NHS GM Health Inequalities Statement 2025

Purpose

Fairer Health for All (FHFA) is our system-wide commitment and framework for reducing health inequalities in Greater Manchester (GM). The framework outlines our priorities for coordinated action to reduce inequalities across the life course through a set of shared principles, enablers, tools and resources and a set of ambitions for 2030 (see box 1).

Box 1: Fairer Health for All Ambitions

The Fairer Health for All Ambitions and Goals for 2030 are to:

1. **Improve the Health & Wellbeing to narrow the gap in life expectancy and healthy life expectancy** –Narrow the gap by at least 15% between Men and Women living in GM between all 10 localities in GM, as well as between GM & England average.
2. **Reduce unwarranted variation in health outcomes and experiences** – Eliminate the difference between the highest & lowest social groups in the experience of having 2 or more multiple health harming behaviours.
3. **Increased social & economic activity because of reduced ill health** – Narrow the 15-year gap in the onset of multiple morbidities between the poorest & wealthiest sections of the population to 5 years.
4. **Reduce preventable or unmet health and care needs leading to reductions in health and care demand** –Close the health inequalities gap in smoking prevalence with England. Reduce avoidable mortality rates by 40%.
5. **Reduce the difference in life expectancy and the incidence of physical health conditions for people with Severe Mental Illness (SMI)** –Narrow the gap with England by 15%.
6. **Reduce infant Mortality** –Narrow the gap in infant mortality with England by 15% & close the school readiness gap.

This report summarises progress against the Fairer Health for All (FHFA) outcome targets and reviews health inequality trend data across Greater Manchester that monitors changes in:

- Health behaviour
- Access experience and outcomes of care*
- Mortality data

*NHS Greater Manchester and GM Trusts are required to report on a set of metrics annually as part of the Health Inequalities Statement which monitors variation in access to screening and immunisations, and specific care services - See Appendix A for a list of indicators.

See the Integrated Care Board (ICB) Annual report for a summary of locality and system wide action on prevention and proactive care programmes in 2024/25 to reduce inequalities and the Academy website for a range of examples of Fairer Health for All in Action happening across our neighbourhoods and localities and 'stories of change' on *how* we are enabling:

- Best Start
- Community-led health and well-being
- Prevention and proactive care
- Health creating places.
- Reduced variation in access, experience and outcomes of care

Process for drafting the report – Phases of review

This report should be read as a working document. It will be updated iteratively over three distinct phases:

Phase 1: Analysis of System Data (March-June 2025)

The first phase of analysis includes a review of GM and locality healthcare and mortality data – using data from the Fairer Health for All outcomes dashboard and the Health Inequality Statement dashboards. This analysis was compiled by Intelligence leads and programme leads working in NHS GM and the GM Cancer Alliance and has identified variation in data quality for each of the healthcare datasets, and gaps in data (see further detail below).

Phase 2: Workshops with Locality and GM partners (Summer/Autumn 2025)

The next phase is to convene a series of workshops, inviting VCSFE and public sector partners that work in each of the ten localities in order to:

- **Review key findings and consider how the system intelligence triangulates with local intelligence** (data and insight on health inequalities collected through VCSFE and public sector partners). What does this shared intelligence tell us about:
    - Health needs and assets of specific communities of interest, identify and geography which shape an individual's opportunity to stay well?
    - Variation in access, experience and outcomes of care in different communities and how this is changing over time
    - What is/isn't improving health outcomes for specific communities? And why?
    - What further Key Lines of Enquiry do we want to prioritise? And how will that shape emerging prevention priorities and research needs?
- **Reflect on how we are using intelligence (data and insight) and VCSFE partnerships to inform:**
    - ❖ *'Where'* care (prevention and treatment) is delivered.

    - ❖ How we prioritise and target care for particular communities and neighbourhoods
    - ❖ *'How'* care is delivered – how are we co-designing culturally appropriate and accessible services that also mitigate against the impact of poverty on health and digital exclusion.
- **Review the relevance of the FHFA outcome and Health Inequalities (HI) metrics** –
    - Are these the correct indicators to help us monitor variation in health across GM?
    - Are there any key data gaps – and how are we addressing those gaps?
    - How are we measuring variation in the activity, outputs and outcomes of community-led health and well-being activity?
    - How are we measuring the building blocks for health? Should we be monitoring variation in 'good employment' and good housing' and building the Marmot metrics that monitor the wider determinants of health into the routine performance dashboards and Fairer Health for All (FHFA) outcome indicators?
- **Develop Logic models** that explore the relationship between output and outcome indicators
- **Consider opportunities to build these metrics into business as usual as part of the evolving process for strategic commissioning** –
    - How will these metrics inform quality and performance processes?
    - How do we ensure we have mechanisms to triangulate data when reviewing neighbourhood and locality outcomes?
    - What is the assurance process to ensure this intelligence is being used to inform resource allocation is proportionate to need?

Phase 3: Review and refine performance monitoring and outcome indicator set (Autumn 2025)

Priorities in phase 3 will include ongoing refresh of data quality – with repeat analysis and findings incorporated into business-as-usual Integrated Care Board (ICB) performance.

Data quality

Demographic data available for the Health Inequalities statement metrics is variable as the completeness and accuracy of recording of ethnicity, country of birth, religion, sexuality or language varies across different NHS datasets (see table 1). This report, therefore, presents an initial analysis, based on current demographic data available at locality and GM level.

Table 1: Data Source estimated percentage of records with missing fields or not specified/unknown for ethnicity and sex

Data Source	**Notes – estimated % of records that have missing fields or categorised as not specified or unknown**	**Notes – estimated % of records that have missing fields or categorised as not specified or unknown**

	Ethnicity	Sex
Mental Health Services Data Set	25%	1%
Emergency Care Data Set	10%	0.3%
Outpatient Appointments	16%	1.7%
Maternity Services Data Set	11%	8.8%

Further work is underway to improve completeness of ethnicity and gender recording, by linking the Master Patient Index to all intelligence hub dashboard, and then to produce age-standardised rates, segmented by ethnicity and gender. Equally, a review of mortality trends by ethnicity and neighbourhood level is also underway and due to be completed by Autumn 2025.

Neighbourhood level data

The analysis compares morbidity and mortality trends between GM and the national average and between the ten localities. Some indicators show comparison between Trusts where relevant. However, neighbourhood level analysis is not yet available as work is ongoing to develop the geospatial boundaries for the neighbourhoods and population size in order to calculate rates. It is anticipated this neighbourhood analysis will be completed by Autumn 2025 and then incorporated into dashboard developments throughout the 2025/26 financial year.

A neighbourhood intelligence task and finish group is managing the development of neighbourhood and Primary Care Network (PCN) level dashboards and will engage with Local Care Organisations to consider new requirements for Neighbourhood Health Providers as part of NHS reform.

Trend data

The analysis of the Fairer Health for All outcome metrics review morbidity and mortality trends between two different time points. It is important to be aware when interpreting these metrics that they present data from a range of time periods. For example, national mortality data on preventable and treatable mortality rates is reviewed over 3-year periods and the latest data available nationally is for 2021-2023. Whereas data on access to care is available for 24/25.

Further work is needed to model trajectories for the FHFA outcome metrics and to review relationships between metrics that monitor health behaviour, access and outcomes of care and longer-term outcome metrics like mortality. This trend analysis has been delayed due to limited intelligence capacity in NHS GM. The aim is to complete the trajectories by the end of the summer 2025.

This report was last updated 20/06/2025

Executive Summary

Best Start

Fairer Health for All Target: Reduce infant Mortality –Narrow the gap in infant mortality with England by 15% & close the school readiness gap.

First 1,000 Days

Positive progress on improving maternal health and the health of children in their first 1,000 days:

- **Preterm births (under 37 weeks) –** in 2024, 8.86% of all births across Greater Manchester and Eastern Cheshire were pre-term (GM Tableau 2024). Preterm birth is the single biggest contributory factor to adverse infant survival and quality of life and the lower the gestation, the greater the risk. Whilst we are seeing a downward trend, the rate remains above the national ambition of 6%.
- **Smoking in Pregnancy** - GM has its lowest ever Smoking at the time of delivery rates (5.7% in Quarter 2 (Q2) 24/25), tracking below the England average (6% in Q2 24/25). This equates to over 6000 smokefree babies to date since the inception of the programme in 2018
- **School readiness** - The proportion of children in Greater Manchester achieving a good level of development by the end of reception increased slightly, from 63.3% in 2022–2023 to 63.6% in 2023–2024 (narrowing the gap with the national average of 67.7%).

However, data on variation in oral health and infant mortality shows worrying signs that inequalities for children and young people remain:

- In 2024, one in three 5-year-old schoolchildren had experience of tooth decay in the deciduous dentition. This was the fourth highest proportion reported at any ICB in England. Children living in areas categorised as the most deprived 20% were more than twice as likely to have experienced tooth decay as those in the least deprived 20% with twice the number of affected teeth and more severe decay, and this social inequality widens across the life course.
- **Rates of infant mortality are increasing in GM** The latest data (2022-2024) shows an increase in infant mortality in all localities apart from Rochdale (see figure 1).

CORE20PLUS5

Early analysis of variation in access and uptake of primary care, community and outpatient services for 5 clinical CORE20PLUS5 pathways (see figure 2) is highlighting cohorts of children that have underdiagnosis/delayed care seeking and high levels of unmet healthcare needs which is resulting in high demand for 111/999/urgent care e.g. Girls (aged 0-17) living in areas of high deprivation (lowest quintile – core 20) have significantly higher rates of urgent care attendance

for asthma and for diabetes, and referrals rates into mental health therapy (Improving Access to Psychological Therapies (IAPT)) compared to girls living in less deprived areas.

Figure 1: Infant mortality rate, GM v England, all available periods

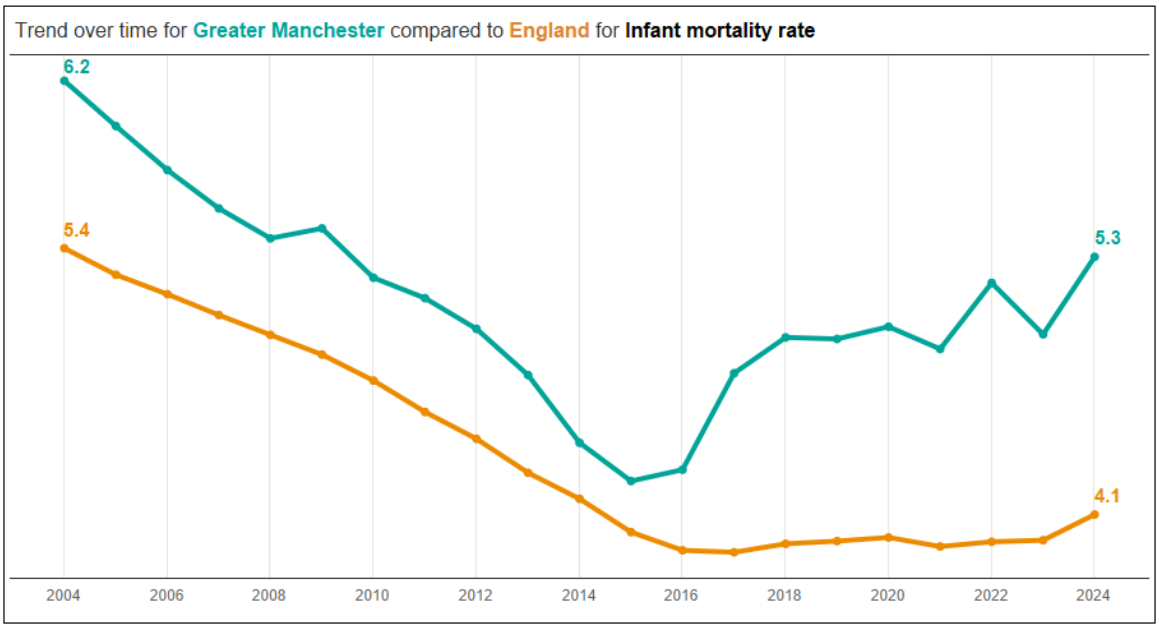
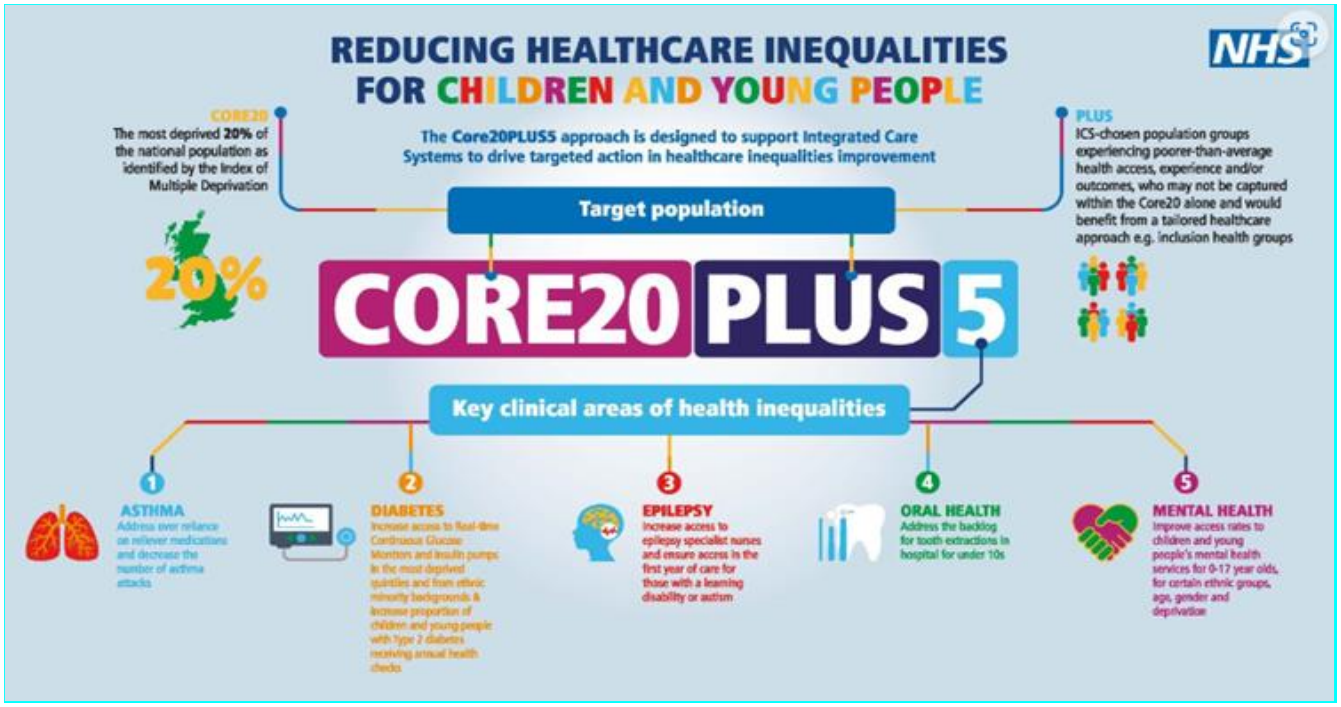


Figure 2: CORE20PLUS5 for children and young people



Hospital admissions

- **Rate of emergency admissions for children aged 0-17 reduced by 1.2% between 2023/24 and 2024/25**. However, inequalities remain, with variation across localities - Manchester and Trafford saw the biggest decline and Wigan saw a large increase (+5.2%).

- **Elective activity vs pre-pandemic levels for under 18s** increased in 2025 compared to pre-pandemic levels (2019/2020) - there was a 2% increase for Outpatient activity but a 2% decrease for Inpatient activity. Two specialties (Ear, Nose and Throat (ENT) and Oral) account for 70% of the Children and Young People (CYP) challenge.
- **Tooth decay is still the most common reason for hospital admission** in children aged between 5 and 9 years.
- Wigan, Stockport, Tameside, and Salford all have under-18 alcohol-related hospitalisation rates above the national average.

Next Steps – Key Lines of Enquiry

A CYP workshop will be convened in summer 2025 to review key findings, triangulate these with insight from people with lived experience and wider public sector data, to better understand:

- **Thematic review of infant mortality -** Do we have a good understanding of what is driving the trends in each area?
- **Review of variation in access to oral health improvement, dental services and dental treatment**
- **Review of variation in emergency admission rates –**What can we learn from localities that have lower rates/decreasing emergency admission rates? What does this shared intelligence tell us about
    - health needs and assets of specific communities of interest, identify and geography which shape an individual's opportunity to stay well?
    - Variation in access, experience and outcomes of care in different communities and how this is changing over time. What is/isn't improving health outcomes for specific communities? And why? How are we using this shared intelligence to inform how we prioritise prevention and how care is delivered?
- What further Key Lines of Enquiry do we want to prioritise? And how will that shape emerging prevention priorities and research needs? Are these the right metrics to monitor health inequalities for CYP at system level? Is there any key data gaps – and how are we addressing those gaps?

Trends in Life expectancy

Fairer Health for All Target: Improve the Health & Wellbeing to narrow the gap in life expectancy and healthy life expectancy –Narrow the gap by at least 15% between Men and Women living in GM between all 10 localities in GM, as well as between GM & England average.

- Healthy Life Expectancy (HLE) is lower in GM than England for both males (61.4 years GM, 63.1 years national) and females (60.9 years GM, 63.9 years national) for the 3-year period 2018-20.
- HLE is greater in males than females and males have seen a greater increase in HLE between 2014-16 and 2018-20 compared to females.
- Between 2020-2022 and 2021-2023 in GM:
  - Under 75 cancer mortality rates have continued to reduce for both males and females
  - Under 75 mortality rates from CVD have increased (greater increase for females than males) although reduced in 4 localities (Manchester, Oldham, Rochdale and Tameside)
  - Under 75 mortality rates from and respiratory disease have also increased
    - Greater increase for males than females
    - Only 3 out 10 local authorities (Bolton, Manchester and Salford) showed reduction in respiratory mortality

Trends in multi-morbidity and in access and outcomes of care

Fairer Health for All Target: Increased social & economic activity because of reduced ill health – Narrow the 15-year gap in the onset of multiple morbidities between the poorest & wealthiest sections of the population to 5 years.

There is a 15-year age gap in multi-morbidity rates. In the most deprived neighbourhoods, by the time people reach age 50-54, 40% have multiple long-term conditions. Whereas in the least deprived neighbourhoods, people develop multiple long term conditions (LTC) later - it isn't until people are aged 60-64 that they have equivalent rates of multi-morbidity.

Trends in Proactive care

Target: Reduce unwarranted variation in health outcomes and experiences – Eliminate the difference between the highest & lowest social groups in the experience of having 2 or more multiple health harming behaviours.

Variation in health behaviours and in access to prevention, early intervention and diagnostic services is reviewed for the following care pathways:

- Health Checks
- COVID-19 and flu vaccine uptake
- Cancer
- Cardiovascular disease
- Mental health

This is the first phase of analysis which reviews locality and GM trends using NHS datasets. Once the neighbourhood level data is available this will provide a more complete understanding of variation in proactive care.

Trends in Health Behaviour

Measuring trends in health-harming behaviour requires a combination of different data sources, including:

1. **Self-reported data on smoking, levels of physical activity and alcohol use from national surveys** which enables us to benchmark GM against other regions/national data.
2. **Data captured in healthcare records as part of routine screening** questions on smoking, physical activity and alcohol use and referral onto behaviour change services or social prescribing. This data is recorded in the following settings:
    a) **primary care (General Practitioner (GP)/ pharmacy)**
    b) **secondary care**
3. **Service level data collected through behaviour change/health and well-being services** (public sector, independent sector and Voluntary Community Sector and Faith Enterprise (VCSFE) providers).

The findings in the first phase of the analysis summarise national trend data which shows:

- ***Adult smoking prevalence continues to reduce*** - Since the Making Smoking History programme began in 2017, the prevalence of smokers has decreased from 18.4% of the GM population to 12.5% of adults in 2023. The proportion of inpatient and maternity settings offering smoking cessation is 100%.

- **Physical activity rates are lower in GM than the national average,** with some significant inequalities by place and demographic group. Greater Manchester activity levels were significantly impacted during the pandemic, but recovered faster than the national rate of recovery, with some key inequality gaps closing. In the last year, levels have stabilised, with no statistically significant change across any of the ten boroughs. Inequalities data will be released in the summer, where further analysis can be done, to steer targeted work across the system.

Health Checks

- NHS Greater Manchester has continued to improve delivery of Learning Disability (LD) Annual Health checks, delivering approximately 10% more checks in 2024-25 than the previous year. At the end of Quarter 3 (Q3) 2024, NHS Greater Manchester had delivered 10,630 checks of a total of 18,070 people on GP LD registers (58.53%). Of the people who have received checks to date this year, 98% have a completed health action plan. Whilst the number of people on LD registers in Greater Manchester has grown in the last two years, a focus on increasing the number of people on registers is required working with social care to ensure that people are not missed.

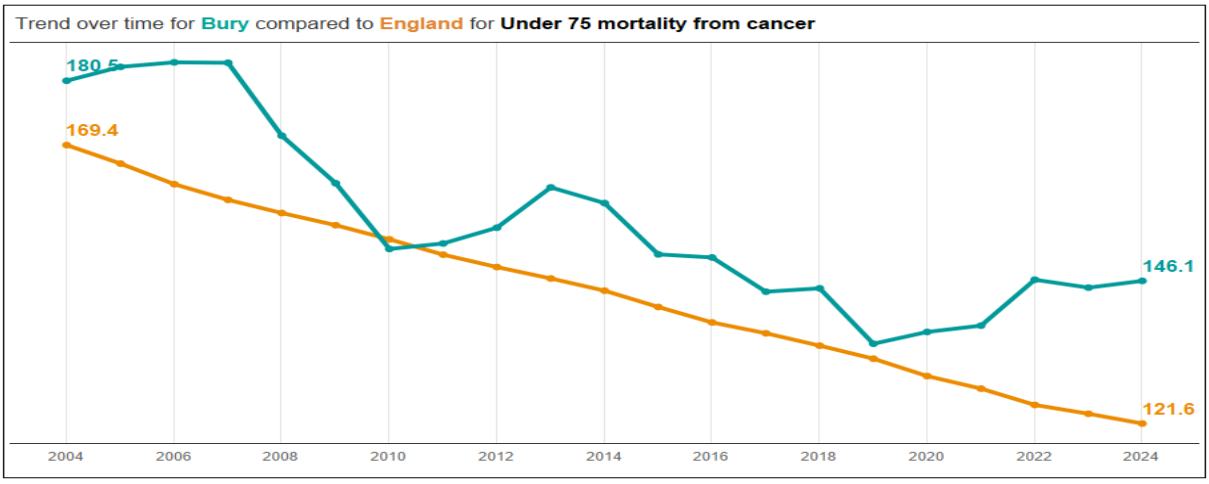
Immunisations

- COVID-19 and flu vaccine uptake has declined year-on-year, mirroring national trends:
    - COVID-19 vaccine uptake dropped from 45% in 2023/24 to 36% in 2024/25
    - Flu vaccine uptake decreased by 3% across most eligible cohorts, except for pregnant women.

Cancer

- **Cancer early diagnosis -** There is a 7.56% difference in early diagnosis between our most and least deprived communities and an 8.88% difference between males and females with males being less likely to be diagnosed early. Some of this difference is explained by difference in cancer type.
- ***Cancer* under 75 cancer mortality rates have continued to reduce** between 2020-22 and 2021-23 for both males and females but remain higher than the national rate. Cancer mortality rates are higher in males. Bury was the only locality that saw an increase in cancer mortality (see figure 3) and Salford had the sharpest decrease.

Figure 3: Under 75 mortality from cancer, Bury v England



Cardiovascular disease (CVD)

Greater Manchester continues to make significant progress on cardiovascular disease secondary prevention, achieving targets for Lipid Management in High-Risk Patients, hypertension treated to target, statin use in established CVD and Low-density Lipoprotein (LDL) optimisation.

However, there is variation in non -elective admission rates for heart attacks (myocardial infarction) and strokes across localities. Tameside has significantly higher admission rates, whereas Stockport, Trafford, and Wigan perform comparatively better, with significantly lower admission rates (43.2% of all admissions for heart attack in the past three years were in people living in the most deprived quintile).

Cardiovascular disease mortality **rates** remain higher than the national average and GM rates increased in 2020 to 2022, although reduced in 4 localities (Manchester, Oldham, Rochdale and Tameside). Bury had the greatest increase and is now the furthest away from the national average it has ever been across all available periods.

Mental Health

- **Overall number of adults with severe mental illness (SMI) who received a physical health check** in 2024/25 has increased from 2023/24. Comparison of uptake rates by ethnicity is not currently possible, however further work is planned to enable this.
- **Rates of total Mental Health Act detentions:** The latest all-age data available from the national dashboard, for Mental Health Act detentions, is for 2023/24. It reports that Greater Manchester (GM) ICB has a crude rate of detentions per 100,000 population of 118. This compares to just 90.9 for all ICB's. The rate of Mental Health Act detentions overall in GM, is significantly higher than the national average, and the fifth highest overall.
- **Rates of restrictive interventions** are higher in Greater Manchester Mental Health (GMMH), than Pennine Care Foundation Trust (PCFT), but this may be in relation to their secure services. Rates of restrictive interventions are higher in people from ethnic minority groups, significantly higher in under 18s than adults, and significantly higher in non-NHS providers than NHS providers.
- **Talking Therapies recovery rate** remains below the national standard, with the main issue being the split commissioning of Step 2 and Step 3 services, creating separate care episodes per patient. To address this GM are working to align providers onto a shared patient care management information system (PCMIS) to enable consistent reporting.
- **CYP Mental Health access rate:** GM continues to exceed its access target rate for CYP community mental health services. This includes contributions from GMMH, PCFT, Manchester Foundation Trust (MFT) and third sector providers. However, access remains unequal, with variation by ethnicity, deprivation, gender, age, and locality. Work is underway to address this.
- **Adult mental health inpatient rates for people with a learning disability and autistic people:** At the end of February 2025, NHS Greater Manchester had 114 inpatients with learning disabilities and/or Autism in mental health beds against a target of 77.

Elective Recovery

During 2024, GM has driven a sustained and targeted reduction in long-waiting patients. Waiting time profiles in terms of average weeks wait varies by ethnicity and deprivation ranged from:

- 19.9 weeks (White) to 21.1 weeks (Black or Black British/Mixed) – a reduction of 0.4 percentage points over 12 months. Although it should be noted that ethnicity recording varies by provider, therefore this analysis will be refreshed later in the year when ethnicity data is more complete.
- 19.7 weeks for the least deprived decile to 20.2 weeks for the most deprived decile. People are more likely to wait longer from more deprived deciles in Trauma and Orthopaedics and Gynaecology in GM. Asian/British Asian are waiting longer consistently in four specialties in GM.

FHFA Outcome Framework Summary

A summary is shown below of FHFA outcome framework metrics for Greater Manchester. The latest data presents a mixed picture in GM, with some positive changes, but many indicators remaining below the national average. Below is a quadrant analysis of these metrics:

	Worse than Target or National	Better than Target or National
Improved	• Female life expectancy • Male life expectancy • Smoking prevalence for adults • Under 75 mortality from cancer • All age all-cause mortality • Percentage of children achieving a good level of development at the end of reception	• People with SMI who received all six physical health checks in the proceeding 12 months (matching national)
Worsened	• Under 75 mortality from cardiovascular disease • Under 75 mortality from respiratory disease • Under 75 avoidable mortality rate • Percentage of physically active adults • Under 75 preventable mortality rate • Under 75 treatable mortality rate • Infant mortality rate	• Hospital admissions for alcohol related conditions

Next Steps – Key Lines of Enquiry:

The next phase of the review will be to convene a workshop with people working across localities in order to:

- Review key findings and consider how the system intelligence triangulates with local intelligence
- Reflect on how we are using this intelligence alongside local data and insight and VCSFE partnerships to inform:

- ❖ *'Where'* care (prevention and treatment) is delivered.
- ❖ How we prioritise and target care for particular communities and neighbourhoods
- ❖ *'How'* care is delivered – how are we co-designing culturally appropriate and accessible services that also mitigate against the impact of poverty on health and digital exclusion.

- Review the relevance of the FHFA outcome and HI metrics –
- Develop Logic models that explore the relationship between output and outcome indicators e.g. to explore variation in CVD proactive care (secondary prevention), health behaviours, wider social factors (e.g. housing conditions), urgent care usage and mortality.
- Consider opportunities to build these metrics into business as usual as part of the evolving process for strategic commissioning.

Further analysis is required once the neighbourhood/Primary Care Network (PCN) data is available to understand variation by neighbourhood/provider and to explore the relationship between health behaviour, health checks and health outcomes.

