Reducing the Risk
of Covid-19 in Trafford

Report of the Director of
Public Health Trafford **2020**

www.trafford.gov.uk

Acknowledgements

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Stay Home

Protect the NHS

Save Lives

Contents

1. Foreword

This report was written in Autumn 2020, in the second wave of coronavirus. The first vaccine has just arrived but supplies are limited and while hospital treatments have improved, there is no magic cure or prophylaxis. We now need to do everything we can in Trafford to reduce our individual and collective risk from Covid-19, from other diseases and conditions, and from socio-economic harm.

The aim of this report is to give some practical suggestions for action, based on what we know from this and other diseases and conditions, as already highlighted in our Health and Well Being strategy and the work of our Health and Wellbeing Board. This advice is set in the context that climate change remains the bigger existential threat to humans so we need to ensure that our reactions to Covid-19 move us to a cleaner, greener future and a healthier, more resilient population.

Eleanor Roaf,
Director of Public Health, Trafford

December 2020

2. Introduction

It seemed impossible, this year, for the Public Health Annual Report to be about anything other than Covid-19, but we remain in the middle of the pandemic. There is much we still don't know about the disease, including, for example, how infectious is it in asymptomatic people, why some people develop debilitating long term conditions following infection but others display no symptoms at all, what is protecting young children, and why are men so much more likely to be seriously ill than women?

One of the key aspects of Covid-19 is that it has highlighted things that we already knew: that poverty and inequality kill; that structural racism leaves many of our BAME population at higher risk; and that the recurrent preoccupations of Public Health (for example, clean air, maintaining a healthy weight and blood pressure, and having good mental health) are paramount for individual resilience. Add to these the evidence for the benefits of a properly funded health and social care system, good employment and housing options, and we have a case study in why population health matters, and the role of the wider determinants of health within this.

In the global North, our rates of non- infectious disease (eg cancer, diabetes, or cardiovascular disease) have been alerting us to this for decades, but it has taken the immediacy of the risks posed by an infectious disease to deliver fast action. In last year's Public Health Annual Report we looked at the changes we need to make to reduce our carbon emissions, including the impact of travel choices, fast fashion and processed foods. This year, Covid-19 has demonstrated how poor employment practices and working conditions contribute to risks in the workplace, and the role of air quality and diet in Covid risk. In this report we will look at the impact of the actions taken to tackle Covid-19, the longer term consequences of these, and how we apply the learning from this to avert or mitigate future crises. We will then use this to make recommendations on how we 'build back better' by reducing inequalities and ensure that our population and services are better equipped to withstand future threats.

"We might all be sailing on the same rough sea, but we are not in the same boats and do not have the same equipment to navigate these waters."

Mental Health Foundation 2020[1]

3. The pattern of disease in Trafford

The figure below shows the number of confirmed cases we have had in Trafford each day since the start of the pandemic. The full extent of the first wave is not shown on this chart as initially, almost all testing was of people admitted to hospital. From the middle of May, testing has been available to anyone with symptoms, so we have a much better idea of the number of people affected. Cases began to rise in mid-July and stayed relatively stable until September, when they started to rise more sharply and, despite a levelling off at the start of October, rose again to a point where we were seeing more than 150 new confirmed cases each day. This started to reduce in November, demonstrating the impact that Tier 3 and subsequent national lockdown has had in reducing the number of cases in Trafford.

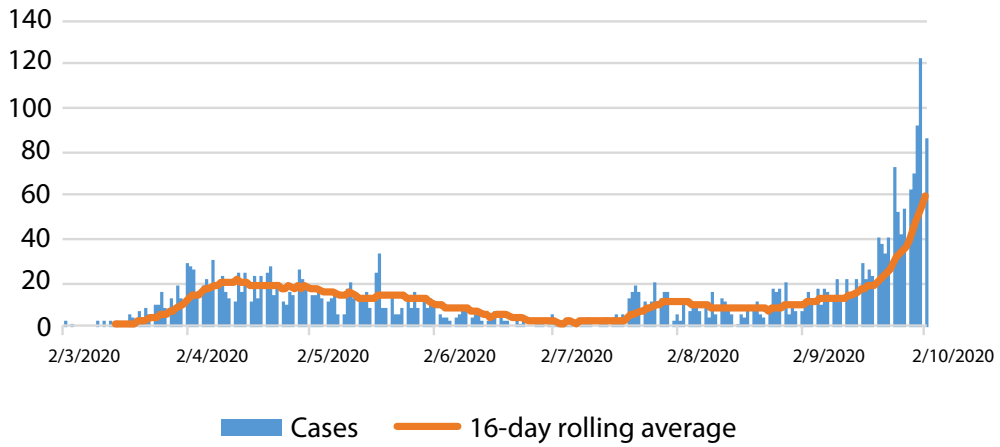


Figure 1. Epidemic curve of daily confirmed cases
Trafford 02 March to November 22

Figure 2 indicates the total number of cases throughout Trafford up until November 22. The heat map indicates how widespread cases have been throughout the borough, with each ward recording more than 300 cases.

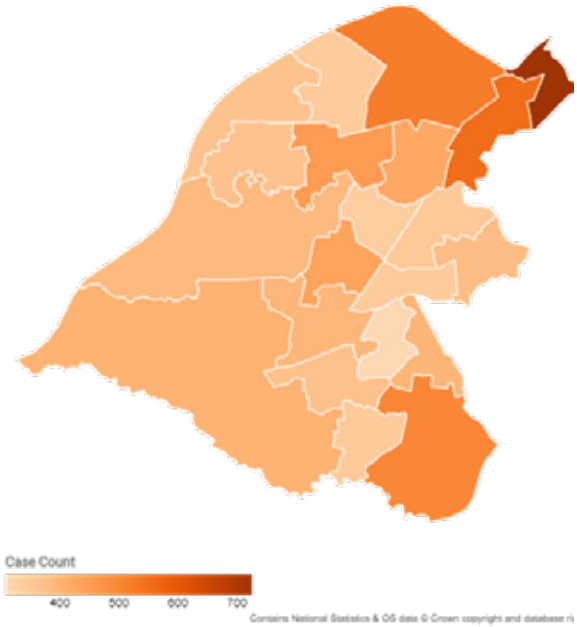


Figure 2. Confirmed cases in both testing sites by Ward
Trafford 02 March to Nov 25[2]

4. Risk Factors -
Who is the virus affecting the most?

A disparity review[3] by PHE shed light on the disproportionate impact the virus has had on different groups in the U.K. In this chapter we will look at five identified risk factors for poor outcomes: age, sex, BAME, deprivation and underlying health conditions (including obesity).

4.1 Age

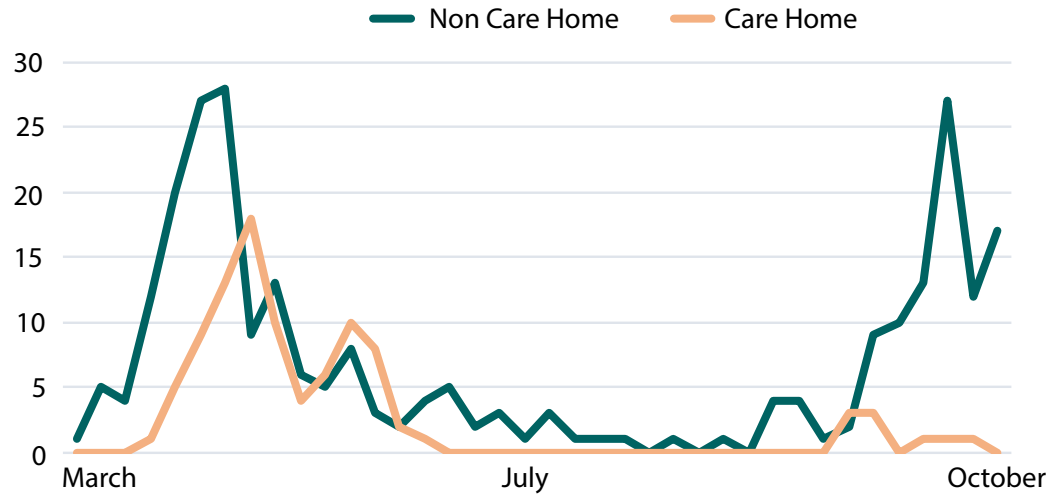
Death rates from Covid-19 increase for both men and women as people get older, with the risks increasing sharply over the age of eighty[4,5,6] . Countries with ageing populations, such as the UK, need to take more aggressive measures to protect these population groups, particularly considering the heightened risk of more severe complications from Covid-19[4]. Figure 4 shows an increased rate of mortality among older adults, particularly adults 85 years and over. The rate of mortality is also more pronounced in males in each of the older adult age groups.

Source: Public Health England analysis of ONS death registration data

Figure 3. Age and gender death rates (per 100,000 population) involving Covid-19 in England and Wales between 28 December 2019 and 13 November 2020.

Protecting care home residents

In the early stage of the pandemic, the emphasis on creating capacity in hospitals combined with a shortage of testing, led to people with Covid-19 being discharged from hospitals into care homes without precautions in place such as adequate PPE, staff screening, or the ability to isolate residents, and consequently there was substantial transmission within the homes. Care homes will always be high risk settings, due to factors such as the underlying health conditions among their residents, the movement of staff between patients and the ease of transmission within a residential setting. In Trafford we tested all people being discharged from hospital to care homes from mid-March onwards, and have worked intensively with our care home sector to reduce the risks of transmission in the home.



Source: Public Health England analysis of ONS death registration data

Figure 4. Location of weekly Covid-19 deaths in Trafford between the first registered death (week 11) and November 27 2020 (week 48).

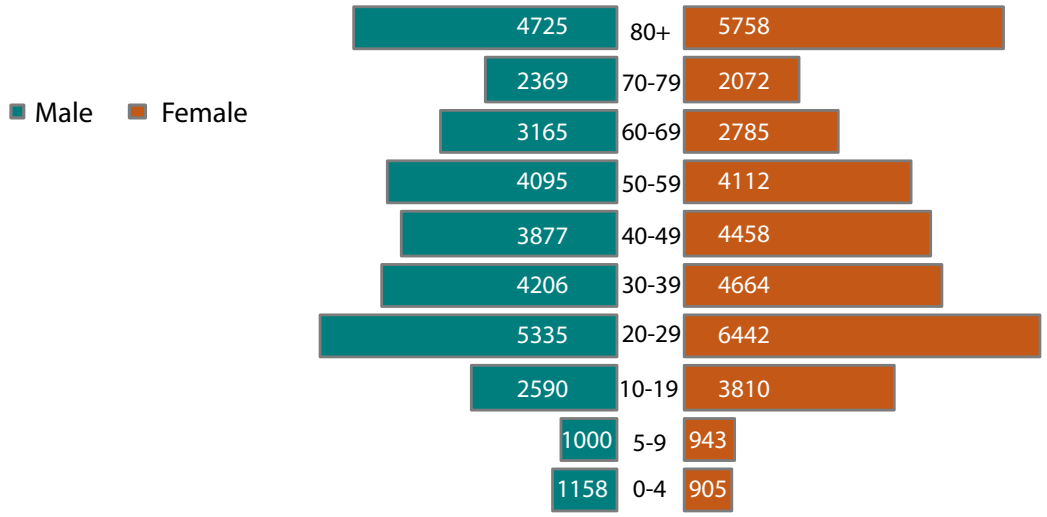
Protecting older people living at home

Most people aged 65 and over living in the UK are fit and healthy and would not see themselves as having significant additional needs. The increased risks from Covid-19 have come as a shock to many in this group, and have led to significant disruption to many individuals and families, not least because of the amount of unpaid care delivered by this group - to their children, grandchildren, and parents - as well as their role in wider society.

The closing of many hospital services in order to provide capacity to manage Covid-19 has meant that routine operations have been cancelled, diagnostic tests have been delayed and that millions will be at risk of deconditioning and deterioration of long term conditions due to months of inactivity[7] and reluctance to visit health care settings, with resulting detrimental health consequences. Ensuring that we are able to reopen services safely has formed a large part of current health and social care planning.

4.2 Sex

Death rates are higher at all ages for men than for women, for various reasons. Men are more likely to have relevant underlying health conditions, they are also more likely to smoke. There may also be differences in immune response between men and women that lead to worse outcomes for men[8]. Additionally we know that certain occupations are predominately done by one sex rather than the other, which may alter the risk of being exposed to the virus.



Source: PHE Covid-19 Situational Awareness Explorer

Figure 5. Trafford diagnosis rates by age and sex, March 03 to November 27 2020. Source: PHE Covid-19 Situational Awareness Explorer

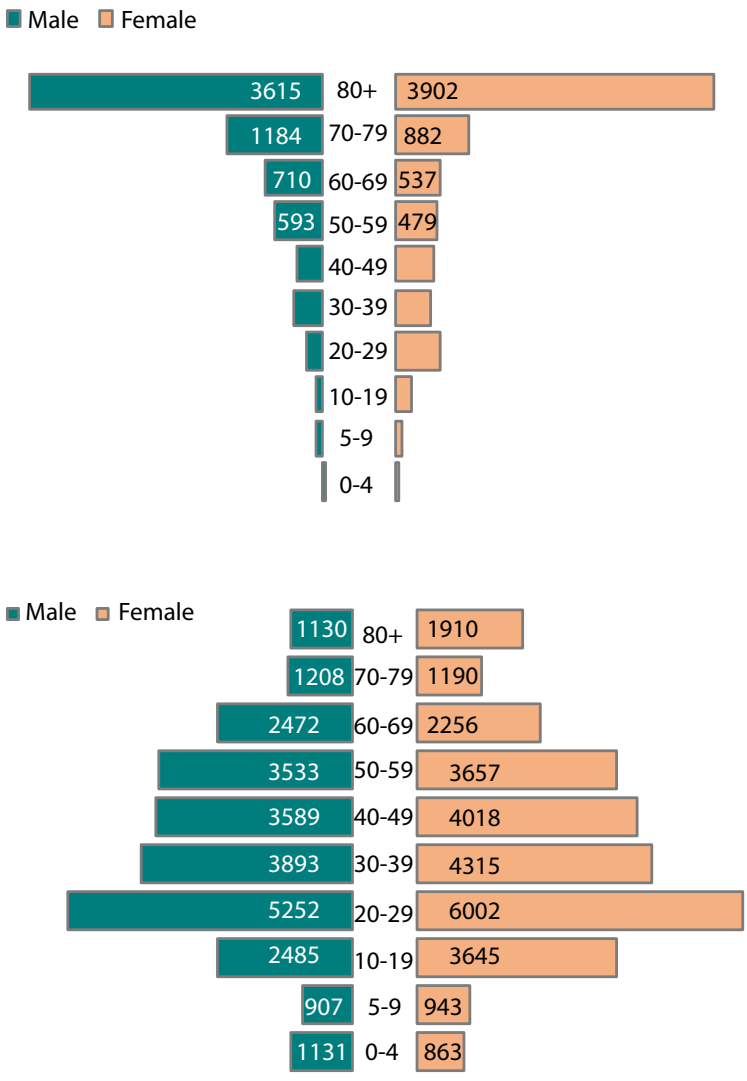
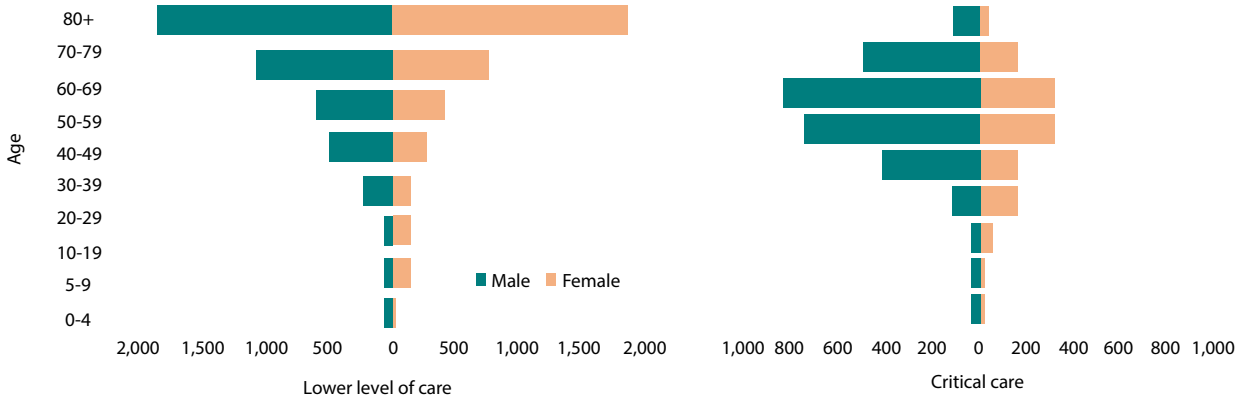


Figure 6. Trafford diagnosis rates by age and sex March 03 – November 27 2020: Pillar 1 (top) and Pillar 2 (bottom) testing sites.

Pillar 1 testing is mainly undertaken in hospital settings, and so is likely to reflect the greater risk of hospitalisation in older age groups.

There is also a large discrepancy between the sexes when it comes to disease severity and hospitalisation with males making up 70.4% of patients in critical care in the peak of the first wave of the epidemic (up to mid-May 2020).



Source: Public Health England Covid-19 Hospitalisations in England Surveillance System (CHESS).

Figure 7. Age sex pyramids of admissions for laboratory confirmed Covid-19 to acute trusts, for lower level of care and critical care, as of May 2020, England.

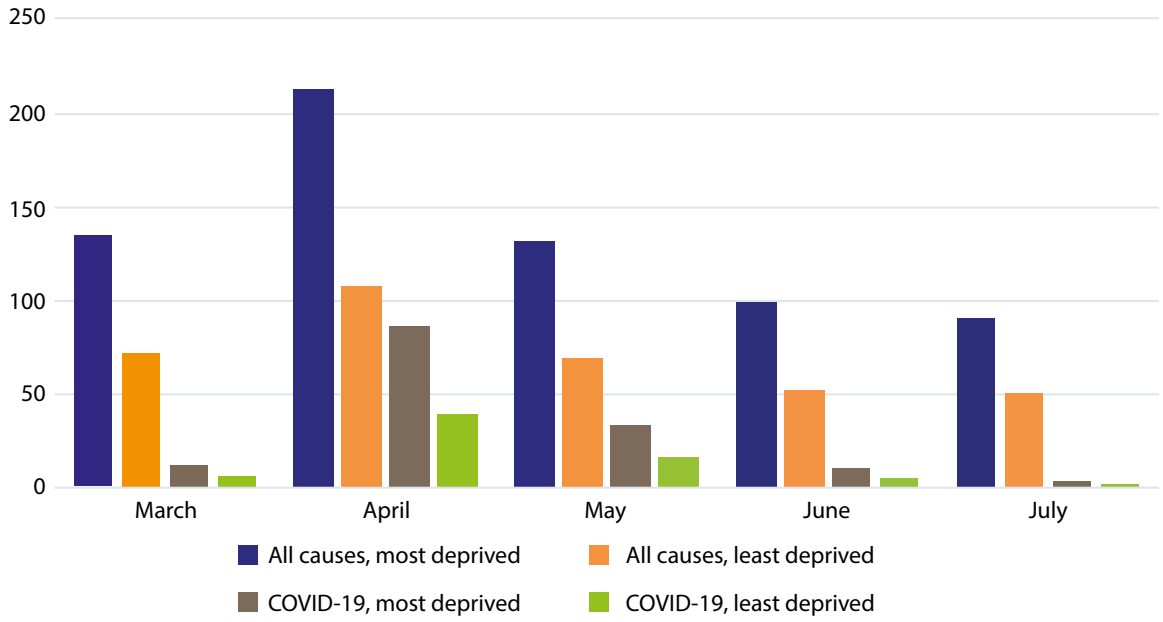
4.3 Deprivation

Trafford ranks 191st of 317 local authority districts in England for 2019 by deprivation and is the least deprived authority in Greater Manchester, but it still has pockets of deprivation[9], notably Bucklow-St Martins (Partington) in the West, and across North Trafford . There is a clear correlation between deprivation and mortality for both Covid-19 and non Covid-19 deaths. Nationally, people living in the most affluent areas are 50% less likely to die of Covid-19 than those in poorer communities[8]. This could be due to a number of factors including an increased likelihood of living in overcrowded houses or increased occupational risk, with individuals who live in deprived areas being more likely to undertake roles involving face to face contact and less likely to be able to negotiate their working conditions[10]. Some jobs will always require face to face contact but the risks from this can be reduced through ensuring that people are provided with appropriate PPE where relevant, and that people are paid properly, including with sick pay to cover any required self-isolation.

Table 1. Relative increase in all cause deaths registered between 21 March and May 2014 to 2018 and 2020, for people aged 20-64, by occupational groups, England.

Occupation	Deaths 2014-18 average all causes	Deaths 2020 all causes	Relative increase between 2014-18 and 2020	Lower 95% confidence interval	Upper 95% confidence interval
Caring personal services	414	760	1.8	1.6	2.1
Nursing auxiliaries and assistants	52	128	2.5	1.8	3.4
Elementary Security Occupations	117	267	2.3	1.8	2.8
Security Guards and related occupations	80	209	2.6	2.0	3.4
Road Transport Drivers	384	694	1.8	1.6	2.0
Taxi and cab drivers and chauffeurs	87	217	2.5	1.9	3.2
All people aged 20-64	**9,440**	**14,409**	**1.5**	**1.5**	**1.6**

Source: Public Health England analysis of ONS death registration data



Source: Public Health England analysis of ONS death registration data

Figure 8. Age-standardised mortality rates: all deaths and deaths involving the coronavirus (Covid-19) by index of Multiple Deprivation in England, occurring between 1 March and 31 July 2020.

4.4 Ethnicity

*"Inequalities are a matter of life and death, of health and sickness, of well-being and misery" (*Marmot et al 2010[11]). The emerging evidence suggests that people from BAME communities in the UK have higher diagnosis rates and death rates of Covid-19[12]. The disproportionate outcomes and Covid infections among ethnic groups are driven by several factors, including: working in frontline occupations, living in large, multigenerational households, a higher burden of underlying conditions, experiences of discrimination, or access to health and community services [13,14,15].

The OpenSafely study[15] is one of the biggest studies to access and use primary care ethnicity data. The study used primary care records of 17.5 million adults between 1 February and 3 August 2020 to help identify associations between the potential inequalities of outcomes between Covid and ethnic groups. Figure 10 presents the hazard ratios (using white ethnic groups as the reference group) after adjusting for age, sex, deprivation quintile, all pre-specified clinical co-morbidities, household size, care home residency, and stratification by STP region.

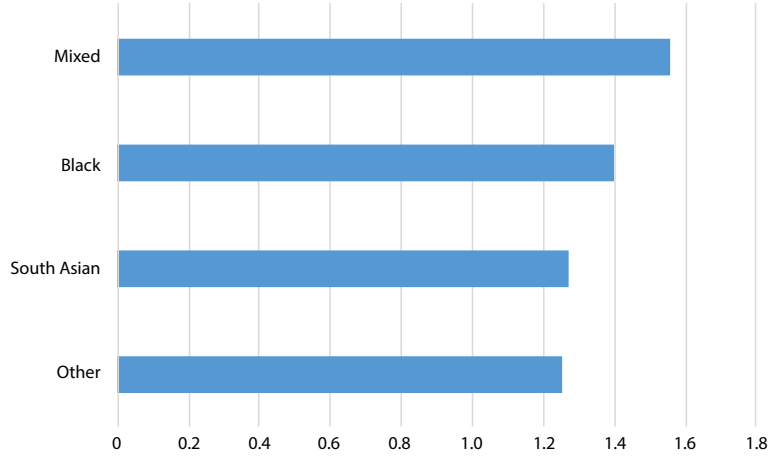


Figure 9. Risk of Covid-19 mortality by ethnic group compared to White British in England[15]

Analysis from the study indicated that, when compared to white ethnic groups, all other ethnic groups had an increased risk of death from Covid (if hazard ratio=1 the ethnic minority group has equal risk of death from Covid compared with White British). The risk for black ethnic groups was over 50% greater than those of white ethnic groups.

While genetics may play a role in influencing ethnic disparities in health outcomes, the fact that we see worse outcomes for very different BAME groups suggests that the reasons for the discrepancy are much more likely to be social, economic, geographic or cultural.

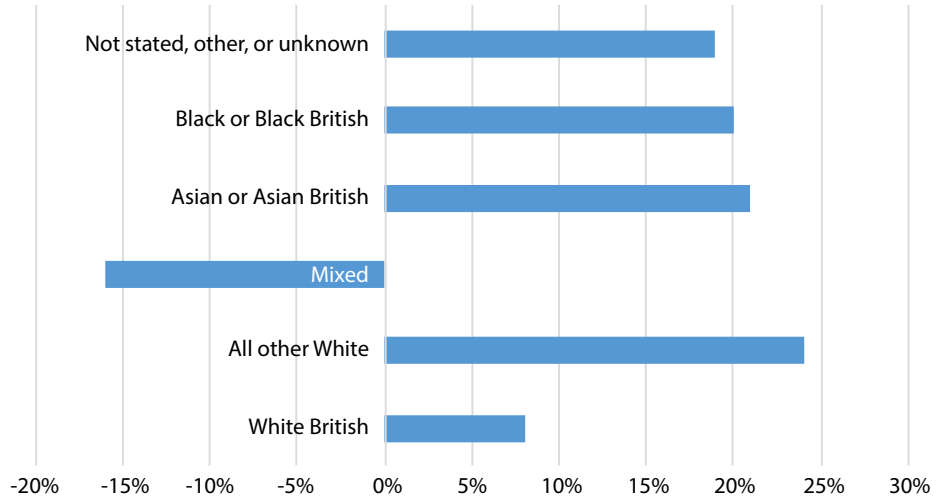


Figure 10. Trafford excess deaths by ethnicity Jan-September 2020
Percentage increase compared to the 4 year average

Public Health England has identified the following key causes for the disparity in mortality among different ethnic groups in the UK:

- **Economic Disparity:** Minority ethnic groups are, on average, much more likely to be economically disadvantaged than White British people. This is strongly associated with the prevalence of smoking, obesity, diabetes, hypertension and their cardio-metabolic complications, which all increase the risk of disease severity.
- **Housing:** BAME households are more likely to experience overcrowding and are more likely to be intergenerational making it harder to self-isolate and easier for people to spread the virus to the more vulnerable older generation.
- **Occupations:** BAME groups are over-represented in the most exposed occupations to Covid-19, being more likely to be cleaners, public transport workers, or be a member of the health and social care workforce.
- **Racism and poor experience of healthcare:** There has been a suggestion that experiences of discrimination have led to a negative impact on health seeking behaviours within BAME communities and the idea that within the workplace BAME members of staff may be less willing to speak out against issues like insufficient PPE.

4.5 Long Term Conditions (including obesity)

Long term conditions (LTCs) such as diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), obesity and depression are predominantly health conditions for which there is currently no simple cure. They are more common in older people, and people with mental illness or learning disabilities. People living in more deprived populations are more likely to have an LTC, for it to be more severe, and are more likely to have more than one LTC compared to people in the least deprived communities[16]. Many of these conditions have preventable aspects or their impact can be reduced through behavioural changes but these changes can be hard to achieve through individual efforts, and typically by the time symptoms manifest, the damage has been done.

Prior to the Covid-19 pandemic, around 85% of the burden of disease in the UK was from LTCs and the NHS was already under considerable pressure. Once the potential impact of the pandemic on hospital services became clear, the NHS diverted resources to hospitals so that they could treat high numbers of Covid patients. This meant that staff and facilities were re-deployed and most planned care for patients with pre-existing conditions was suspended. During the national lockdown 14.9% of women and 11.1% of men reported a worsening health condition, but around half of these people have not been seeking advice, for a number of reasons – see figure 11 below. During the easing of lockdown 15.2% of women and 10.5% of men reported a worsening health condition (survey data from week ending 26/09/2020).

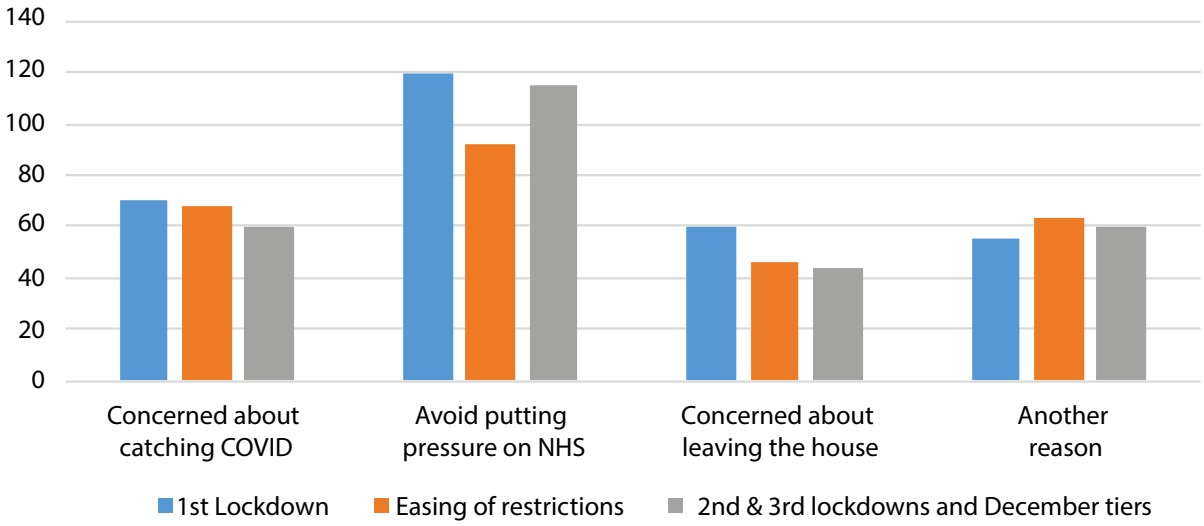
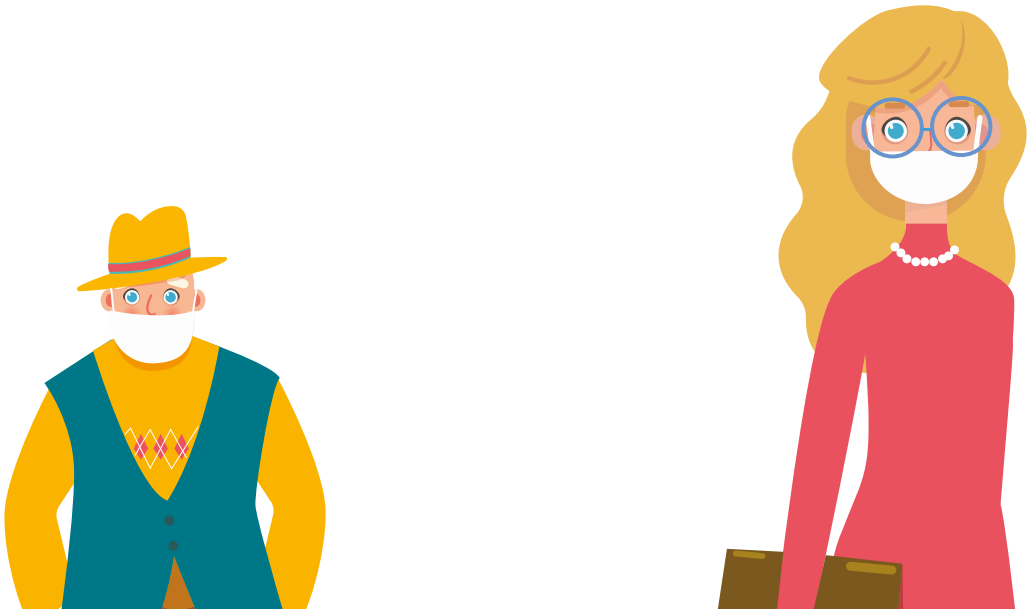


Figure 11: Access to care – reasons for not seeking advice (WICH)



The protection of hospital capacity, while necessary to manage the immediate impact of seriously ill people needing hospitalisation, has led to worse health outcomes for people with LTCs and has even increased hospitalisation rates as people with LTCs are more susceptible to severe Covid. Better management of LTCs can reduce this risk, as seen in the likelihood of death from Covid with uncontrolled diabetes in figure 12 below:

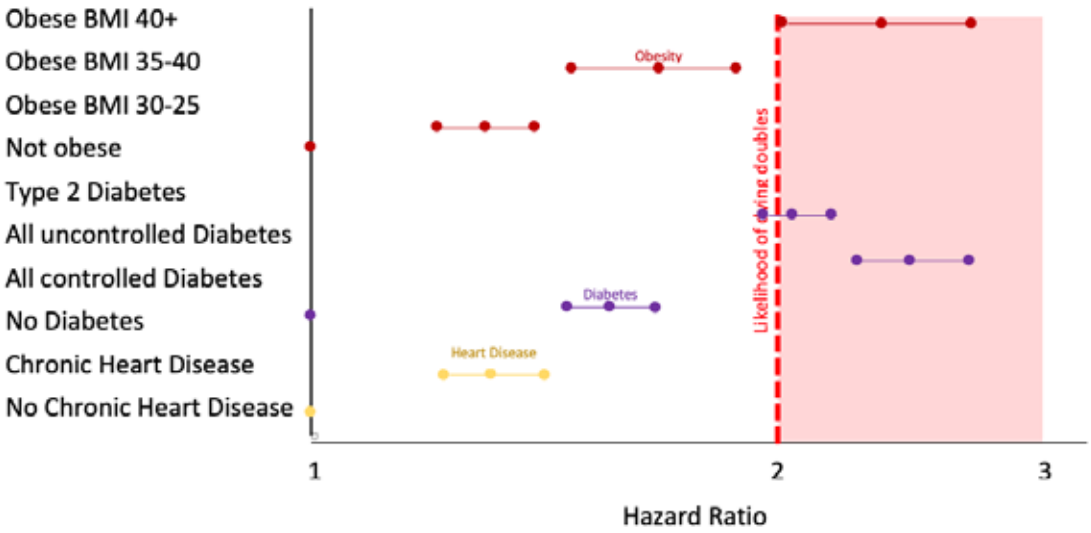


Figure 12: Diet related disease sharply increases likelihood of death from Covid-19

The focus now, therefore, should be on ensuring that people with LTCs are supported to manage these as well as possible. For many people, this is about supported self-management, but it is important that people's conditions are monitored and specialist support, usually from GPs and community services, is quickly available as required. This will not only improve people's quality of life but will also save health and social care costs, now and in the future.

4.6 Supporting people with additional vulnerability

In addition to the vulnerabilities listed above, there are other key groups in the population for whom the impact of Covid-19 is likely to be greater. These include (among others) people with learning disabilities, people experiencing domestic abuse, our homeless population, and LGBT people.

4.7 Air quality

Some studies suggested that long-term exposure to air pollution prior to the pandemic may be linked with more severe Covid symptoms and an increased risk of death, however, this effect is likely to be smaller than previously thought. As the virus spread across the country from the initial concentration of cases in London (where pollution levels are higher), the correlation between air pollution exposure and Covid mortality decreased.

Death rates have generally been higher in polluted areas, but this alone does not prove that pollution exposure is a cause of Covid deaths. However, it is possible that the higher death rates in BAME communities could count air pollution as a contributing factor, as people from these backgrounds are more likely to live in polluted inner city areas than white people.

It has been difficult so far to separate out factors such as pollution and ethnicity and their impact on Covid mortality, and significant further work is required to establish any definite links.

5. Areas of increased risk or concern

The impact of Covid-19 has not just been limited to those who have caught the disease. Instead it has had a wide effect across all of society, including the consequences from social isolation, economic uncertainty, concerns regarding employment and closure of facilities. This section looks at how Covid-19 has affected people across Trafford, looking firstly at the impact on mental health, and then the impact on children and young people.

5.1 Mental Health

The pandemic is affecting many people's mental wellbeing. Most people have experienced some distress (e.g. feelings of anxiety, stress, sadness, difficulty sleeping, and irritability). All of us have experienced a loss of some kind – of freedom, of a way of life, of routine, a job, of health, of a loved one[17]. What we used to have has been taken away. Many of us will have felt alone or helpless at times.

It is important to remember that trauma and distress is a normal reaction to a crisis, just as grief is an understandable reaction to a bereavement

It is completely normal to feel a whole range of emotions in relation to a traumatic event such as a pandemic. Data has shown that almost 50% of the general population have felt anxious or worried and 19% of us have felt hopeless. For people with a pre-existing mental health problem, these feelings are even more common[18].

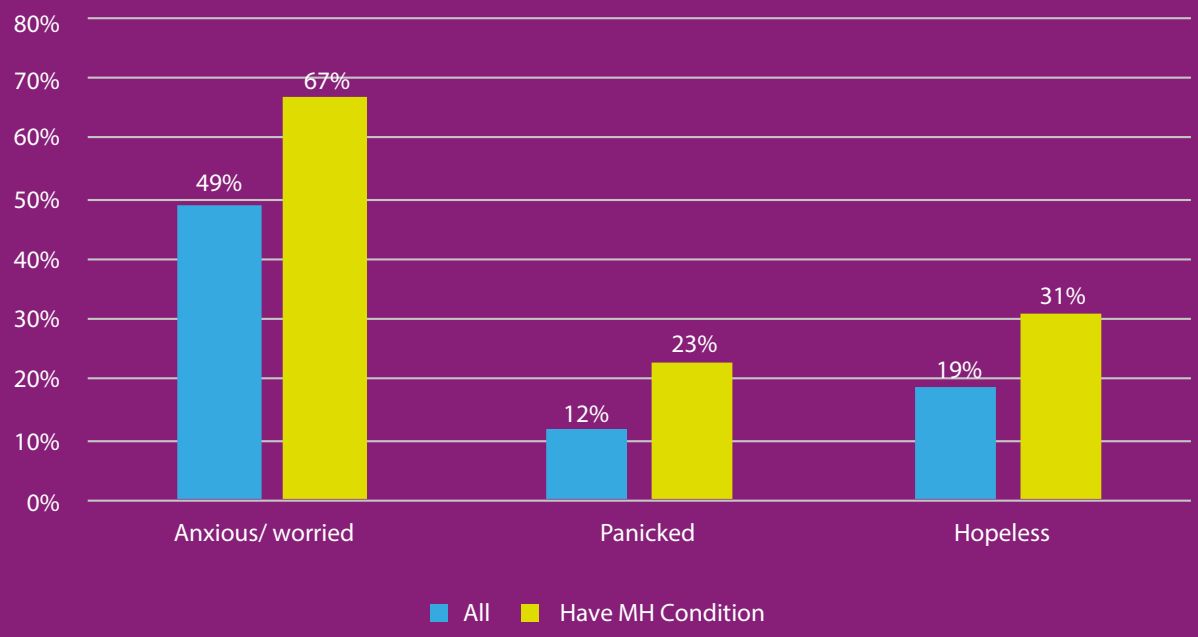


Figure 13. Emotions felt as a result of Covid-19 by total population compared to those with a pre-existing mental health condition[18]

The majority of people, even those working on the frontline, will not need specialist mental health support. For most of us, any difficult feelings will pass with time and won't be long lasting.

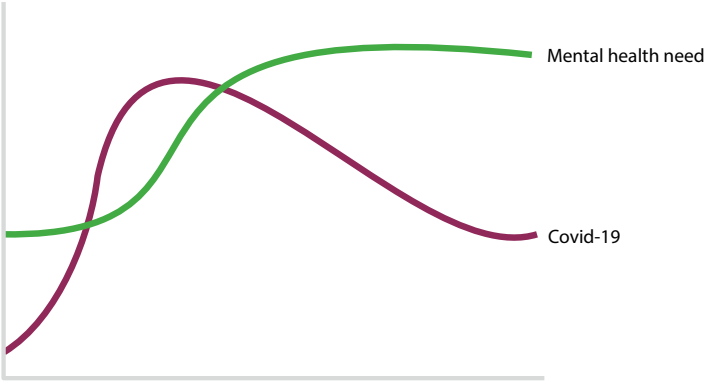


Figure 14. Projection of mental health needs relating to Covid-19 and how it compares with the trajectory of the virus itself

However, some people and communities are at much greater risk of worsened mental wellbeing:

- Those of us struggling to maintain our basic needs (food, warmth, shelter, safety) e.g. due to poverty, poor quality housing or precarious or no employment
- Those of us living with an existing mental health problem, including addiction to drugs, alcohol or gambling
- Older people who are more susceptible to Covid-19 and more likely to lose a loved one to the virus
- Women and children exposed to violence and trauma at home
- People with long-term health conditions
- People from BAME communities where prevalence of Covid-19 is higher and outcomes are worse

"Many will have felt isolated and disempowered at some point during the lockdown, and all will have experienced a loss – of their freedom, of their job, of their health, of a loved one."

Centre for Mental Health, May 2020[16]

During times of trauma, our need for togetherness and connectedness is even greater. We saw this in:

- The rapid establishment of our community hubs,
- The NHS rainbows in windows throughout the borough,
- The kind acts of many members of our communities.

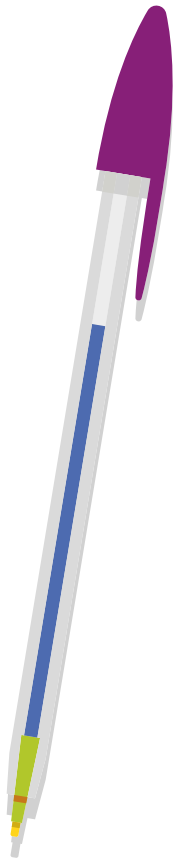
Our community hubs acted as a first port of call for many of our residents for practical aspects e.g. food and medicines and emotional support. Many of the people working in the hubs were volunteers from the local community. While this has been very positive, people living in more deprived areas have overall seen a reduction in trust in their neighbourhood at this time[19].

In Trafford, data from before the pandemic showed that 14% of our adult residents have a recorded depression diagnosis[20] and 16.7% of adults reported high levels of anxiety[21]. 2,382 adults in Trafford have a severe mental illness[20]. Our residents with a severe mental illness are almost five times as likely to die early than the general population of England[22]. Anecdotally, we have been hearing of worsening mental health conditions for many and this is something that we need to address urgently as we go through the winter.

The management of addictions (specifically gambling and drug/alcohol addiction) have been a particular concern. Gambling related harms include relationship breakdown, financial difficulties, and can lead to homelessness and indeed raised suicide risk. People experiencing drug or alcohol problems tend to have worse physical and mental health than the general population, and are also at increased risk of homelessness. As such, they are at increased risk from Covid-19.

Steps to improve your mental wellbeing

- Use the practical and emotional support available to you through our community hubs, our commissioned health and behaviour change services, and from GPs and other primary care providers
- Give yourself time and space to grieve the many losses to our way of life
- Accept that life is different and uncertain right now; focus on the things that you CAN control rather than the things you cannot
- Try to find activities that bring enjoyment and fulfilment despite the pandemic
- Expect less from yourself right now, be gentle with yourself and give yourself permission to achieve less
- Talk to others about their experiences. This can increase feelings of connection and reduce feelings of isolation
- Help others e.g. check in on friends and neighbours, volunteer at a local hub



5.2 Children & Young People

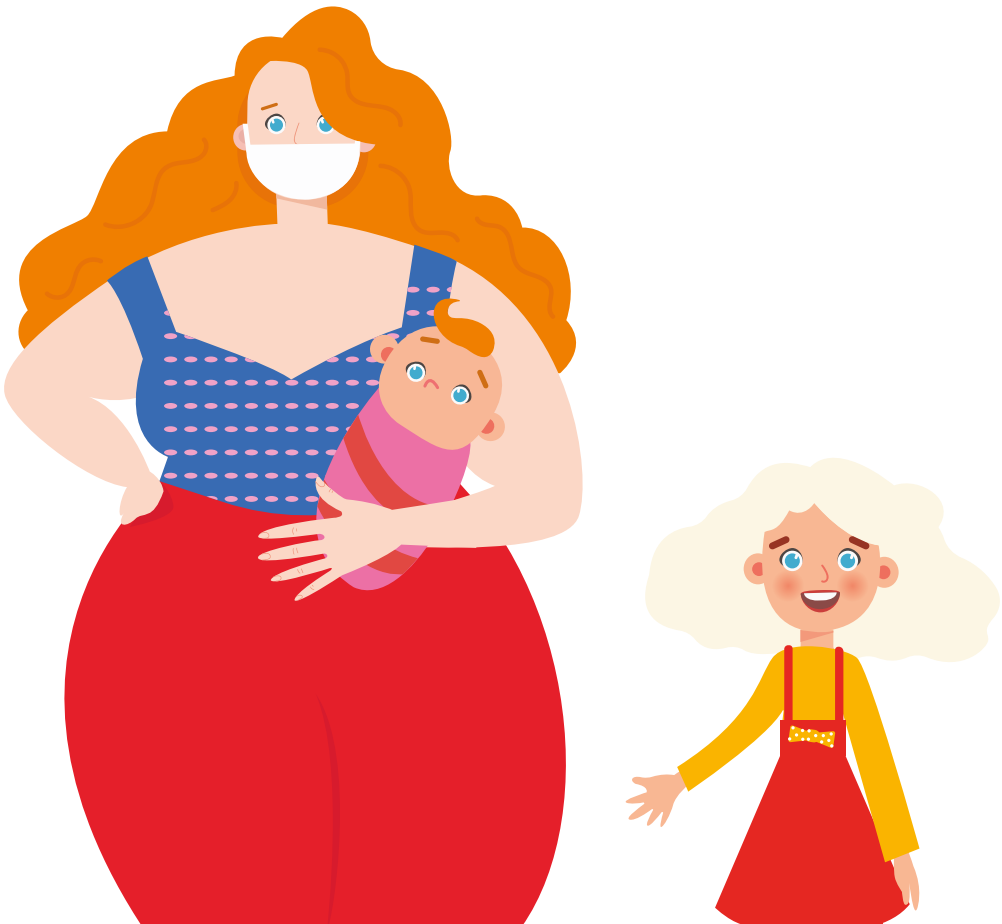
The pandemic and subsequent lockdown came as a shock to everyone, but the periods of lockdown form a bigger proportion of children's lives, and so can be expected to have a disproportionate effect, especially given the disruption to social activities and education.

For new and expectant parents changes in maternity services caused anxiety and worry. A study of new parents, Babies Born in Lockdown[13] reported that;

- Almost 7 in 10 found their ability to cope with their pregnancy or baby had been affected by Covid-19
- Nearly 7 in 10 felt the changes brought about by Covid-19 were affecting their unborn baby, baby or young child
- Families on lower incomes, from Black, Asian and minority ethnic communities and young parents have been hit harder by the Covid-19 pandemic and were less likely to receive the support they needed. This is likely to have widened existing inequalities.

On the whole, our children and young people are a resilient group. For many the pandemic has provided an opportunity to learn and experience life in a way that other generations have not. They have spent time at home with their families and for many this will have been a special and unique experience. For others, however, it has been highly challenging.

The closure of early years settings, support groups and schools in order to reduce the spread of Covid and protect the NHS brought challenges as these settings help us to ensure children and young people's wellbeing and learning is supported and that they are safe and fed. While safeguarding services have been working throughout, it has been harder to keep an eye of some of our children and young people with schools closed. Children living in homes where there is domestic abuse have been a particular concern, and all professionals have been working together to reduce any risks.



Early years and education settings, schools and colleges reopened fully in September. Things look different in the classroom. Pupils are grouped in 'bubbles' so that contacts can be quickly identified. Head teachers and senior managers have become expert risk assessors and contact tracers. However, no matter how hard nurseries and schools have worked to prevent Covid, it has been impossible to stop all cases in children or staff. All our schools have reported cases, largely as a result of high levels of transmission in the community. The Public Health team has worked alongside the schools to manage any cases or outbreaks.

Schools in the north of our borough have been more affected than schools in other areas, and disruption due to missed days of education as a result of being a contact is a huge concern. Children and young people in the north of Trafford already experience poorer health and educational outcomes than their peers elsewhere in the borough, and this further disruption to their schooling is likely to exacerbate these inequalities. For our children and young people with learning and/or complex health needs, the pandemic has been a particularly challenging time, and the risk of infection and an outbreak in a special school setting is a huge worry. For some children, managing social distancing, changing routines and social isolation is exceptionally difficult. Our special schools and support services have risen to the challenge, working closely with the Public Health team to keep our most vulnerable children and young people safe.

For services such as school nursing and health visiting, the challenge has been delivering services when staff have been redeployed into other parts of the NHS. However, these core public health services have endeavoured to maintain essential provision, giving our children the best start in life, supporting the most vulnerable families and ensuring our children are vaccinated from other communicable diseases. Health visitors have continued contact with all Trafford families but have targeted additional support towards those with higher levels of need.

The impact of lockdown has been significant on the mental health of young people and is likely to increase our already wide inequalities. Our mental health services for children and young people (Trafford Sunrise, 42nd Street, Kooth and CAMHS) continued to provide support throughout via telephone or online. Our CAMHS service also offered face to face appointments to young people who required them. All of these services now offer a blended model offering face to face, digital and telephone options to young people and their families. However, despite these efforts, the level of need for mental health support has meant that children and young people have sometimes had long waits to access services.

Covid-19 has brought particular challenges to the engagement of young people in suitable education, employment and training:

- We have had variable uptake of the in school offer in the first lockdown, with many children not taking up the places. Often children with additional vulnerabilities have not attended because of concerns about taking the virus home, but this has added to the inequality that they experience.
- Not all children and young people have access to suitable IT and broadband provision to continue to learn while not able to access school/college or training.
- Across the whole of Trafford there has been a two thirds reduction in the numbers of young people on programmes of study/work preparation courses and a one third reduction in those in employment with no training.
- Young people coming out of custody have found it difficult to engage in work or training as plans have been disrupted as a result of lockdown. All young people have been made alternative offers and we have a number of providers offering online activity however this does not suit all young people's needs.
- The cancellation of sport and physical activity at every level, from grassroots, recreational sport to elite international competition has had an effect on physical and mental health and well-being, as well as social and economic development[10]

As we emerge from the second lockdown, we need to reflect on what we have learned so far and use this information to build back better. For children and young people, key learning points are:

- the significance of services working together as a system; education, safeguarding, public health, mental health, health visiting and school nursing.
- family first, considering a child and young person's home environment in managing the relative risk form infection versus other harms.
- early years and education settings remain key to improving population health outcomes, and the skills and experience they have demonstrated has been outstanding.

6.1 Designing Our Future

Key to our response to Covid-19 is understanding how we can not only support communities to recover from the impact of the virus but also improve upon what we had before. This section looks at a number of different topics to identify areas for improvement in Trafford, all of which will lead to a healthier and more resilient population in the future – which is essential if we are to overcome the financial and other difficulties that we will be facing in the borough in the future.

6.1 Housing

Covid-19 has highlighted a number of issues relating to housing -

- We need to reduce overcrowding and improve the quality and quantity of affordable housing. Overcrowding and poor living conditions have not only increased Covid risk but have also made life more difficult for those people who have been working from home, especially for those with children who have been off school for long periods. We also know that poor quality housing is associated with many other health risks such as asthma and poor mental health.
- As well as this, there have been increases in the complexity of domestic abuse and the lockdown periods have left many women at extremely high risk. We need to increase refuge and accommodation support. Trafford Domestic Abuse Service supported this by opening a second refuge site during Covid-19 and this will be further supported by changes to safe accommodation brought about by the Domestic Abuse Bill.
- Certain groups, such as people with no recourse to public funds, cannot access housing benefit so risk being further marginalised, as they are unable to access Council accommodation.
- The value of high quality parks and green spaces have come to the fore, especially for people living in small houses or flats without gardens.

6.2 Reduce the number of people on low incomes or precarious employment

We need to focus on ensuring that people are paid the real living wage, and that they are in secure employment, as the risks from poor working conditions have been stark over the last six months. Furthermore, changes to furlough schemes and the lack of other employment opportunities are in danger of leading to long term unemployment, especially for younger people and those at the end of their careers.

In Trafford, the work of the Community Hubs was vital in supporting people to stay connected, receive food and medication, and also signpost to specific support services and resources where required. The hubs distributed information on mental health and healthy eating amongst other health and wellbeing support. We need to make it easy for everyone to find out about the support and services available in Trafford, and in particular tailored mental wellbeing support for our BAME communities requires further focus and investment.

We need to be **mindful of digital exclusion** which may increase inequity in access to support for the people who need it most.

6.3 Improve working conditions

The impact of the pandemic has had a massive impact on how we are working in Trafford.

- There has been a large increase in remote and flexible working. It has made separating our private and work life challenging, but for many people there have been positive aspects, not least in reduced commuting. We should explore making some of the digital innovations made during Covid-19 a part of 'business as usual' for our services in the future.
- The virus has had a major impact on some sectors most notably: hospitality, leisure, retail and airlines. Some of these sectors will need to change anyway if we are to have a healthier workforce or tackle climate change. We need a move away from zero hours contracts and precarious employment, and consider how these sectors can reduce their carbon footprints.
- Low paid workers, including migrant workers and those working for agencies may not be entitled to claim full sick pay, or may be worried about losing their job if they are required to self-isolate. In order for people to be able to abide by the essential regulations and not go into work if they have symptoms we need to make sure that all staff (agency or otherwise) have the appropriate T&C and employment standards to be able to self-isolate, and that all employers are paying the real living wage.
- Greater support for our workforce is needed as staff continue to work under immense pressure and face a high risk of burn out, and are also often working in sub-optimal settings. We need to make sure that people are not working long hours, and that they take their holidays.

Risks in specific workplaces

Nationally, it has been identified that there is an increased risk of Covid-19 in food processing and fashion manufacturing businesses. This risk relates both to the characteristics of the business and of the workforce. For example, factories contain noisy machinery, which requires people to talk more loudly, which can increase the spread of infected droplets. Added to this, some food factories are refrigerated and cold and damp environments may allow the virus to linger and spread more easily. We also know that people working in these businesses tend to be lower paid compared with employees in other sectors. These businesses typically have a high turnover of agency staff, many of whom are migrant workers who may not speak or read English very well, making it more difficult to understand or follow public health advice to keep themselves and their colleagues safe. Some people who work in our local food and fashion businesses also live together, commute together and socialise with one another outside work, meaning that there is increased opportunity for spread of diseases within the group.

Both food processing and fast fashion are currently based on a low wage economy and have a significant impact on our carbon emissions, water use and waste. In addition, highly processed food tends to be lower in nutritional value than fresh food and contributes to obesity[24]. Both industries should be further regulated to ensure that they pay the real living wage, that the nutritional quality of food is improved, and that their carbon footprint reduces significantly. This would raise the cost of their products – but we are currently paying hidden costs in the consequences of obesity and waste.

6.4 Support behaviour change and reduce inequalities

We need to **reduce the inequalities in long terms conditions and healthy life expectancy,** as these inequalities have contributed to the disparities in impact of Covid. In youth and middle age it is easy to ignore the potential consequences of leading an unhealthy life, as many of the impacts on the individual are far in the future. Covid-19 has made the risks from factors such as obesity or physical inactivity immediately relevant. All UK and international evidence[25] suggests that obesity and heart disease are risk factors for Covid-19 and that heavy alcohol drinking can suppress the immune system and make you more susceptible to Covid[26] and so smoking, physical activity and diet matter more than ever.

Diet

In Trafford, 64% of adults are overweight or obese, with obesity prevalence higher in our more deprived communities in the West and North of the borough, and lowest in the South. Although the percentage is similar to the England average, statistically similar local authorities perform better, with York having 56.9% of adults overweight or obese. We are also seeing overweight and obesity rates rising in Trafford

In children, the trends are the same, with obesity prevalence over twice as high for children living in the most deprived areas compared to the last deprived. In Reception (age 4-5), nearly 1 in 5 children are overweight or very overweight (19.9%), and by Year 6, this increases to almost 1 in 3 (31.8%). Children and young people who are overweight or very overweight, will generally go on to become overweight or obese adults[27]

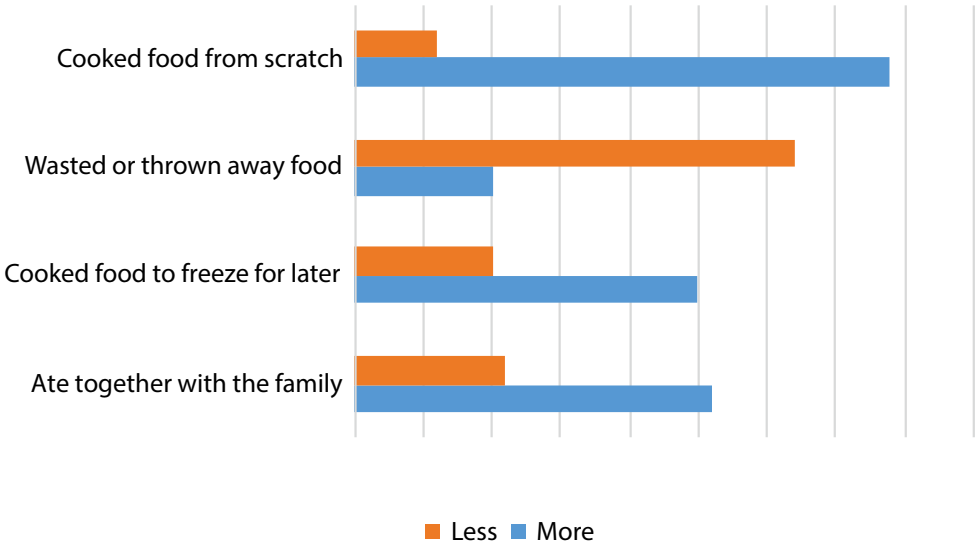


Figure 15: National Food Strategy Part One

- The inequalities that already contributed to poor diet were exacerbated during the lockdown period, with poorer children snacking more and eating less fruit and vegetables, and vulnerable adults eating 21% less fruit and 10% less vegetables (figure 16).
- 40% of people reported snacking more on cakes, sweets and savoury snacks, and 40% reported that their body weight had increased during lockdown. There were conflicting behaviours – lots of people ate healthier meals, but snacked a lot more on foods high in salt, fat and sugar (figure 15 & 16).

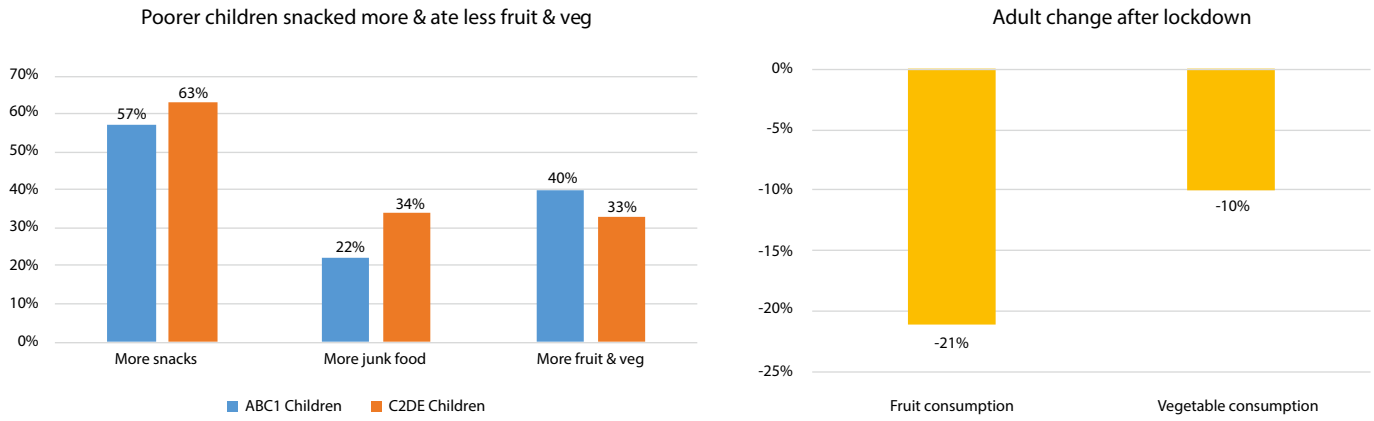


Figure 16: National Food Strategy Part One

This year (up to 19 July 2020), total **purchasing of food and drink** was11.4% higher in volume than it was in the same period for 2019. The food categories which have shown the largest increase in volume are: savoury home cooking (an increase of 27.0%) e.g. pizza bases, cooking kits and oils; sweet home cooking (an increase of 24.2%) e.g. sponge puddings and home baking products, and frozen meat (an increase of 21.2%)[28]The increases were predominantly in meat and processed food, which are products with higher carbon footprints as well as being ones that should form a reducing part of our diets.

These increases are likely to lead to increased obesity, which increases the risk of diabetes, cancer and health disease. Rates of obesity and alcohol related harm in Trafford as for the UK were already high before Covid.

Alcohol

Data from ONS in the year to July suggests that alcohol sales increased by 28.1%, largely driven by an increase in beer and cider sales[29].

YouGov commissioned a UK-wide online representative survey to measure adults (18+) drinking habits since the imposition of the national lockdown on 23rd March 2020.

Results from the survey (see Figure 17) show that around 29% of adults drank less alcohol during lockdown[30] and 35% of drinkers reported drinking more. Data from February to April shows that prevalence of higher risk drinking increased from 10.9% to 19.4%[31].

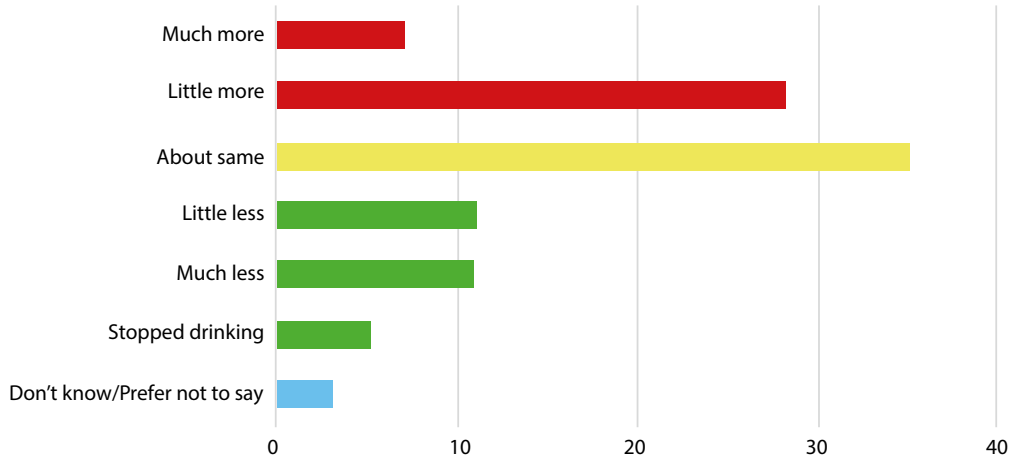


Figure 17. Change in drinking since lockdown

Smoking

It is estimated that more than one million people in the UK stopped smoking in the first period of the pandemic, with 41% reporting that it was as a result of Covid-19 and concerns for their health[32,33]. Helping people maintain this is critical to improving health and reducing inequalities.

Physical activity

47.5% of children and young people and 69% of adults in Trafford are physically active. However, as people get older, physical activity levels decrease. 73.7% of people aged 16-34 are active, compared to 64.6% of those aged 55-74, and just 37.5% of over 75s. In addition, more people who are white British are active (66.7%) than people from an Asian background (54.3%). When comparing to our statistical neighbours, York leads the way at all ages from 16+ with 82.9% of adults aged 16-34 physically active. People in C2DE social class were less likely to be doing more physical activity than people in AB social classes.

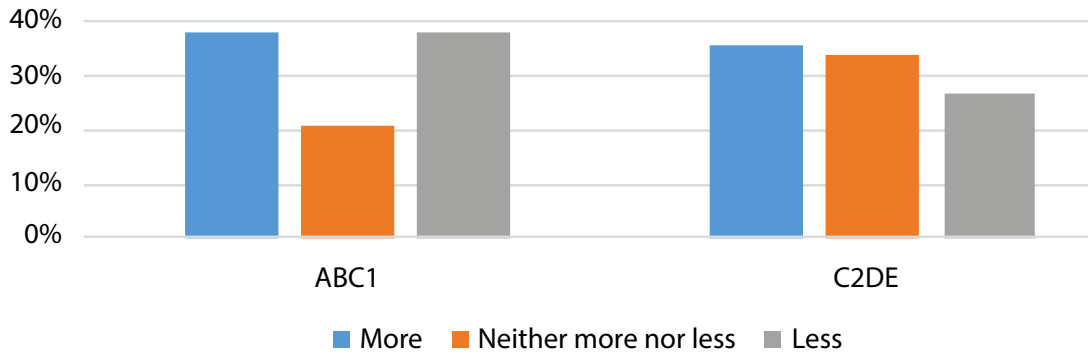


Figure 18. Percentage of adults doing more or less physical activity than usual by social class – pooled survey wave data from 03/04/2020 to 11/05/2020.

6.5 Tackling climate change – reducing our carbon emissions

Climate change remains the greatest threat to humanity, so all of our post-Covid actions need to reflect how we will reduce this risk. We should be considering how we move from unsustainable industries to those that can lead us into a green recovery. This will include a range of actions for many sectors of our economy. For example, retrofitting homes and building carbon neutral housing; providing loans to promote green recovery for businesses or changing our transport infrastructure to reduce reliance on cars and lorries.

We have a significant difficulty in relation to public transport as this is a vital part of active travel and removing cars from the road. We need to establish what safe levels of public transport usage are, and how we regain public confidence in the sector.

During lockdown there were large decreases in motor vehicle traffic and an increase in cycling and a decrease in flying. All of these had enormous benefits to our carbon emissions and to our air quality: the difficulty will be in maintaining these benefits as the economy reopens, as the lockdown wasn't long enough to embed changes. We are now seeing people reverting to car reliance fairly quickly (figure 1 below).

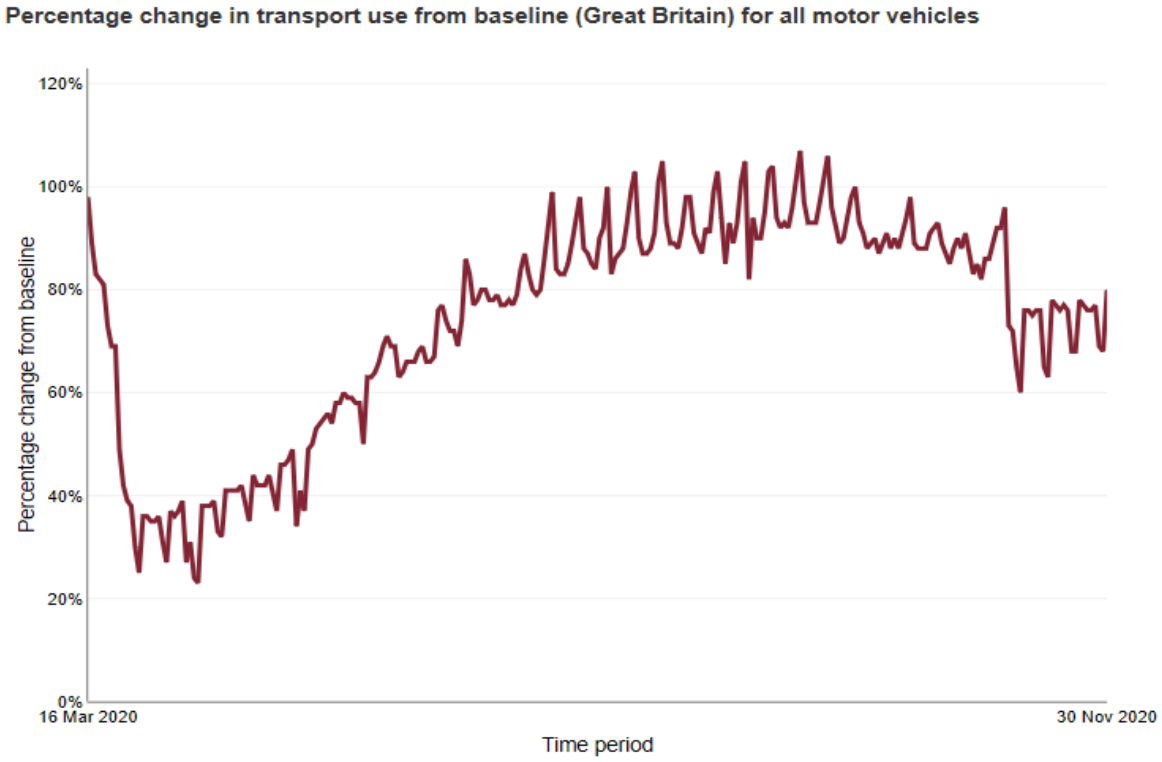


Figure 19: percentage change in transport use from baseline (Great Britain) for cars (WICH)

We know that the public appetite for cycling is there but the lack of high quality infrastructure remains a barrier. We need to be developing active travel neighbourhoods across Trafford, with infrastructure changes that support walking and cycling, and also ensure that all those who want to cycle can have access to a bike. The lockdown has also demonstrated that many people can do their jobs effectively without commuting into the office, so this may help reduce traffic volume and allow us to carve out more road space for walking and cycling.

7.1 Recommendations: What needs to change?

We know that we can make rapid change when we feel we must. This year, we saw a level and speed of change that seemed impossible last year. Some of these changes have been very bad for our economy and often for our mental and physical health too, but it shows that we can cope with more change than we thought, and so it should inspire us to make the positive changes that we need for healthy, enjoyable lives and a sustainable future.

What can we each do on our own or in our families?

- **Stop smoking**
- **Healthy diet:** take advantage of schemes such as Healthy Start to make eating healthily more affordable, and look into local affordable food provision, such as community shops and pantries.
- **Be more active:** walk more. It is the simplest way to be more active, most people can do it, and it's free. Think about making short journeys on foot, or on a bike or scooter if you have one.
- **Stick to safe alcohol limits**
- **Take up offers of screening and immunisation**
- **Look after our mental health**
- Keep our carbon footprint down – stay within a 10 tonne lifestyle[34]

What do we need to do as a borough?

Over the next year we must

- **continue to invest in programmes that support behavioural change**, including linking in with PHE Better Health campaign.
- reach those who need support the most such as individuals from BAME communities, people with disabilities, older people and those from deprived communities. This should include easy access to stop smoking support (including via e-cigarettes), weight management and physical activity programmes.
- continue to provide the information and resources to enable and empower people to maintain their own mental wellbeing, including tailored mental wellbeing support for our BAME communities.
- reduce our inequality gap: ensure services are monitored for their performance and outcomes in all groups in our population.
- reduce the impact of poor mental health, including the implementation of our suicide prevention strategy.

What national changes do we need?

Reduce alcohol consumption including introducing a Minimum Unit Price for alcohol

Minimum unit pricing (or MUP) ensures that the floor price of alcohol is set according to the alcoholic content of a drink. For example, a MUP of 50p would mean that a drink containing 10 units of alcohol such as a bottle of wine would have to cost at least £5. The biggest price rises would be on currently cheap products with high alcohol content, such as white cider. The Association of Directors of Public Health (ADPH) concluded that, following the evidence review of alcohol policy, reducing affordability of alcohol through taxation and MUP is the most effective and cost-efficient way of reducing alcohol harm[32].

A minimum unit price of 50p per unit was introduced in Scotland in May 2018 and Wales in March 2020. Modelling work by Sheffield University and Cancer Research UK found that over a 20 year period, a 50p minimum price per unit of alcohol in England, could reduce deaths linked to alcohol by around 7,200[36]. It would also reduce healthcare costs by £1.3 billion.

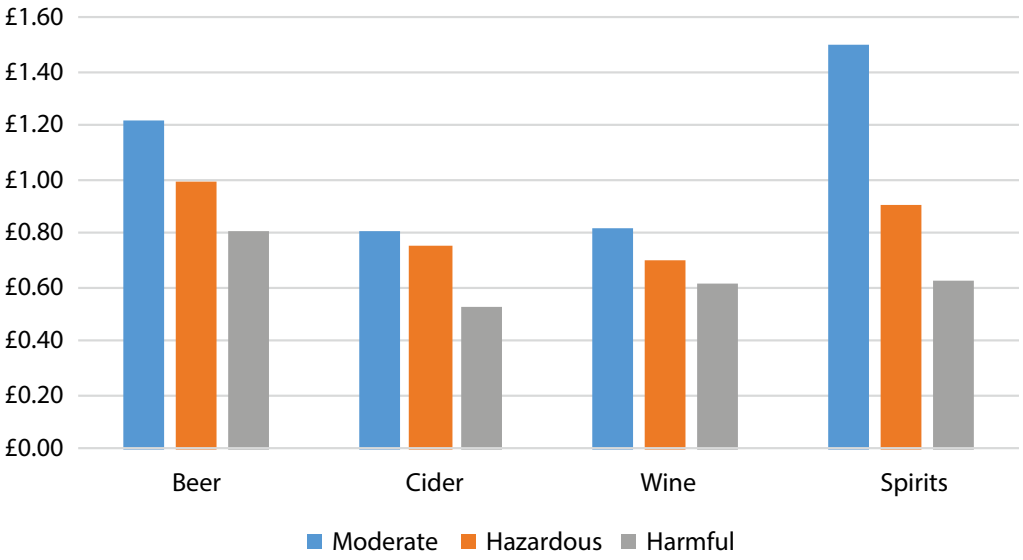


Figure 20. Mean Prices paid per unit by beverage type and drinker group[37]

Strengthen the sugar tax

Public Health England is leading on a sugar reduction programme with food industry, aiming to reduce the amount of sugar in foods that contribute most to children's intakes by 20% by 2020. However, by September 2019, only a 2.9% reduction had been achieved[38] , despite the introduction of the Soft Drinks Industry Levy (SDIL) in April 2018.

The recent obesity policy paper proposes complementing this by banning promotion of foods high in fat, salt and sugar (HFSS) by both price and location (i.e. no prominent placement of HFSS foods in shops, and no two for one or other price offers)[39], as a widespread legislative approach is likely to have greater impact than voluntary work with manufacturers and retailers.

There is now a live consultation on a proposed online advertising ban on HFSS products (closing on 22/12/20). As expected, this has met with resistance from industry with several international manufacturers unhappy with the approach, despite the limited progress made by industry itself in reformulating products to improve nutritional content. The purpose of the consultation is to understand the impacts of a total ban online, with a second option of a 9pm watershed for online advertising.

Introduce measures to increase active travel

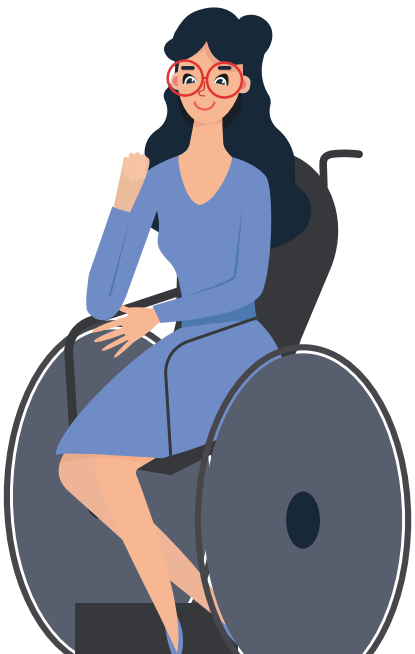
In 2014, the UK government published a report by Sustrans into Active Travel, which recommended a legislative approach with duties and incentives to improve walking and cycling infrastructure and encourage individuals to use it[40]. In 2018 PHE highlighted a study by Deakin Health Economics[41] in Australia from 2017 which reviewed the evidence of increasing fuel prices on physical activity and concluded that a moderate increase of 10c per litre in fuel tax could lead to 'best case' savings of AUS$34.2 million in healthcare cost savings. This was before considering other benefits such as personal cost savings on parking and travel time, and public savings from decongestion and environmental benefits.

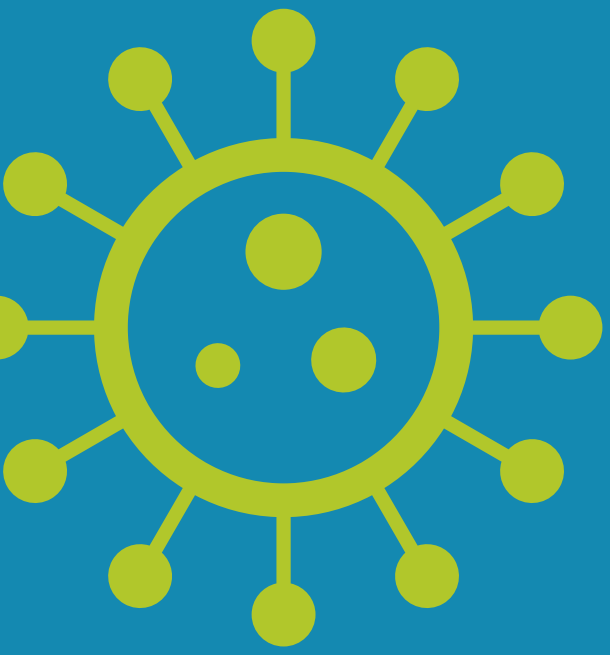
However, the recent increase in hybrid and electric vehicles means that fuel duty revenue has decreased since the year 2000, an impact further exacerbated by the sudden decrease in vehicle use by the pandemic and associated lockdown. One alternative proposal is a road-use tax[42], based on the impact of road use by vehicles, including congestion, air pollution and carbon emissions. This could still improve health as active travel methods would be much more affordable than vehicle use, even hybrid/electric vehicles.

Invest in health and social care

Part of the reason for the impact of Covid-19 in the UK was that we already had a health and social care system under pressure. Our health services (both hospital and community services, including primary care) were under-resourced and had frequent capacity issues and a very limited capacity to increase provision to meet additional demand. Adult social care has also been severely underfunded for many years. One reason that so many people were in hospital and awaiting discharge was due to a lack of available and/or acceptable care home beds. Ultimately, we will not be able to protect care home residents effectively without substantial investment in the sector.

We are now seeing a post viral syndrome affecting many people who have had Covid ('long Covid') and this is creating additional demands on our already over stretched community rehabilitation services.





8. Conclusion

The risk of harm from Covid-19 is not evenly spread across the population, and the impact of the known risk factors is increased when more than one factor is present. In this report we have described and recommended a number of approaches and interventions, many of which have been aimed at tackling multiple issues. Some of the interventions were aimed at specific settings, geographies or demographic characteristics, but many have been cross cutting. Nationally, the evidence tells us that Covid is increasing health inequalities, with the greatest impact falling on those who already have poorer health and wellbeing. We need to ensure that we address this locally, as we already have steep inequalities between our most and least deprived wards. Once the virus has faded, these inequalities will remain.

More work needs to be done to ensure people's concerns and needs are reflected in service provision across Trafford. We must recognise the disproportionate effect on older people, particularly in deprived areas and from BAME communities, and the implications this will have in the future for reducing existing health inequalities, which have been amplified by Covid-19. Those with cognitive impairment, such as dementia, may be disproportionately affected by Covid-19, both in terms of the number of deaths, and resulting detrimental consequences caused by restriction on visiting in care homes and restrictions in social interaction with people from outside your household, which may hasten cognitive decline. The fact that BAME groups are disproportionately affected by Covid-19, thus further exacerbating existing inequalities, has understandably led to a feeling of dismay and anger from within the BAME communities.

The Covid-19 pandemic has emphasised the need for better preventative services and of taking a whole system approach to health improvement. At a policy level, it has shown that we can no longer wait for the food and drinks industry to behave responsibly. We need to impose tighter controls on the composition of the food we eat – in particular, to reduce our consumption of fat, sugar and salt.

Similarly, we need to apply a 'polluter pays' methodology to travel choices, moving away from the car being the default choice for people and making the roads safe and pleasant enough for everyone to be able to choose cycling and walking.

We need to improve housing and job security, and to challenge systemic racism wherever we find it.

Covid has reinforced much that we already knew, in a way that is hard to ignore. We have seen many positive changes in how we have responded to this public health crisis, as individuals, communities and organisations. Let's not let the positive impact be temporary; this is our chance to make changes, listen to the lessons and build back a better future.

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