STOCKPORT
METROPOLITAN BOROUGH COUNCIL

21st Annual
Public Health Report
for Stockport

Level 1 - Overview
Level 2 - Key Messages
Level 3 - Full Analyses

NHS The Council's public health duties are part of the comprehensive
health service established under the National Health Service Acts

21st ANNUAL PUBLIC HEALTH REPORT FOR STOCKPORT

2012/13

<u>Contents</u>

The report is broken down in to levels and sections.

There are three levels:

- **Level 1** contains a one page summary followed by a five page overview in which each chapter of the report is summarised in a paragraph, each section on a page.

- **Level 2** is 32 pages in length and each chapter is summarised in one or two pages.

- **Level 3** is 196 pages in length and contains the full report.

Within each level there are five sections:

- **Section A** describes and considers an overview of the health of the people of Stockport.

- **Section B** covers the diseases which cause death and disability in Stockport.

- **Section C** explores the major risk factors for disease, death and disability so we understand how we can address the issues described in section B

- **Section D** looks at these issues as part of the life-cycle, considering the health of children through to healthier aging.

- **Section E** summarises our response; how we are addressing the causes of ill-health and reducing health inequalities for the people of Stockport.

Within level 2 of the report there are two key chapters:

- Recommendations highlights the key messages of this report for organisations

- Advice to individual citizens of Stockport highlights the key message to individuals

A full content list follows on pages 3, 4 and 5, and you can access any level and section of the report by clicking the chapter name in the content list. Each page contains a "return to contents" button to enable you to return to this list and navigate to other levels and sections of the report easily.

Contents 2

Return to contents

21st ANNUAL PUBLIC HEALTH REPORT FOR STOCKPORT

2012/13

LEVEL 1

Overview

LEVEL 1 (OVERVIEW) SUMMARY

The health of Stockport is broadly similar to that of the country at large with life expectancy of 79.7 years for men and 83 years for women. There are however considerable inequalities due to the borough boundaries including both affluent and deprived areas. Bramhall has life expectancy 13.3 years greater than Brinnington for men and 10.9 years for women. These inequalities narrowed considerably in the 1990s but then widened somewhat before starting to narrow again more slowly. Overall the health of Stockport has improved by 10% more than the health of the country as a whole in the last quarter of a century, largely due to the reduction in inequalities in the 1990s. The alcohol epidemic has had a serious impact on Stockport and was a major factor in the slower improvement.

The main causes of death are heart disease, cancer and respiratory disease causing between them three quarters of all deaths. However if we look at years of life lost, rather than numbers of deaths, then injuries, which are the main cause of death in young people, replace respiratory disease in third place. The main causes of disability are mental illness, sight and hearing impairments and musculoskeletal conditions. I believe the major determinants of health are various aspects of mental well being including stress, social relationships and social integration, although there is some scientific disagreement about this. The next six major determinants are smoking, high blood pressure, obesity, physical activity, alcohol and diet. Smoking causes heart disease and cancer (including 80% of lung cancer.) Tobacco is highly addictive and we need to provide support to those wishing to give up, including the continued further denormalisation of tobacco. High blood pressure causes heart disease and stroke, and we must strive to detect and treat hypertension early. Physical activity helps prevent heart disease, obesity, mental illness, osteoporosis and diabetes. We should provide exercise opportunities including exercise in schools and the promotion of walking and cycling as the preferred modes for making short journeys. Obesity causes heart disease, diabetes, high blood pressure and some cancers. Poor diet contributes to obesity, diabetes, heart disease, and some cancers. Alcohol causes injuries, liver disease and some cancers. To confront inertia, lack of cooking skills, and commercial marketing we need action at a number of levels from Government to local communities and individuals. Alcohol causes liver disease and cancer. Government action is needed.

The Council and the NHS both face financial challenges more serious than they have faced at any time previously. It will not be possible to solve these by simple efficiencies or by minor adjustments of a traditional pattern of service provision. It will only be possible to meet these challenges by a preventive strategy, one which recognises that a stitch in time saves nine and that we serve people best if we avoid them needing services in the first place. A healthy ageing strategy is the best way to ensure that we are able to afford high quality care for older people. Resilient communities will make less demand on both health services and Council services. Preventing illness is the best way to reduce the pressures on healthcare services. Early intervention can stop a problem getting worse and needing major remediation.

LEVEL 1 (OVERVIEW) INTRODUCTION

This is a personal professional report by the Director of Public Health to Stockport Council, addressed also to the NHS, the people of Stockport and all those with the ability to influence the health of the people. It is a report <u>to</u> the Council not a report <u>of</u> the Council and the views expressed are those of the DPH not necessarily a corporate view.

LEVEL 1 (OVERVIEW) SECTION A: THE HEALTH OF THE PEOPLE

1.1.   ILL HEALTH IN BRITAIN AND STOCKPORT

Life expectancy in Stockport is similar to that in the country as a whole but with marked differences across the Borough, life expectancy in Bramhall South being 13.3 years greater for men and 10.8 years greater for women than life expectancy in Brinnington & Central. Cancer and heart disease are the main causes of death, with respiratory disease coming third if we consider numbers of death but accidents coming third if we consider years of life lost (this is because accidents are the main cause of death in young people). These main three causes of death account for three quarters of all deaths. The main causes of disability are mental health, sight and hearing impairments and musculoskeletal conditions. Some would view the six main determinants of health as smoking; high blood pressure; obesity; physical activity; alcohol; and diet. Others put social relationships, social integration and wellbeing ahead of these six (with the more traditional six then following). Whilst there is scope for scientific debate, I am professionally convinced of the latter analysis, valuing social support and wellbeing.

1.2.   INEQUALITIES

Stockport has an unusual diversity of affluence and deprivation in its population. We are the third most polarised local authority in England, which means we have the third greatest gap between our most deprived and least deprived ward. This isn't the result of any local failure of policy or services. It simply results from the fact that our boundaries embrace some of the most affluent areas in the country but also some of the most deprived areas. This context actually means that Stockport has a spread of affluence and deprivation similar to that of the country as a whole. Inequalities in health in Stockport improved dramatically in the 1990s but then the gap widened slightly before resuming a slower narrowing.

1.3.   HEALTH OF STOCKPORT COMMUNITIES

Bramhall and Cheadle are healthy but make greater use of health services and have low physical activity levels. Heatons has slight problems with mental health and drinking but otherwise is healthier than the average for the borough. In Reddish, Offerton and Central Area lifestyles are generally less healthy than in the rest of the borough except for physical activity. Alcohol related harm has had a significant adverse effect on health in these areas in the early years of this century but life expectancy is now improving. Stepping Hill Area (excluding Offerton) shows better mental well being, life expectancy and alcohol consumption, but worse diet and physical activity. It has high levels of health service use. Marple, given its affluence, shows disappointing life expectancy, possibly due to high levels of alcohol consumption. In Werneth life expectancy is slightly worse than in the borough as a whole as are most lifestyle factors except for physical activity.

1.4. HEART DISEASE AND CANCER

Heart disease is caused by smoking; low fibre high fat diets; lack of exercise; genetic predisposition; stress; high blood pressure and diabetes, both of which are contributed to by obesity which in turn is caused by diet and lack of exercise. Smoking is also a major cause of cancer including over 80% of lung cancer. Alcohol is a major cause of gastrointestinal cancer as is diet. Cervical cancer is predisposed to by a woman or a sexual partner having infection with a particular papilloma virus or working in dirty or oily occupations or with biological material. Smoking and multiple sexual partners are also risk factors.   . Breast cancer can be genetic but usually is predisposed to by affluence, diet and delayed childbearing with reduced rates in women who have breastfed their babies.

1.5. RESPIRATORY DISEASE

One person in 20 suffers from some degree of chronic obstructive pulmonary disease and it is important to detect and treat it. Asthma is difficulty breathing due to contraction of the respiratory passages in an allergic reaction which can be aggravated by poor air quality. There is a relationship to traffic density. It is usually said that asthma is not caused by traffic emissions, but that these emissions condition the airways to react more to the actual allergens. However if the effect is that people suffer regular attacks when they otherwise would not have done, then the distinction between causing asthma and predisposing to asthma may seem an artificial one.

1.6. INJURIES

Most injuries occur in one or other of five settings - on the road, at work, at leisure, at home or as a result of violence. A few accidents are genuinely unavoidable or are due to bad luck with the inherent risks in excitingly dangerous activities such as mountaineering or motor racing, and are avoidable only by constraining the human spirit. But most should not be called accidents as they have readily avoidable causes. Injuries occur more commonly to the poor, because they are most likely to work in poor quality work settings, they are more exposed to risks as pedestrians and they often cannot afford safe equipment.

1.7. MENTAL ILLNESS

One person in 3 will suffer from mental illness at some time in their lives. In about the last third of the 20th century the treatment of mental illness went through a shift from being based in institutions to being more fully integrated with the rest of the health service and with more care in the community. Around the turn of the century it went through a further shift towards the wider use of psychological therapies. It now needs to go through yet another shift – towards fuller integration of mentally ill people into society. It is essential that we should take steps to reduce the prejudice and stigma associated with mental illness including in employment Coproduction is a method of organising services where users participate in design to structure them around supporting that individual in living as independently as possible. Integral to coproduction is the involvement of the community in addressing issues of stigma and prejudice.

1.8. MUSCULOSKELETAL DISEASE

Is an important cause of disability and includes osteoporosis (best avoided by physical activity), back and neck pain (best avoided by good posture and ergonomics), rheumatoid arthritis (an inflammatory joint disease often lifelong) osteoarthritis (a degenerative condition that develops as people age) and poor balance in old age which results in falls and injuries.

1.9. HYPERTENSION

Persistent high blood pressure (hypertension) causes strokes and heart disease. It can often remain free of symptoms until it has caused much damage but if caught early it can be treated and the damage avoided. It is important that blood pressure is regularly checked.

1.10. SMOKING

Tobacco is the only lawful product which regularly causes addiction in those who use it in the way and the quantities that the manufacturer intended. It is the only lawful product to kill a quarter of those who use it as intended. About a fifth of the people of Stockport smoke ; the figure is greater in deprived areas. The product is highly addictive and most smokers wish they did not smoke. Denormalising smoking is an important step to help people give up and must run alongside services supporting those seeking to quit and publicity of the harm caused.

1.11. DIET

A low fat, low sugar, low salt, high fibre diet contributes to the prevention of heart disease, stroke, diabetes, obesity and cancer. The low fat, low sugar, low salt, high fibre message is a constant and scientifically well-established message and must not be confused with transient scares. There are a number of reasons why people do not eat a healthy diet despite this. The evolutionary instinct to build up stores of energy in preparation for scarcity; skilful marketing; the inertia of eating patterns; lack of cooking and shopping skills; healthy food is more expensive to obtain easily. To address these cultural and commercial pressures we need action at a number of levels from Government to local communities and individuals.

1.12. PHYSICAL ACTIVITY

Physical activity improves well-being, fitness, concentration and academic attainment and helps prevent mental illness, diabetes, heart disease, obesity and   osteoporosis. *"The potential health benefits of physical activity are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'."(Sir Liam Donaldson, Chief Medical Officer for England, March 2010)* Physical activity in school is important for health and academic reasons. Walking and cycling can easily be built into everyday life and should be promoted by transport planners and spatial planners. Opportunities for play and recreation should be preserved and developed.

1.13. ALCOHOL

Alcohol related diseases have been the major cause of our failure further to close the gap in life expectancy during the last decade, despite continuing with the progress in addressing cardiovascular diseases. Over 8,000 hospital admissions of Stockport residents in 2012/13 were attributable to alcohol, double the number seen in 2003/4. Key factors include larger and stronger drinks and the consumption of cheap alcohol from supermarkets, often as pre-loading before a night out to make it cheaper to get drunk. It is regrettable that Government It has reneged on its commitment to introduce a minimum unit price.

1.14. WELLBEING

Social support, autonomy, tranquillity, aesthetically attractive surroundings, meaningful work in which you are trained and adequately resourced for the responsibilities you carry, control of your own work, a sense of control of your own life, and a strong sense of personal identity all have major benefits to health. Stress, working under pressure to deadlines, threats hanging over you, feeling trapped in unsatisfactory situations and low social status have an adverse effect. Life changes which affect areas of your personal identity, like losing your job or bereavement damage health from the time that the change starts to be feared until after adjustment to the change. The stress reaction may explain these links, which are considerable.

1.15. SAFETY AND HEALTH PROTECTION.

Various agencies protect us from chemical, physical, occupational, infectious hazards and risks of injury. We can all help with a sensible attitude to risk.

1.16.   HEALTH OF CHILDREN AND YOUNG PEOPLE

Indicators where Stockport performs better than the England average	Indicators where Stockport is similar to the England average	Indicators where Stockpot performs worse than the England average
• Immunisations • Children in care immunisations • Acute sexually transmitted infections • Low birthweight • Obese children (age 4 – 5) • Breastfeeding at 6 – 8 weeks • A & E attendances (age 0 – 4)	• Infant mortality • Child mortality (age 1 – 17) • Obese children (age 10 – 11) • Participation in sport / PE • Teenage conceptions • Admissions due to substance use • Admissions for mental health	• Children's tooth decay • Admissions due to oral cavity disease • Admissions due to alcohol • Maternal smoking • Breastfeeding initiation • Admissions due to injury • Admissions due to asthma • Admissions for self harm

1.17.   HEALTH AND WORK

Poor quality work and unemployment both damage health and affect the same group – those most marginal to the labour market suffering unemployment or poor quality work dependent on the economy. All people in Stockport should enjoy good quality work:
* Meaningful
* Enjoyable
* Able to be integrated into life
* Has pleasant and safe surroundings
* Significant autonomy with resources, power and training appropriate to responsibilities
* No unnecessary deadlines
* Good social support
* No bullying

Disabled people in Stockport should be employed for their abilities instead of rejected for their disabilities.

1.18.   HEALTHY AGEING

The ratio normally used for measuring the proportion of people who are dependent due to old age is calculated by taking the number of people over age 65 and dividing it by the number of people of working age. This is at an all-time high. An alternative measure however would take the number of people within 15 years of life expectancy and divide it by the number of people actually in employment. This is at an all-time low. The difference between the two measures is the dual effect that life expectancy has on the numerator and the impact on the denominator of participation in the workforce by women and by older people. A healthy ageing strategy must encourage people to remain active into old age, to maintain friendships and a purpose to life, and to continue with healthy lifestyles, such as healthy diets. It must ensure that people are not encouraged to accept that they suffer from old age when in fact they suffer from treatable illness. We must make it easier for old people to remain active and involved, and support people in staying independent when old age does begin to affect them.

1.19.   RESILIENT COMMUNITIES

If we can create resilient communities full of self-reliant individuals who feel empowered to address their own needs, and with a commitment to mutual help so that the community works together, we could potentially improve health because self-reliant empowered individuals are healthier and strong social support networks improve health. We could also reduce excessive reliance on the NHS and social care and on local authority services because of increased self-reliance and more mutual help. Community development has an important role in enhancing community resilience. There is evidence that improving community and individual resilience can improve health and reduce demand although evidence for reduced demand is more limited than evidence for improved health.

1.20.   EARLIER DIAGNOSIS

It can be important to diagnose conditions only, perhaps through screening systems, but this is only the case where earlier diagnosis makes it possible to give treatment which will be more effective than the treatment available later.

1.21.   NHS CHANGES

The health service has been radically reshaped this year. I particularly welcome the transfer of public health to the local authority, the creation of the Health and Well Being Board as a committee of the local authority providing a single focus for strategic oversight within a democratically accountable context and the strong clinical input into commissioning and the extra power given to GPs. I am concerned however about risks of fragmentation and commercialisation and the major financial challenges.

1.22.   NHS CHALLENGES

Challenges for the NHS include quality of care, the NHS contribution to prevention, rising demand, unifying health and social care, optimising resources and using those preventive services which can achieve quick benefits as a response to immediate financial challenges.

1.23.   PREVENTION – A CORNERSTONE OF "PUBLIC SECTOR REFORM"

The term "public sector reform" is used in Greater Manchester to describe a set of design principles for services which ensure that they intervene early, reduce need, and create resilient thriving communities.

1.24.   COUNTRY CITY

is a spatial strategy focused on supportive sustainable communities in green environments.

1.25.   HEALTH AND WELL BEING STRATEGY

is a multi agency strategy focused on these goals

1.26.   RECOMMENDATIONS

- My recommendations to the Council and the NHS include investing in prevention to reduce demand and address the financial problems. I also recommend pursuing the health and well being strategy, pursuing public sector reform, pursuing earlier diagnosis of hypertension, improving screening programme uptake   in deprived areas, a sustainable food strategy, walking and cycling, healthy ageing, co-production in mental health, workplace health, creation of a preventive culture, enhanced public health input to planning applications, signing the Local Authority Declaration on Tobacco Control and creating smoke free areas in parks.
- I ask law enforcement agencies to prioritise illicit tobacco.
- I urge people to declare their homes and cars smoke-free.
- I ask local MPs and political parties to press for reversal of the Government's abandonment of a minimum unit price for alcohol and also for plain packaging of tobacco products.
- I ask that all schools have a programme of SRE consistent with best practice guidance.
- I advise individuals to follow the Five Ways to Well Being. I also ask them to stop smoking, drink sensibly, eat a healthy diet, be physically active, maintain a healthy weight, make use of NHS preventive services such as vaccination and screening, take sensible steps to avoid accidents and infections, deal with stress, keep good social relationships and have fun.

21st ANNUAL PUBLIC HEALTH REPORT FOR STOCKPORT

2012/13

LEVEL 2

Key messages

LEVEL 2 (KEY MESSAGES) INTRODUCTION

Since 1848 communities have employed doctors to treat the population as a collective patient, improving health by acting as a change agent wherever necessary. Since 1998 people without a primary medical qualification can directly enter postgraduate medical training for specialist recognition as a public health consultant. From 1848 to 1974 this office was called Medical Officer of Health. It was Area Medical Officer from 1974- 1982 and District Medical Officer 1982-9. Since 1989 it has been Director of Public Health. On 1st April 2013 Directors of Public Health and their staff and functions returned to local government but also remain part of the health service.

One duty of the DPH is to write an annual report on the health of the people. This duty existed until 1974, was then abolished, but was reinstated in 1989. The Metropolitan Borough of Stockport was founded in 1974 by merging the County Borough of Stockport with some surrounding urban districts so the 1st Annual Public Health Report for that population – Health for Many but not for All – was written in 1989 by the Acting DPH, Dr. David Baxter. This is the 21st report in that series, 19 of them (since the 3rd onwards) being written under my authority, as I have held the office of Stockport DPH since 1990.

The first few reports described comprehensively the health of the Borough, each in greater depth and, from the 4th report onwards, with a special topic covered in greater depth still. However it is unnecessary to attempt a comprehensive description every year. This is now done periodically with this role being played by the 7th, 10th, and 16th. This report fulfils that same function. An annual public health report is a report by a DPH to the council, not a report of the council. Its contents are my personal professional opinions. Personal in that nobody tells me, or is entitled to tell me, what to write; responsibility for the opinions is mine. Professional in that the report is the advice of a doctor to the population which is my patient; it must be based on competent professional analysis of local information and the scientific body of knowledge.

Where I address issues of political or philosophical controversy, I do so in accordance with Stockport's guidelines on public health advocacy which require that comments on issues of political controversy are based on scientific facts and are not distorted for political purposes. These guidelines can be found at the third level of this report.

This report is written at three levels. The first is an overview including a one page summary and five pages containing a paragraph about each chapter. This is the second level which sets out the key messages. More detailed analysis can be found at the third level. Still further information can be found in the Joint Strategic Needs Assessment and in due course extracts of that information will be arranged for each chapter of this report creating a fourth level.

STEPHEN J. WATKINS

Director of Public Health

2.1.   ILL HEALTH IN BRITAIN AND STOCKPORT

One key measure of the general health of any population is the age that you can expect to live to, or life expectancy, for that area. Life expectancy in Stockport is 79.7 years for men and 83 years for women.

The life expectancy for men equates to that of Sweden, Canada, Italy and Singapore. That for women equates to that of Germany, New Zealand, Ireland and Portugal. These rates are slightly higher than those for the UK.

The overall high life expectancy does not tell the whole story for the general health of Stockport. Male life expectancy varies from 71.7 years in Brinnington & Central, equivalent to life expectancy in Mexico, Iran, Poland or Malaysia to 85 years in Bramhall South, better than that of any country in the world (the best national figure being 83 years for Qatar). Bramhall South also has better life expectancy than any country in the world for women at 87.7 years (the best being Japan at 86years) whilst Brinnington & Central at 76.9 years equates to the life expectancy of women in Dominica, China, Serbia or Thailand. Bramhall North for men and Cheadle Hulme South for women also exceed the best life expectancy of any country in the world.

When we consider what affects life expectancy, we need to understand the causes of death in the population. Heart disease and cancer account for almost 60% of all deaths. If respiratory disease is added these three causes account for three quarters of all deaths. This is similar to the position in England and Wales and also in Europe (although in Europe respiratory disease is less prominent). Internationally the picture is similar except that infections account for 13% of all deaths in the world but only about 1% in Europe, England & Wales and Stockport.

If we focus on years of life lost, weighting the deaths of younger people instead of counting all deaths equally, injuries become a major contributor, moving from a small role (only 4%) up to third place, since they account for the greatest number of deaths in children, young people and young male adults.

We must be concerned not just with causes of death but also the causes of disability. The most significant causes of disability for high income countries relate to mental health (depression, alcohol dependence and dementia) hearing, sight and musculoskeletal conditions (osteoarthritis).

When it comes to determinants of health which cause those diseases, it's not entirely clear as to the extent of the contribution of different factors. We find scientific disagreement focussed mainly on how much high blood cholesterol is caused by diet and how much by stress.

Some would view the six main determinants of health as smoking; high blood pressure; obesity; physical activity; alcohol; and diet. Others put social relationships, social integration and wellbeing ahead of these six (with the more traditional six then following). Whilst there is scope for scientific debate, I am professionally convinced of the case for the latter analysis, valuing social support and wellbeing. We explore the contribution of all of these factors, in this report.

2.2.   INEQUALITIES

Chapter 1 shows us that death rates in Bramhall are better than those in highest countries Qatar and Japan) and those in Brinnington & Central are more like those of Mexico or China.

Stockport has an unusual diversity of affluence and deprivation in its population. We are the third most polarised local authority in England, which means we have the third greatest gap between our most deprived and least deprived ward. This isn't the result of any local failure of policy or services. It simply results from the fact that our boundaries embrace some of the most affluent areas in the Country but also some of the most deprived areas. This context actually means that Stockport has a spread of affluence and deprivation similar to that of the country as a whole.

As you can see from the graph above, the gap in death rates between the most deprived areas and the average for all of Stockport is narrowing over time. Yet we saw a worrying reversal of this trend in the early part of this century. We're getting back on track to narrow the gap but need to consider why did the gaps stop narrowing?

There are a few possible explanations. It could be a natural cycle, which might be the case if the changes were due to cohort effects. Alternatively, it may be explained by loss of drive behind various programmes (such as those made as part of the Stockport Health Promise) when they were mainstreamed. This is the hypothesis that underpins our plans to pilot a reassertion of the 1990s initiatives.

We also consider that as heart disease is not causing the same number of deaths, the narrowing of inequalities seen in heart disease have been outweighed by other diseases (especially cancer and gastrointestinal/liver diseases). Finally, the alcohol epidemic may offer explanation, as impact of cancer and gastrointestinal diseases suggest alcohol as a factor.

2.3.   THE HEALTH OF STOCKPORT COMMUNITIES

Bramhall is healthy. Its use of health service resources is disproportionately large when account is taken of its general good health. It is also noticeable that the percentage of people who are not physically active is higher than in Stockport as a whole. Given the attractive footpath network of the area and the availability both of Bramhall Park and of the Ladybrook Valley this is disappointing.

Cheadle is adversely affected by aircraft noise. In much of the Area the natural patient flow is towards Wythenshawe Hospital rather than Stepping Hill. The large social housing areas of Councillor Lane and Brookfield are within the nationally most deprived quintile but not within the most deprived decile. Overall its health is slightly better than the borough as a whole and its lifestyles slightly healthier but it makes slightly more use of health services and less than a quarter of its population are physically active.

Heatons is a mixed area bordering Manchester. Its health is somewhat better than the Stockport average, apart from mental wellbeing which is slightly worse. It makes less use of health services than the Borough as a whole and lifestyles are generally healthier apart from drinking which is very slightly worse.

Brinnington & Central Ward has markedly lower life expectancy, markedly worse lifestyles and markedly worse health than Stockport as a whole. Brinnington is an attractive community with good facilities and ample greenspace set close to the town centre but still amidst countryside and with strong community spirit. It is possible that the health indicators are affected by the inclusion of the Town Centre within the ward and by the use of some housing in Brinnington for short term housing.

Reddish also shows worse life expectancy, health and lifestyles, especially in the North of the township, but to a much less marked extent than in Brinnington

Victoria is the other major deprived area of the borough. Life expectancy is intermediate between that of Brinnington and Reddish. It has shown marked improvements in lifestyles over the last decade to the point that it has one of the best levels of physical activity in the borough and low levels of high risk drinking. Its proportions of people with multiple risks are only slightly worse than the affluent areas.

Life expectancy and self-reported health are slightly better in **Stepping Hill** Area than in the borough as a whole. Mental wellbeing is slightly better except in Offerton where it is markedly worse. Physical activity is better in Offerton and markedly worse in Hazel Grove. Diet is slightly worse, the alcohol epidemic slightly better. Use of health services is high, perhaps reflecting the proximity of Stepping Hill Hospital.

Disappointingly for an affluent rural area, life expectancy in **Marple** is slightly lower than in the Borough as a whole. Self-reported health is very slightly better. Smoking, diet and physical activity levels are better but levels of high risk drinking are markedly worse and the levels of physical activity are not as high as might be expected from the excellent walking opportunities in the area. Use of health services is lower.

In **Werneth** life expectancy, self-reported health and mental wellbeing are slightly worse than in the borough as a whole. Rates of problem drinking are high. Rates of smoking, obesity and unhealthy diets are slightly higher than in the borough as a whole. Physical activity rates are slightly better.

Neighbourhood management teams were developed to work on the four most deprived areas of Stockport. The following graphs show trends in life expectancy in the neighbourhood management areas.

Figure 3.11: Trend in Life Expectancy – by Neighbourhood Management Area
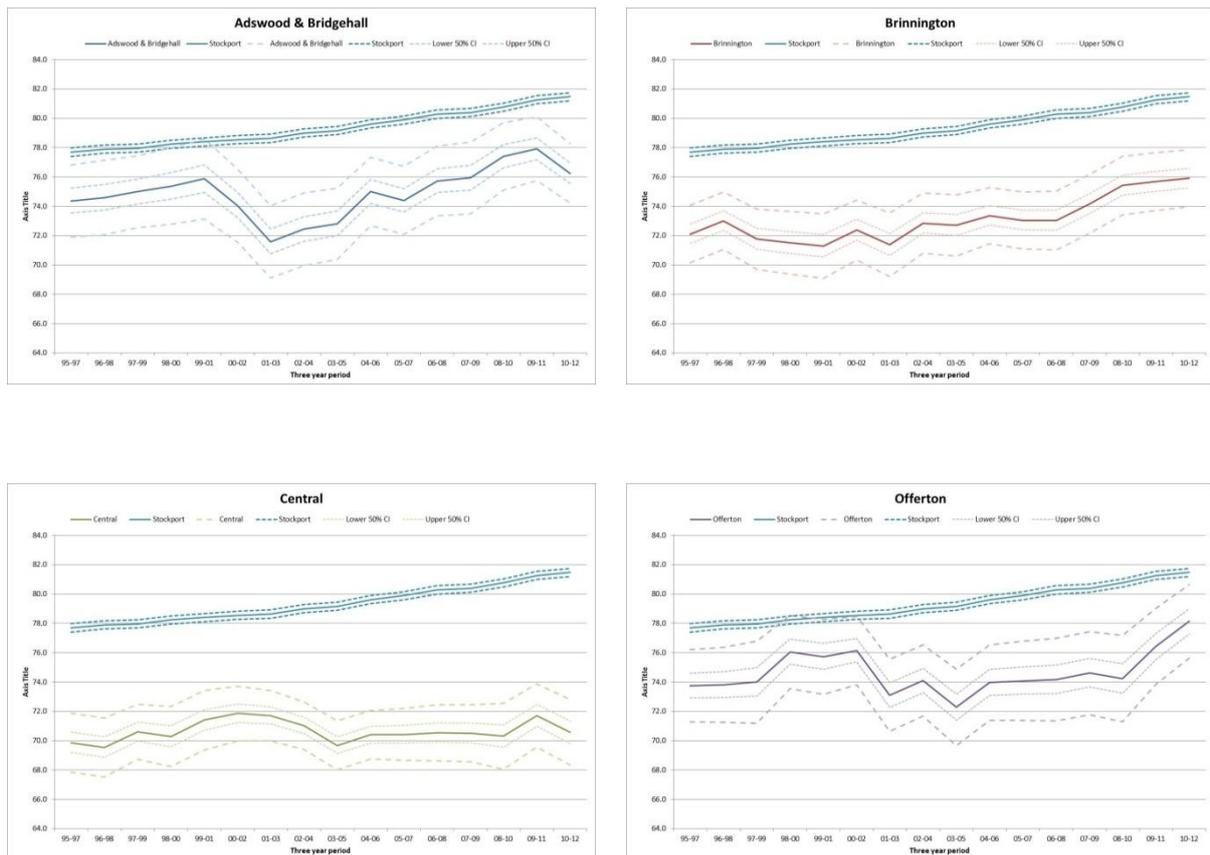
In neighbourhood management areas lifestyles are generally less healthy than in the rest of the borough except for physical activity. Alcohol related harm has had a significant adverse effect on health in these areas in the early years of this century.

2.4. HEART DISEASE AND CANCER

As we described in chapter 1, heart disease and cancer are the two greatest killers of our time. Due to the recent decline in heart disease, cancer has now taken over as the biggest killer. Smoking, stress, physical inactivity and diet contribute to both heart disease and cancer; our preventive strategies focused on those factors therefore benefit both diseases.

Cancer

Cancer arises when a cell starts to multiply out of control leading to tissues growing uncontrolled and ultimately spreading throughout the body interfering with other organs. This occurs as a result of factors that damage chromosomes, depress the immune system, or stimulate cell multiplication. We knows that for all cancers, these factors can include old age; smoking; chemicals and radiation; stress; genetic predisposition; and diseases of the immune system.

Considering some specific examples, we can consider the role that different factors play in the development of different cancers.

Over 80% of lung cancer is caused by smoking (including about 1 to 2 people in every thousand who die each year as a result of passive smoking). About 10% is caused by occupational exposure to chemicals. Smoking also increases the risk of many other cancers.

Breast cancer and testicular cancer are two of the very small number of diseases that are most common in the most affluent. Age, not breastfeeding, and delayed childbearing contribute to breast cancer.

Cervical cancer is commonest in women who have multiple sexual partners, smokers, or who work in oily or dirty surroundings or with biological material, or whose partner does any of these things. Many cases result from papillomavirus infection.

Skin cancer is increased by overexposure to sun, or excessive use of sunbeds.

Gastrointestinal cancer is predisposed to by low fibre diets or by physical inactivity. Oesophageal cancer is increasing in incidence and is associated with reflux of stomach contents in the oesophagus whilst stomach cancer may be caused by an infection which also causes stomach ulcers and heart disease. Mouth cancers can be caused by smoking. All three of these cancers are also predisposed to by excessive consumption of alcohol or certain kinds of food

Heart Disease

Heart disease was the most common cause of death for many years until recently when cancer overtook it.

Moderate (really, we mean low!) consumption of alcohol protects against heart disease. Aspirin, statins and other measures to reduce cholesterol, and eating fish (especially oily fish also reduce the risk of heart disease.

What can we do about cancer and heart disease?

The health service can help by providing services to screen for early disease or risk factors for disease and advice on healthy choices. It can diagnose and treat existing disease. It can sponsor and empower the community.

The Local Authority's Public Health Function can ensure that people living in Stockport can access good quality advice to improve their lifestyles and reduce their risk of developing disease

The wider local authority can create safe and healthy communities, protect and promote our environment and heritage, protect areas of peacefulness and tranquillity as refuges from a stressful world and promote exercise opportunities through leisure facilities, countryside management etc. They can develop a transport strategy that makes more provision for walking and cycling

Employers can encourage and reward healthy behaviours and have policies to reduce stress.

Caterers can adopt a pricing policy that encourages healthy choices, develop imaginative menus that make the healthier choices attractive and ensure that all food is cooked in the healthiest way possible for that particular food. They can also avoid excessively large portion sizes.

All organisations and businesses can help reduce the barriers to physical activity and can discourage smoking.

Schools can ensure that health is included as a cross curricular theme and that the school makes it easier for children to make healthy choices, thus laying the groundwork for a healthy lifestyle. School meals should be healthy – one sensible step to take is to find out what healthy food children like and provide that. Vending machines and tuck shops should also make it easier to choose healthy options. Schools should promote physical activity and should try to encourage children to walk or cycle to school instead of coming by car.

People

You can help yourself avoid heart disease and cancer by:

- Drinking healthily (less than 14 units a week for women and 21 for men with no more than 6 units on any one day)
- Not smoking
- Maintaining a healthy shape (body mass index less than 30)
- Taking at least moderate activity for at least 30 minutes on at least 5 days a week
- Eating at least 5 portions of fruit & vegetables a day, and choose low salt, high fibre, low fat, and low saturated fat products
- Using stairs instead of lifts and making short journeys on foot instead of driving
- Covering up and using sun protection on holidays and when working in the open air in fine weather
- Making full use of screening services.

2.5. RESPIRATORY DISEASE

One of the major public health successes of the last 50 years has been the reduction in the rates of respiratory disease. This has been achieved by Clean Air, by tackling occupational causes of lung disease and by reductions in smoking. However respiratory disease remains a significant problem.

Chronic Obstructive Pulmonary Disease (COPD)

One person in 20 suffers from some degree of COPD and it is important that this is recognised and steps taken to stop its continuing deterioration.

The CCG have been working with colleagues in the FT and LA to raise awareness of COPD with the aim of identifying more people who have COPD so that the impact of their disease can be minimised by treatment and stopping smoking.

Asthma

Asthma is a disease of difficulty in breathing caused by contraction of the small air passages to the lungs. Sufferers are usually perfectly normal between attacks although some permanent damage can occur over time. Asthma attacks can range from severe coughing attacks (especially at night) through to totally obstructed breathing threatening life. Asthma rates have increased considerably over the last few decades.

Asthma is caused by

- genetic predisposition
- allergies to specific substances
- sensitisation to chemicals by repeated exposure, for example in an employment situation
- poor air quality caused by traffic
- other air pollutants
- meteorological conditions
- inhaling tobacco smoke from other people

As well as providing sufferers with good quality services and education about their disease we also need to address the fundamental causes of poor air quality.

There is a relationship to traffic density. It is usually said that asthma is not caused by traffic emissions, but that these emissions condition the airways to react more to the actual allergens. However if the effect is that people suffer regular attacks when they otherwise would not have done, then the distinction between causing asthma and predisposing to asthma may seem an artificial one.

2.6. INJURIES

Injuries account for a relatively small proportion of all deaths. However they cause very much the greatest proportion of deaths in young people, so they are the third largest cause of lost years of life.

Most injuries occur in one or other of five settings - on the road, at work, at leisure, at home or as a result of violence. There are some injuries in other settings, rail or air crashes or weather incidents for example, but the five main settings account for almost all of them.

A few accidents are genuinely unavoidable or are due to bad luck with the inherent risks in excitingly dangerous activities such as mountaineering or motor racing, and are avoidable only by constraining the human spirit. But most should not be called accidents as they have readily avoidable causes, such as

- alcohol
- failure to warn about and protect against hazards
- unsafe systems of work
- defective equipment
- inadequate training
- inexperience in children and young people
- binge drinking in young people
- short cuts taken for convenience or profit
- people taking unnecessary risks out of bravado, carelessness, lack of knowledge, misjudgement of risk, lack of self worth, familiarity breeding contempt
- absurdly risk averse safety procedures which discredit the concept of safety and lead people to ignore advice (the "cry wolf" syndrome)
- poor housekeeping in workplaces
- failure to appreciate hazards in the home, including
- fire risks
- unsafe storage of dangerous substances, including both prescription and non-prescription drugs
- unsafe equipment and furniture, especially where poor households buy cheaply

Injuries occur more commonly to the poor, because they are most likely to work in poor quality work settings, they are more exposed to risks as pedestrians and they often cannot afford safe equipment.

2.7.   MENTAL ILLNESS

One person in 3 will suffer from mental illness at some time in their lives. In Stockport in 2011/12 32,588 people suffered from depression and anxiety and 2,247 people suffered from schizophrenia, bipolar disorder or other psychoses. Low levels of wellbeing increase the risk of mental illness, and stress can also be a factor in an incident of mental illness. Strong social networks help provide protection and physical activity reduces the incidence of depression.

New Approaches to Mental Health Services

In about the last third of the 20th century the treatment of mental illness went through a shift from being based in institutions to being more fully integrated with the rest of the health service and with more care in the community. Around the turn of the century it went through a further shift towards the wider use of psychological therapies. It now needs to go through yet another shift – towards fuller integration of mentally ill people into society.

There is a very considerable stigma attached to the various mental illnesses. The old Victorian idea that mentally ill people should pull themselves together, and if they can't do that they should be sent to an asylum, dies hard. Few would articulate it or indeed believe it, but many would behave as if they believed it, which for the sufferer is as bad.

This stigma worsens the experience of mental illness and constitutes a stress which exacerbates it. It often prevents people with mental illness from participating in activities which might ease their problems – physical activity or social networking for example. It is therefore essential that we should take steps to reduce this prejudice and stigma associated with mental illness. Employment is of value to mentally ill people as a source of status, of social networking and of structure to the day. Often lack of employment creates needs for day care. It is unfortunate therefore that the stigma of mental illness extends very much to employment and creates high unemployment rates amongst mentally ill people. Coproduction is a method of organising services where users participate in design to structure them around supporting that individual in living as independently as possible. Integral to coproduction is the involvement of the community in addressing issues of stigma and prejudice. This can be made part of a process of creating resilient mutually supportive communities and this would bring the issues of mental illness and mental wellbeing together into a truly comprehensive mental health process.

Suicide

There were 75 deaths of Stockport residents due to suicide and undetermined intent in the two years 2009-11 The groups with the highest rates were young (15-34 yrs) and middle aged men (35-49yrs) particularly living in deprived wards such as, Brinnington and Central ward. Risk factors for suicide include, being male, unemployment, living alone, having a mental health problem and experiencing a recent significant life event, such as, a bereavement.

2.8.   MUSCULOSKELETAL DISEASE

Osteoporosis

Osteoporosis is a disease of low bone density which can result in fractures. It is particularly common in women beyond the age of the menopause. The most effective form of prevention is physical activity.

Osteoporosis increases the risk of fractures with falls in elderly people. Given the increasing incidence of the condition with age it is important to prevent falls in older people.

However, the factors that lead to falls in older people are often multi-faceted and difficult to predict. Whilst the risks and implications of falls for someone known to be suffering from osteoporosis are greater, they are also potentially easier to prevent with effective advice about how to reduce the risk of falls at the time of diagnosis and in on-going management of the condition.

Low Back Pain

60-80% of adults report having had low back pain at some time during their lives. Physical activity, good posture, good ergonomics and the use of lifting techniques which do not put the strain through the back are the best preventive measures.

Neck Pain

Neck pain is also very common and is often produced by poor posture when sleeping or when working. The preventive measures are similar to those for low back pain but with the added issue of attention to sleeping position.

Rheumatoid Arthritis

Rheumatoid arthritis is an inflammatory joint disease which causes much disability but does not often cause death. There are no clear risk factors amenable to prevention – the most obvious predisposing factors are genetic. It affects about 0.1% of the population often on a lifelong basis.

Osteoarthritis

Osteoarthritis is a degenerative disease of joints which increases in prevalence with age to the point where more than half of the population over the age of 50 have at least one joint radiographically showing evidence of osteoarthritis and in old age radiographic evidence of osteoarthritis somewhere is to be expected. However many of these abnormalities found radiographically do not actually cause pain.

2.9.   HYPERTENSION

Hypertension is a persistently raised blood pressure. Blood pressure goes up temporarily in exercise and under stress and this is perfectly normal. It is when it happens persistently that it is a serious health problem. It is a serious health problem because it can damage blood vessels and thereby damage important organs such as the heart. It also considerably increases the risk of stroke. Hypertension can be caused by kidney disease, various other diseases, high salt intake or persistent stress. It can also occur without apparent cause. Hypertension is treatable but unfortunately it is often without symptoms and people can have it, and be damaged by it, without realising it.

It used to be said that only a third of people with high blood pressure knew that they suffer from it and that only a third of those were adequately treated. Much effort has been put in, especially by general practitioners, to ensure that this bleak statistic is improved. People are now screened for hypertension at health checks and opportunistically at visits to their GP. As a result things are now much better, with far more cases of hypertension being recognised and the blood pressure successfully controlled.

There are still however a lot of people who slip through the net. It is important that we continue to pursue the early diagnosis of hypertension vigorously.

2.10.   SMOKING

One in 4 smokers will die of a smoking related disease so the only difference between smoking and playing Russian roulette is the delayed effect. Tackling smoking is the single most effective thing we can do to improve health and tackle health inequalities. Deaths from smoking accounts for around 500 deaths a year in Stockport

It's shocking to consider that tobacco is the only lawful product which kills such a high proportion of those who use it in the way the supplier intended and that tobacco is the only drug of addiction that can lawfully be purchased without a prescription. Most smokers are introduced to tobacco in their youth and often become addicted before they fully realise the risk they are running.

Smoking in Stockport

In Stockport, around a fifth of adults are still smoking. Smoking prevalence is over 3x greater in our most disadvantaged than our affluent areas. Although Stockport has one of the lower smoking rates in Greater Manchester, the deprivation profile is steeper than in other boroughs.

In 2012/13 around 13% of new mothers smoked at the time they gave birth. Furthermore, exposure to passive smoke will still impact until local people make their homes and cars smoke free.

The cost of smoking to the economy is also huge; the cost to the NHS alone in Stockport is £15.5 million. It also affects inequalities, as tobacco is a significant factor in helping perpetuate poverty in our most disadvantaged areas with much household income spent on the habit

How to tackle smoking

In tackling the problems of smoking, we must remember that all smokers need help to quit and must not be demonised for their addiction. Brief interventions are an effective way of encouraging people to attempt to quit and more organisations need to be skilled and committed to delivering brief interventions ensuring every contact counts.

The Healthy Stockport Service, all Stockport GP's and some Stockport pharmacies provide smoking cessation services. The total numbers accessing services are higher in deprived areas but success rates are lower for people from deprived areas. We need to tackle the lower success rates by additional support and community initiatives to challenge smoking norms

Tobacco control is pursued through a multiagency partnership. I recommend that the Council adopt the Local Government Declaration on tobacco control. Enforcement of the law must continue to be a priority. I recommend smoke free play areas in parks in order to assist the de-normalisation of smoking. I also recommend that the reduction of illicit tobacco should be a priority objective in the Safer Stockport Partnership Strategy.

Tackling smoking needs commitment of Government to bring in appropriate legislation. I regret the Government's failure to introduce standardised plain packaging.

2.11. DIET

Poor nutrition causes at least a third of heart disease and cancer deaths and also contributes to obesity, hypertension, diabetes, bowel disorders, tooth decay, mental illness and osteoporosis.

A low fat, low sugar, low salt, high fibre diet contributes to the prevention of heart disease, stroke, diabetes, obesity and cancer. The low fat, low sugar, low salt, high fibre message is a constant and scientifically well-established message and must not be confused with transient scares.

It is important to eat food which is nutrient dense rather than simply energy dense. Over the last few decades the tendency has been towards energy-rich food and, along with declining physical activity, this has caused the obesity epidemic.

Poor nutrition contributes to the inadequate social, physical and mental development of people of all ages. There is evidence that poor nutrition contributes to behaviour disorders and impairs learning and poor nutrition increases hospital costs by delaying recovery.

For individuals, there are lots of simple ways to eat a more healthy diet www.healthystockport.co.uk and www.nhs.uk/change4life are useful resources. Simple steps include:
- **Eat more fruit and vegetables**. Aim for at least 5 portions a day.
- **Eat a balanced diet**. Meals should include a starchy food e.g. bread, rice, pasta or potatoes, and a protein food e.g. meat, fish, eggs, poultry, beans, pulses, tofu, quorn, vegetables or fruit
- **Eat regular meals.** Try to eat 3 meals a day plus 2 healthy snacks. Don't skip breakfast, it's a really important meal which makes maintaining weight easier and helps concentrate better.
- **Look out for red, amber and green on food labels** making it easier to choose food that is lower in total fat, saturated fat, sugar and salt. Choose more greens and ambers and fewer reds.
- **Eat less salt.** About three-quarters of the salt we eat comes from processed foods we buy.
- **Eat less saturated fat**. It tends to come from animal sources e.g. butter, ghee and lard. Switch to unsaturated fats e.g. vegetable oils, oily fish and avocados. Remove fat from meats. Avoid transfats (which are often found in fried fast food).
- **Eat less sugar** – sugar has no nutritional benefit and too many sugary foods can lead to excess weight gain. Excess sugar can cause tooth decay especially if eaten between meals. Cut down on cakes, biscuits, sweets, chocolate and fizzy drinks.

Most people know what a healthy diet is, although some confusion is caused by food fads and food scares. There are a number of reasons why people do not eat a healthy diet despite this. The evolutionary instinct to build up stores of energy in preparation for scarcity; skilful marketing; the inertia of eating patterns; lack of cooking and shopping skills; healthy food is more expensive to obtain easily. To address these cultural and commercial pressures we need:
- Action from Government to counter food industry unhealthy marketing
- Action in local communities to address local cultural determinants
- Social enterprises to make it easier to obtain healthy food
- Wider understanding of the commercial pressures and willingness to confront them and make genuine personal choices.

2.12.   PHYSICAL ACTIVITY

"The potential health benefits of physical activity are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'."

(Sir Liam Donaldson, Chief Medical Officer for England, March 2010)

Regular physical activity has the ability to reduce the risk of several major chronic diseases, as well as promote quality of life and a sense of wellbeing. Despite the many benefits of exercise and physical activity that are now well documented, 71% of women over 16, 61% of men over 16, 76% of girls (2-15 years) and 68% of boys (2-15 years) in England do not meet the minimum physical activity recommendations for their age.

Health benefits of regular physical activity

Regular physical activity will help to:

- reduce the risk of a heart attack;
- maintain a healthier weight;
- lower blood cholesterol level;
- lower the risk of type 2 diabetes and some cancers;
- lower blood pressure;
- have stronger bones, muscles and joints and lower the risk of osteoporosis;
- feel better – with more energy, happier, more relaxed, and sleep better

UK recommended minimum levels of physical activity

Each week adults should take 150 minutes of moderate activity in sessions of at least 10 minutes each, or 75 minutes of more intense activity. You should also avoid prolonged periods of not moving at all. Children and young people should do more than this – at last 60 minutes a day. This also improves academic attainment so the supposed conflict for time is actually a false dichotomy. Children under 5 should do at least 180 minutes a day.

Pre-exercise screening

Pre-exercise screening by a medical professional is recommended before starting a new physical activity program if physical activity causes chest pain, individuals often faint or have spells of severe dizziness, moderate physical activity causes breathlessness, an individual is at a higher risk of heart disease, in pregnancy or when starting a very intense physical activity programme when no longer young. This doesn't mean these things should be avoided; just that care should be taken**.**

Helping people take physical activity

Physical activity in school is important for health reasons but also for academic attainment. Walking and cycling can easily be built into everyday life and should be promoted by transport planners and spatial planners. Opportunities for play and recreation should be preserved. .

2.13.   ALCOHOL

In the 20 years from 1986/7 to 2006/7 the real cost of alcohol fell by more than a third, and consumption increased by a fifth, according to ONS data. Despite some reductions since 2005, consumption remains significantly higher than in the 1990s. Alcohol sales in on-licensed premises fell by nearly half (44%) between 2001/2 and 2010 while off-sales increased. Two thirds (65%) of alcohol sales are now for consumption at home.

Key factors include larger and stronger drinks and the consumption of cheap alcohol from supermarkets, often as pre-loading before a night out to make it cheaper to get drunk.

The Government Alcohol Strategy recognises the compelling evidence that problematic alcohol use tends to vary in line with overall consumption across the population, and affordability of alcohol is a key determinant of consumption. However, it has reneged on its commitment to introduce a minimum unit price, leaving responsibility for tackling alcohol harm to the alcohol industry and local councils. It is deeply regrettable that Government has recently decided against this.

We measure quantities of alcohol in units, based on a calculation of the strength and volume of the alcoholic drink. Men should not drink more than 21 units in a week (three or four units per day, which is equivalent to about a pint and a half of beer). Women should not drink more than 14 units in a week (two to three units per day, that's a large glass of wine).

For each unit people have drunk they should wait an hour before engaging in dangerous activities or activities requiring skill.

Alcohol harm in Stockport

It is estimated that over 8,000 hospital admissions of Stockport residents in 2012/13 were attributable to alcohol, double the number seen in 2003/4. 2,376 admissions involved alcohol-specific diagnoses such as intoxication, dependency or alcoholic liver disease.

If current trends were to continue, we should anticipate an increasing financial and human cost affecting all our communities and all sectors of the economy. Alcohol related ill-health and deaths disproportionately affect the more deprived communities, and are key factors in maintaining health inequalities in the borough. Stockport Lifestyle Survey (2012) found:

- 3% of the respondents reported drinking at high risk levels in the previous week, (men more than 50 units and women more than 35 units in a week), with a further 17% drinking at increasing risk levels.
- 19% of the survey respondents reporting drinking twice the daily guidelines ('binge drinking') at least once in the last week.
- Young adults and people in their 40s are most likely to 'binge' drink, while middle aged adults aged 45-64 are the most likely to drink at increasing risk levels and people aged 45-49 are the most likely to drink high risk amounts.

Alcohol related diseases have been the major cause of our failure further to close the gap in life expectancy during the last decade, despite continuing with the progress in addressing cardiovascular diseases.

2.14.   WELLBEING

Various aspects of wellbeing have been shown to have a major impact on health. These include social support, autonomy, tranquillity, aesthetically attractive surroundings, meaningful work in which you are trained and adequately resourced for the responsibilities you carry, control of your own work, a sense of control of your own life, a strong sense of personal identity.

Various aspects of poor wellbeing have been shown to have a major adverse impact on health including stress, working under pressure to deadlines, threats hanging over you, feeling trapped in unsatisfactory situations, low social status.

Life changes which affect areas of your personal identity, like losing your job or bereavement damage health from the time that the change starts to be feared until after adjustment to the change. (This is true of pleasant life changes like promotion or getting married as well but the effect is less and adjustment is quicker).

It is biologically plausible that the stress reaction is the explanation for these links.

The effects are considerable – for example variation of death rates associated with strength of social support networks is as great as that associated with poverty. Wellbeing is not therefore some soft luxurious afterthought to public health strategies; it needs to be considered as a major determinant of health.

There are actions that individuals can take to improve their wellbeing. These have been described as *5 Ways to Wellbeing*, and can be built into everyday life:

- *Connect*: develop your social and friendship networks; spend time with other people
- *Be Active*: find physical activities that boost your heart-rate and you enjoy
- *Keep Learning*: be curious, explore new opportunities or ways of doing things
- *Take Notice*: think about patterns and cycles in your life, how you react to things around you focus on 'now' and take pleasure in the moment
- *Give*: your time, your energy, your attention to those around you in small ways or big ones

For those aged between 10 and 17 years wellbeing factors include: creative imaginative play; the balance of family conflict or harmony; the level of support (emotional and practical) within the family and; the level of autonomy parents allow children (**autonomy** and **achievement** are vital at this age).

2.15.   SAFETY AND HEALTH PROTECTION

The protection of the public from infectious diseases continues to be a major element of the public health process. Preventing transmission of infections depends on the type of infection and can be as simple as regularly washing your hands. Vaccination also offers a preventative measure for several infections, for example the flu jab to protect against influenza viruses and MMR vaccine for measles, mumps and rubella. It is really important that those who are eligible for vaccination have it. Vaccinating populations helps to project the most vulnerable in our societies, as well as the individuals who are vaccinated.

Preventing injuries and crashes

Another issue safety issue for public health is preventing injuries and crashes. There are several things we can do to help:

- Don't drink and drive
- After drinking, allow at least one hour for each alcoholic unit you have drunk before driving, using machinery or undertaking any other dangerous tasks requiring care. This will keep the number of units in the bloodstream of a person of average size and build below one unit, which should be safe. To be completely alcohol free allow an extra hour. Also allow extra time if you are below average height and weight (this includes many women), and be aware of how many units you're really taking in.
- Fit smoke alarms and test them weekly to make sure they are working properly.
- Drive at no more than 20mph on side roads.   This will add no more than a couple of minutes to most journeys, since you rarely travel far before you join the main road, and yet it would save most child pedestrian deaths.
- Think about the safety of toys, furniture and domestic equipment.
- Talk to your health visitor about preventing home accidents to toddlers.
- Wear seat belts in cars, crash helmets on motor cycles and cycle helmets on bicycles.
- Learn advanced driving techniques - they not only protect you and other people, but they make driving more enjoyable.
- Always ask sales people about the safety features of the product.   The message eventually get through if enough people do it, and it's fun watching their reactions.

The difference between safe and risk adverse systems

In a safe society people who climb mountains use the proper equipment, train properly, check the weather, inform others of their route and support a mountain rescue service.

In a risk-averse society people do not climb mountains.

Ultimately a risk averse culture is an unsafe culture because people lose patience with it and then have no parameters for safe behaviour, it absorbs resources which are needed to create a safer and healthier world, it limits human growth, creates dependency, and leaves people unfitted to handle risks when there are no regulations to direct them, people concentrate on documenting risk avoidance rather than on tackling hazards and it asks too much of people and they fail so that absurdly excessive levels of precaution coexist with blatant danger. But beware the siren voices who use our concern at risk aversion to entice us to abandon safety itself.

2.16.   HEALTH OF CHILDREN AND YOUNG PEOPLE

There are a number of measures of how healthy our children and young people are. The following table compares Stockport's performance on key indicators and the England average.

Indicators where Stockport performs better than the England average	Indicators where Stockport is similar to the England average	Indicators where Stockpot performs worse than the England average
• Immunisations • Children in care immunisations • Acute sexually transmitted infections • Low birthweight • Obese children (age 4 – 5) • Breastfeeding at 6 – 8 weeks • A & E attendances (age 0 – 4)	• Infant mortality • Child mortality (age 1 – 17) • Obese children (age 10 – 11) • Participation in sport / PE • Teenage conceptions • Admissions due to substance use • Admissions for mental health	• Children's tooth decay • Admissions due to oral cavity disease • Admissions due to alcohol • Maternal smoking • Breastfeeding initiation • Admissions due to injury • Admissions due to asthma • Admissions for self harm

Stockport compares very well against North West averages. Rates for virtually all the above indicators are similar to, or better than, the North West average. One exception to this is hospital admissions for asthma where Stockport rates are worse than the North West average.

To improve the health and wellbeing of our children and young people, Stockport's Joint Health & Wellbeing Strategy identified 5 'We Wills'**:**
- **We will ensure children get the best, healthy start in life from conception to 5 years by enabling parents to access effective child care and advice, family support and quality early education and childcare provision**
- **We will keep children safe from harm and reduce childhood injury**
- **We will support and promote healthy lifestyles for 5 – 19s through schools and other community settings**
- **We will promote positive emotional health, self-esteem and wellbeing for children, young people, parents and carers**
- **We will work closely with families to provide early interventions and preventative programmes to reduce the development or impact of health or wellbeing problems**

Areas where further developmental work is needed includes reducing the health inequalities that existing on key indicators (e.g. breastfeeding, maternal smoking, hospital admission for unintentional injury). Development is also needed in mental health support for families with children under 5; joint working between children's and adult services; school nursing capacity and development of the Healthy Child Programme for 5 – 19s; weight management; services for 16 – 19 year olds; hospital admission rates for several conditions; and development of a prevention pathway for oral health.

2.17.   HEALTH AND WORK

Worklessness

Being out of work has negative effects on the health of individuals and the health of communities. The effects of unemployment spread more widely – to those who fear losing their jobs, those who accept shorter hours or worse conditions, those who are affected by overwork in workforces that have been reduced, and those who lose the benefits of the work the unemployed could have done.

Healthy work

Poor quality work and unemployment both damage health and this damage falls on the same group – those most marginal to the labour market. All people in Stockport should enjoy good quality work:

- Meaningful
- Enjoyable
- Able to be integrated into life
- Has pleasant and safe surroundings
- Significant autonomy with resources, power and training appropriate to responsibilities
- No unnecessary deadlines
- Good social support
- No bullying

Disabled people in Stockport should be employed for their abilities instead of rejected for their disabilities. They are often rejected when they would make good employees. Employers quote fears about attendance and sickness but the evidence is that these fears are groundless. Employers say they need the best person for the job, but the words "for the job" matter. It is not discrimination to reject visually impaired people as cricket umpires. It is utterly wrong to reject somebody for an office job just because you don't want to buy a braille keypad (that is the meaning of "reasonable adjustment"). It is positively foolish to reject a visually impaired person for a job that depends on other senses (a wine taster for example) as visually impaired people are likely to have developed those other senses in a compensatory way.

A Healthy Economy

We should shape the economy of Stockport so that it creates good quality work for everybody. A healthy economy would protect open space and create peace and beauty, reduce motor vehicle exhaust emissions, reduce unemployment, grow slowly and steadily rather than fitfully, provide security, relieve poverty and avoid pressures for geographical mobility, avoid chemical and physical hazards and noise and avoid accidents, provide pleasant working conditions, train people for the responsibilities they carry and avoid giving people responsibilities without resources and power, avoid overwork, underwork or working under pressure to deadlines, provide work that is meaningful and satisfying, under the control of the worker and flexible enough to accommodate other roles, avoid the disruption of communities, empower consumers to act to promote health and protect the environment and empower people to do not just to demand. By treating culture and environment as economic drivers it would attract knowledge based industries which can relocate in places where it is good to live.

2.18.   HEALTHY AGEING

Stockport, like most of the country, has an ageing population. Indeed our population is ageing more than many parts of the country because we lack the renewing effect of high levels of immigration.

Older people use more health and social care than younger people. Therefore it is often said that an ageing population must mean the cost of health and social care will rise. This was certainly true when the main factor ageing the population was demography. Does this change when increasing life expectancy is also a factor? Do older people use more health and social care resources because they are older or because they are closer to death? If it is the former then an ageing population will use more resources. If it is the latter they might not. Indeed a lengthening life expectancy might reduce the burden of an ageing population because a smaller proportion of the population will be in their last few years of life.

In fact, certain analysis raises the rather startling prospect that the financial burden of an elderly population is actually greatest in those areas where people do not live as long; and that increasing life expectancy reduces the cost of care for the elderly, rather than increasing it, provided that healthy life expectancy rises at least as fast.

The ratio normally used for measuring the proportion of people who are dependent due to old age is calculated by taking the number of people over age 65 and dividing it by the number of people of working age. This is at an all-time high and will rise continuously into the foreseeable future even if it is adjusted for changes in state pension age. An alternative measure however would take the number of people within 15 years of life expectancy and divide it by the number of people actually in employment. This is at an all-time low and is still falling although, dependent on the assumptions you make about employment trends, it may rise slightly between 2020 and 2050 but not to anything like the levels seen in the last century. The difference between the two measures is the dual effect that life expectancy has on the numerator and the impact on the denominator of participation in the workforce by women and by older people.

About two thirds of centenarians remain fit and active well into their 90s, so these groups definitely demonstrate a desirable characteristic. About 30% of the chance of living to be over 100 seems to be genetic but about 70% seems to be environmental. The best documented environmental factors are a healthy diet, exercise (and especially remaining active into old age), social support networks with a strong marriage and good friendships, a strong sense of personal identity with a goal to life, and some element of continuing challenge.

People often abandon their active lives because the NHS has told them a treatable condition is "just your age". This is something we have to root out and bring to an end. It is essential that we take steps to stop this common error and its devastating effects.

A healthy ageing strategy must encourage people to live the kind of healthy life described in the preceding section, especially to remain active into old age, to maintain friendships and a purpose to life, and to continue with healthy lifestyles, such as healthy diets. It must ensure that people are not encouraged to accept that they suffer from old age when in fact they suffer from treatable illness. We must make it easier for old people to remain active and involved, and support people in staying independent when old age does begin to affect them.

2.19.   RESILIENT COMMUNITIES

If we can create resilient communities full of self-reliant individuals who feel empowered to address their own needs, and with a commitment to mutual help so that the community works together, we could potentially

- Improve health because self-reliant empowered individuals are healthier
- Improve health because strong social support networks improve health
- Reduce excessive reliance on the NHS and social care because of increased self-reliance
- Reduce excessive reliance on the NHS and social care because of more mutual help
- