intervention module will enable primary care staff to assess a person's consumption of alcohol and then either deliver a brief intervention or refer the person on to other specialist services. Following evaluation of the training in primary care decisions will be taken about which other appropriate groups should be trained.
Develop links between the criminal justice system and alcohol treatment services	Police custody staff are included amongst staff receiving training for Alcohol Brief Interventions. The Alcohol Strategy Group are considering proposals to develop work in this area which may lead to the establishment of an arrest referral scheme following national pilots currently being rolled out and evaluated by early 2008.
Develop and commission new alcohol treatment models	Alcohol Concern was commissioned to help the PCT and Council redesign the alcohol treatment system. New service specifications for the redesigned system were developed along with an outcomes focused monitoring system. The new system will have a single point of entry and will provide clients with time limited evidence based therapeutic interventions. The PCT has also invested additional resources in the new treatment system which went live on 29th October 2007.

Chapter 3 - Cancers

Recommendation	Progress
Encourage more people to seek help from Bolton's stop smoking service. Develop and promote new ways to support people to give up, particularly people from deprived areas	Bolton Community College's Learning Ambassadors were trained over a period of weeks in skills such as public speaking, communication and self esteem and then smoking specific knowledge such as brief intervention training, smoke free homes project, smoke free legislation and general facts about smoking, second hand smoke and ill health. The ambassadors went out in twos to make as much contact as possible with individuals and groups across Bolton raising awareness of the importance and benefits of quitting and highlighting the fact that smokefree legislation would be coming and would effect all smokers to a greater or lesser extent. They did presentations at group level and attended a range of community events setting up displays and giving out specific information and leaflets. They

	signposted people to the stop smoking service and arranged for the stop smoking service to come out and deliver sessions in community venues. The project rolled on to become a specific Smoke Free Homes Project which began to operate in February 2007 and has just signed up its 1000th family
Support people to make and maintain healthier choices with regard to their diet in order to reduce the burden that obesity and poor diet play in increasing the number of cancer deaths	Bolton PCT in partnership with Bolton Gathering of Organic Growers and Bolton at Home have supported the establishment of Food Access Bolton (FAB) project which aims to increase access to fresh fruit and vegetables in disadvantaged target areas where consumption is particularly low and amongst young people. Over the past year the following progress has been made :- * a mobile fruit and vegetable shop has been running a one day a week for the past year. The mobile shop has been successful in increasing consumption of fruit and vegetables through street sales, sales at Children's Centres and through supplying a local community cafe. Funding has been acquired for 1 1/2 workers to develop the service in other areas on other days. The van is run on biodiesel made from recycled vegetable oil sourced from local schools, private businesses and the Royal Bolton Hospital. *a pilot school-based food co-op has been set up *two growing projects targeting children excluded from mainstream education have been established *a growing project involving clients from Bolton Alcohol & Drug Support Services has been set up
Initiatives which seek to increase physical activity, such as cycling and walking projects, are recommended as effective ways to prevent cancer deaths	A number of initiatives have been developed and implemented: o Get Active programme: A major initiative employing 5 full staff members with the aim of increasing participation in physical activity in the Neighbourhood Renewal Strategy areas of Bolton. o A physical activity audit has been undertaken across 11 wards in Bolton involving 4000 door to door questionnaires. o Implementation of ride to work scheme for health service staff o Recruitment of a cycle 4 health worker to further develop cycling across Bolton PCT o Community forums created to understand in more detail the existing localised block to taking part in Physical activity
Implement the multi-agency alcohol strategy, which recommends the use of national guidance on sensible drinking limits as a key health message	A Bolton Alcohol Strategy Steering Group was established early in 2007 to oversee the implementation of the strategy. The Steering Group brings together local stakeholders including: Health, Police, Council, Trading Standards and others. Work is currently underway to develop campaign and communication materials to be used in various settings to reinforce the 'Safe and Responsible Drinking' message within the Alcohol Strategy.
Efforts which raise awareness of the early signs of disease are recommended. The relatively high	A social marketing campaign is under development to raise awareness of the earl signs of disease. The first stage will research with local communities to better understand their views of the information and messages which will encourage people to present to services early with symptoms of a range of chronic diseases. The research will also include primary

lung cancer mortality rate in Bolton will require particular efforts to encourage people form deprived areas to present to their GP if they have chronic cough. The use of community development and social marketing approaches should be employed to increase awareness amongst the Borough's most deprived communities	care professionals to enable us to understand their views about what can be done to encourage early symptom recognition and overcome barriers to presentation at services in deprived areas.
Efforts which support the provision of clear information, local delivery, patient choice and culturally sensitive services are recommended as key measures to increase access to services and deliver high quality care	A discrete research project is underway to promote access to the cervical screening programme and identify barriers to access. In addition, a cervical screening equity audit has been completed (breast screening equity audit is in progress). Outcomes from the equity audit exercise and the research project will inform the development of a framework for promoting the delivery of cancer screening programmes and improving uptake locally.

Chapter 4 - Circulatory disease

Recommendation	Progress
In order to reduce premature mortality from circulatory disease in the short, medium and long term, the reorientation of services towards a focus on prevention, particularly primary prevention, need to be accelerated	Primary care services receive additional local incentives to address primary prevention of circulatory disease through an incentive scheme. This requires practices to develop primary prevention registers of those at risk and to conduct regular reviews with these patients to reduce risk. In addition, practices are encouraged to better identify risk by systematic screening patients for their blood pressure, cholesterol and body mass index.
Health Trainers need to be embedded within mainstream provision, ensuring they retain their focus on primary prevention and health promotion	In January 2007 16 new members of staff were recruited to begin working as Health Trainers and at the same time GP Practices were invited to join the Health Trainer Programme to provide mentorship and learning experiences. A total of 18 Practices from the more deprived areas of Bolton signed up to the Programme. For the past 9 months the new Health Trainers have undertaken a very intense programme of learning, both within General Practice and at the University of Bolton, where they are studying towards a Foundation Degree in Health & Social Care.

	They are now starting to work with patients who are over 45, who have been identified on the Practice-based Registers as not having established circulatory disease or diabetes, but who have a high risk of developing the conditions within the next 10 years. The identified patients are receiving one-to-one support to make lifestyle changes. The support includes the use of an on-line health and lifestyle assessment called Vie-life. A further 14 Health Trainers have recently been recruited and began working in GP Surgeries in October. This means that a total of 32 GP Surgeries are now involved in the Health Trainer Programme.
A thorough evaluation of the Health Trainer programme should be carried out to ensure optimum impact	Information from the on-line health assessments will be compiled by Vie-life on a quarterly basis for evaluation purposes. A customised database has been developed for use by the Health Trainers to provide local information not covered by the on-line assessment tool. A Greater Manchester wide evaluation of the Health Trainer Programme is currently being developed. A national evaluation of the Health Trainer programme is currently being developed. All these processes will be assessed as the Programme progresses to ensure they continue to be fit for purpose and meet our information needs in relation to the Health trainer Programme both locally and regionally.
Further mainstream development of services to support behaviour change is required to reduce the need for drug therapies	In the last year local partner agencies worked together to commission the University of Manchester to investigate the effectiveness of different approaches to behaviour change and provide support to local agencies to develop evidence based behaviour change strategies. A proposal has now been developed to develop skills and tools for effective behaviour change
The expansion of the chronic disease management service (across a range of disease areas) should particularly target practices serving deprived areas	The service has been delayed due to recruitment, however the administrator, GpwSI (GP's with a Special Interest) and team leader are now in place. There are still some outstanding posts to be filled. The team is currently identifying target practices.

Chapter 5 - Respiratory conditions

Recommendation	Progress
Undertake a review of stop smoking services to inform development of a new service	A review of stop smoking services has been completed.

specification to maximise its contribution to reduced life expectancy and other local priorities.	
Ensure that social prescribing for affordable warmth interventions is clearly reflected within developing respiratory disease pathways	The Chronic Obstructive Pulmonary Disease (COPD) Network has been established and has several task and finish groups. This group has the aim of ensuring Social Prescribing and in particular Affordable Warmth referral is integrated into the care pathway.
Undertake community engagement in deprived areas to identify barriers to presentation with respiratory conditions and identify opportunities to deliver a social marketing programme to encourage people with breathlessness and chronic cough to consult their GP about their condition	A social marketing campaign is under development to raise awareness of the early signs of disease. The first stage will research with local communities to better understand their views of the information and messages which will encourage people to present to services early with symptoms of a range of chronic diseases. The research will also include primary care professionals to enable to ensure a comprehensive understanding of views about what can be done to encourage early symptom recognition and overcome barriers to presentation at services in deprived areas.
Evaluate impact of Breathlessness clinic and COPD primary care service on respiratory health outcomes	The service has been operational since March 2007. There has been a review of the operational service and it is continuing until at least Jan 2008.
Compliance with treatment for COPD is variable, with people from lower socio economic groups less likely to adhere to their treatment. Opportunities to deliver patient education about COPD and its treatment should be explored, particularly with community pharmacists who might have particular opportunities to discuss medication with COPD	The chronic disease management team will address COPD and medication management.

Glossary

Accommodation Needs Assessment
The Housing Act 2004 imposes a duty on local authorities to carry out an assessment of the accommodation needs of gypsies and travellers living in their district to inform policies relating to topics such as housing, health, and education & also support the promotion of equality and diversity.

Affordable Warmth
Affordable warmth is the solution to fuel poverty. A fuel-poor household needs to spend more than 10% of its disposable income on all fuel use in order to heat the home to an adequate standard of warmth (generally defined as 21°C in the living room and 18°C in other occupied rooms).

Deprivation
'Deprivation' is often used as shorthand for 'multiple deprivation'. Deprivation is the enforced lack of goods, services or social relations which result from a lack of financial resources. This lack is measured in relation to social norms or expectations, so what is considered as deprivation may change over time. Multiple deprivation is when several forms of deprivation occur together, such as low income, poor housing, and unemployment.

Equality Impact Assessment
This is a way of anticipating whether a new or current policy or service is likely to have an unequal impact on people because of their gender, race, disability, age, religion or faith, or sexual orientation. This is done so that, as far as possible, any negative consequences are eliminated or minimised and opportunities for promoting equality are maximised.

BME Communities
Black and minority ethnic communities

BRASS
Bolton Refugee and Asylum Support Service

COPD,
Chronic Obstructive Pulmonary Disease. A progressive condition of the lungs that makes breathing more difficult. COPD includes both emphysema and chronic bronchitis.

Equality and Diversity
Equality is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. It is backed by legislation designed to address unfair discrimination based on membership of a particular group. Diversity is about the recognition and valuing of difference in its broadest sense. It is about creating a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual, including patients.

Female Genital Mutilation
Also known as female circumcision or female genital cutting. This is all procedures which involve the partial or complete removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reason.

Gateway Protection Programme
Home Office resettled programme for refugees.

Health Trainers
This is a new role within the NHS. Health Trainers use techniques based on psychological evidence and theories to help people change behaviours that are known to cause ill-health

homogeneous
Made up of things that either look the same or are the same.

Infant Mortality
The number of deaths of children less than one year of age, per 1000 live births.

NASS
National Asylum Support Service ..

MRI Scan
Magnetic Resonance Imaging Scan

OC2 return
Outcome indicators for looked-after children. Looked after children are those in public care who are placed with foster carers, in residential homes or with parents or other relatives.

Primary Care
Health care focused on the point at which a patient ideally first seeks help from the medical care system. This includes the GP practice team, together with health visitors, dentists, opticians, pharmacists, NHS Direct and NHS walk-in-centres.

Refugee Action
An independent charity that supports refugees and asylum seekers to resettle and build new lives in the UK

Social Marketing
The application of marketing knowledge, concepts, and techniques to non-commercial activities such as those connected with health, community, welfare and social services.

Social model of disability
The social model contrasts with the medical model of disability. According to the medical model, management of the disability is mainly focussed on medical treatment, or the individual's adjustment and behaviour change. In contrast, the social model sees the main issue with disability as being a socially created problem. The social model therefore sees the management of disability as being a collective responsibility to make modifications to the environment that are necessary so that people with disabilities can play a full part in all areas of social life.

Social Prescribing
This enables primary care workers to refer patients/clients to a wide range of non-medical projects/services to address the socio-economic and emotional problems that have a negative impact on health.

We recognise that not everyone will find this annual report easy to read. If you would like further explanation, or a summary in a different language or format such as large print or audio, please contact us on **01204 462174**

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