End of Executive Summary

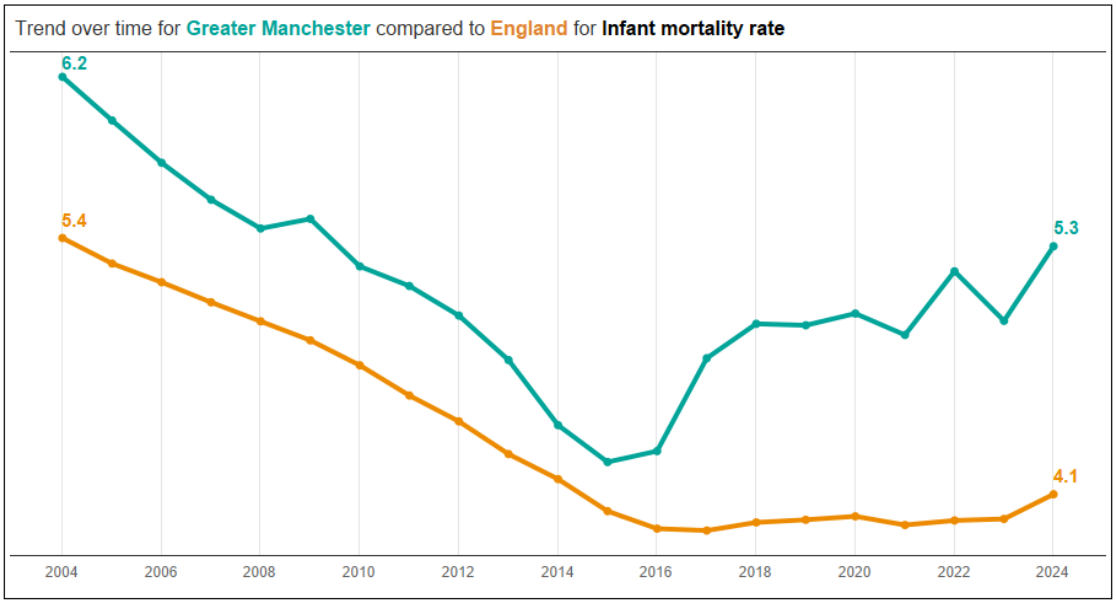
Best Start

Fairer Health for All Target: Reduce infant Mortality –Narrow the gap in infant mortality with England by 15% & close the school readiness gap.

1st 1,000 Days

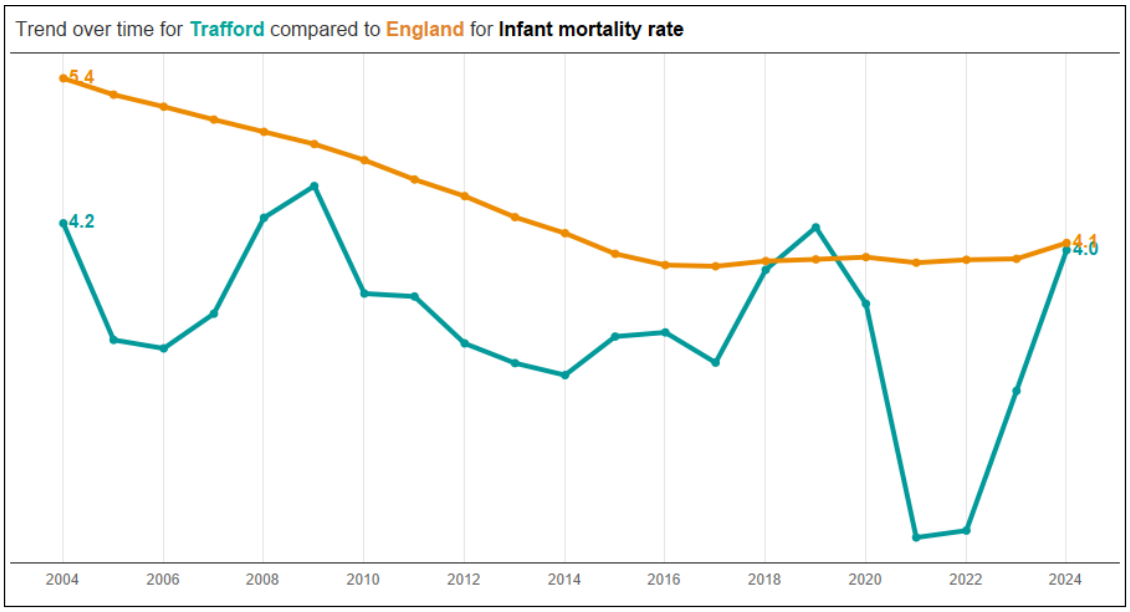
The infant mortality rate in Greater Manchester increased from 4.9 per 1,000 live births in the 2020 to 2022 period to 5.3 per 1,000 live births in the 2021 to 2023 period. This is above the national average of 4.1 per 1,000. While this follows the national trend, an increase from 3.9 per 1,000 live births, it now means that Greater Manchester is the furthest away from the national average compared to all other time periods. The plot below shows the trend between Greater Manchester and England across all available periods.

Figure 4: Infant mortality rate, GM v England, all available periods



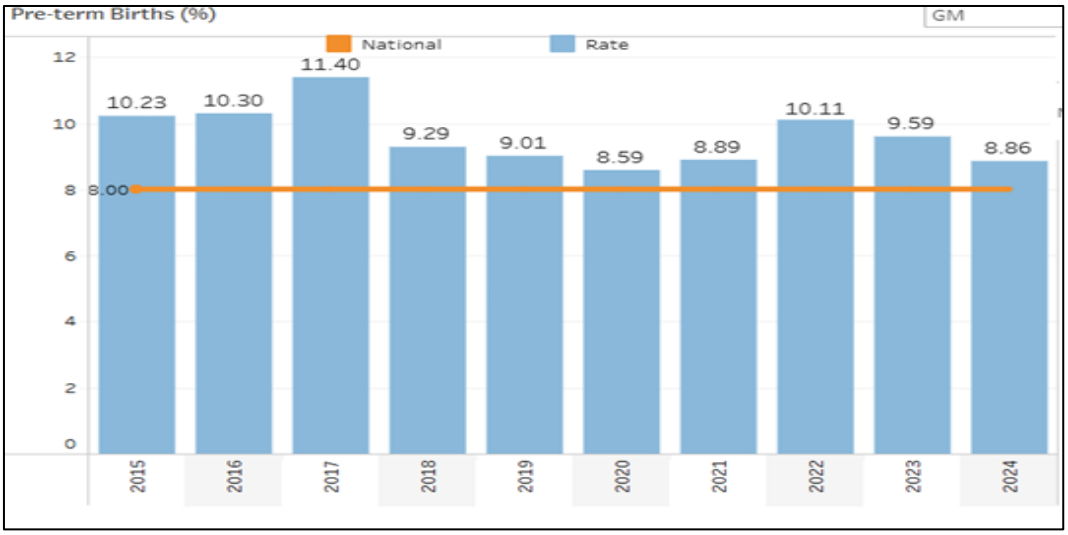
Inside Greater Manchester, 9 out of 10 local authority areas saw an increase in infant mortality rates. Trafford saw the sharpest increase over the last two periods, moving from 1.8 per 100,000 in the 2019 to 2021 period to 4 per 100,000 in the 2021 to 2023 period. The plot overleaf shows Trafford against the national average over time:

Figure 5: Infant mortality rate, Trafford v England, all available periods



Preterm births (under 37 weeks) – in 2024, 8.86% of all births across Greater Manchester and Eastern Cheshire were pre-term (GM Tableau 2024). Preterm birth is the single biggest contributory factor to adverse infant survival and quality of life and the lower the gestation, the greater the risk. Whilst we are seeing a downward trend, the rate remains above the national ambition of 6%.

Figure 6 Trend over time from 2015 to 2024 of preterm births (percentage) in Greater Manchester compared to National.



Greater Manchester and Eastern Cheshire Strategic Clinical Network has undertaken a significant amount of work to date, to identify women at risk of preterm birth. The withdrawal of Quantitative Fetal Fibronectin (a robust diagnostic test) was a significant backward step in terms of identifying preterm labour and no equivalent investigation exists currently. To combat this, Greater Manchester and Eastern Cheshire maternity providers have been supported to introduce Actim Partus, a test that indicates the possibility of preterm labour.

More than 50% of preterm births are to women with no identified risk factors and in response to this work has taken place with the Local Maternity and Neonatal Voice Partnership leads to coproduce a 'Signs and Symptoms of Preterm Birth' leaflet, that will be given to every woman in early pregnancy across the Northwest. This leaflet will be translated into key languages and will be printed for those women who cannot access a digital format. Further work will be undertaken to link the Equity and Equality action plan with preterm birth services.

Within Greater Manchester, babies are at greater risk of being born preterm if they are from the most deprived decile e.g. in November 2023 babies from the most deprived decile were nearly 7 times more likely to be born preterm than those in the least deprived decile, in November 2024 preterm babies were 8 times more likely to be from the most deprived decile than being from the least deprived decile. The majority of babies born before 37 weeks gestation were in the 30-34 week age group (November 23 approximately 30% and November 24 approximately 39%). In terms of ethnicity-whilst the majority of preterm births in Greater Manchester are born to white women, babies of Black and Asian ethnicity are over-represented in the preterm birth group in comparison to babies of white ethnicity.

The overall compliance of Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System in relation to the infant optimisation work is 73% which is one of the highest rates nationally, and in some interventions, Greater Manchester and Eastern Cheshire is excelling. It is known that despite best efforts in predicting or preventing preterm birth - they can still occur, and so this work in preparing for the preterm birth infant is essential in improving outcomes.

School readiness - The **proportion of children in Greater Manchester achieving a good level of development by the end of reception** increased slightly, from 63.3% in 2022–2023 to 63.6% in 2023–2024. However, this figure still lags behind the national average of 67.7% and there is a difference between boys and girls:

For girls, this increased from 70.4% to 71.5% while boys saw a decrease from 56.5% to 56.1%. 4 areas inside Greater Manchester saw decreases from the 2022 to 2023 period. Salford saw the sharpest decrease from 61.5% to 60.7%.

Oral Health

Dental caries (tooth decay) is largely a preventable disease. We have worked hard with partners across our system to improve the oral health of our children, but it remains a significant health and social problem in Greater Manchester. It results in destruction of the teeth and frequently leads to pain and infection. Poor oral health has an impact on children and their families. It can affect a child's ability to eat, sleep and take part in normal activities with time of school and work for parents to bring children to the dentist for treatment. Dental disease is at least three times more common in deprived areas, compared to affluent communities.

Measures of oral health in childhood are a good direct measure of dental health and an indirect, proxy measure of child health and the child's uptake of health improving behaviours and access to health care services. They are one of the earliest indicators of health inequality. Dental decay

in childhood may be an indication that a child has not received or accessed health improving self-care and or, had a healthy diet.

Two national statistics were published in February 2025

1. **National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5-year-old schoolchildren, 2024 - a report on the prevalence and severity of dental decay**

2. **Hospital tooth extractions in 0- to 19-year-olds, 2023 – 2024**

These statistics should be included in a suite of metrics for monitoring and evaluation of whole-systems approach to improve the oral health improvement of our children. The suite of metrics would include short-term service monitoring outputs and these longer-term population evaluation outcomes:

- Prevalence & severity: proportion (%) of 5-year-olds with experience of visually obvious dental decay; average number of decayed teeth in 5-year-olds with experience of visually obvious dental decay; presence or absence of plaque on the teeth of 5-year-old children
- Dental access: proportion of decayed teeth that have been treated at 5-year-old (Care Index); number of finished consultant episodes (FCEs) where a tooth extraction was performed on a child to age 10 years at the start of the episode of care, due to tooth decay, per 100,000 resident population; to be used with service waiting list numbers and waiting time.

National Dental Epidemiology Programme, 2024

In Greater Manchester ICB, it was found that 30.4% (Northwest 28.7%, England 22.4%) of 5-year-old schoolchildren who participated in the survey had experience of obvious dentinal tooth decay in the deciduous dentition. This was the fourth highest proportion reported at any ICB in England. Of the 25 Lower Tier Local Authorities (LTLAs) with the highest proportion of children with experience of tooth decay, four are in Greater Manchester (Manchester, Salford, Oldham and Bolton). At LTLA, the proportion of 5-year-old schoolchildren with experience of tooth decay ranged from 18.2% in Stockport to 38.2% in Manchester. Children with obvious tooth decay had four or five affected baby teeth.

The prevalence of enamel caries and /or dentinal decay experienced in the Greater Manchester ICB (39.1%) was comparably the highest of any ICB (North West (NW) 36.8%, England 26.9%). The reported proportion of children with enamel and/or any dentinal decay, was lowest in Bury (25.1%) and highest in Manchester (60.8%). It is important to look at enamel decay as it is possible to implement preventive measures to help halt the progression of enamel decay to obvious dentinal decay and prevent these children from needing invasive dentistry (fillings) to restore loss of tooth structure and extractions in the future.

Most 5-year-old children's decayed teeth across the region were untreated. The Care Index is the proportion (%) of decayed deciduous teeth treated by filling, varied between LAs with the lowest Care Index reported in children in Rochdale (4.0%) and the highest in Salford (9.9%) (GM ICB 6.8%, NW 7.4%, England 10.5%). Caution should be taken in making any assumptions about the extent or the quality of clinical care available when using the Care Index.

Hospital tooth extractions in 0- to 19-year-olds, 2024

Tooth decay is still the most common reason for hospital admission in children aged between 5 and 9 years. Dental extractions in hospital can be an indication that a child may not have received or accessed appropriate oral health improvement self-care, such as toothbrushing with a fluoride toothpaste, and/or primary care dental services as the dental cavities they experience is severe enough to require hospital treatment. In addition, hospital admissions rates for tooth extraction correlate with deprivation – and numbers are higher for children living in the most deprived decile.

In 2024, there were 3,555 episodes of tooth extractions in NHS GM hospitals for children and young people aged 0- to 19-year-olds resident in the region (England 49 112). This represents a rate of 482 episodes per 100 000 children (England 368 per 100 000 children). The total number of hospital episodes for tooth extraction has increased since last year but is still lower than the pre-pandemic figure of 5190 episodes in 2019.

Of the total in 2024, there were 2705 episodes of decay-related tooth extractions for 0- to 19-year-olds (England 30 587). This represents 76.1% of all tooth extraction episodes for children to age 19-years (England 62.3%) i.e. some episodes are for tooth extractions but are not coded for a diagnosis of decay-related tooth extraction.

There were 1885 decay-related extraction episodes in NHS GM hospitals for children up to the age of 10-years. This was a rate of 181.2 and 837.0 episodes per 100 000 children aged 0-4 years and 5-9 years respectively (England 124.9 and 527.5 per 100 000 children).

There were variations by Lower Tier Local Authority in the rates of decay-related tooth extraction episodes. The highest rate of decay-related tooth extraction episodes occurred in Wigan, (523.0 per 100 000 population of 0- to 19-year-olds with the proportion of decay-related tooth extraction episode 77.9%). The lowest rate was reported in Oldham (194.2 with the proportion of decay-related tooth extraction episode 64.3%).

In 2024/25, a range of programmes to reduce inequalities in oral health were delivered including a targeted Oral Health Improvement Programme, a Quality Access Scheme, a Looked After Child e-referral scheme and Child Friendly Dental Practices. It is anticipated that these schemes will continue throughout 2025/26 but is dependent on funding being approved through the ICB Governance structures.

Urgent and Emergency Care

Emergency admissions for children under 18 serves as a crucial indicator of population health, reflecting both acute healthcare needs and broader socioeconomic and systemic health factors. Overall, emergency admissions for children aged 0-17 have reduced by 1.2% between 2023/24

and 2024/25, with a large reduction of admissions due to respiratory conditions (-24.5 % across GM).

The reduction in admissions was greater in the least deprived areas of Greater Manchester. Admissions from the 50% most deprived areas saw an average decrease of 0.4%. Admissions from the 50% least deprived areas saw a average decrease of 1.2%. Admissions from non-white populations increased by an average of 3.4%, while white populations saw a decrease of 6.4%.

However, significant variations exists by geography and ethnicity. Manchester and Trafford saw a decline in under 18 emergency admissions, which may suggest improved healthcare interventions or changes in patient pathways. Conversely, admissions increased in Wigan (+5.2%). Increases in emergency admissions could indicate:

- Poor access to GP services and preventive care
- High levels of unmet healthcare needs
- Exposure to violence/trauma in the home/school setting/public space
- Change in alcohol/substance misuse - Wigan, Stockport, Tameside, and Salford all have under-18 alcohol-related hospitalisation rates above the national average.
- Delayed care-seeking due to low health awareness
- Poor housing, employment, education, and environmental conditions
- Food insecurity and poor nutrition affecting childhood development.

CORE20PLUS5

Early analysis of variation in access and uptake of primary care, community and outpatient services for 5 clinical CORE20PLUS5 pathways (see figure 6) is highlighting cohorts of children that have underdiagnosis/delayed care seeking and high levels of unmet healthcare needs which is resulting in high demand for 111/999/urgent care e.g. Girls (aged 0-17) living in areas of high deprivation (lowest quintile – core 20) have significantly higher rates of urgent care attendance for asthma and for diabetes, and referrals rates into mental health therapy (IAPT) compared to girls living in less deprived areas.

Figure 7: CORE20PLUS5 for Children and Young People

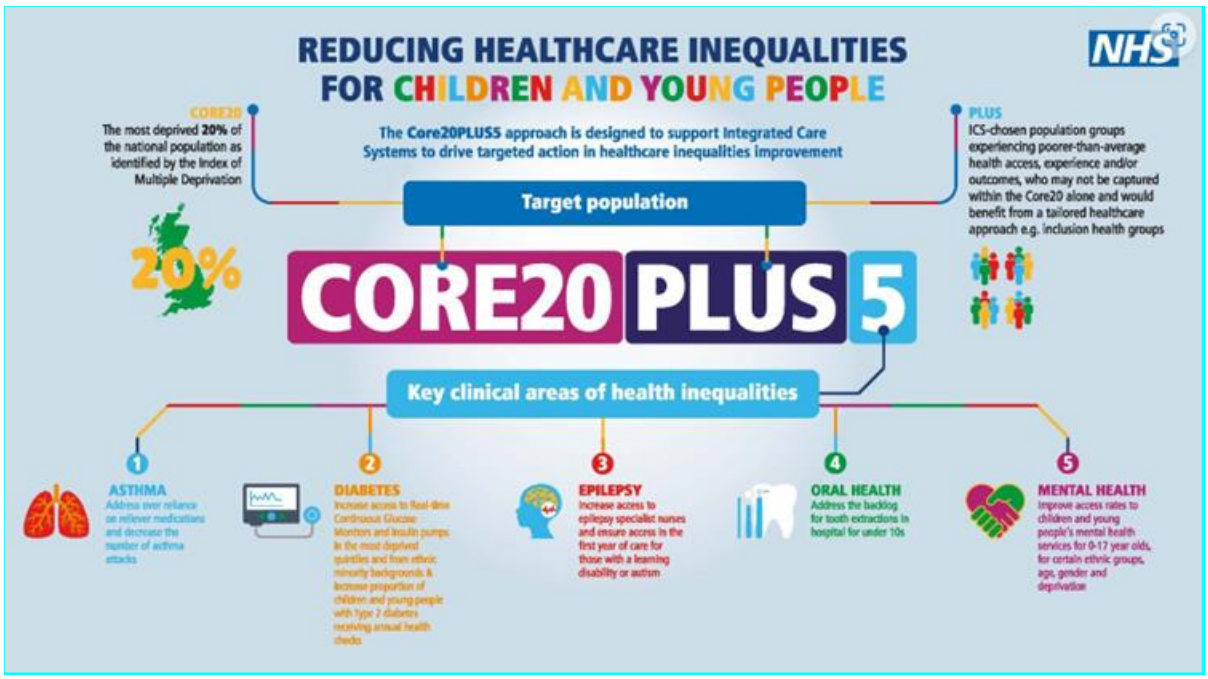


Table 2: Maternal and Children and Young People Inequalities Metrics

	Trend	**Comparison with national average**	Deteriorating **Locality perspective/Outliers**	Improving **Locality perspective/Outliers**
Smoke Free pregnancy	Downward (green)	5.7% (Q2 24/25), tracking below the England average (6% Q2 24/25)		
Preterm births under 37 weeks	Downward (green)	In 2024, 8.86% of all births across Greater Manchester and Eastern Cheshire were preterm (GM Tableau 2024) there is a downward trend in Greater Manchester but the rate remains above the national average of 7.93% in 2024 (NHS Maternity Annual Statistics 23-24 MSDS data Microsoft Power BI) and above the national ambition of 6%	Provider specific data latest 12 months as of 4.6.25 showing deterioration • Bolton (8.27%) • MFT Oxford Road (11.23%) • Stockport (8.25%) • Tameside (8.73%) • Wigan (8.65%)	Provider specific data latest 12 months as of 4.6.25 showing improvement • East Cheshire (6.85%) • MFT North Manchester (6.91%) • MFT Wythenshawe (7.11%) • NCA Oldham (8.10%)
Infant Mortality	Increase (red)	GM rate in 2021-23 is 29% higher than the national average	9 out of 10 local authority areas saw an increase in infant mortality rates	Rochdale
School Readiness 2022–2023 to 2023–2024	Improvement (amber) 63.3% to 63.6%	Lower than national average	Bolton, Bury, Rochdale and Salford localities saw decreases Salford saw the sharpest decrease from 61.5% to 60.7%	
Oral Health - prevalence of enamel caries and		GM rate is 30.4% highest of any ICB (NW 28.7%, England 22.4%).	Manchester, Salford, Oldham and Bolton	lowest in Stockport (18.2%)

/or dentinal decay date				
Hospital admission for tooth extraction (2024 data)	Increased (but still lower than pre-pandemic)	rate of 482 episodes per 100 000 children (England 368 per 100 000 children	highest rate in Wigan, (523.0 per 100 000 population of 0- to 19-year-olds with the proportion of decay-related tooth extraction episode 77.9%)	lowest in Oldham (194.2 with the proportion of decay-related tooth extraction episode 64.3%).

Healthy Life Expectancy

Fairer Health for All Target: Improve the Health & Wellbeing to narrow the gap in life expectancy and healthy life expectancy –Narrow the gap by at least 15% between Men and Women living in GM between all 10 localities in GM, as well as between GM & England average.

Healthy life expectancy at birth (HLE) is an estimate of the number of years a newborn baby would live in good health if they experienced the age specific mortality rates and prevalence of self-reported good health for that area and time period throughout their life. Therefore, it is an estimate of the average number of years people would live in a state of good general health.

HLE is lower in GM than England figures for both males (61.4 years GM, 63.1 years national) and females (60.9 years GM, 63.9 years national) for the 3-year period 2018-20. HLE is greater in males than females and males have seen a greater increase in HLE between 2014-16 and 2018-20 compared to females. However, there is significant variation across localities:

- Salford has the lowest females HLE in GM
- Oldham has the lowest male HLE in GM and ranks in the bottom 10 localities nationally. Male HLE has been declining in Oldham between 2009-11 and 2018-20.
- Bury male HLE has been steadily increasing since a low point in 2014-2016 and is now above the national average. However, female HLA in Bury remains below the national average
- Manchester has seen steady increases in both male and female HLE since 2014-16
- Trafford HLE is above the England average for both males and females
- Female HLE has been steadily decreasing in Stockport since 2014-16 and is now less than the national average

Further analysis is required to compare the drivers behind the variation in HLE across localities by reviewing age specific mortality rates in each locality using the ADSP. This is planned as part of phase 2 analysis.

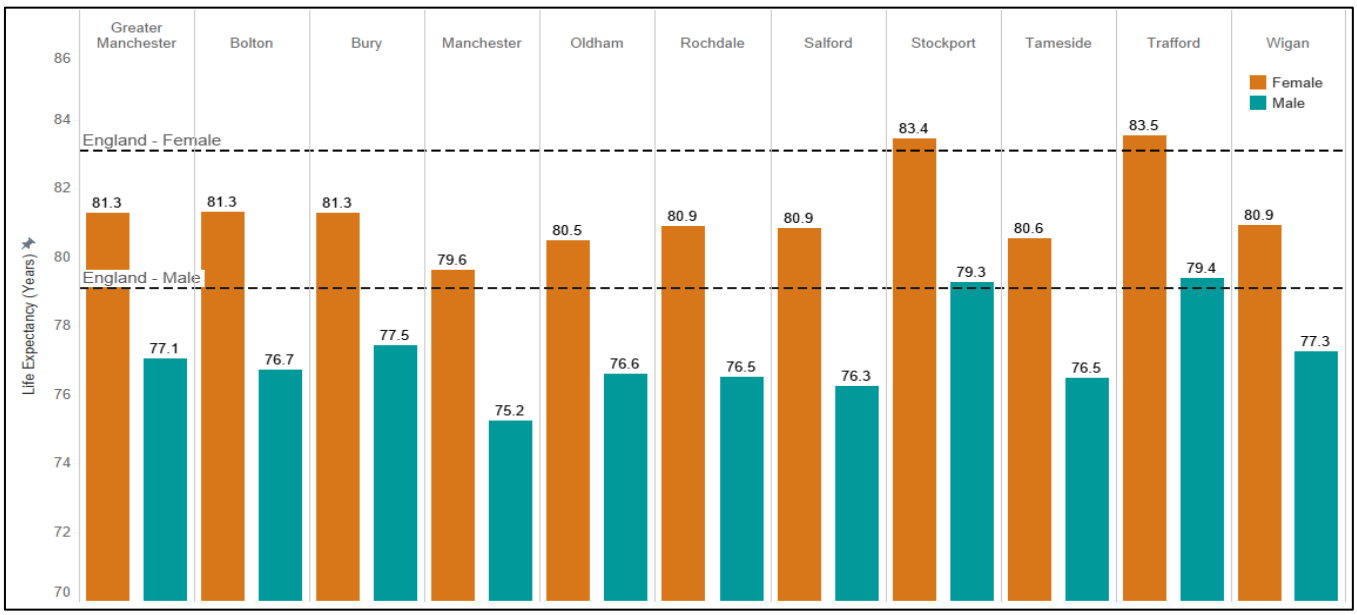
The HLE metric is calculated nationally by the Office of National Statistics (ONS), however it has been discontinued due to issues with sampling. In the future, there is an opportunity to calculate a similar metric to HLE utilising the self-reported health metrics in the GM residents survey and GM mortality data. This will enable a more detailed analysis that compares the drivers behind the variation in HLE across localities by reviewing age specific mortality rates in each locality and correlation with place-based indicators.

Life Expectancy

Life expectancy at birth in GM has been significantly impacted by the COVID-19 pandemic and the increased mortality reported in this period. As the ONS have commented, "While improvements in life expectancy have been slow for over a decade, the pandemic led to increased mortality in recent years; the impact of this is seen in lower period life expectancy estimates between 2018 to 2020 and 2021 to 2023" (Reference National life tables – life expectancy in the UK - Office for National Statistics (ons.gov.uk) 2021 to 2023, 23rd October 2024).

This plot below shows life expectancy values for areas in GM from the most recent 2021 to 2023 period which are lower than England average for females and males in all localities apart from Stockport and Trafford.

Figure 8: Life Expectancy by Local Authority and Sex, 2021 to 2023



See appendix C for a further breakdown of mortality trends for All age all-case mortality and Under 75 avoidable mortality - classified as deaths that are either preventable and/or treatable:

- **Preventable mortality** refers to causes of death that can be mainly avoided through effective public health and primary prevention interventions (Reference Avoidable mortality in England and Wales - Office for National Statistics (ons.gov.uk). These are things that intervene before someone has a disease or injury. Such as deaths caused by infectious diseases, certain types of cancer such as lung and skin cancer, diseases related to high blood pressure and heart disease, and injuries. COVID-19 is also included in preventable mortality causes of death.
- **Treatable mortality** refers to causes of death that can be avoided through healthcare interventions including secondary prevention. Meaning the interventions that happen once a person already has a disease. These include cancers such as colorectal and breast cancer, cardiovascular diseases and respiratory conditions such as asthma and

pneumonia, conditions of the digestive system and kidneys (Reference Workbook: Fairer Health for All Dashboard (gmtableau.nhs.uk)).
- Some conditions are classed as both preventable and treatable such as cardiovascular conditions, Tuberculosis (TB) and diabetes.

Rates of avoidable mortality increased significantly in 2020 during the first wave of the COVID-19 pandemic and have remained higher than pre-pandemic levels in all 10 localities. This is largely due to an increase in preventable mortality. Manchester has the highest avoidable mortality rate in GM and is ranked second worst in the country (2000-2002).

Trends in health behaviour

Target: Reduce unwarranted variation in health outcomes and experiences – Eliminate the difference between the highest & lowest social groups in the experience of having 2 or more multiple health harming behaviours.

Measuring trends in health-harming behaviour requires a combination of different data sources, including:

- **Self-reported data on smoking, levels of physical activity and alcohol use from national surveys** which enables us to benchmark GM against other regions/national data.
- **Data captured in healthcare records as part of routine screening** questions on smoking, physical activity and alcohol use and referral onto behaviour change services or social prescribing. This data is recorded in the following settings:
    - **primary care GP**
    - **primary care pharmacy**
    - **secondary care**

However, these questions are not consistently asked during all healthcare interactions, and they are not consistently recorded. Therefore, some of the variation in rates will be due to variation in screening rates and how the screening is conducted, coding and reporting by provider. Equally, 7.57% of patients have opted out of sharing their health records for secondary use purposes and these patients that opt-out may have differing rates of health-harming behaviours.

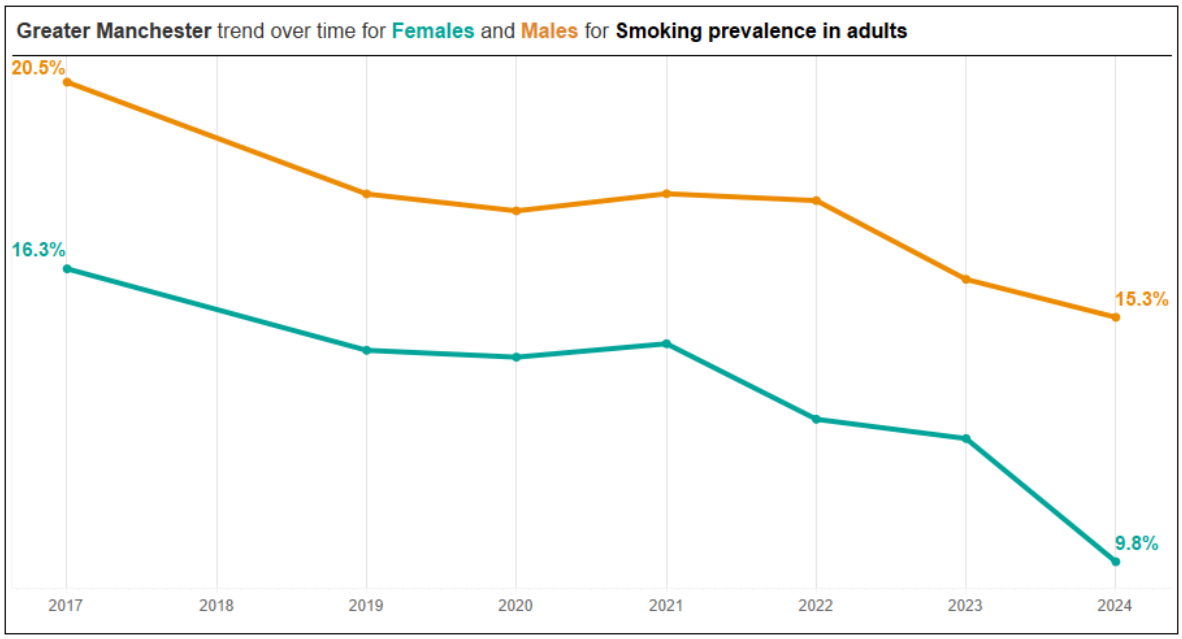
The findings overleaf summarise trends in smoking prevalence reviewing national surveys data and GM primary care data (data sources 1 and 2a).

Making Smoking History

Since the Making Smoking History programme began in 2017, the prevalence of smokers has decreased from 18.4% of the GM population to 12.5% of adults in 2024. This decrease was seen

for both female and males in the same period. For females, this decreased from 12.6% to 9.8% and for males this decreased from 16.1% to 15.3%. For the first time the female prevalence is below the national average:

Figure 9: Smoking prevalence in adults, GM, Females and Males, all available periods

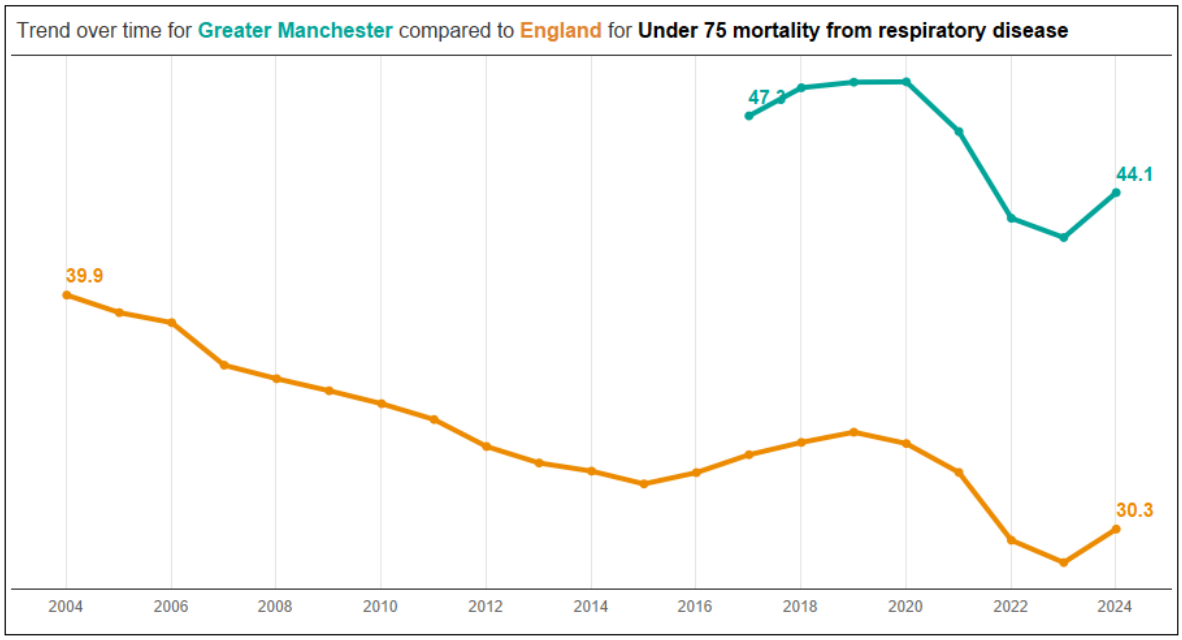


6 out of 10 localities saw decreases from the 2020 to 2022 period. Bolton, Oldham, Salford and Trafford saw increases. Manchester saw the largest decrease. However, Bolton, Oldham, Salford and Trafford saw increases. Trafford saw the largest increase in smoking prevalence, increasing from 8% to 9.6%. This was driven by an increase in smoking prevalence in males, moving from 6.8% to 12.2%. Females saw a decrease from 9.1% to 6.9%.

Smoking prevalence taken from GP records is higher than from national survey data (recorded as 15.5% in July 2024). As anticipated, these smoking prevalence rates are higher than national survey prevalence rates as people accessing primary care are more likely to have a long-term condition (and smoker have higher rates of illness). The GP data shows variation between ethnic groups ranges from 7.9% in the Black, African, Caribbean or Black British group to 17.4% in the White British group, i.e. people in the White British ethnic group are 2.2 times likely to be current smokers than people in the Black, African, Caribbean or Black British ethnic group. However, caution is needed when interpreting these rates as it may reflect differences in access to primary care, differences in coding (Manchester locality has been working with primary care colleagues to review coding for patients that use shisha or other forms of tobacco) or in patient-care giver interactions and trust in disclosing smoking status.

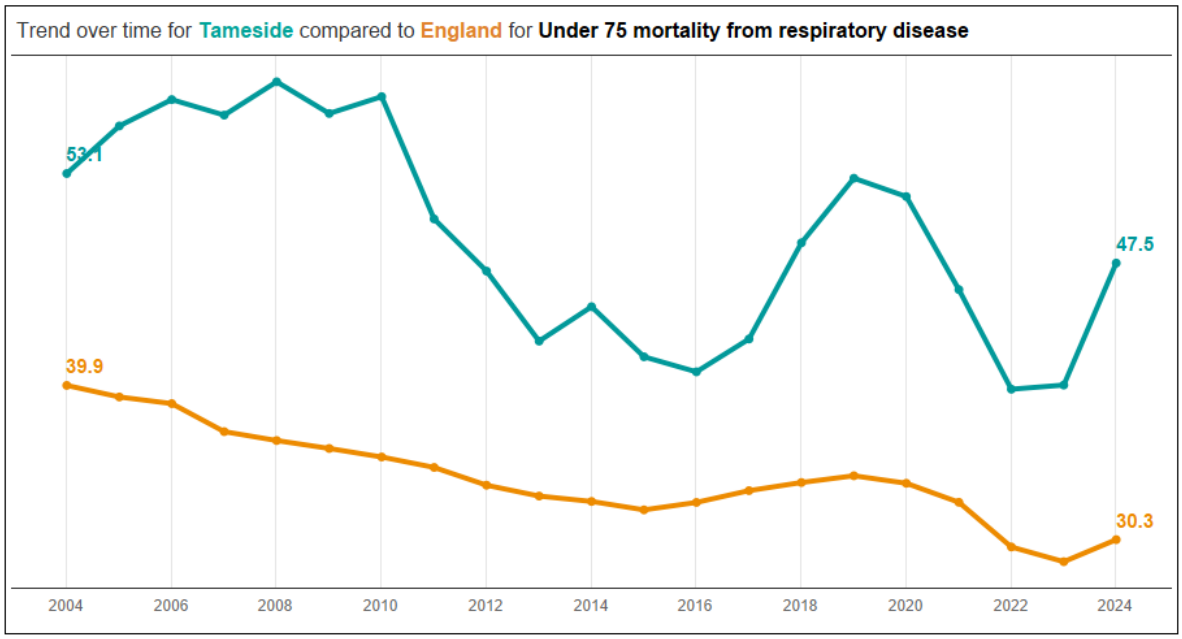
Under 75 cancer mortality rates for cancer have continued to reduce for both males and females but remains higher than the national rate (GM rate in 2023-23 was 46 % higher than the national average. However r*espiratory disease* under 75 mortality rates have increased and GM rates remain higher than the national average for males and females.

Figure 10: Under 75 mortality from respiratory disease, GM v England, all available periods



Only 3 out 10 localities (Bolton, Manchester and Salford) show reduction in respiratory mortality). Tameside had the greatest increase, from 39.9 per 100,00 to 47.5 per 100,000. Tameside is now the furthest away from the national average since 2016 to 2018 period. In the most recent period, this is being driven by males, who saw a greater increase in mortality than females.

Figure 11: Under 75 mortality from respiratory disease, Tameside v England, all available periods



Greater Manchester Moving

The proportion of physically active adults in Greater Manchester in 2021-22 remained at 64.1% in 2021–2022, below the national average of 67.1%.

- 5 Areas showed improved percentages in the most recent data, with Salford having the greatest increase moving from 58.5% to 67.5%.
- Oldham and Rochdale showed steep declines, moving from 62.7% to 57% and 60.9% to 54.6% respectively

Further data on variation in physical activity will be published in the summer as part of the Active Lives Survey.

Alcohol

Hospital admissions for alcohol-related conditions in Greater Manchester are **better the national average but worsened from the previous period** rose from 441.9 per 100,000 in 2022–2023 to 478.5 per 100,000 in 2023–2024 but remains 5% lower than the national rate of 504.1 per 100,000.

  - 9 out of 10 areas inside Greater Manchester saw increases from the 2022 to 2023 period. Oldham experienced the sharpest increase from 439.3 per 100,000 to 527.5 per 100,000.
  - Wigan was the only area that showed a decrease, moving from 490.7 per 100,000 to 485.7 per 100,000

- **Record High Alcohol Deaths**: 1,505 people died in Greater Manchester due to alcohol (2021-2023), rising by over 25% in five years.

- **Worse Than National Average**: Greater Manchester's alcohol death rate is 19.3 per 100,000, exceeding the Northwest average of 18.3 and the England & Wales average of 14.4.

- **Borough Disparities**: Some areas in Greater Manchester have alcohol-related death rates and alcohol-related hospital admissions nearly 50% higher than the England average.

- **Alcohol Dependency:** In 2019/20, there were an estimated 38,032 alcohol dependent people in Greater Manchester (17 per 1,000 population versus a national rate of 14). With eight out of ten of localities above the national average (Office for Health Improvement and Disparities (OHID), 2024).

- **Healthcare Cost Crisis**: Alcohol-related harm costs the Greater Manchester healthcare system £1.67 billion annually.

- **Hospital Admissions Soaring**: More than 1,600 hospital admissions per year in Greater Manchester are directly caused by alcohol.

- **Unmet Needs**: In 2022/23, estimated unmet treatment need for alcohol dependency in Greater Manchester ranged from 64% to 84%, with two localities above the national rate of 80% (NDTMS, 2024).

Proactive Care: Trends in Uptake of vaccination and screening

COVID-19 & Flu Vaccinations

As of March 2025, 32.5% (910,300) and 51% (1,431,200) of GM residents were eligible for an Autumn-Winter COVID-19 or Flu vaccine. These vaccinations were delivered through local pharmacies, Primary Care Networks and pop-up clinics. 200,000 people opted for vaccines to be administered at the same time, which is an increase on previous years and improved efficiency.

However, vaccine uptake has declined year-on-year, mirroring national trends:

- COVID-19 vaccine uptake dropped from 45% in 2023/24 to 36% in 2024/25
- Flu vaccine uptake decreased by 3% across most eligible cohorts, except for pregnant women.

Equally, inequalities in uptake persist across GM, varying by age, ethnicity, and deprivation:

- Uptake in areas of high deprivation (Index of Multiple Deprivation (IMD) Decile 1) was 29% compared to 61% in the most affluent areas (IMD Decile 10).
- Non-White British groups showed lower vaccination rates, with Black, African, and Caribbean groups reporting 13.21% COVID-19 uptake and 44% flu uptake in those over 65, compared to 75.6% for White British individuals.

A significant amount of work has been done to improve uptake of COVID-19 and Flu vaccinations across GM, especially among underserved groups building in on the Behavioural Insights work completed in 2024. This included additional investment to increase outreach, mobile vaccination clinics and bespoke clinics, as well as targeted engagement to build trust within our lowest-uptake communities and a communications campaign. Approaches that have been effective at improving uptake include:

- Targeted mobile clinic sessions at places of worship and community events e.g. PCN-led clinics working alongside community groups supporting older people, homeless and other at-risk residents
- VCSFE-led engagement with small community and faith groups to constructively challenge myths around vaccination and positively engage community leaders to promote uptake of the vaccination offer
- Translated materials including leaflets, posters, social media posts and videos were shared in the most common languages

Health Checks

NHS Greater Manchester has continued to improve delivery of Learning Disability (LD) Annual Health checks, delivering approximately 10% more checks in 2024-25 than the previous year. At the end of Q3 2024, NHS Greater Manchester had delivered 10,630 checks of a total of 18,070 people on GP LD registers (58.53%). Of the people who have received checks to date this year, 98% have a completed health action plan. Whilst the number of people on LD registers in Greater Manchester has grown in the last two years, a focus on increasing the number of people on registers is required working with social care to ensure that people are not missed.

Trends in multi-morbidity and in access and outcomes of care

Fairer Health for All Target: Increased social & economic activity because of reduced ill health – Narrow the 15-year gap in the onset of multiple morbidities between the poorest & wealthiest sections of the population to 5 years.

Multi-morbidity

The Cambridge Multimorbidity Score was developed by researchers at the University of Cambridge to evaluate the impact of individual long-term conditions (LTCs) on the health and care system. This was done by linking patient level General Practice data to Secondary Care data. Rather than looking at "count of LTCs" the Cambridge Multimorbidity Score reviews total LTC burden per patient and the impact of these conditions. This can be used to review:

Rates of multi morbidity [number of LTCs] - Each LTC is given a weighting, based on the relative impact on that condition. This is used to measure impact of

- Any long-term condition
- One long term condition
- Developing a second long term condition [multimorbidity]
- Burden of multi morbidity [CMS score]

It is possible to look at the impact of multimorbidity by banding the Cambridge Multimorbidity Score into "segments":

- The higher the segment the greater the health needs and service utilisation
- Going from one segment to the next roughly halves the number of patients.
- We can consider patients in Segments 4 and 5 as having high health burden

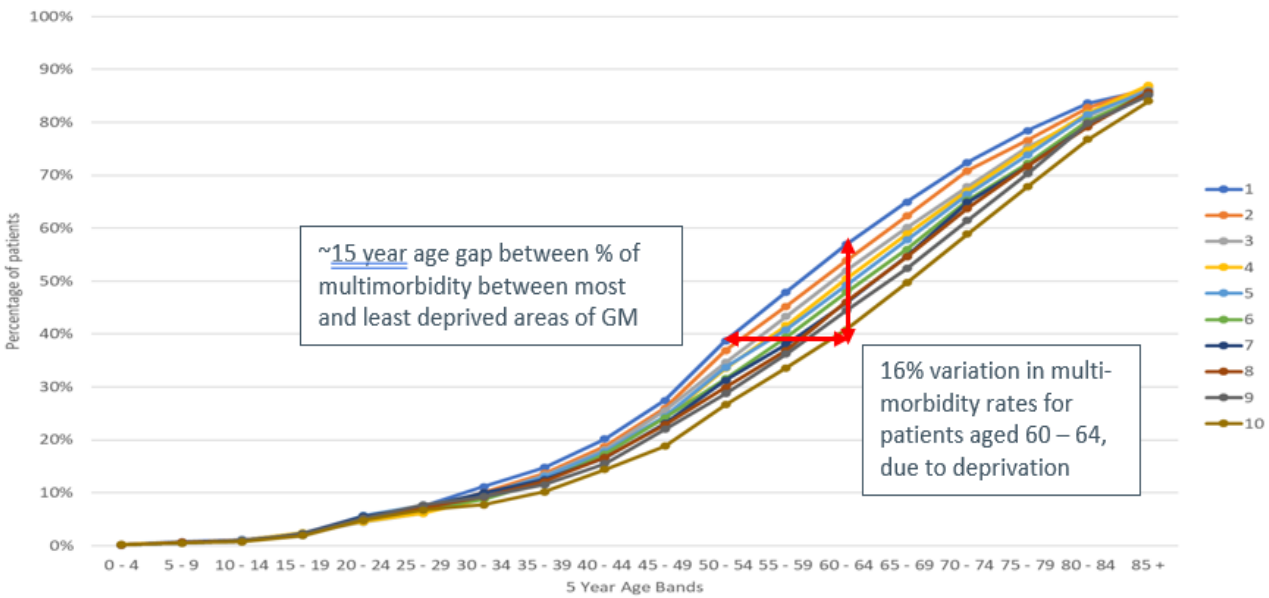
Table 3: Patients by segment based on Cambridge Multimorbidity Score

Segment	CMS Score	Patients
1	0 – 0.09	1,828,237
2	0.10 – 0.69	607,503
3	0.70 – 1.58	347,023
4	1.59 – 2.96	182,178
5	2.96 +	88,157

The graph below shows the percentage of patients in GM with multimorbidity by age band and deprivation. This shows:

- A 15-year age group in multi-morbidity rates - In the most deprived neighbourhoods, by the time people reach age 50-54, then 40% have multiple LTC. Whereas in the least deprived neighbourhoods, people develop multiple LTC later - it isn't until people are aged 60-64 that they have equivalent rates of multi-morbidity.
- the biggest difference in rates of multi-morbidity between deprivation deciles is at age 60-64. At that point, multi-morbidity rates are 16% higher for patients from the most deprived decile.

Figure 12: Percentage of patients with a multi morbidity by age band and IMD decile (deprivation).



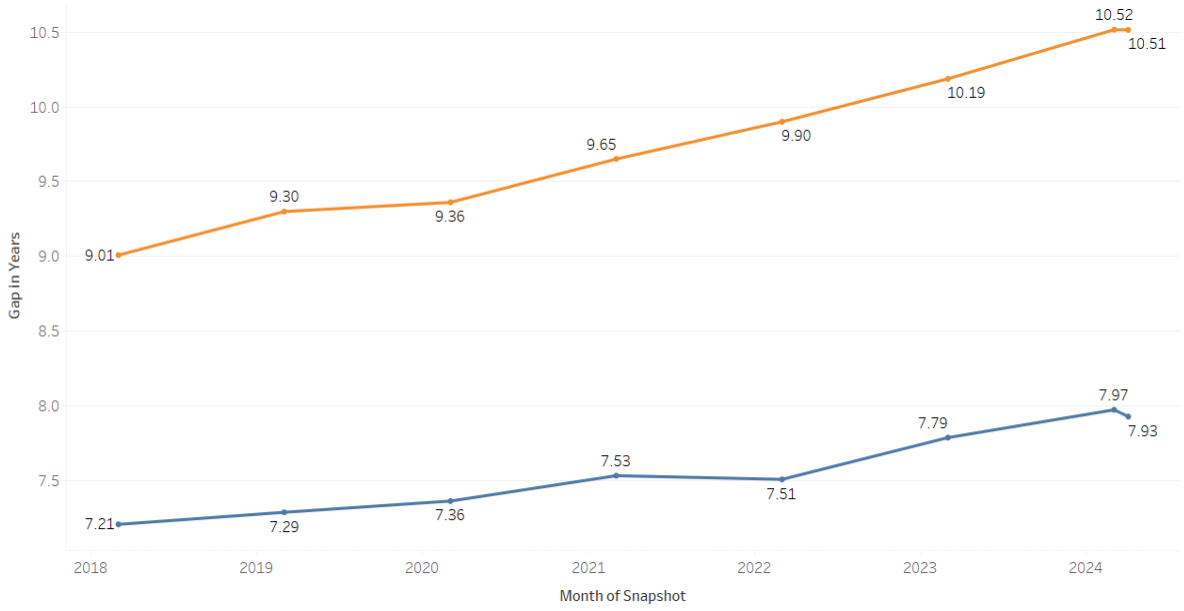
Multi-morbidity Trends

Initial trend analysis suggests that inequalities in multi-morbidity are increasing between 2018 and 2024:

- The blue line shows a widening age gap for age at first diagnosis of a LTC between people living in the most and least deprived neighbourhoods
- The orange line shows a larger age gap for diagnosis of a second LTC, and this gap is widening - in 2018, someone from a deprived neighbourhood was likely to have a 2nd LTC diagnosed 9 years earlier and this has increased to a 10.5 year gap in 2024

This widening gap in age at which people are diagnosed with their first long term condition or their second long term condition may be due to improved access to primary care and/or to diagnostics for people in most deprived decile which is uncovering 'hidden harm'. Or it may be due to a true increase in disease prevalence. Further analysis to review associations between access and uptake of primary care is required and to compare health-care investment with disease burden.

Figure 13 Gap between most deprived (IMD Decile 1) and least deprived (IMD Decile 10) parts of GM for first long-term condition diagnosis (Blue) and second long term condition diagnosis (Orange) in time



Cancer

Early cancer diagnosis is critical for reducing the impact of cancer on people's health and wellbeing, their requirement for health and care services, and for maximising positive outcomes and response to treatment.

Percentage cancers diagnosed at stage 1 and 2

This indicator measures the number of patients with early-stage cancer diagnosis (stage 1 & 2) as a percentage of all cancer diagnoses. A higher percentage indicates better outcomes. Improvements in the rate of early diagnosis increasing from 51.1% in February 2021 to 59.9% in February 2025 (12 month rolling position), with GM overtaking England for the first time. Further progress required to reach the NHSE ambition of 75% of cancers being diagnosed at stages 1 and 2.

However, there is variation in early diagnosis figures across Greater Manchester by locality; with the proportion of people diagnosed at an early stage in 2021 varying from 50.9% in Salford to 58% in Rochdale. Since the most recent available inequality annual data ends in December 2021, the impact of improvement initiatives aimed at enhancing early diagnosis, such as targeted lung health checks and Faecal immunochemical test (FIT) for bowel cancer, may not be reflected.

National Cancer Outcomes and Services Dataset up to December 2021 shows that in GM:

- There is a 7.56% difference in early diagnosis between our most and least deprived communities.
- There is very little difference between different ethnic groups
- There is an 8.88% difference between males and females with males being less likely to be diagnosed early. Some of this difference is explained by difference in cancer type

Figure 14A Proportions of Cancer diagnosed at early stage, advanced stage or missing, via ethnicity

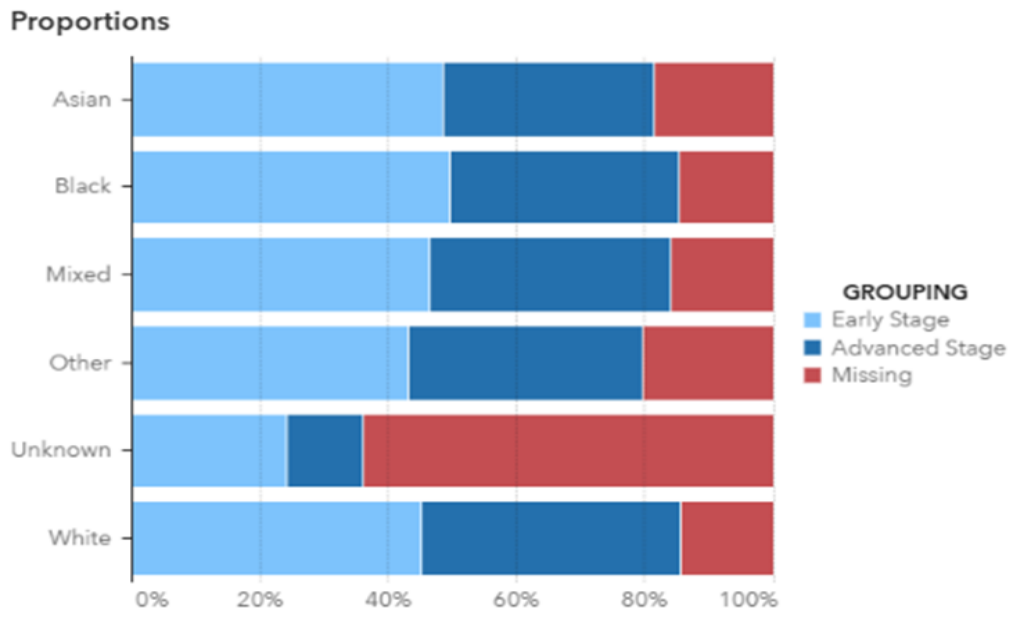
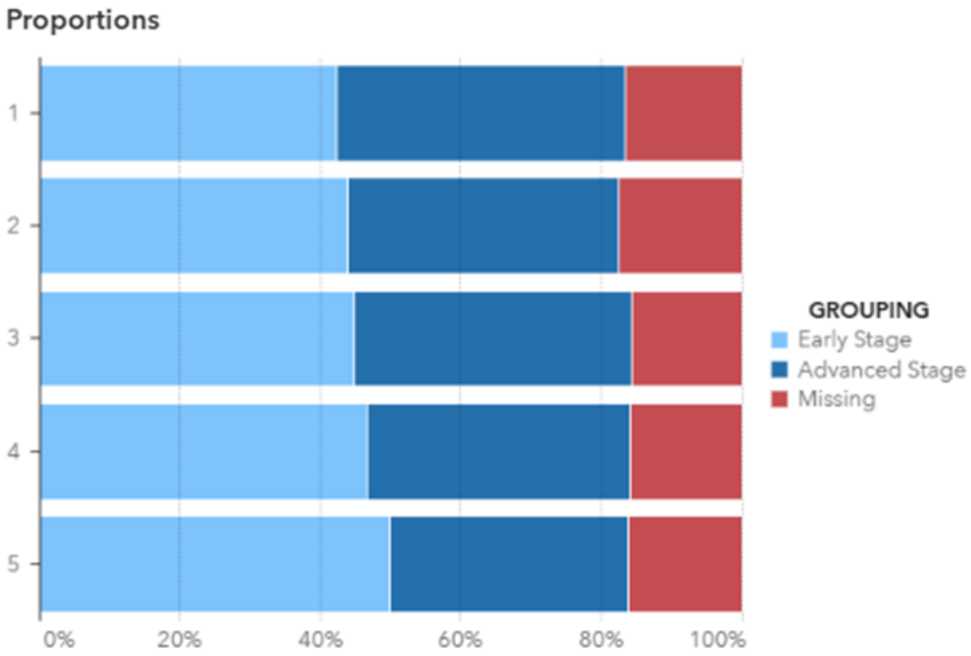


Figure 14B Proportions of Cancer diagnosed at early stage, advanced stage or missing via deprivation IMD



The Greater Manchester Early Cancer Diagnosis Strategy focuses on raising public awareness, reducing health inequalities, fostering collaboration with primary care, enhancing cancer screening programs, and driving innovation to improve early diagnosis rates and outcomes. Work in 24/25 to meet these priorities has included:

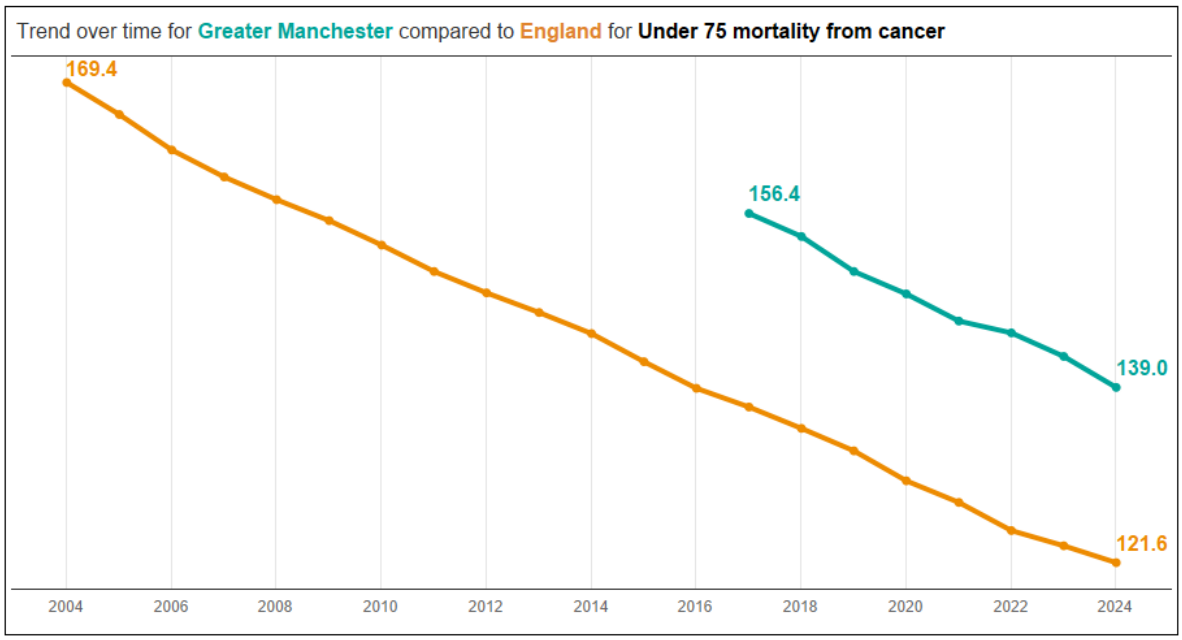
- Targeted engagement with local populations, GP practices, and specific communities,
- Targeted Lung Health Check (Lung Cancer Screening) programme, where a stratified roll out has been planned based on deprivation, smoking rates, and lung cancer mortality at a Primary Care Network population level.

- VCSFE grant funding to support reduction in inequalities of early diagnosis, timely presentation and screening uptake.

Cancer mortality

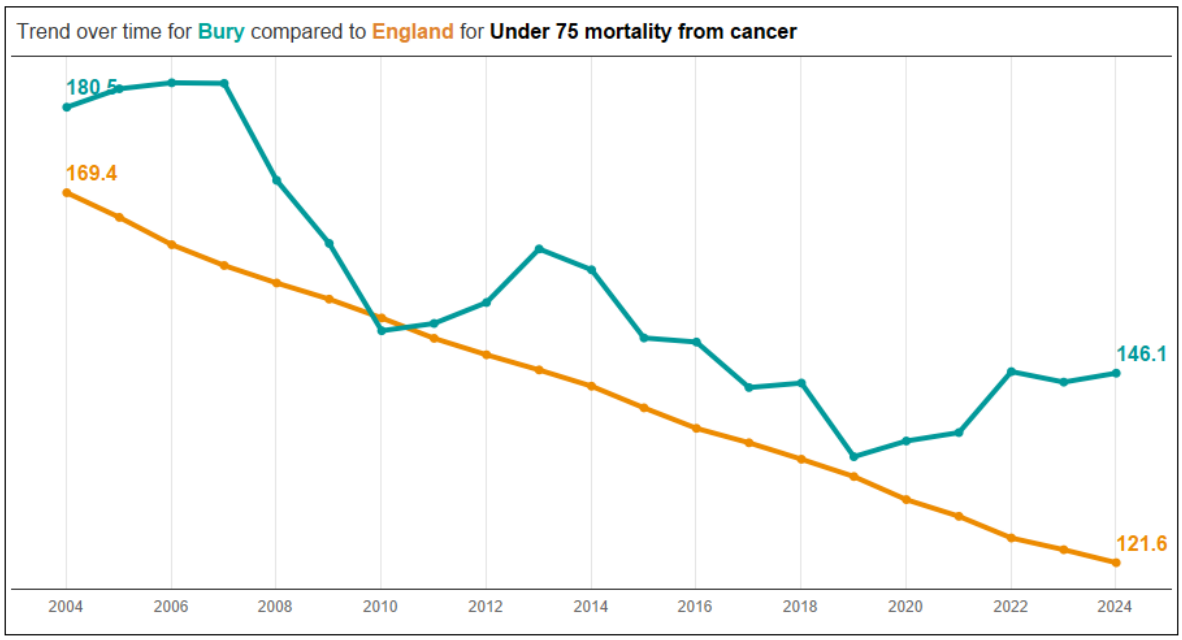
Under 75 cancer mortality rates have continued to reduce for both males and females. However, in 2021-23 the GM rate remains 14% higher than the national rate.

Figure 15: Under 75 mortality from cancer, GM v England, all available periods



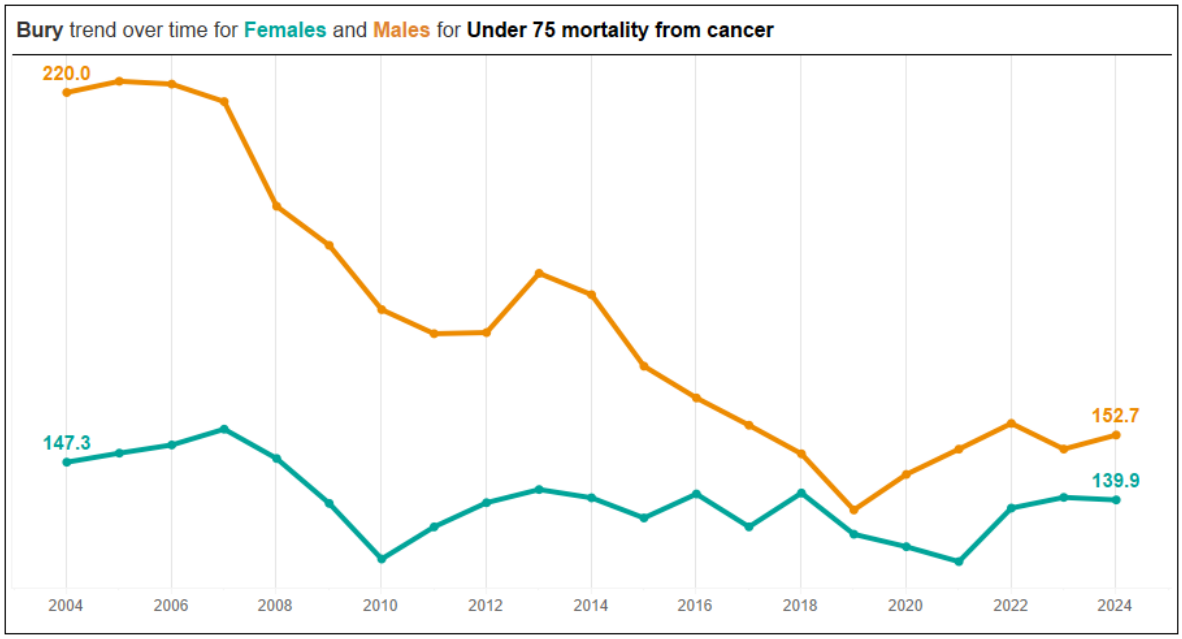
Bury was the only locality that saw an increase, from 144.9 per 100,00 to 146.1 per 100,000. Bury is now the furthest away from the national average it has ever been across all available periods. The plot below shows Bury against the national average over time:

Figure 16: Under 75 mortality from cancer, Bury v England, all available periods



In the most recent period, this is being driven by males who saw an increase in under 75 cancer mortality from 149.9 per 100,000 to 152.7 per 100,000. The plot overleaf shows the trend for females and males over all available periods:

Figure 17: Under 75 mortality from cancer, Bury, Females and Males, all available periods



Cardiovascular Disease

Greater Manchester continues to make significant progress on cardiovascular prevention, with latest CVDPrevent data (September 2024) demonstrating system-wide improvements in both primary and secondary prevention. These gains reflect the coordinated use of tools such as CVNeed, targeted primary care incentives, and localised population health interventions, aligned to NHS GM's health inequalities objectives.

Lipid Management in High-Risk Patients: Percentage of patients aged 18+ with no GP recorded CVD but with a QRISK ≥20%, who are prescribed lipid-lowering therapy.

- GM has achieved **65.83%**, **exceeding the revised national ambition of 65%**.
- The **most deprived quintiles perform better (67.06%)** than the least deprived (59.79%), and uptake is also highest in **Asian (72.2%) and Black (66.5%) groups**, demonstrating progress in tackling inequality.

Hypertension Treated to Target*:* Percentage of patients aged 18+ with diagnosed hypertension whose most recent blood pressure is below the age-appropriate threshold.

- GM performance: **67.48%** – the **highest in the Northwest**, and above the NW average (66.75%).
- **6 of the top 15 Primary Care Networks regionally are in GM**, highlighting system impact.
- However, inequalities persist with lower control in the most deprived quintiles and among groups with unrecorded ethnicity.

Statin Use in Established CVD*:* Percentage of patients with GP recorded CVD (narrow definition) who are prescribed lipid-lowering therapy.

- GM has achieved **86.2%**, leading the Northwest region.
- Variation between localities is narrowing, with strong, consistent delivery supported by the GM lipid optimisation pathway.

LDL Optimisation in Established CVD: Percentage of patients with CVD whose most recent LDL is ≤2.0 mmol/L or non-HDL ≤2.6 mmol/L in the past 12 months.

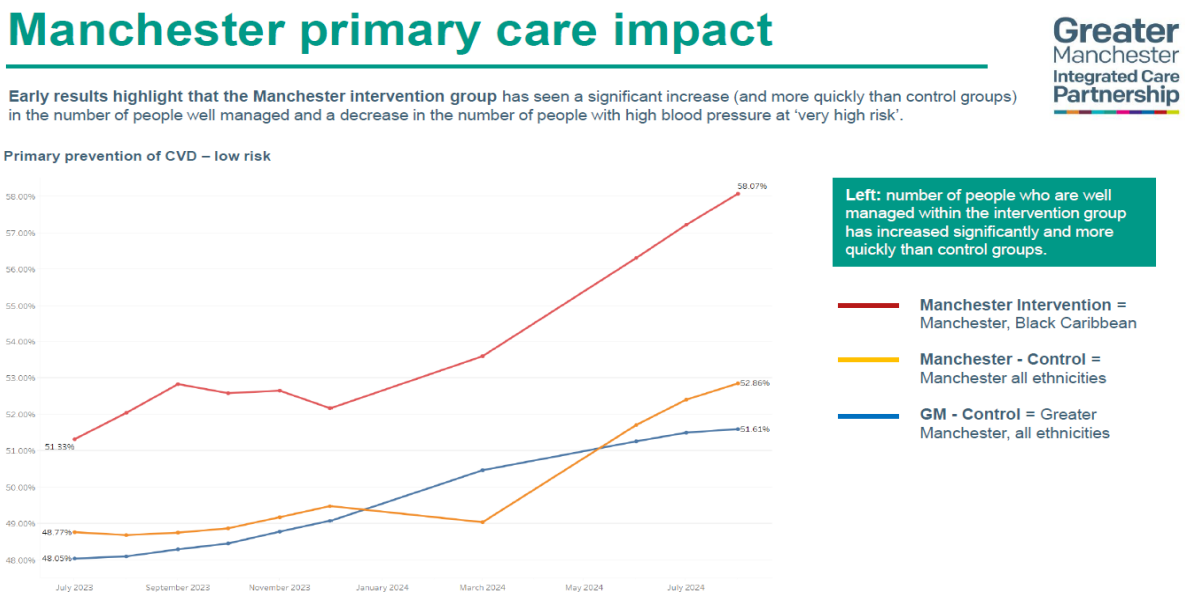
- GM performance: **48.56%**, above both NW and England averages.
- **All top 5 Primary Care Networks in the Northwest for this indicator are in GM**, reflecting clinical leadership and strategic focus.

Anticoagulation in Atrial Fibrillation (AF): Percentage of patients aged 18+ with AF and a CHA_2DS_2-VASc score ≥2 who are prescribed anticoagulation.

- GM performance: **91.29%**, close to the 95% ambition.
- Local variation remains, with some areas requiring focused support.

These data highlight the need to complement prevention efforts with strengthened post-event care, rehabilitation, and targeted action in areas of persistent inequality. By aligning intelligence-led, NHS-driven prevention models with patient, public, and community engagement, Greater Manchester is leading the way in cardiovascular prevention. Through targeted risk stratification, cross-sector collaboration, and culturally competent public engagement, we prove that CVD inequalities can be systematically addressed through aligned, strategic, and scalable action.

Figure 18 Manchester Primary Care Impact – Primary prevention of CVD



Stroke - Non-elective Admission Rate (age-sex standardised per 100,000 population):

- Recent data highlights significant variation across Greater Manchester, with higher rates generally observed in more deprived areas. Ongoing work continues to improve early identification, community awareness, and timely management to reduce stroke admissions.

Myocardial Infarction (MI) - Non-elective Admission Rate (age-sex standardised per 100,000 population):

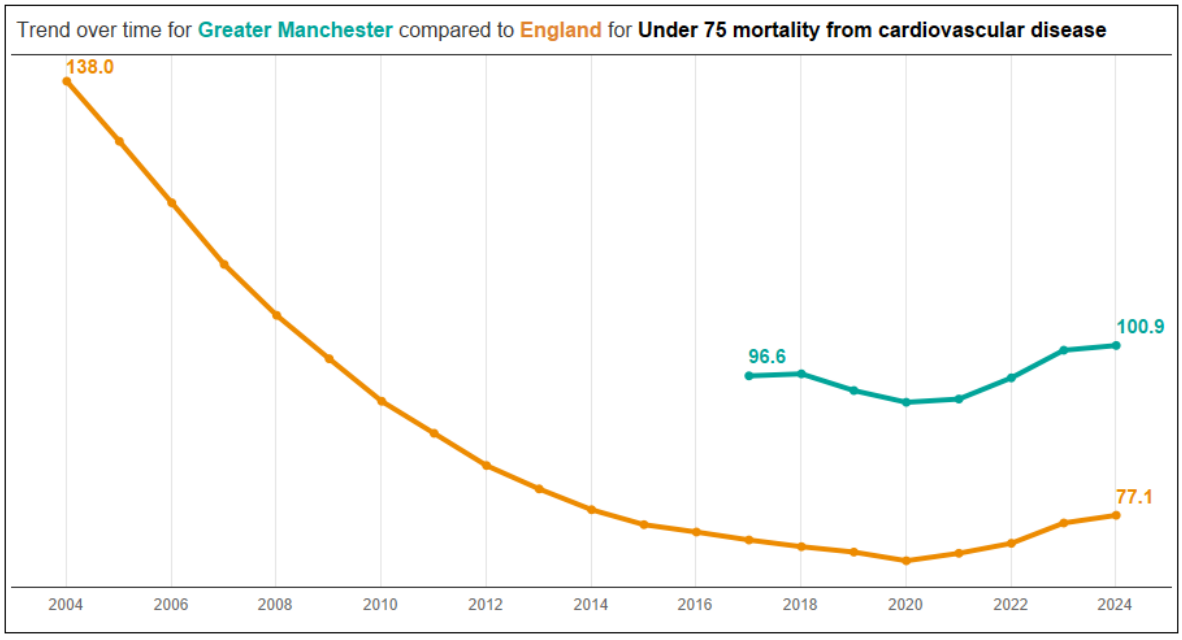
- Greater Manchester's average rate for MI admissions is 187.9 per 100,000, with notable variation across localities. Tameside has significantly higher admission rates, whereas Stockport, Trafford, and Wigan perform comparatively better, with significantly lower admission rates.

- Admissions for MI remain strongly correlated with deprivation, with the most deprived quintile accounting for 43.2% of all MI admissions in the past three years. Men, particularly from the most deprived areas, represent the largest group of hospital admissions, highlighting ongoing inequalities and the critical need for targeted prevention and intervention strategies in these populations.

Cardiovascular disease mortality

Under 75 mortality rates from cardiovascular disease have increased with a greater increase for females than males. 2021-23 rates show GM rates remains higher than the national average.

Figure 19: Under 75 mortality from cardiovascular disease, GM v England, all available periods



Bury had the greatest increase, from 90.1 per 100,00 to 95.8 per 100,000. Bury is now the furthest away from the national average it has ever been across all available periods.

However, 4 out 10 localities (Manchester, Oldham, Rochdale and Tameside) saw decreases from the 2020 to 2022 period. Manchester saw the greatest decrease with 125.3 per 100,000 to 119.1 per 100,000.

Diabetes

There is continued improvement in diabetes care - the proportion of people with diabetes that have received all eight diabetes care processes for **type 1 diabetes** (figure 20) and type 2 (figure 21) increased from December 2024 to December 2025:

- **Type 1 Diabetes** - 30.9% to 34.1%
- **Type 2/other diabetes** - 48.7% to 52.2%

However, there is significant variation across localities with very low numbers in Tameside:

- Type 1 Diabetes - Significant variation in uptake of structured education by deprivation and ethnicity
- Type 2 Diabetes – variation by ethnicity in treatment targets and HbA1c

Figure 20 Proportion of people with Type 1 Diabetes that received all 8 diabetes care processes

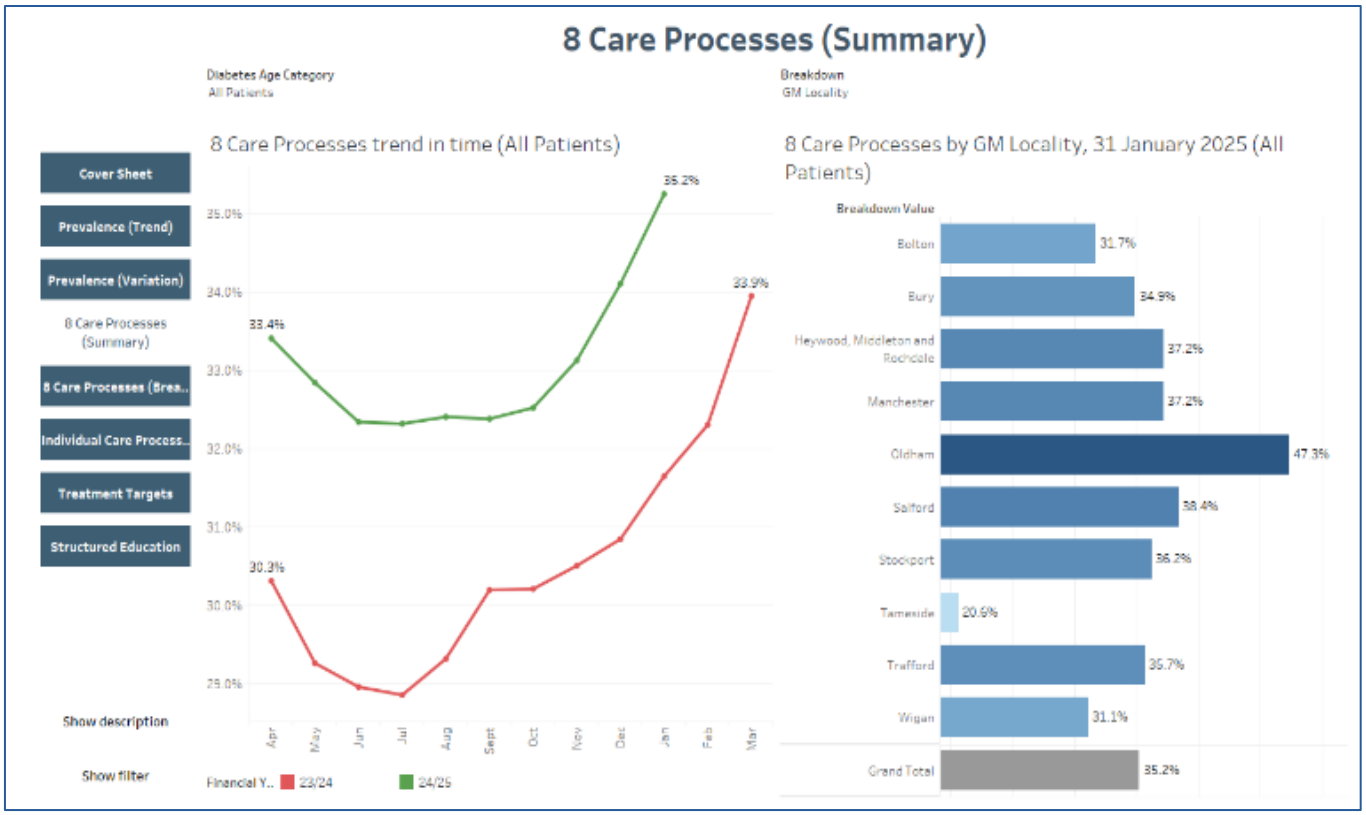
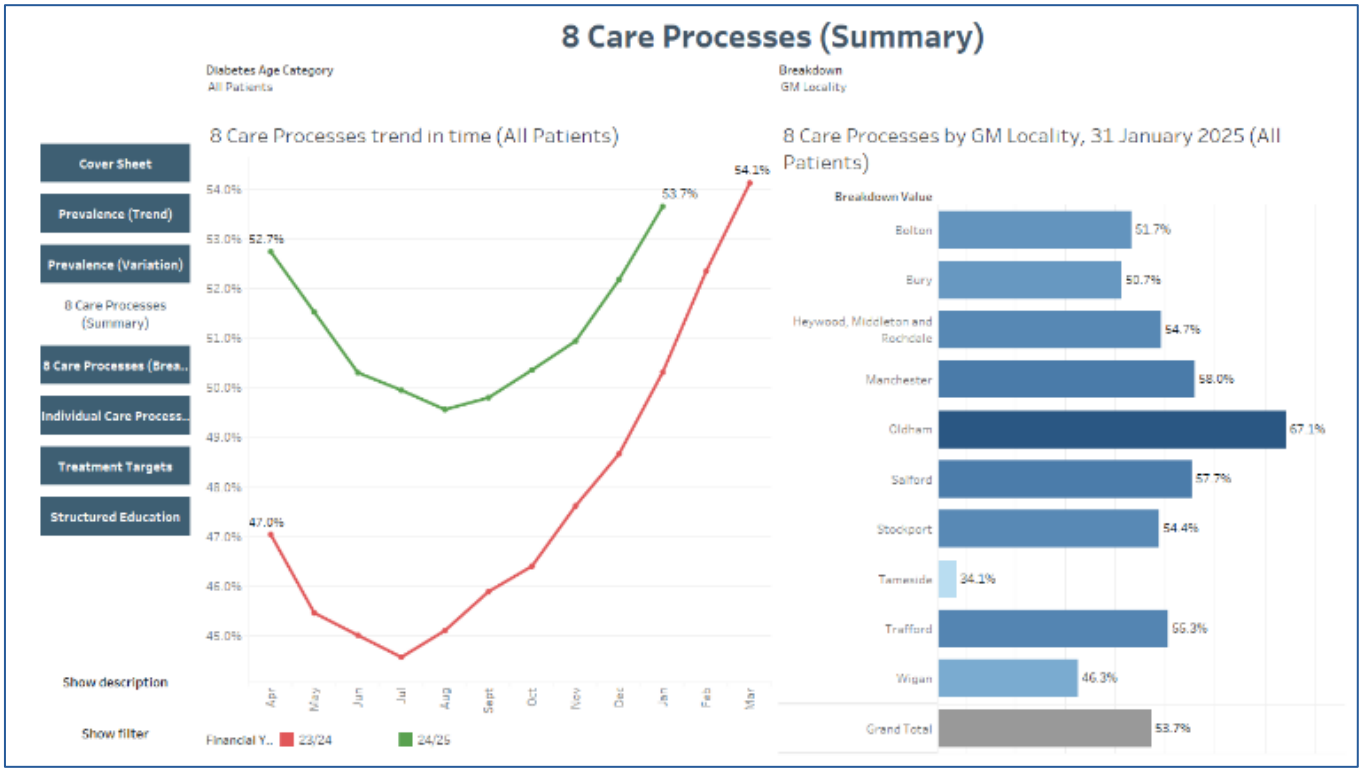


Figure 21 Proportion of people with Type 2 Diabetes that received all 8 diabetes care processes



The achievement rates and, in particular, the ethnicity and deprivation gaps are summarised in Figure 22 overleaf for a range of key diabetes metrics recorded in the GM Single Prevention Plan Dashboard as of January 2025.

Figure 22: Single Prevention Plan

Name	Snapshot	Denominator	Achievement	Target	Difference to Target	Change from previous month	Change from previous year	Ethnicity: White British	Ethnicity: BAME	Ethnicity: Gap	Deprivation: Most 20% Deprived	Deprivation: Least 20% Deprived	Deprivation: Gap
Care Processes - 8CP Type 1	Feb 25	10,894	41.2%			2.1%	5.3%	41.7%	43.9%	-2.2%	40.7%	41.8%	1.2%
Care Processes - 8CP Type 2	Feb 25	181,722	55.7%			2.0%	3.3%	55.1%	58.3%	-3.2%	55.4%	58.2%	2.8%
Structured Education - SE Type 1 Attendance (Of Eligible)	Feb 25	291	4.8%			1.0%	3.9%	6.3%	2.2%	4.1%	5.4%	7.1%	1.7%
Structured Education - SE Type 1 Attendance (Of Offered)	Feb 25	120	11.7%			2.9%	10.0%	13.5%	5.9%	7.6%	14.3%	14.3%	0.0%
Structured Education - SE Type 1 Referrals	Feb 25	291	41.2%			-1.2%	-8.1%	46.5%	37.8%	8.8%	38.0%	50.0%	12.0%
Structured Education - SE Type 2 Attendance (Of Eligible)	Feb 25	15,764	6.3%			0.0%	2.0%	7.3%	4.6%	2.6%	5.8%	8.8%	3.0%
Structured Education - SE Type 2 Attendance (Of Offered)	Feb 25	11,307	8.8%			0.1%	2.7%	9.7%	6.8%	2.9%	8.2%	11.9%	3.7%
Structured Education - SE Type 2 Referrals	Feb 25	15,764	71.7%			0.0%	0.9%	74.9%	68.0%	6.8%	70.7%	74.0%	3.3%
Treatment Targets - 3TT Type 1	Feb 25	5,039	18.4%			-0.2%	-0.9%	19.0%	15.0%	4.0%	14.2%	27.0%	12.8%
Treatment Targets - 3TT Type 2	Feb 25	138,164	33.5%			0.3%	0.0%	36.3%	27.3%	8.9%	31.7%	36.5%	4.8%
QDiabetes - QDiabetes > 5.6% HbA1c check (age 25 to 84) [estimated centrally]	Feb 25	465,278	55.2%	75.0%	-19.8%	0.6%		58.9%	50.4%	8.5%	53.3%	59.9%	6.7%
QDiabetes - QDiabetes > 5.6% HbA1c check (age 40 to 74) [estimated centrally]	Feb 25	373,202	54.8%	75.0%	-20.2%	0.5%		57.4%	52.5%	4.9%	53.9%	57.5%	3.6%

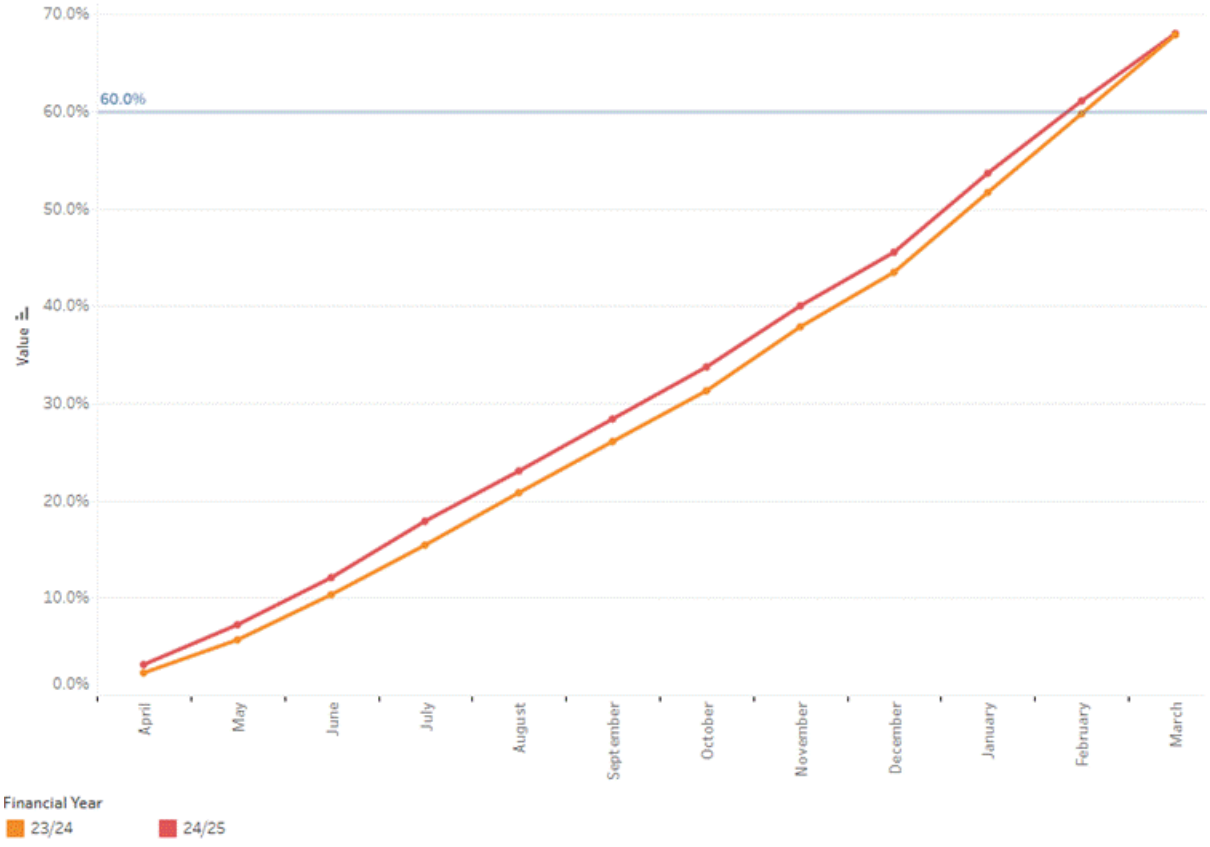
Mental Health

Target: Reduce the difference in life expectancy and the incidence of physical health conditions for people with Severe Mental Illness (SMI) –Narrow the gap with England by 15%.

Overall number of SMI physical health checks:

Figure 23 shows the ICB's performance against the PH SMI target for the last two years. In every month so far in 2024/25, the number of adults with SMI receiving a physical health check in the previous 12 months has exceeded the number from 2023/24. The latest data available for March 2025 shows that performance was 68.0% against the target of 60% compared to 67.9% in March 2024.

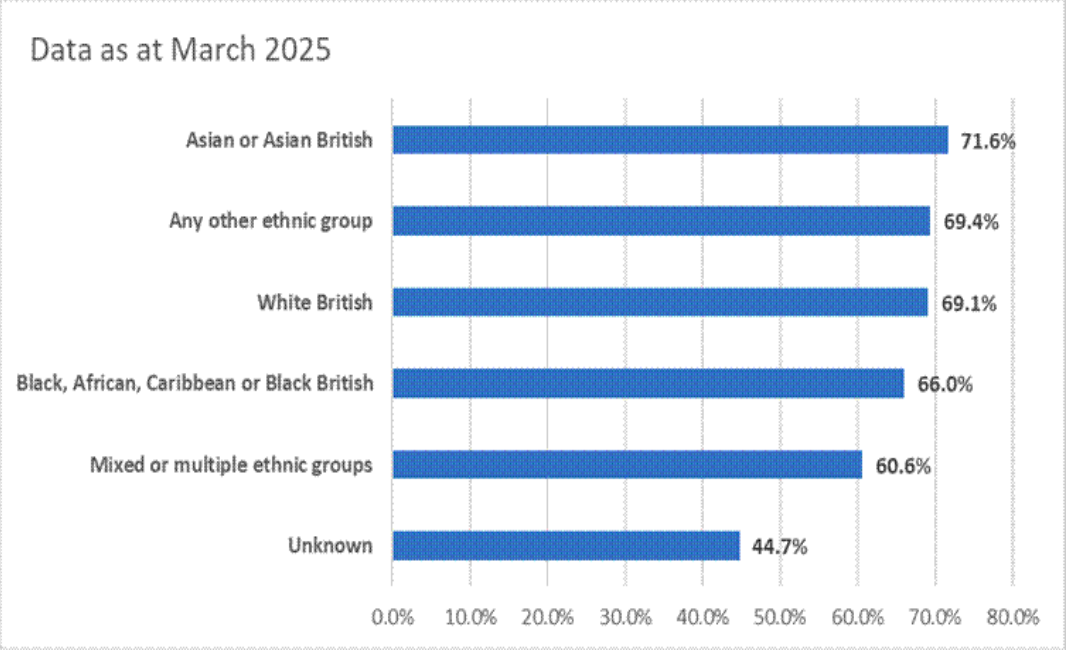
Figure 23': PH SMI target achievement in ICB



Looking at variation in uptake by ethnic group (Figure 24) is not currently possible as 30% of the patient records in the dataset do not have ethnicity recorded. Further work planned to utilise the Master Patient index to improve completion of ethnicity data, and

to calculate rates for each ethnic group (relative to the number of people with SMI in each ethnic group).

Figure 24 PH SMI target achievement by ethnic category

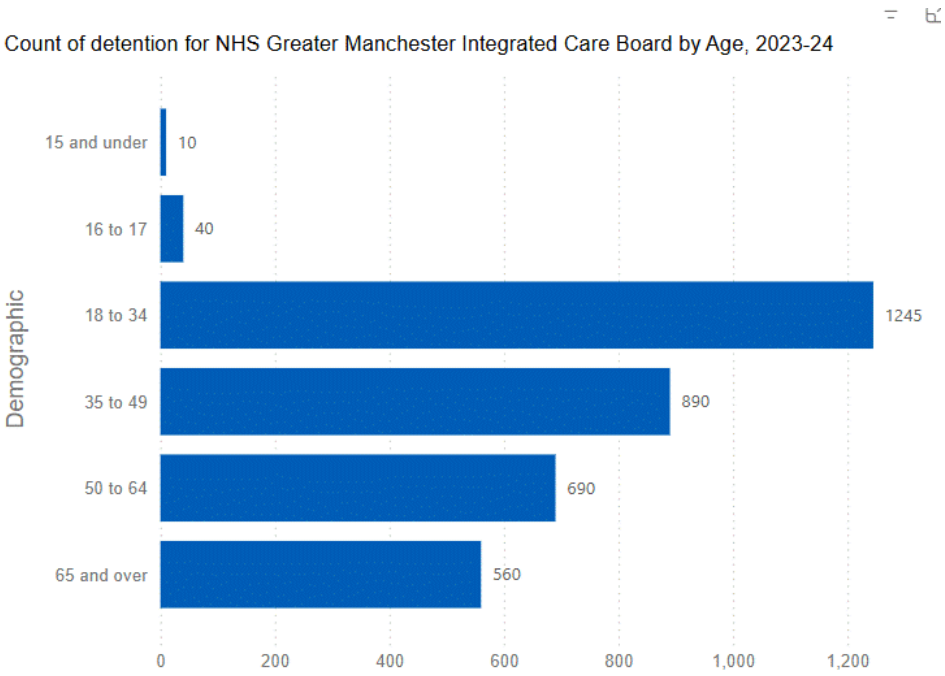


Overall number of adults with SMI who receive a physical health check in 2024/25 increased from 2023/24. Comparison of uptake rates by ethnicity is not yet possible - however this analysis will be added in phase 2 once the age standardised tool is available.

Rates of total Mental Health Act detentions:

The latest all-age data available from the national dashboard, for Mental Health Act detentions, is for 2023/24. It reports that Greater Manchester (GM) ICB has a crude rate of detentions per 100,000 population of 118. The highest detention rate seen is for 18-34 year olds.

Graph 1 Count of Detention by Age 2023/24



This compares to just 90.9 for all ICB's. The rate of Mental Health Act detentions overall in GM, is significantly higher than the national average, and the fifth highest overall.

The data in Table 4 shows that people from an ethnic minority are detained at a higher rate in GM than white people. Black people are detained at more than twice the rate of white people, but the lowest detention rate is for Asian people. The disparity between detentions in our black populations compared to white and Asian is marked and in line with national and is a focus of the inequalities work with the Royal College of Psychiatrists and under the Inpatient Quality Transformation programme but will also be key in our transformation work in CMHTs and in working with our VCSFEs.

Table 4 Detention rate by ethnicity 2023/24

Ethnicity	Detention rate per 100,000
White	103.8
Mixed	144.5
Asian	78.3
Black	212.5
Other	164.3

Table 5 shows that people from more deprived areas of GM are detained at higher rates than those from less deprived areas. Someone from the most deprived area is more than 3 times as likely to be detained than someone from the least deprived area.

Table 5 Detention rates by deprivation 2023/24

Deprivation	Detention rate per 100,000
1 – least deprived	54
2	44
3	65
4	70
5	90
6	91
7	108
8	130
9	141
10 – most deprived	165

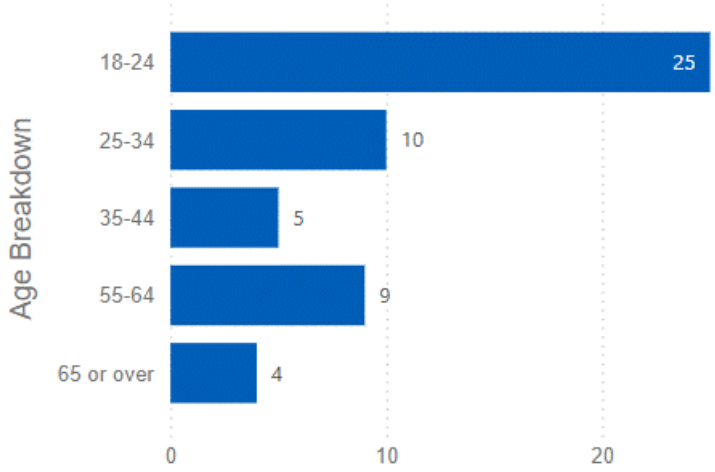
Rates of restrictive interventions:

The latest all-age data available from the national dashboard, for rates of restrictive interventions, is for March 2025. In this month, Greater Manchester Mental Health (GMMH) NHS Foundation Trust had a rate of 22 restrictive intervention types per 1,000 occupied bed days compared to 30 in March 2024. Pennine Care NHS Foundation Trust (PCFT) had a rate of 8 restrictive intervention types per 1,000 occupied bed days in March 2025 compared to 9 in March 2024. Restrictive practice rates being higher within GMMH, may be in relation to their secure services.

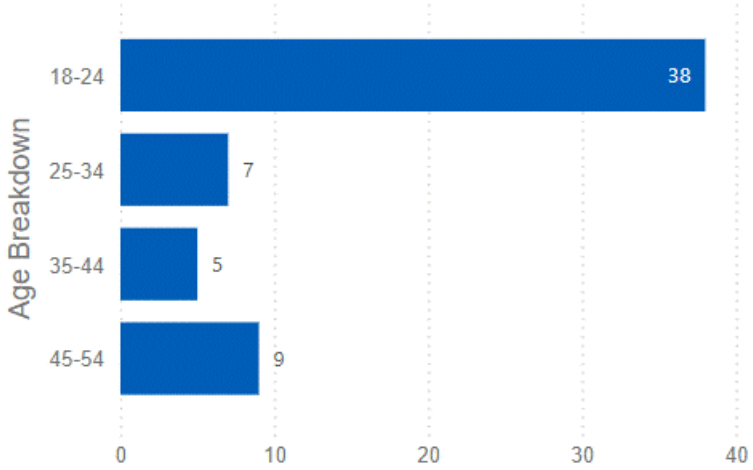
Within GMMH and PCFT in March 2024, the number of restrictive intervention types per 1,000 occupied bed days was the highest for 18-24 year olds.

In March 2025, for PCFT, this remains the same. However, for GMMH in March 2025, the highest number of restrictive intervention types per 1,000 occupied bed days was seen in the under 18 age group according to the dashboard. This is often related to complex individual cases within Tier 4 / Psychiatric Intensive Care Unit in young people's inpatient services; however, this could be a data error which is currently being reviewed with NHSE.

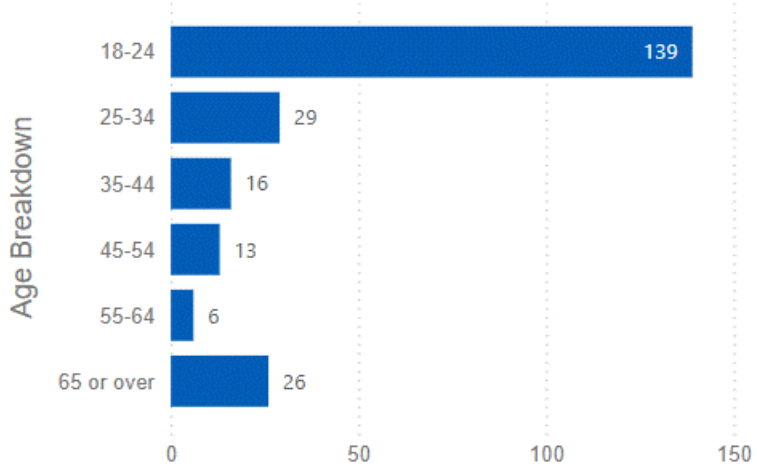
Graph 2 PCFT Number of Restrictive Intervention Types, per 1,000 occupied bed days, by Age Group March 2024



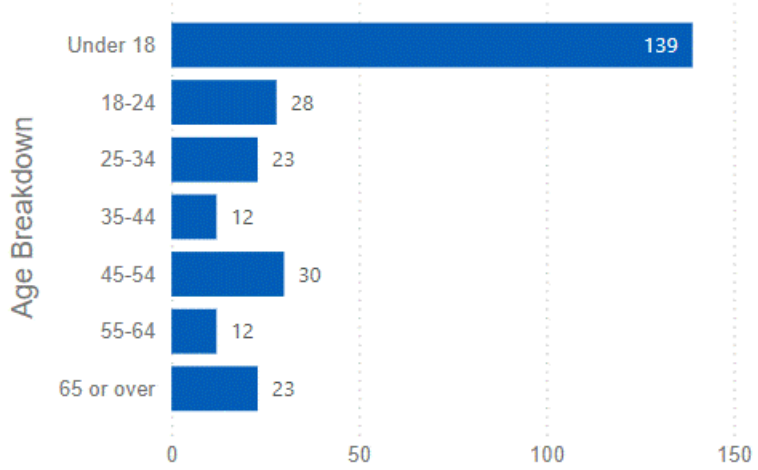
Graph 3 PCFT Number of Restrictive Intervention Types, per 1,000 occupied bed days, by Age Group March 2025



Graph 4 GMMH Number of Restrictive Intervention Types, per 1,000 occupied bed days, by Age Group March 2024

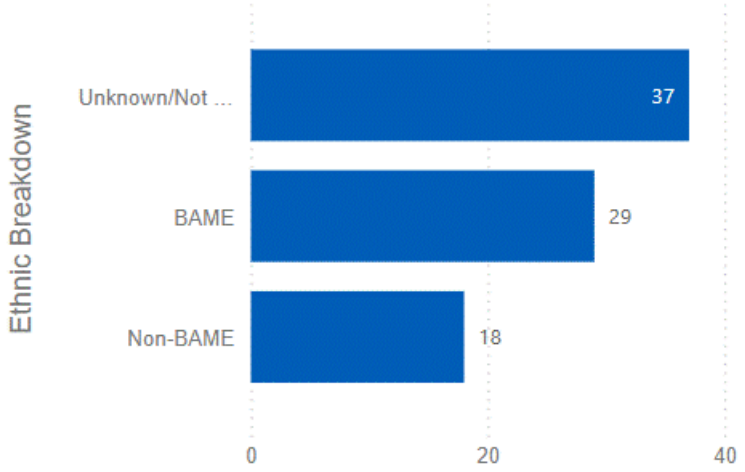


Graph 5 GMMH Number of Restrictive Intervention Types, per 1,000 occupied bed days, by Age Group March 2025



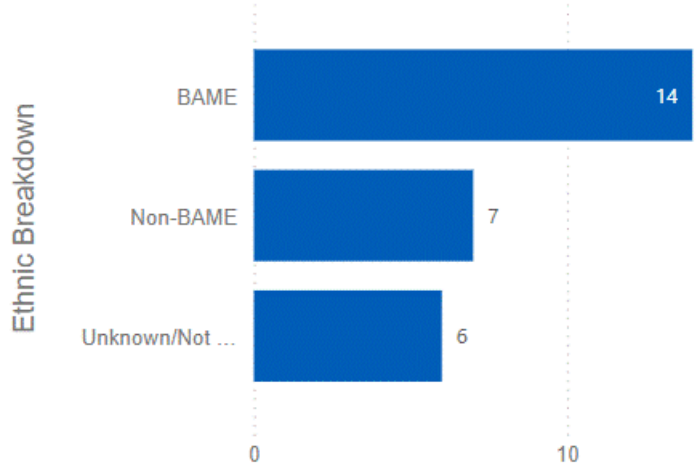
Within GMMH in March 2025, people from ethnic minority groups had 29 restrictive intervention types per 1,000 occupied bed days compared to 18 for people from non-minority ethnic groups. For those with unknown ethnic origin, the rate was 41 per 1,000 occupied bed days. Please see graph 6.

Graph 6 GMMH Number of Restrictive Intervention Types, per 1,000 occupied bed days, by Ethnic Group March 2025



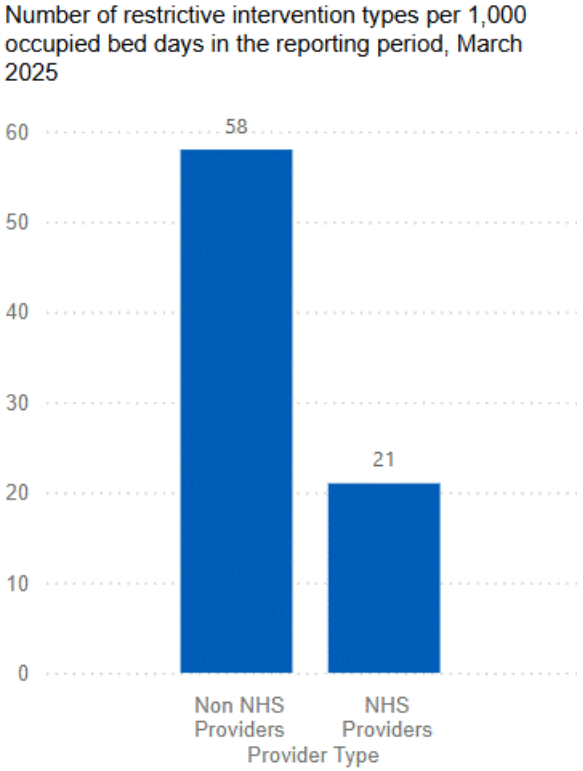
Within PCFT in March 2025, people from ethnic minority groups had 14 restrictive intervention types per 1,000 occupied bed days compared to 7 for people from non-minority ethnic groups. For those with unknown ethnic origin, the rate was 6 per 1,000 occupied bed days. Please see graph 7.

Graph 7 PCFT Number of Restrictive Intervention Types, per 1,000 occupied bed days, by Ethnic Group March 2025



Nationally, the data looks at NHS and non NHS providers; restrictive practice is significantly higher in non NHS providers. Please see graph 8.

Graph 8 Number of Restrictive Intervention Types, per 1,000 occupied bed days, by NHS / non-NHS provider (within England, North West Commissioning Region), March 2025



Improving rates of restrictive practice is a key element within the national and regional Inpatient Quality Transformation Programme work. It will be important to note the greater use within 18-24 year olds.

NHS Talking Therapies recovery:

The ICB's Talking Therapies recovery rate has remained below the national standard. In 2023/24, the rate was 47% against a 50% target. In 2024/25, it has varied between 47% and 49%, slightly improving but still below the revised 48% reliable recovery target.

The main issue is the split commissioning of Step 2 and Step 3 services, creating separate care episodes per patient. This limits recovery reporting, as patients are only counted as recovered if they meet criteria in the second episode. NHS Digital has confirmed this is not currently a priority to resolve.

To address this, GM Integrated Care is working to align providers onto a shared PCMIS system, enabling consistent reporting. This is expected by Q4 2025/26, pending agreement implementation. The issue affects Manchester, Salford, and Stockport.

In 2023/24, GMMH reported 45% recovery and PCFT 51%. In 2024/25 to date, GMMH has ranged 45–48%, and PCFT 46–52%. GMMH's lower rates reflect data challenges linked to service separation, while PCFT's integrated model supports more accurate reporting.

In the 2024/25 period, patients from the 20% least deprived areas had the highest percentage of patients entering treatment from referral at 58.3%, compared to 45.7% for those in the 20% most deprived areas. Additionally, the most deprived areas also saw the lowest percentage of patients finishing treatment at 36.7% compared to the 52.9% in the least deprived areas. The percentage of patients finishing treatment worsened from the previous 2023/24 period, with patients from the most deprived areas seeing the largest decline, moving from 41.5% to 36.7%. Patients from the most deprived areas also had the lowest percentage of recovery at 41% compared to 58% for patients in the least deprived areas.

Even though a larger number of patients from the most deprived deciles complete treatment provided by the NHS Talking Therapies programme, they are less likely to recover than their least deprived counterparts. This pattern is similar to that observed for over a decade nationally, where analysis of NHS Talking Therapies data led researchers to note individuals who live in deprived areas are more likely to need mental healthcare but less likely to recover following treatment. Deprivation and mental health are inextricably linked. Poor housing conditions, unemployment and income insecurity are all factors for poor mental health. Often, mental healthcare alone cannot improve mental health without changes in wider factors that can give rise to and exacerbate mental health conditions.

Children & young people's mental health access:

The ICB continues to exceed its access target for children and young people's community mental health services, with just under 55,000 CYP having at least one contact in the past year (target: 48,968). This includes contributions from gr (17%), Pennine Care (32%), Manchester Foundation Trust (MFT) (40%), and third sector providers.

However, access remains unequal. Data from the past 12 months shows variation by ethnicity, deprivation, gender, age, and locality. On average, children are referred at age 10.3. Boys are referred younger (9.5 years) than girls (10.9), and children from more deprived areas are referred earlier (age 10) compared to those from the least deprived areas (11.1). CYP from more deprived areas often have greater need but still face more barriers, particularly in communities with higher proportions of racially minoritised children. Missing ethnicity data in referrals also limits our full understanding of these trends.

To start addressing this, we've focused Mental Health Support Team expansion in schools with the highest need, increased flexibility through digital and phone-based support, and invested VCSFE offers of support as well as digital platforms e.g. Kooth and Silver Cloud. Local areas are also taking action through targeted outreach, digital access campaigns, and trauma informed workforce training helping ensure services are more inclusive, accessible, and responsive to the needs of all children and young people. In line with NHS operational planning priorities for 25 26 we will continue to take action and to reduce inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population.

Elective Recovery

GM has driven a sustained and targeted reduction in long-waiting patients over the last year. Adult services are now delivering ~110% or more of 19/20 levels of activity but paediatric services are still ~0-5% below 19/20 levels and recovery varies by locality.

Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks

GM has driven a sustained and targeted reduction in long-waiting patients over the last year: we have eliminated 104ww, virtually eliminated 78ww, reduced 65ww by 71% and 52ww by 36%. While the GM share of national 65ww position fell from 16% in Aug-23 to 4% in Nov-24 (share of GM list fell from 3.1% to 0.2% over same period). GM waiting list is 2nd largest per capita (c490,000) and RTT performance is 4th lowest in England at 53% (Nov-24)

While GM is now close the England average for long waits, total waiting list size (reduced by only 2% in last 12 months) and RTT performance remains very challenged meaning GM needs to improve at twice the rate of best performing ICBs to meet the national target.

More than 90% of the waiting list growth has been non-admitted pathways; recovery needs to focus on actions to bring down the non-admitted waiting list. Since February 2020 growth in non-admitted pathways has driven 91% of the overall waiting list growth with growth in wait to first appointment driving 80% of the increased wait time.

10 specialties account for 70% of the overall challenge across GM and for Paediatrics two specialties (ENT and Oral) account for 70% of the Children and Young People challenge.

Further recovery requires a sustained focus on non-admitted waits across these 10 priority specialties through a combination demand optimisation/management initiatives and service right-sizing and additionality delivered through productivity and backlog reduction waiting list initiatives.

Table 6 Highest and Lowest rates (age standardised) for Elective admissions, first outpatient attendance (virtual and face to face) and overall outpatient attendance (face to face and virtual)

	Highest rates (age standardised)	**Lowest rates (age standardised)**
Elective admissions	Salford, Stockport, Rochdale	Bury, Tameside, Bolton
First Outpatient Attendances Face to Face	Salford, Oldham, Bolton	Bury, Rochdale, Trafford, Tameside, Wigan, Manchester
First Outpatient Attendance – Virtual	Manchester, Trafford, Stockport, Rochdale	Bolton
Outpatient Attendances – Face to Face	Trafford, Manchester, Salford, Oldham	Bury, Wigan, Tameside, Bolton
Outpatient Attendances – Virtual.	Tameside, Oldham, Wigan, Stockport	Bolton, Bury, Rochdale

Elective activity vs pre-pandemic levels for under 18s and over 18s between year to date 1st January 2025 and pre-pandemic (2019/2020) there was a 2% increase for Outpatient activity but a 2% decrease for Inpatient activity.

Table 7A, Elective activity of Outpatients in 24/25 versus pre pandemic elective activity for under and over 18s

Age of Outpatients	**Year to Date 24/25**	**%**	**Year to Date 19/20**	**%**
Under 18	695,419	14%	442,260	12%
Over 18	4,151,651	86%	3,402,198	88%
Grand Total	4,847,070	100%	3,844,458	100%

Table 7B, Elective activity of Inpatients in 24/25 versus pre pandemic elective activity for under and over 18s

Age of Inpatients	**Year to Date 24/25**	**%**	**Year to Date 19/20**	**%**
Under 18	112443	13%	140,100.00	15%
Over 18	721182	87%	806,305.00	85%
Grand Total	833,625	100%	946,405	100%

For Paediatrics two specialties (ENT and Oral) account for 70% of the Children and Young People challenge. The Elective Care CYP pillar is focusing on expanding surgical hub capacity and working with anaesthetists wanting to develop a CYP competency to organically expand CYP capacity particularly for paediatric ENT and paediatric dentistry.

Figure 29: Elective Admissions for Greater Manchester Local Authorities 23/24 and Age standardised rate for electrical hospital admissions from 2018/19 to 2023/24

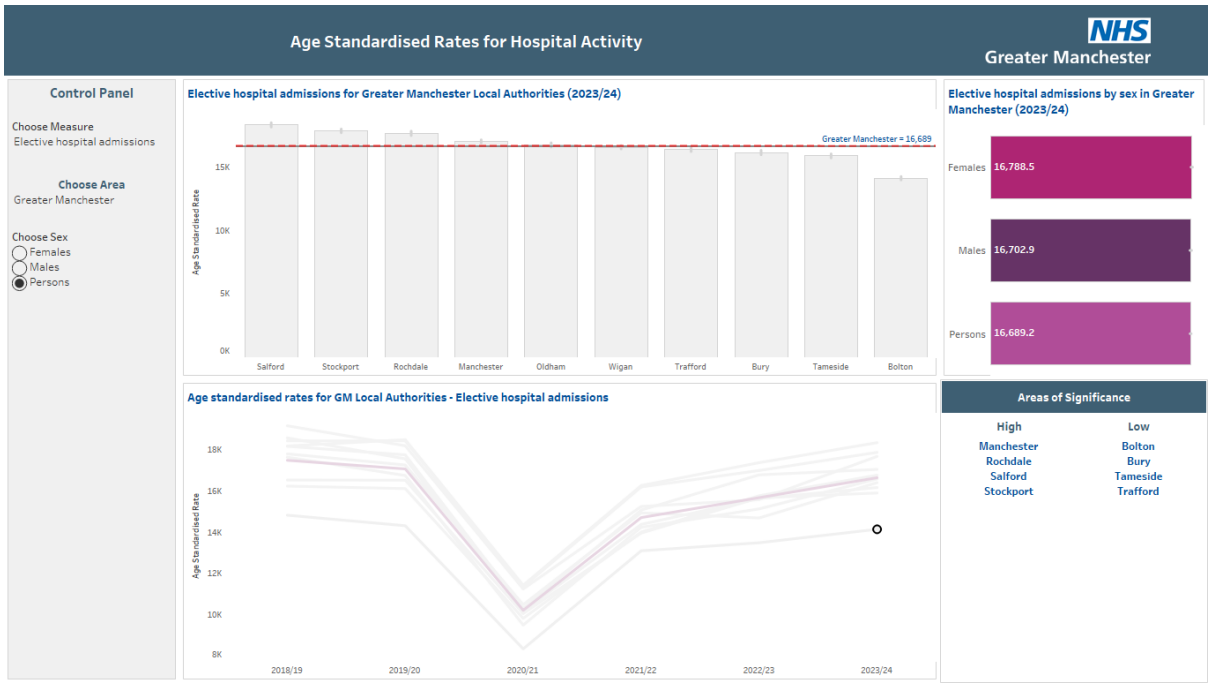


Figure 30: First Outpatient Attendances - Face to Face

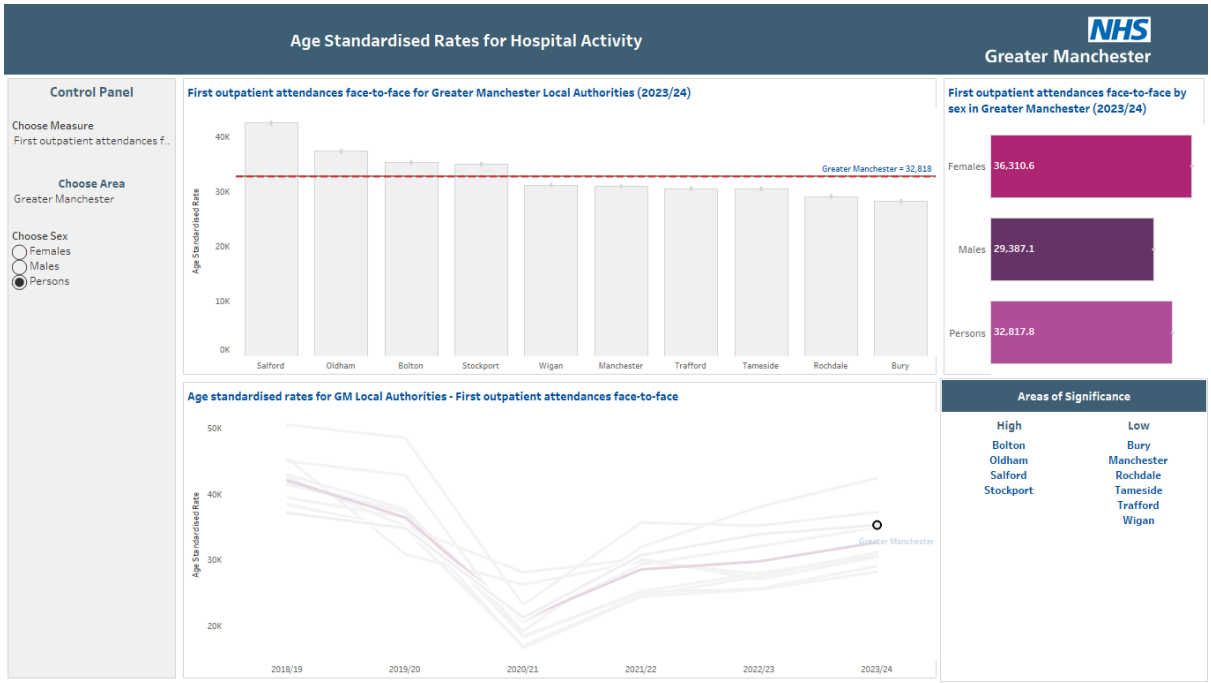
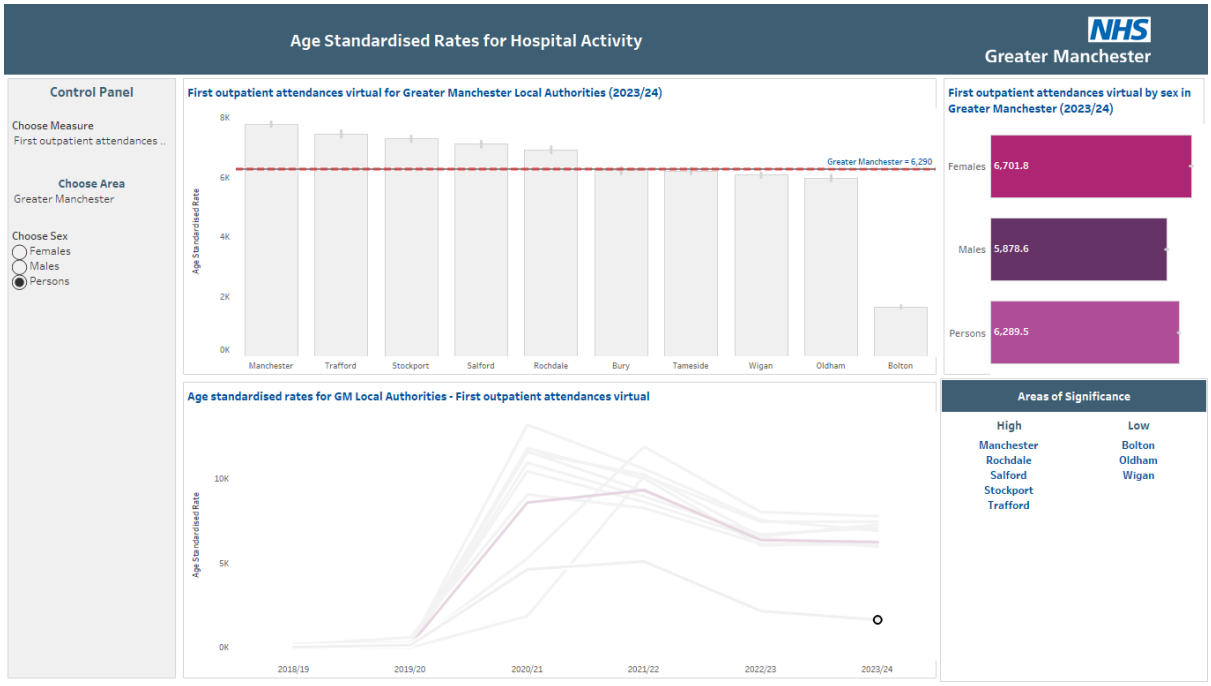


Figure 31: First Outpatient Attendances – Virtual



Manchester has the highest Age Standardises Rate (ASR) for virtual first outpatient appointments at 7,818.6 per 100,000 with Bolton again the lowest locality with 1,676.7 - a significant difference. The GM position is 6,289.5 per 100,000.

Figure 32: Outpatient Follow Up Attendances – Face to face

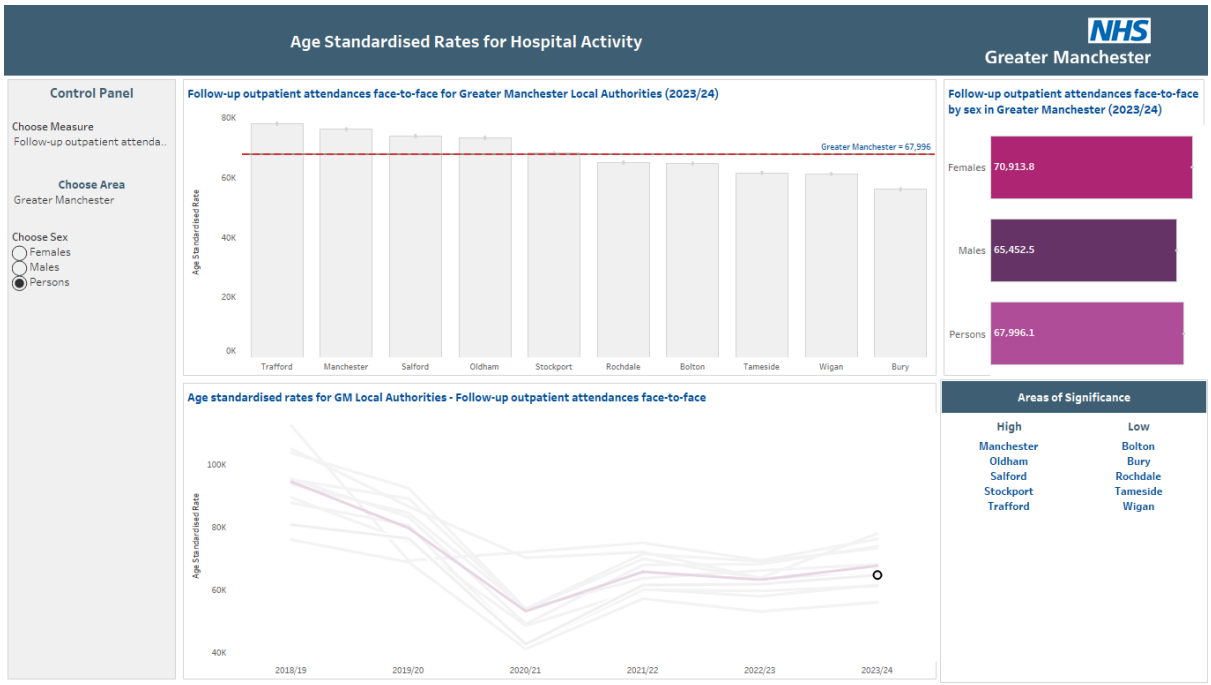
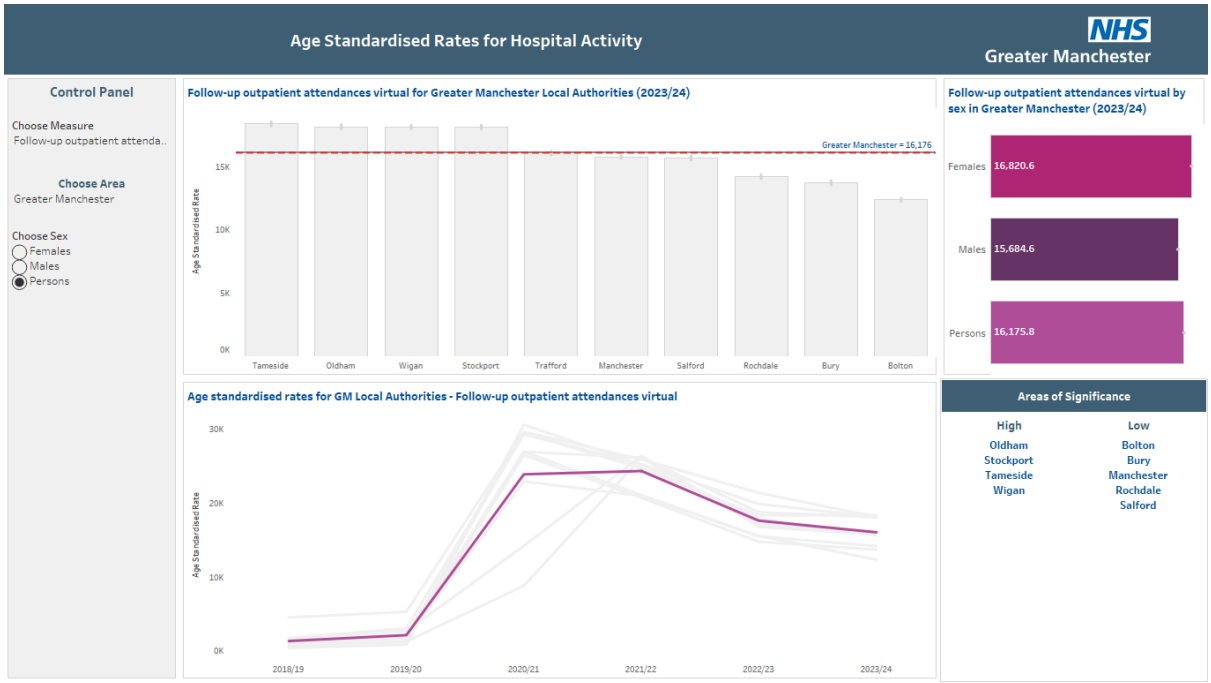


Figure 33: Outpatient Follow UP Attendances – Virtual



There is range and variety of work led at locality level targeting engagement with specific socio-economic groups and within providers addressing access e.g., missed appointments for specific under-served groups who struggle to access care.

- Around 2,000 long-waiting patients have been transferred between NHS hospitals and seen faster as a result. To support this, we identified a transport fund to help patients who felt they were unable to transfer without support with travel costs. Around 10% of patients took up this offer.
- The National Getting It Right First Time (GIRFT) team are now working with Northern Care Alliance to pilot an inequalities approach to elective recovery. Analysis has been undertaken at the site and at specialty level to identify where most significant health inequalities are with an initial focus on missed appointments. An Equity Index has been applied to this analysis.

Variation in Elective care by sex

58% of patients on the waiting list are female and 44% are male (a significant variation to the make-up of the resident population in Greater Manchester: Female – 50.6%; male – 49.4%). Three Trusts have a higher proportion of records with no sex recorded. Therefore, a refresh of the analysis will be required once data on patient sex is refreshed.

Table 8 Patient Gender data via NHS Trust

NHS Trust	Female	Male	Unknown / Indeterminate	Grand Total
Manchester University FT	57%	43%	0.03%	201,158
Northern Care Alliance FT	56%	44%	0.16%	139,606
Wrightington, Wigan and Leigh	56%	41%	3.23%	50,616
Stockport FT	57%	43%	0.02%	35,525
Bolton FT	57%	41%	2.35%	41,182
Tameside FT	60%	38%	1.35%	17,346
Christie FT	51%	49%	0.00%	3,271
Independent Sector (IS) Providers	53%	47%	0.08%	6,552
Grand Total	58%	44%	0.63%	495,256
	58%	44%	1.00%	100%

Variation in Elective Care by Ethnicity and Deprivation

In 2024, the waiting time profiles in terms of average weeks wait varies by ethnicity and deprivation ranged from:

- 19.9 weeks (White) to 21.1 weeks (Black or Black British/Mixed) – a reduction of 0.4 percentage points over 12 months. Although it should be noted that ethnicity recording varies by provider, therefore this analysis will be refreshed later in the year when ethnicity data is more complete.
- 19.7 weeks for the least deprived decile to 20.2 weeks for the most deprived decile.
- People are more likely to wait longer from more deprived deciles in Trauma and Orthopaedics and Gynaecology in GM. Asian/British Asian are waiting longer consistently in four specialties in GM.

However, ethnicity data should be interpreted with caution given that 23% of records do not have ethnicity recorded.

Table 9 Number of Patients of each Ethnic Category per NHS Trust (page 1 of 2)

NHS Trust	African	Any other Asian background	Any other Black background	Any other ethnic group	Any other mixed background	Any other white background	Bangladeshi	British	Caribbean	Chinese
Manchester University FT	6,601	3,586	1,660	6,814	2,327	3,995	1,730	102,952	2,552	1,826
Northern Care Alliance FT	2,025	1,602	783	2,148	790	2,897	2,154	85,490	353	510
Wrightington, Wigan and Leigh	277	237	197	513	236	773	11	40,483	31	106
Stockport FT	114	408	62	354	106	629	54	26,212	50	145
Bolton FT	566	560	87	559	118	567	75	22,247	59	68
Tameside FT	110	118	32	229	66	195	273	12,526	25	23
Christie FT	13	7		9		33	11	1,474	10	18
IS Providers	29	39		31	13	45	17	1923	15	12
Grand Total	9,742	6,582	2,830	10,765	3,677	9,262	4,329	302,132	3,098	2,724
Percentage	2%	1%	1%	2%	1%	2%	1%	61%	1%	1%

Table 9 Number of Patients of each Ethnic Category per NHS Trust (page 2 of 2)

NHS Trust	Indian	Irish	Not known	Not Mapped	Not stated	Pakistani	White + Asian	White + Black African	White +Black Caribbean	Grand Total
Manchester University FT	3,796	2,284	108	26	43,511	14,471	832	649	1,438	201,158
Northern Care Alliance FT	876	871		12	30,085	8,202	310	237	261	139,606
Wrightington, Wigan and Leigh	142	123	6,259		976	143	64	25	20	50,616
Stockport FT	292	265	70		6,019	518	88	69	70	35,525
Bolton FT	1,922	135	5,266		6,693	2,035	97	46	82	41,182
Tameside FT	178	55			2,936	498	25	24	33	17,346
Christie FT	24	14	1,532		60	38		6	17	3,271
IS Providers	61	20	592	806	2816	109		6	10	6,552
Grand Total	7,326	3,795	13,827	3,610	93,096	26,039	1,440	1,070	1,941	495,256
Percentage	1%	1%	3%	1%	19%	5%	0%	0%	0%	100%

Table 10 Number of Patients of each IMD (deprivation) Decile per NHS Trust

NHS Trust	**IMD Decile** Unknown	**IMD Decile** 1	**IMD Decile** 2	**IMD Decile** 3	**IMD Decile** 4	**IMD Decile** 5	**IMD Decile** 6	**IMD Decile** 7	**IMD Decile** 8	**IMD Decile** 9	**IMD Decile** 10	Grand Total
Manchester University NHS Foundation Trust	3,951	58,968	33,777	28,506	24,700	18,816	16,609	16,093	19,289	16,367	14,424	201,158
Northern Care Alliance NHS Foundation Trust	2,509	38,388	26,421	21,497	19,727	14,200	13,655	11,634	15,093	12,133	6,915	139,606
Wrightington, Wigan and Leigh NHS Foundation Trust	878	8,598	9,719	7,700	4,870	5,152	5,147	5,778	7,942	7,052	3,129	50,616
Stockport NHS Foundation Trust	309	4,155	2,940	4,151	5,355	4,638	4,647	4,831	5,167	5,846	5,465	35,525
Bolton NHS Foundation Trust	487	10,764	9,821	6,726	4,031	3,927	3,525	3,997	4,413	3,965	2,731	41,182
Tameside And Glossop Integrated Care NHS Foundation Trust	182	4,022	4,169	3,087	2,455	2,970	2,381	1,118	1,351	1,009	688	17,346
The Christie NHS Foundation Trust	26	681	553	499	396	391	385	360	413	363	263	3,271
IS Providers	55	1335	1094	931	750	701	688	726	903	888	579	6,552
Grand Total	8,397	126,912	88,496	73,100	62,288	50,800	47,043	44,544	54,579	47,632	34,204	495,256
	2%	26%	18%	15%	13%	10%	9%	9%	11%	10%	7%	100%

Appendix A: Health Inequality Statement Indicators

Fairer Health for All indicators

- Life expectancy at birth
- Under 75 mortality from cancer
- Under 75 mortality from cardiovascular disease
- Under 75 mortality from respiratory disease
- Smoking prevalence in adults
- Percentage of physically active adults
- Hospital admissions for alcohol related conditions
- All age all-cause mortality
- Under 75 avoidable mortality rate
- Under 75 preventable mortality rate
- Under 75 treatable mortality rate
- Percentage of people with serious mental illness (SMI) who received all six physical health checks in the preceding 12 months
- Infant mortality rate
- Percentage of children achieving a good level of development at the end of reception

Health Inequality Statement Indicators

Elective recovery

- Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks
- Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances
- Elective activity vs pre-pandemic levels for under 18s and over 18s

Urgent and emergency care

- Emergency admissions for under 18s

Respiratory

- Uptake of COVID and flu by Socio-demographic group

Mental Health

- Overall number of severe mental illness (SMI) physical health checks
- Rates of total Mental Health Act detentions
- Rates of restrictive interventions
- NHS Talking Therapies (formerly IAPT) recovery
- Children and young people's mental health access

Cancer

- Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

Cardiovascular disease

- Stroke rate of non-elective admissions (per 100,000 age-sex standardised)
- Myocardial infarction - rate of non-elective admissions (per 100,000 age-sex standardised)
- CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold, by data
- CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy (QRISK is a Clinical tool used to estimate the risk of developing cardiovascular disease (CVD) over the next 10 years).
- CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

Diabetes

- Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes
- Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile

Smoking cessation

- Proportion of adult acute inpatient settings offering smoking cessation services
- Proportion of maternity inpatient settings offering smoking cessation services

Oral Health

- Tooth Extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted)

Learning disability and autistic people

- Learning Disability Annual Health Checks
- Adult mental health inpatient rates for people with a learning disability and autistic people

Maternity and neonatal

- Preterm births under 37 weeks

Appendix B: Fairer Health for All Outcomes – Area Summaries

Bolton

Measures that are **worse the national average and worsened from the previous period**

- The **under-75 mortality rate due to cardiovascular disease** increased in Bolton rising from 108.9 per 100,000 in 2020–2022 to 110.3 per 100,000 in 2021–2023. This was driven by males which increase from 149.7 per 100,000 to 155.9 per 100,000
- The **smoking prevalence for adults** for Bolton increased from 14.2% to 15.3%, this is above the 11.6% national average
- **Under 75 avoidable mortality** increased from 334.3 per 100,000 in 2019-21 to 345 per 100,000 in 2020-22 in Bolton, this is above the national average of 253 per 100,000
- **Under 75 preventable mortality** increased from 227.8 per 100,000 in 2019-21 to 237.8 per 100,000 in 2020-22 in Bolton, this is above the national average of 171.4 per 100,000
- **Under 75 treatable mortality** increased from 106.5 per 100,000 in 2019-21 to 107.2 per 100,000 per 100,000 in 2020-22 across Bolton, this is above the national average of 81.6 per 100,000
- The **infant mortality rate** for Bolton increased from 5.2 per 1,000 in 2020-22 to 5.8 per 10,000 in 2021-23. This is above the national average of 4.1 per 100,000
- The percentage of **children achieving a good level of development at the end of reception** decreased slightly from 63.9% to 63.8%, below the national average of 67.7%

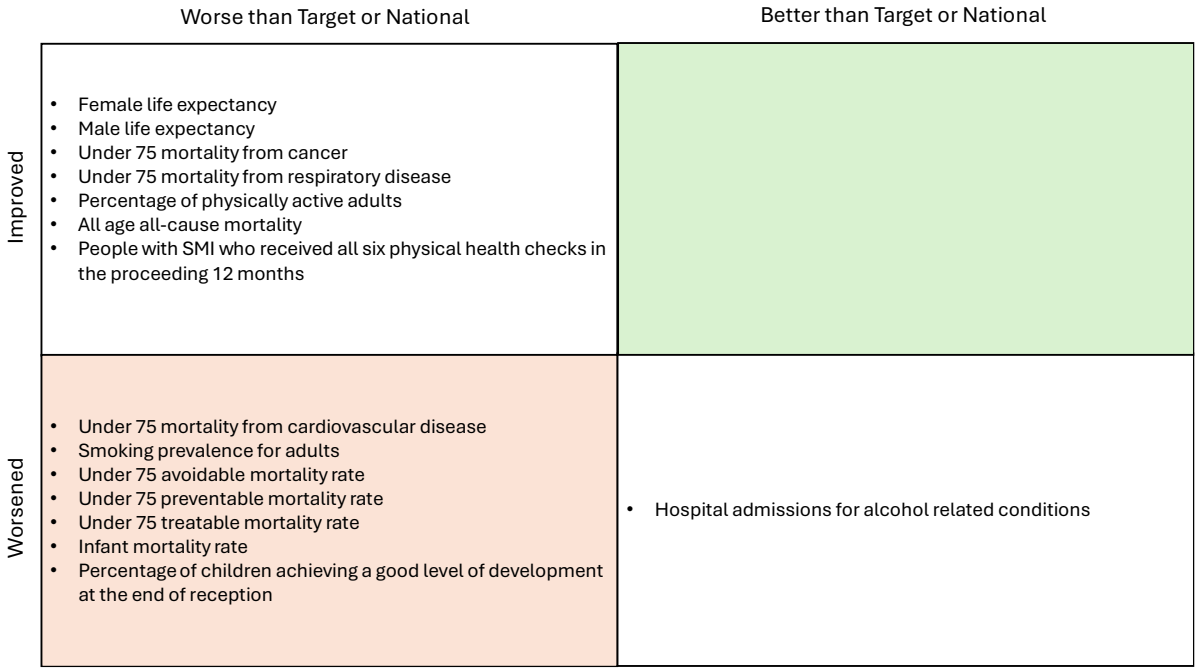
Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for men in Bolton has improved to 76.7 years in the 2021 to 2023 period, up from 76.6 years in the 2020-2022 period. Female life expectancy also increased 80.7 years to 81.3 years.
- The **mortality rate from cancer among those under 75** in Bolton saw a slight decline, dropping from 136.2 per 100,000 in 2020–2022 to 135.6 per 100,000 in 2021–2023.
- The **under 75 mortality rate from respiratory disease** in Bolton saw a slight decline from 45.1 per 100,000 in 2020–2022 to 44.1 per 100,000 in 2021–2023
- The proportion of **physically active adults** in Bolton increased to 62.3% but remains below the national average of 67.1%.
- The **all-age all-cause mortality rate** decreased from 1188.8 per 100,000 to 1,144.5 per 100,000, this is above the national average of 981 per 100,000
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 56.2% to 67.7%, just below the national average of 68.5%

Measures that are **better than the national average but worsened from the previous period**

- **Hospital admissions for alcohol related conditions** increased from 390.7 to 427 per 100,000. This is below the national average of 504.1

Figure 34: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Bolton



Bury

Measures that are **worse the national average and worsened from the previous period**

- The **under-75 mortality rate due to cardiovascular disease** increased in Bury, rising from 90.1 per 100,000 in 2020–2022 to 95.8 per 100,000 in 2021–2023
- **Under 75 avoidable mortality** increased from 297.7 to 313.8 per 100,000 in Bury, this is above the national average of 253 per 100,000
- **Under 75 preventable mortality** increased from 204.5 to 217.1 per 100,000 in Bury, this is above the national average of 171.4 per 100,000
- **Under 75 treatable mortality** increased from 93.2 to 96.7 per 100,000 in Bury, this is above the national average of 81.6 per 100,000
- The **infant mortality rate** for Bury increase from 5.3 per 1,000 to 6.2 per 1,000. This is above the national average of 4.1 per 1,000
- The percentage of **children achieving a good level of development at the end of reception** decreased from 65.7% to 65%, below the national average of 67.7%
- The **mortality rate from cancer among those under 75** in Bury saw an increase from 144.9 per 100,000 in 2020–2022 to 146.1 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **under 75 mortality rate from respiratory disease** in Bury saw an increase from 30.5 per 100,000 in 2020–2022 to 32.5 per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000
- The proportion of **physically active adults** in Bury decreased from 69.2% to 65.5%, below the national average of 67.1%.

Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Bury has improved to 77.5 years in the 2021 to 2023 period, up from 77.2 years in the 2020-2022 period. Female life expectancy increased from 80.9 years to 81.3 years.
- The **all-age all-cause mortality rate** decreased from 1164.2 per 100,000 to 1107.2 per 100,000, this is above the national average of 981 per 100,000
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 49.1% to 64.9%, below the national average of 68.5%

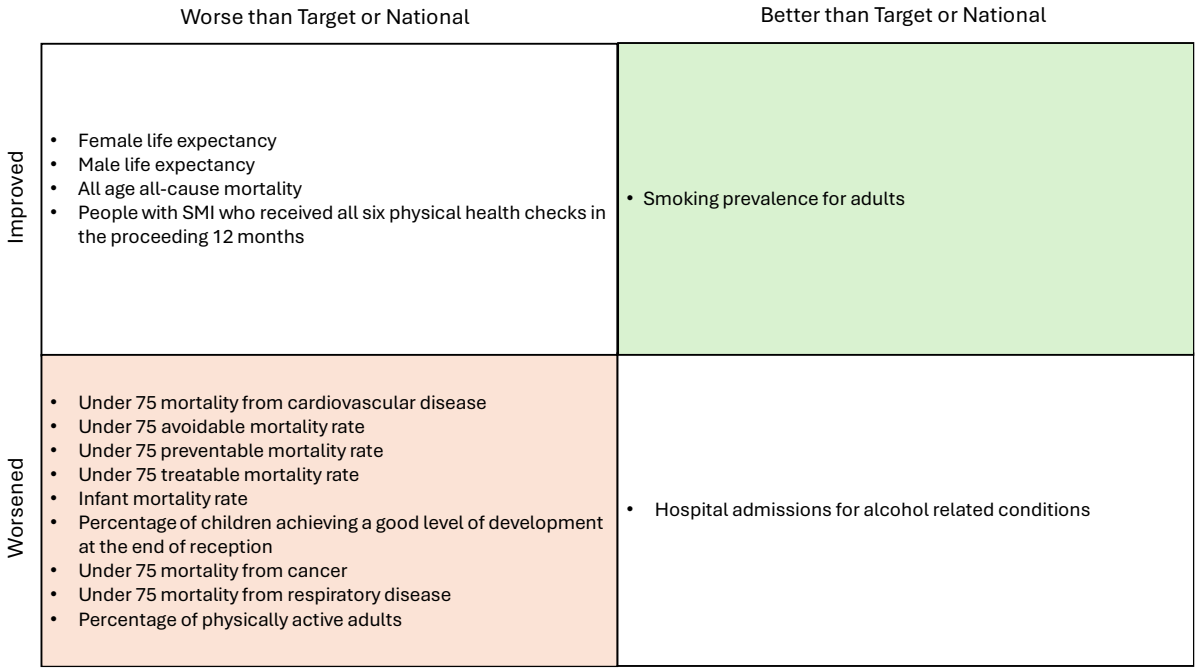
Measures that are **better than the national average but worsened from the previous period**

- **Hospital admissions for alcohol related conditions** increased from 367.7 to 408.8 per 100,000. This is below the national average of 504.1 per 100,000

Measures that are **better than the national average and improved from the previous period**

- The **smoking prevalence for adults** for Bury decreased from 11.7% to 10.5%, this is below the 11.6% national average

Figure 35: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Bury



Manchester

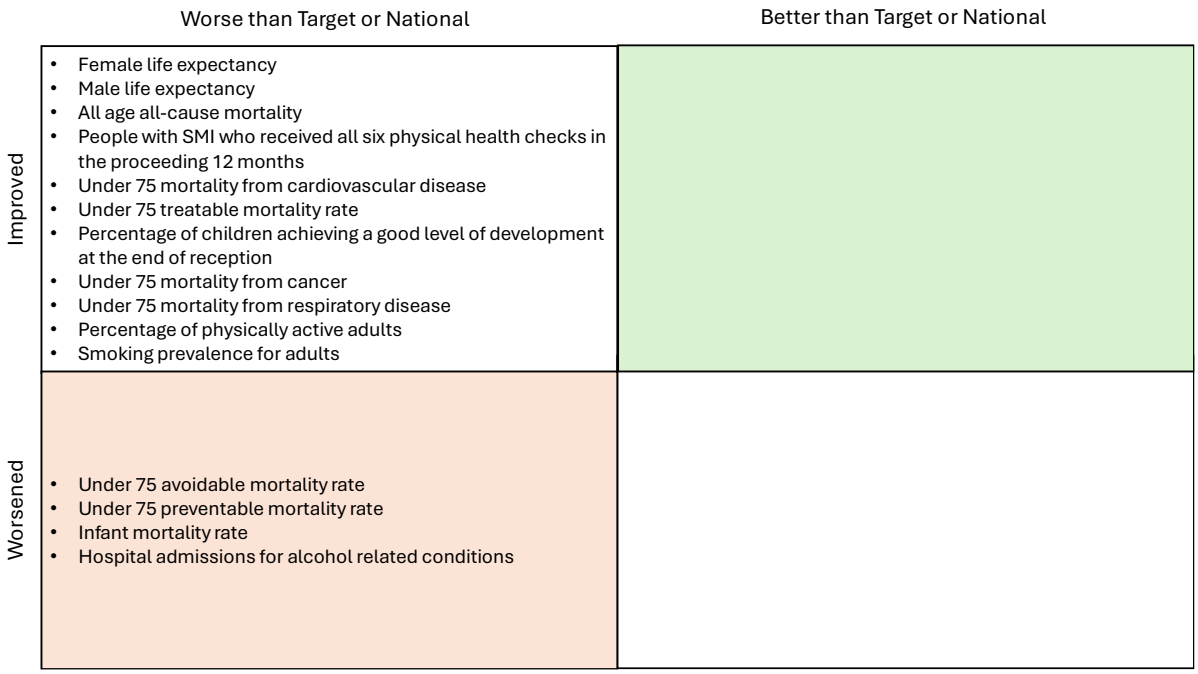
Measures that are **worse the national average and worsened from the previous period**

- **Under 75 avoidable mortality** increased from 413.5 to 423.9 per 100,000 in Manchester, this is above the national average of 253 per 100,000
- **Under 75 preventable mortality** increased from 291.2 to 304.9 per 100,000 in Manchester, this is above the national average of 171.4 per 100,000
- The **infant mortality rate** for Manchester increased from 6.7 per 1,000 live births to 6.9 per 1,000 live births. This is above the national average of 4.1 per 100,000
- **Hospital admissions for alcohol related conditions** increased from 484 to 535.8 per 100,000. This is above the national average of 504.1 per 100,000

Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Manchester has improved to 75.2 years in the 2021 to 2023 period, up from 74.8 years in the 2020-22 period. Female life expectancy increased from 79.2 years to 79.6 years.
- The **all-age all-cause mortality rate** decreased from 1,380.7 per 100,000 to 1,304.7 per 100,000, this is above the national average of 981 per 100,000
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 61.1%to 67.7%, just below the national average of 68.5%
- The **under-75 mortality rate due to cardiovascular disease** decreased in Manchester, moving from 125.3 per 100,000 in 2020–2022 to 119.1 per 100,000 in 2021–2023. This is above the national average of 77.1 per 100,000
- **Under 75 treatable mortality** decreased from 122.3 to 119 per 100,000 in Manchester, this is above the national average of 81.6 per 100,000
- The percentage of **children achieving a good level of development at the end of reception** decreased from 58.5% to 59.6%, below the national average of 67.7%
- The **mortality rate from cancer among those under 75** in Manchester saw a decrease from 170.1 per 100,000 in 2020–2022 to 163.7 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **under 75 mortality rate from respiratory disease** in Manchester saw a decreased from 61.4 per 100,000 in 2020–2022 to 58.8 per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000
- The proportion of **physically active adults** in Manchester increased from 63.6% to 65%, below the national average of 67.1%.
- The **smoking prevalence for adults** for Manchester decreased from 17.3% to 11.9%, this is above the 11.6% national average

Figure 36: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Manchester



Oldham

Measures that are **worse the national average and worsened from the previous period**

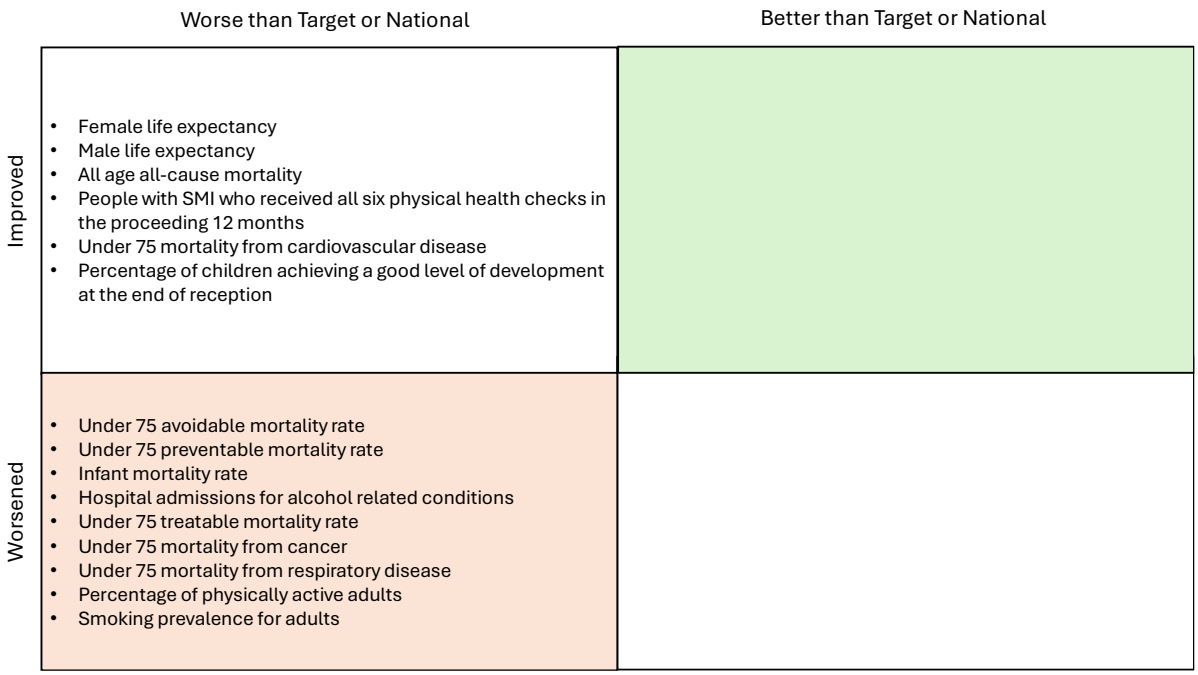
- **Under 75 avoidable mortality** increased from 350.9 to 354.2 per 100,000 in Oldham, this is above the national average of 253 per 100,000
- The **infant mortality rate** for Oldham increased from 6.4 per 1,000 live births to 6.7 per 100,000. This is above the national average of 4.1 per 100,000
- **Hospital admissions for alcohol related conditions** increased from 439.3 to 527.5 per 1,000 live births. This is above the national average of 4.1 per 1,000
- **Under 75 treatable mortality** increased from 109.8 to 113 per 100,000 in Oldham, this is above the national average of 81.6 per 100,000
- The **mortality rate from cancer among those under 75** in Oldham saw a slight increase from 146.76 per 100,000 in 2020–2022 to 147.85 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **under 75 mortality rate from respiratory disease** in Oldham saw an increase from 39.7 per 100,000 in 2020–2022 to 45.6 per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000

- The proportion of **physically active adults** in Oldham decreased from 62.7% to 57%, below the national average of 67.1%.
- The **smoking prevalence for adults** for Oldham increased from 10.9% to 12%, this is above the 11.6% national average

Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Oldham improved to 76.6 years in the 2021 to 2023 period, up from 76.3 years in the 2020-22 period. Female life expectancy increased from 80.1 years to 80.5 years.
- The **all-age all-cause mortality rate** decreased from 1,245.2 per 100,000 to 1,182.1 per 100,000, this is above the national average of 981 per 100,000
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 60.2% to 65.4%, below the national average of 68.5%
- The **under-75 mortality rate due to cardiovascular disease** decreased in Oldham, moving from 107.3 per 100,000 in 2020–2022 to 106 per 100,000 in 2021–2023. This is above the national average of 77.1 per 100,000
- The percentage of **children achieving a good level of development at the end of reception** increased from 62.8% to 63.6%, below the national average of 67.7%
- **Under 75 preventable mortality** remained at 241.2 per 100,000 in Oldham, this is above the national average of 171.4 per 100,000

Figure 37: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Oldham



Rochdale

Measures that are **worse the national average and worsened from the previous period**

- **Under 75 avoidable mortality** increased from 352.6 to 372.3 per 100,000 in Rochdale, this is above the national average of 253 per 100,000
- **Under 75 treatable mortality** increased from 108.8 to 115.5 per 100,000 in Rochdale, this is above the national average of 81.6 per 100,000
- The **under 75 mortality rate from respiratory disease** increased from 43 per 100,000 in 2020–2022 to 45.8 per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000
- The proportion of **physically active adults** in Rochdale decreased from 60.9% to 54.6%, below the national average of 67.1%.
- The percentage of **children achieving a good level of development at the end of reception** decreased from 62.8% to 62.2%, below the national average of 67.7%
- **Under 75 preventable mortality** increased to 256.7 per 100,000 in Rochdale, this is above the national average of 171.4 per 100,000

Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Rochdale improved to 76.5 years in the 2021 to 2023 period, up from 75.7 years in the 2020-22 period. Female life expectancy increased from 80.4 years to 80.9 years.
- The **mortality rate from cancer among those under 75** in Rochdale saw a decrease from 143.5 per 100,000 in 2020–2022 to 138 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **all-age all-cause mortality rate** decreased from 1,254.4 per 100,000 to 1,185.9 per 100,000, this is above the national average of 981 per 100,000
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 60.2% to 66.6%, below the national average of 68.5%
- The **under-75 mortality rate due to cardiovascular disease** decreased, moving from 116.3 per 100,000 in 2020–2022 to 113.9 per 100,000 in 2021–2023. This is above the national average of 77.1 per 100,000
- The **smoking prevalence for adults** for Oldham decreased from 15.3% to 13.1%, this is above the 11.6% national average

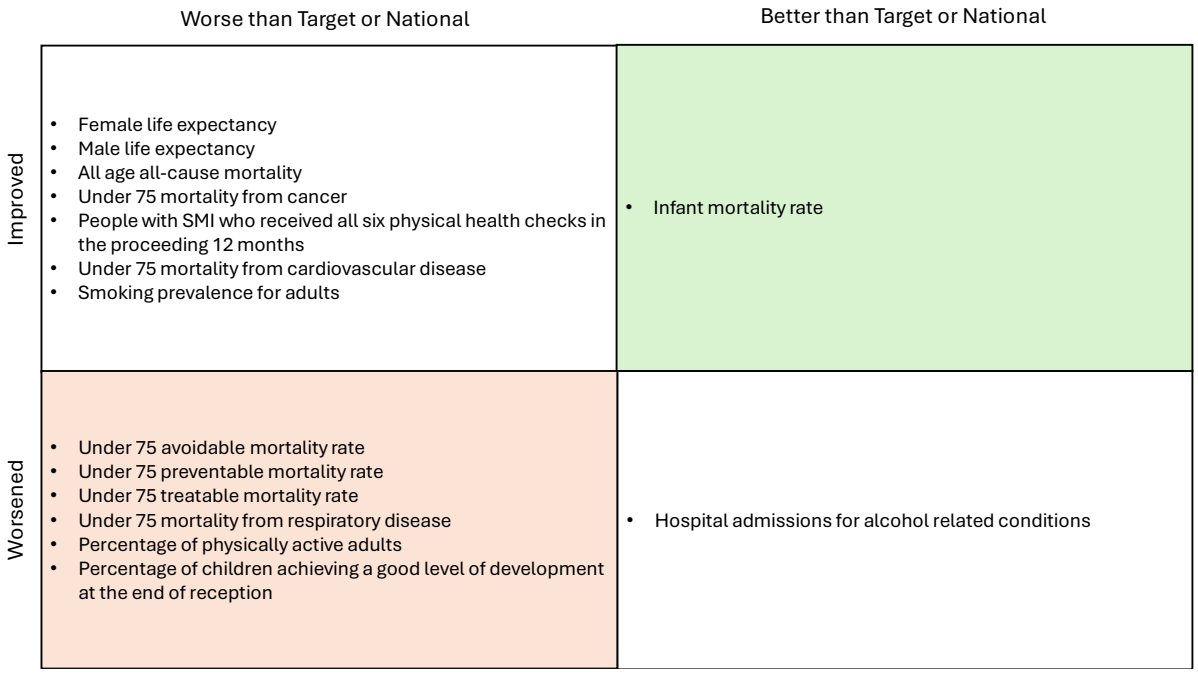
Measures that are **better than the national average but worsened from the previous period**

- **Hospital admissions for alcohol related conditions** increased from 451.3 to 485.2 per 100,000. This is below the national average of 504.1 per 100,000

Measures that are **better the national average and improved from the previous period**

- The **infant mortality rate** for Rochdale decreased from 4.1 per 1,000 live births to 3.8 per 1,000 live births. This is below the national average of 4.1 per 1,000 live births

Figure 38: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Rochdale



Salford

Measures that are **worse the national average and worsened from the previous period**

- **Under 75 avoidable mortality** increased from 363.9 to 375.4 per 100,000 in Salford, this is above the national average of 253 per 100,000
- **Under 75 treatable mortality** increased from 110 to 111.8 per 100,000 in Salford, this is above the national average of 81.6 per 100,000
- The percentage of **children achieving a good level of development at the end of reception** decreased from 61.5% to 60.7%, below the national average of 67.7%
- **Under 75 preventable mortality** increased to 263.6 per 100,000 in Salford, this is above the national average of 171.4 per 100,000
- The **under-75 mortality rate due to cardiovascular disease** increased, moving from 108.0 per 100,000 in 2020–2022 to 110.6 per 100,000 in 2021–2023. This is above the national average of 77.1 per 100,000
- The **smoking prevalence for adults** for Salford increased from 15.1% to 15.4%, this is above the 11.6% national average
- **Hospital admissions for alcohol related conditions** increased from 479.3 to 522.3 per 100,000. This is above the national average of 504.1 per 100,000
- The **infant mortality rate** for Salford increased from 4.9 per 1,000 live births to 5.2 per 1,000 live births. This is below the national average of 4.1 per 1,000 live births

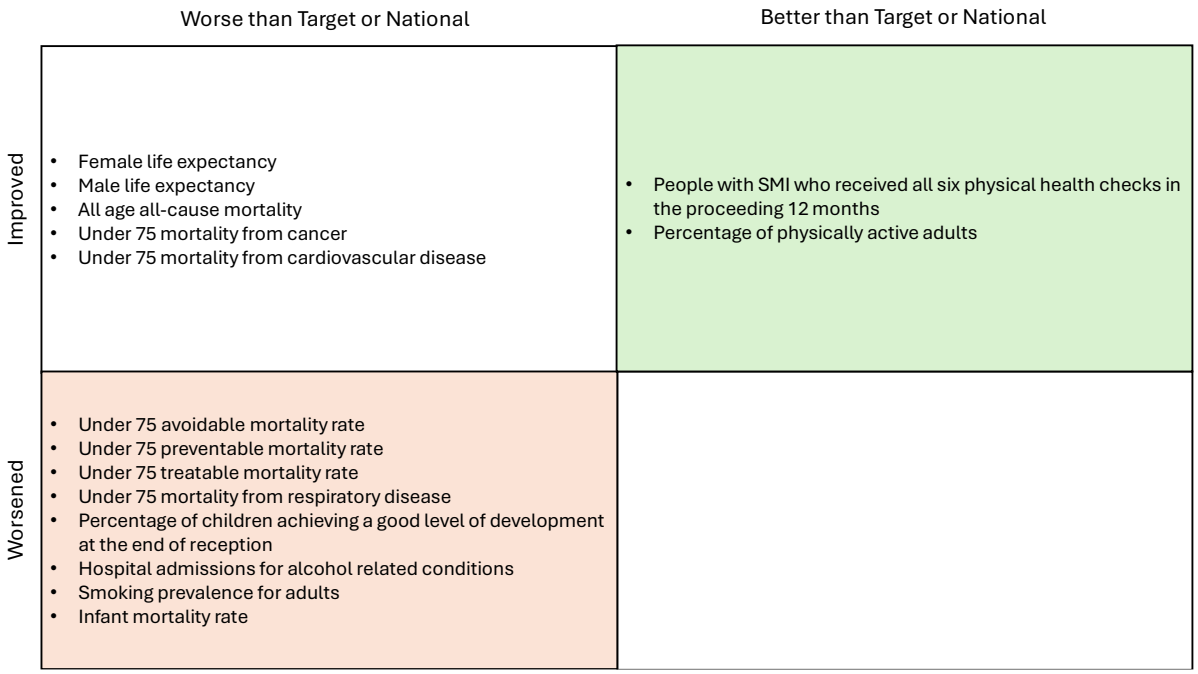
Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Salford improved to 76.3 years in the 2021 to 2023 period, up from 75.9 years in the 2020-22 period. Female life expectancy increased from 80.1 years to 80.9 years.
- The **mortality rate from cancer among those under 75** in Salford saw a decrease from 153.8 per 100,000 in 2020–2022 to 141.1 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **all-age all-cause mortality rate** decreased from 1,299.6 per 100,000 to 1,233.8 per 100,000, this is above the national average of 981 per 100,000
- The **under 75 mortality rate from respiratory disease** decreased from 60 per 100,000 in 2020–2022 to 58.2. per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000

Measures that are **better the national average and improved from the previous period**

- The proportion of **physically active adults** in Salford increased from 63.1% to 67.5%, above the national average of 67.1%.
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 56.6% to 70.7%, above the national average of 68.5%

Figure 39: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Salford



Stockport

Measures that are **worse the national average and worsened from the previous period**

- **Under 75 avoidable mortality** increased from 245.7 to 256 per 100,000 in Stockport, this is above the national average of 253 per 100,000
- **Under 75 preventable mortality** increased to 174.4 per 100,000 in Stockport, this is above the national average of 171.4 per 100,000
- **Under 75 treatable mortality** decreased from 81.9 to 81.6 per 100,000 in Stockport, this matches the national average of 81.6 per 100,000

Measures that are **worse the national average but improved from the previous period**

- The **mortality rate from cancer among those under 75** in Stockport saw a decrease from 124.6 per 100,000 in 2020–2022 to 121.7 per 100,000 in 2021–2023. This is slightly above the national average of 121.6 per 100,000

Measures that are **better than the national average but worsened from the previous period**

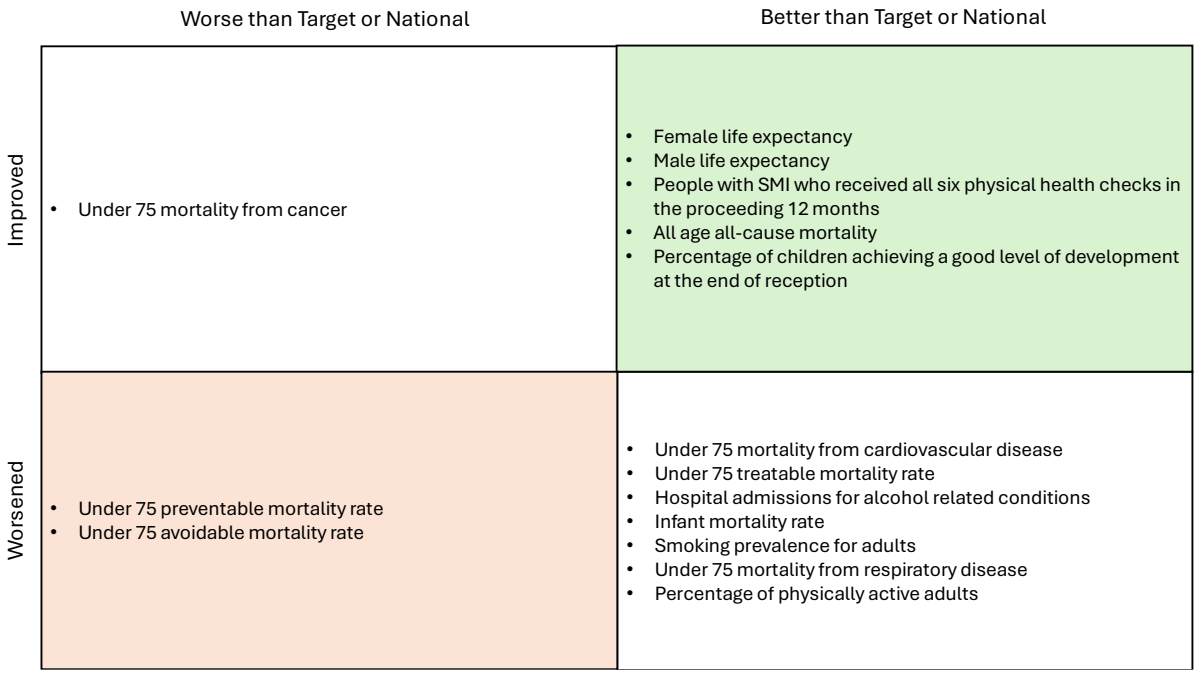
- The **under-75 mortality rate due to cardiovascular disease** increased, moving from 75.5 per 100,000 in 2020–2022 to 76.5 per 100,000 in 2021–2023. This is below the national average of 77.1 per 100,000
- **Hospital admissions for alcohol related conditions** increased from 460.4 to 467.8 per 100,000. This is below the national average of 504.1 per 100,000
- The **infant mortality rate** for Stockport increased from 2.9 per 1,000 live births to 3.1 per 1,000 live births. This is below the national average of 4.1 per 1,000 live births
- The **under 75 mortality rate from respiratory disease** increased from 26.1 per 100,000 in 2020–2022 to 27.7 per 100,000 in 2021–2023. Below the national average of 30.3 per 100,000
- The proportion of **physically active adults** in Stockport decreased from 68.7% to 68.6%, above the national average of 67.1%.

Measures that are **better the national average and improved from the previous period**

- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 65.0% to 73.5%, above the national average of 68.5%
- The percentage of **children achieving a good level of development at the end of reception** increased from 67.6% to 68.7%, above the national average of 67.7%
- The **smoking prevalence for adults** in Stockport decreased from 11.8% to 10.6%, this is below the 11.6% national average
- The **life expectancy** for males in Stockport improved to 79.3 years in the 2021 to 2023 period, up from 78.9 years in the 2020-22 period. Female life expectancy increased from 83.35 years to 83.44 years

- The **all-age all-cause mortality rate** decreased from 986.4 per 100,000 to 959.6 per 100,000, this is below the national average of 981 per 100,000

Figure 40: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Stockport



Tameside

Measures that are **worse the national average and worsened from the previous period**

- **Under 75 avoidable mortality** increased from 342 to 349.2 per 100,000 in Tameside, this is above the national average of 253 per 100,000
- **Under 75 preventable mortality** increased from 237.9 per 100,000 to 245.6 per 100,000 in Salford, this is above the national average of 171.4 per 100,000
- **Hospital admissions for alcohol related conditions** increased from 471.1 to 540.8 per 100,000. This is above the national average of 504.1 per 100,000
- The **infant mortality rate** for Tameside increased from 4.5 per 1,000 live births to 4.7 per 1,000 live births. This is below the national average of 4.1 per 1,000 live births
- The **under 75 mortality rate from respiratory disease** increased from 39.9 per 100,000 in 2020–2022 to 47.5 per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000

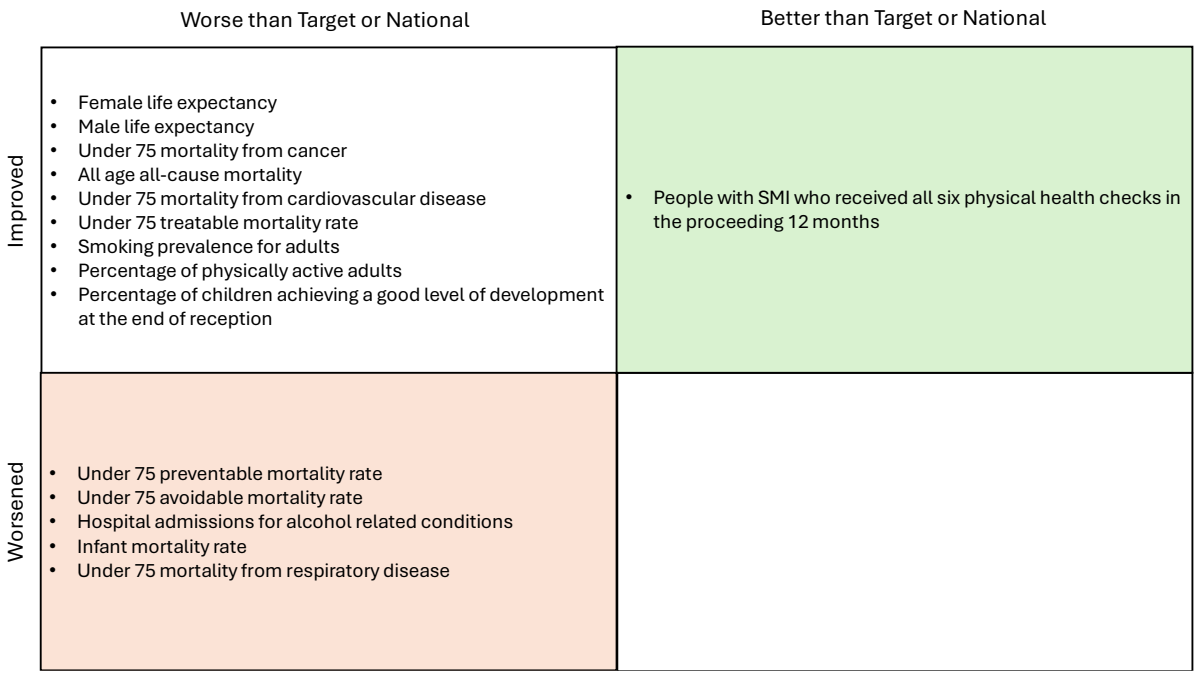
Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Tameside improved to 76.5 years in the 2021 to 2023 period, up from 76.3 years in the 2020-22 period. Female life expectancy increased from 80.2 years to 80.6 years.
- The **mortality rate from cancer among those under 75** in Tameside saw a decrease from 145.2 per 100,000 in 2020–2022 to 140.2 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **all-age all-cause mortality rate** decreased from 1,269.8 per 100,000 to 1,203.6 per 100,000, this is above the national average of 981 per 100,000
- **Under 75 treatable mortality** decreased from 104 to 103.6 per 100,000 in Tameside, this is above the national average of 81.6 per 100,000
- The percentage of **children achieving a good level of development at the end of reception** increased from 60.9% to 62%, below the national average of 67.7%
- The **under-75 mortality rate due to cardiovascular disease** decreased, moving from 101.4 per 100,000 in 2020–2022 to 100.4 per 100,000 in 2021–2023. This is above the national average of 77.1 per 100,000
- The **smoking prevalence for adults** in Tameside decreased from 20.2% to 15.9%, this is above the 11.6% national average
- The proportion of **physically active adults** in Salford increased from 57.7% to 62.1%, below the national average of 67.1%.

Measures that are **better the national average and improved from the previous period**

- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 60.5% to 69.7%, above the national average of 68.5%

Figure 41: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Tameside



Trafford

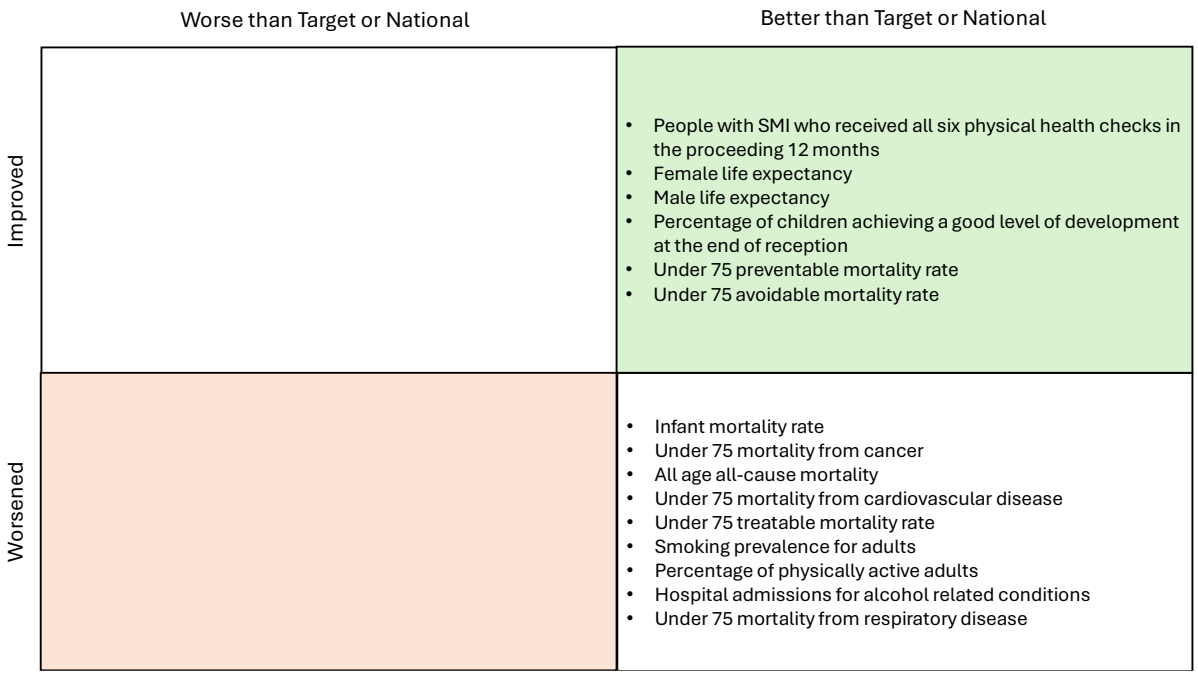
Measures that are **better than the national average but worsened from the previous period**

- The **under-75 mortality rate due to cardiovascular disease** increased, moving from 73.9 per 100,000 in 2020–2022 to 76.9 per 100,000 in 2021–2023. This is below the national average of 77.1 per 100,000
- **Hospital admissions for alcohol related conditions** increased from 353.6 to 365.5 per 100,000. This is below the national average of 504.1 per 100,000
- The **infant mortality rate** for Trafford increased from 2.9 per 1,000 live births to 4 per 1,000 live births. This is below the national average of 4.1 per 100,000
- The **under 75 mortality rate from respiratory disease** increased from 26.5 per 100,000 in 2020–2022 to 30 per 100,000 in 2021–2023. Below the national average of 30.3 per 100,000
- The proportion of **physically active adults** in Trafford decreased from 71% to 68.4%, above the national average of 67.1%.
- **Under 75 preventable mortality** increased to 164.3 per 100,000 in Trafford, this is below the national average of 171.4 per 100,000
- The **mortality rate from cancer among those under 75** in Trafford saw an increase from 115.8 per 100,000 in 2020–2022 to 116.1 per 100,000 in 2021–2023. This is below the national average of 121.6 per 100,000
- The **smoking prevalence for adults** in Trafford increased from 8% to 9.6%, this is below the 11.6% national average

Measures that are **better the national average and improved from the previous period**

- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 61.3% to 72.8%, above the national average of 68.5%
- The percentage of **children achieving a good level of development at the end of reception** increased from 72.2% to 72.6%, above the national average of 67.7%
- The **life expectancy** for males in Trafford remained at 79.4 years in the 2021 to 2023 period. Female life expectancy increased from 83.3 years to 83.5 years
- The **all-age all-cause mortality rate** decreased from 992.1 per 100,000 to 953 per 100,000, this is below the national average of 981 per 100,000
- **Under 75 avoidable mortality** decreased from 238 to 237.8 per 100,000 in Trafford, this is below the national average of 253 per 100,000
- **Under 75 treatable mortality** decreased from 77.6 to 73.5 per 100,000 in Trafford, this is below the national average of 81.6 per 100,000

Figure 42: Quadrant Analysis of FHFA measures using most recent data available (February 2025) - Trafford



Wigan

Measures that are **worse the national average and worsened from the previous period**

- **Under 75 avoidable mortality** increased from 312.5 to 321.5 per 100,000 in Wigan, this is above the national average of 253 per 100,000
- **Under 75 treatable mortality** increased from 96.6 to 97.6 per 100,000 in Wigan, this is above the national average of 81.6 per 100,000
- **Under 75 preventable mortality** increased to 223.9 per 100,000 from 215.9 per 100,000 in Salford, this is above the national average of 171.4 per 100,000
- The **under-75 mortality rate due to cardiovascular disease** increased, moving from 94.8 per 100,000 in 2020–2022 to 98.6 per 100,000 in 2021–2023. This is above the national average of 77.1 per 100,000
- The **infant mortality rate** for Wigan increased from 3.7 per 1,000 live births to 4.5 per 1,000 live births. This is above the national average of 4.1 per 100,000
- The **under 75 mortality rate from respiratory disease** increased from 44.4 per 100,000 in 2020–2022 to 47.2 per 100,000 in 2021–2023. Above the national average of 30.3 per 100,000

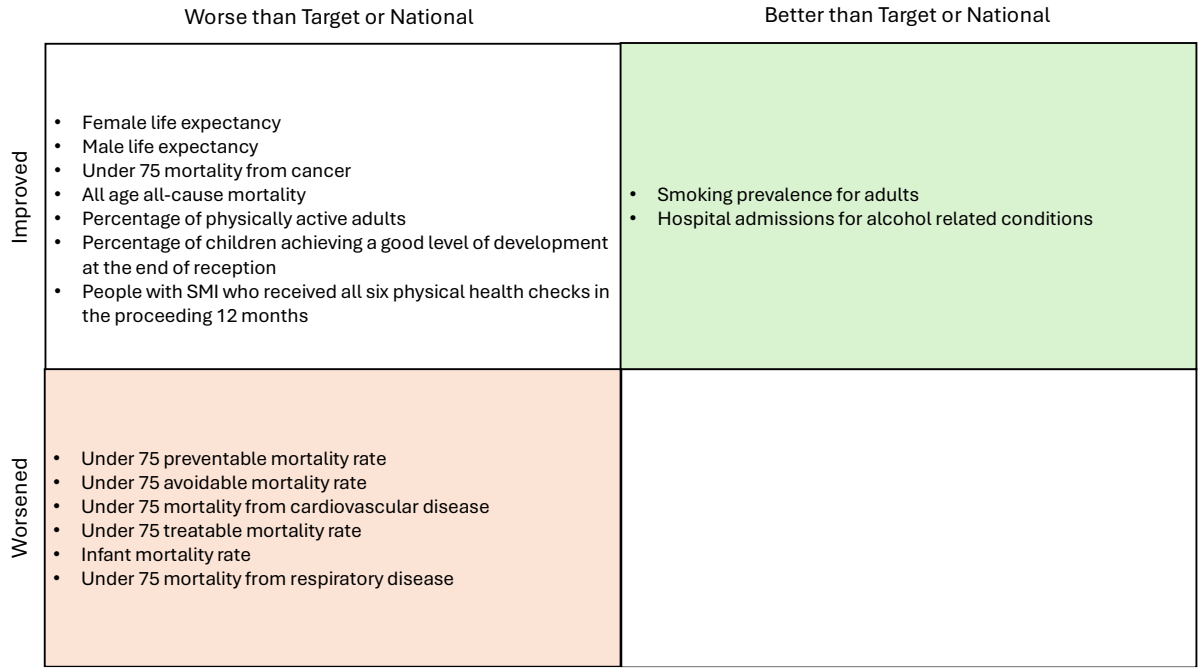
Measures that are **worse the national average but improved from the previous period**

- The **life expectancy** for males in Wigan improved to 77.3 years in the 2021 to 2023 period, up from 77 years in the 2018–2020 period. Female life expectancy increased from 80.7 years to 80.9 years.
- The **mortality rate from cancer among those under 75** in Wigan saw a decrease from 138.1 per 100,000 in 2020–2022 to 137.5 per 100,000 in 2021–2023. This is above the national average of 121.6 per 100,000
- The **all-age all-cause mortality rate** decreased from 1,195.4 per 100,000 to 1,142.3 per 100,000, this is above the national average of 981 per 100,000
- The percentage of **children achieving a good level of development at the end of reception** increased from 63.4% to 63.9%, below the national average of 67.7%
- The proportion of **physically active adults** in Wigan increased from 64.5% to 65.5%, below the national average of 67.1%.
- The **percentage of people with SMI who received all six physical health checks** in the preceding 12 months increased from 59.2% to 67%, below the national average of 68.5%

Measures that are **better the national average and improved from the previous period**

- The **smoking prevalence for adults** in Wigan decreased from 14.7% to 11.3%, this is below the 11.6% national average
- **Hospital admissions for alcohol related conditions** decreased from 490.7 to 485.7 per 100,000. This is below the national average of 504.1 per 100,000

Figure 43: Quadrant Analysis of FHFA measures using most recent data available (February 2025) – Wigan

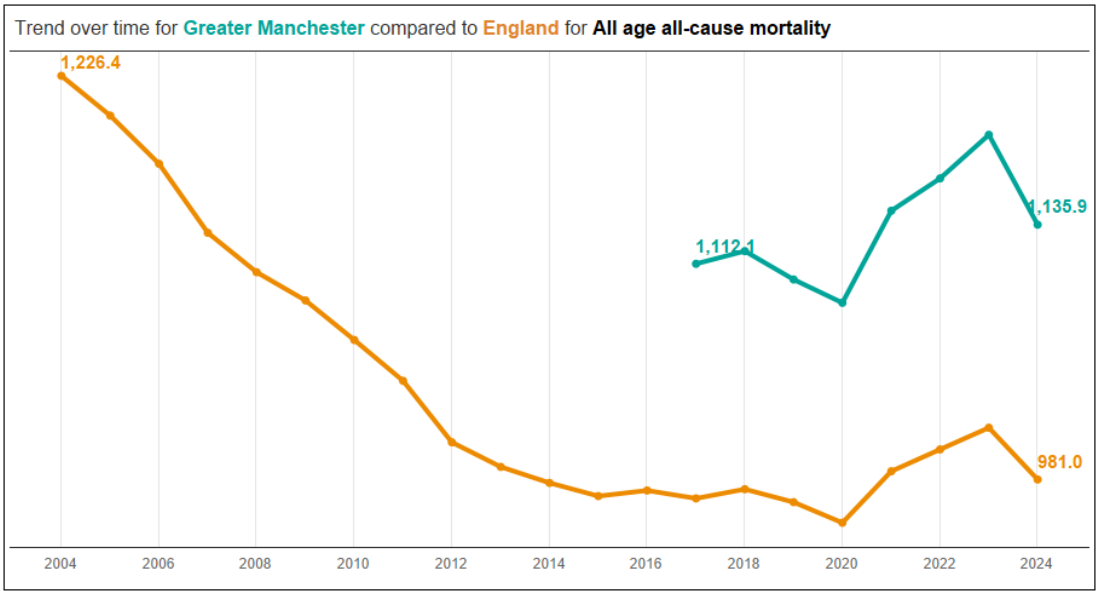


Appendix C: Mortality Trends

All age all-cause mortality

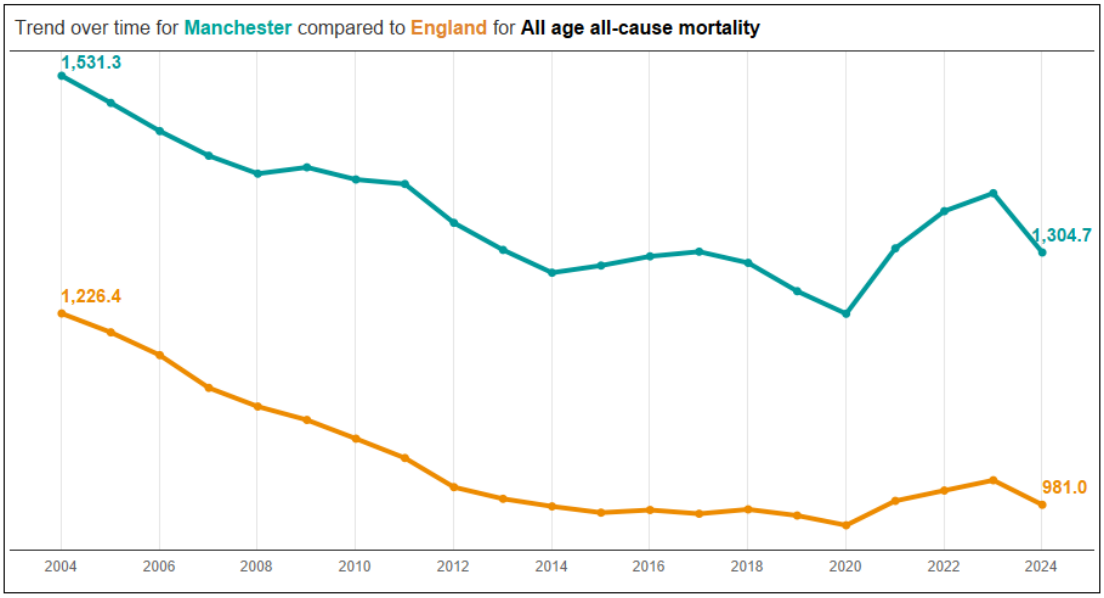
All age all-cause mortality in Greater Manchester decreased from the 2020 to 2022 period from 1,190.6 per 100,000 to 1,135.9 per 100,000 in the 2021 to 2023 period. This is above the national average of 981 per 100,000. The decrease follows the national trend which decreased from 1,012.5 per 100,000. The plot below shows the trend between Greater Manchester and England over across all available periods.

Figure 44: All age all-cause mortality, GM v England, all available periods



This decrease was seen for both female and males in the same period. For females, this decreased from 1,019.1 per 100,000 to 970.7 per 100,000 and for males this decreased from 1,401.5 per 100,000 to 1,338.8 per 100,000. All areas inside Greater Manchester saw decreases from the 2020 to 2022 period. Manchester experienced the sharpest decrease from 1,380.7 per 100,000 to 1,304.7 per 100,000. The plot below shows Manchester against the national average over time:

Figure 45: All age all-cause mortality, Manchester v England, all available periods



Under 75 avoidable mortality rate

Avoidable mortality (under 75) is classified as deaths that are either preventable and/or treatable:

- **Preventable mortality** refers to causes of death that can be mainly avoided through effective public health and primary prevention interventions (Reference Avoidable mortality in England and Wales - Office for National Statistics (ons.gov.uk) . These are things that intervene before someone has a disease or injury. Such as deaths caused by infectious diseases, certain types of cancer such as lung and skin cancer, diseases related to high blood pressure and heart disease, and injuries. COVID-19 is also included in preventable mortality causes of death.

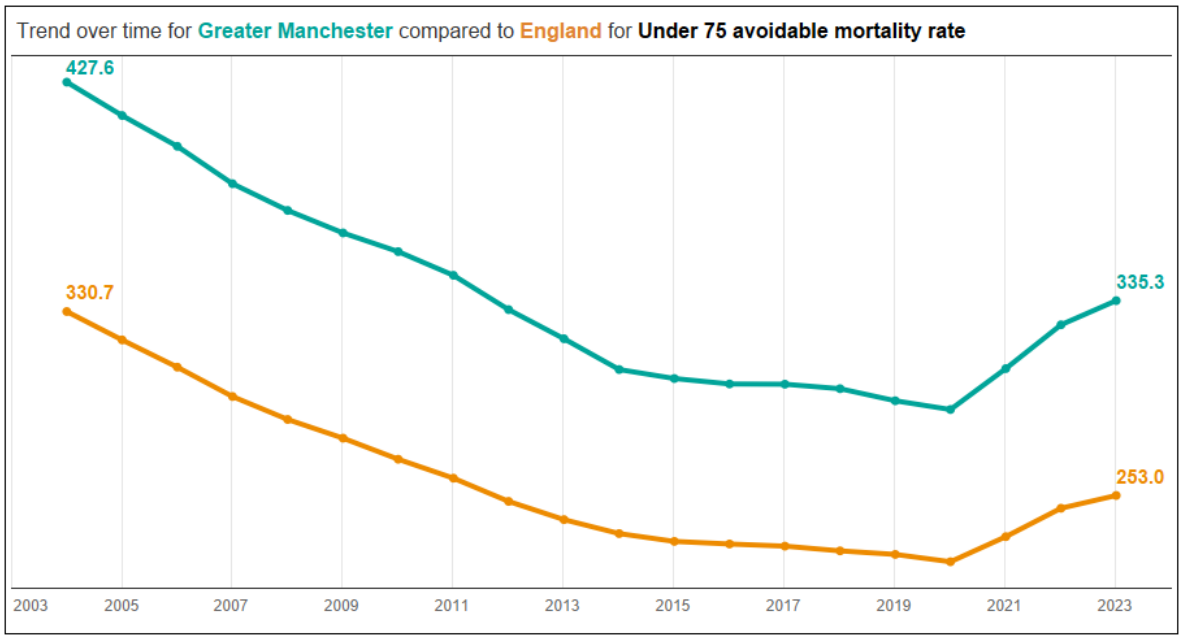
- **Treatable mortality** refers to causes of death that can be avoided through healthcare interventions including secondary prevention. Meaning the interventions that happen once a person already has a disease. These include cancers such as colorectal and breast cancer, cardiovascular diseases and respiratory conditions such as asthma and pneumonia, conditions of the digestive system and kidneys (Reference Workbook: Fairer Health for All Dashboard (gmtableau.nhs.uk).
- Some conditions are classed as both preventable and treatable such as cardiovascular conditions, Tuberculosis (TB) and diabetes.

Rates of avoidable mortality increased significantly in 2020 during the first wave of the COVID-19 pandemic and have remained higher than pre-pandemic levels in all 10 localities. Manchester has the highest avoidable mortality rate in GM and is ranked second worst in the country (2000-2002).

Under 75 avoidable mortality in Greater Manchester increased from 325.1 per 100,000 in the 2019 to 2021 period to 335.3 per 100,000 in the 2020 to 2022 period. This is above the national average of 253 per 100,000. The increase follows the national trend which increased from 247.6

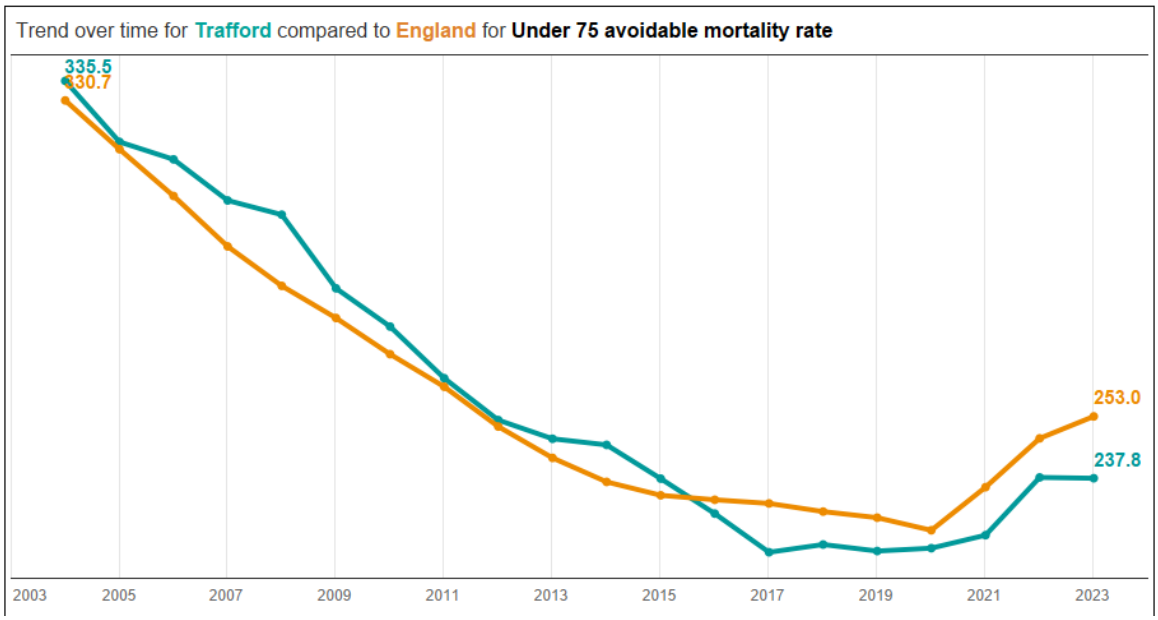
per 100,000. The plot below shows the trend between Greater Manchester and England over across all available periods.

Figure 46: Under 75 avoidable mortality rate, GM v England, all available periods



This increase was seen for both female and males in the same period. For females, this increased from 250.9 per 100,000 to 256.7 per 100,000 and for males this increased from 401.7 per 100,000 to 416.5 per 100,000. 9 out 10 areas inside Greater Manchester saw increases from the 2019 to 2021 period. Trafford was the only area that experienced a slight decrease from 238 per 100,000 to 237.8 per 100,000. The plot below shows Trafford against the national average over time:

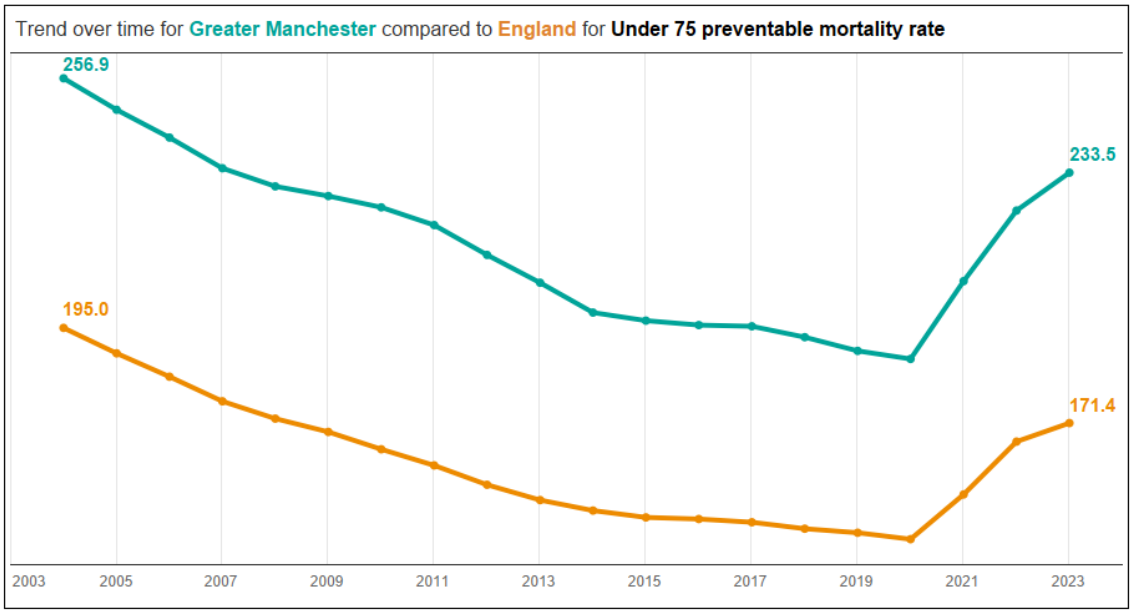
Figure 47: Under 75 avoidable mortality rate, Trafford v England, all available periods



Under 75 preventable mortality rate

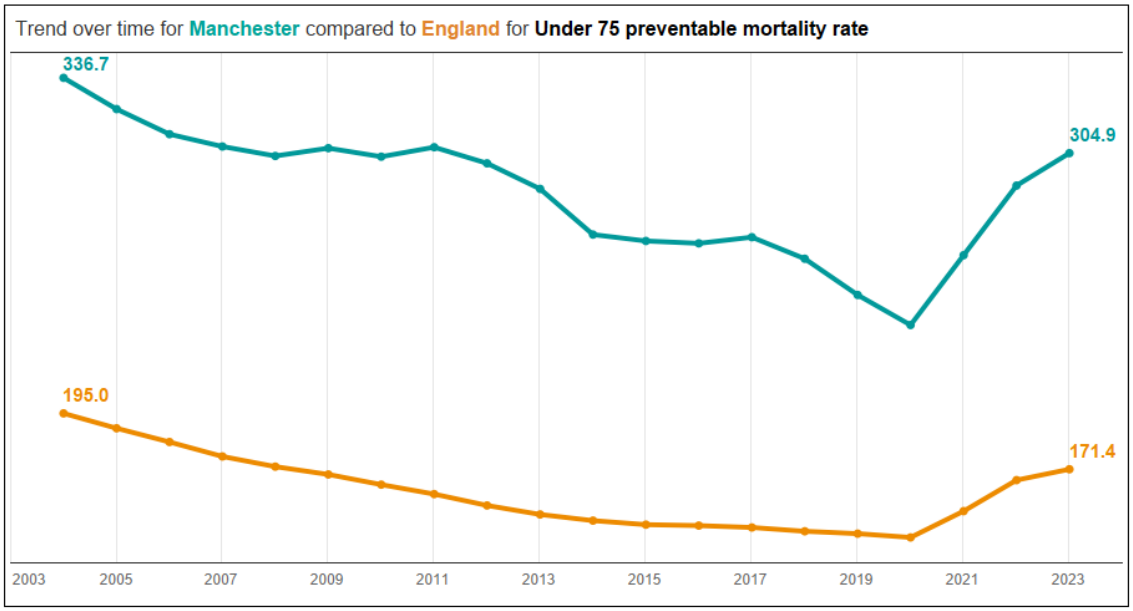
Under 75 preventable mortality in Greater Manchester increased from 224.1 per 100,000 in the 2019 to 2021 period to 233.5 per 100,000 in the 2020 to 2022 period. This is above the national average of 171.4 per 100,000. The increase follows the national trend which increased from 166.8 per 100,000. The plot below shows the trend between Greater Manchester and England over across all available periods.

Figure 48: Under 75 preventable mortality rate, GM v England, all available periods



This increase was seen for both female and males in the same period. For females, this increased from 163.1 per 100,000 to 169.3 per 100,000 and for males this increased from 287.2 per 100,000 to 299.8 per 100,000. All areas inside Greater Manchester saw increases from the 2019 to 2021 period. Manchester saw the sharpest increase from 291.2 per 100,000 to 304.9 per 100,000. The plot below shows Manchester against the national average over time:

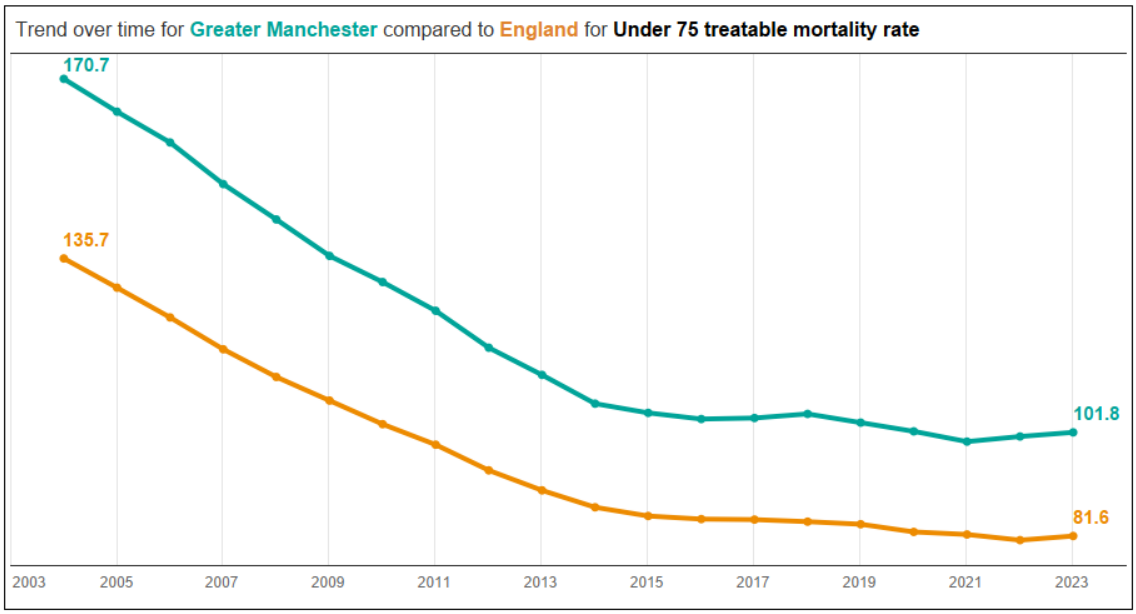
Figure 49: Under 75 preventable mortality rate, Manchester v England, all available periods



Under 75 treatable mortality rate

Under 75 treatable mortality in Greater Manchester slightly increased from 101 per 100,000 in the 2019 to 2021 period to 101.8 per 100,000 in the 2020 to 2022 period. This is above the national average of 81.6 per 100,000. The increase follows the national trend which increased from 80.8 per 100,000. The plot below shows the trend between Greater Manchester and England over across all available periods.

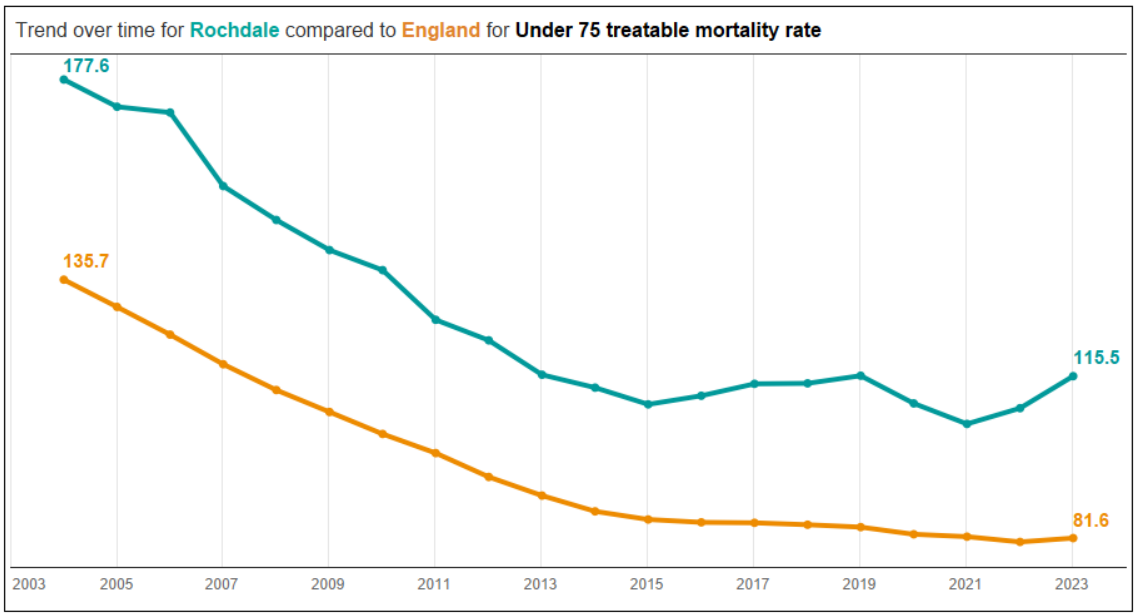
Figure 50: Under 75 treatable mortality rate, GM v England, all available periods



For males, this increased from 114.5 per 100,000 to 116.8 per 100,000 while females saw a slight decrease from 87.9 per 100,000 to 87.4 per 100,000. 5 areas inside Greater Manchester saw

increases from the 2019 to 2021 period. Rochdale saw the sharpest increase from 108.8 per 100,000 to 115.5 per 100,000. The plot below shows Rochdale against the national average over time:

Figure 51: Under 75 treatable mortality rate, Rochdale v England, all available periods



Appendix D: Abbreviations List

Abbreviation	Full Wording abbreviation stands for
AF	Atrial Fibrillation
ASR	Age Standardised Rate
CVD	Cardiovascular Disease
CYP	Children and Young People
CVNeed	Not an abbreviation but this is a Cardiovascular tool
CVDPrevent	Not an abbreviation but this is a Cardiovascular Disease Prevention Audit
ENT	Ear, Nose and Throat
FCEs	Finished Consultant Episodes
FHFA	Fairer Health for All
FIT	Faecal immunochemical test (screening test for bowel cancer)
GM	Greater Manchester
GMMH	Greater Manchester Mental Health
GP	General Practitioner
HI	Health inequalities
HLE	Healthy Life Expectancy
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
IMD Decile	Index of multiple deprivation decile
IS Providers	Independent Sector Providers
LD	Learning Disability
LDL	Low-density Lipoprotein
LTC	Long Term Conditions
LTLA	Lower Tier Local Authorities
MI	Myocardial Infarction

MFT	Manchester Foundation Trust
NW	North West
OHID	Office for Health Improvement and Disparities
ONS	Office National Statistics
PCFT	Pennine Care Foundation Trust
PCMIS	Patient care management information system
PCN	Primary Care Network
PICU	Psychiatric Intensive Care Unit
QRISK	This is a Clinical tool used to estimate the risk of developing cardiovascular disease (CVD) over the next 10 years).
Q2	Quarter 2
Q3	Quarter 3
SMI	Severe Mental Illness
TB	Tuberculosis
VCSFE	Voluntary Community Sector Faith Enterprises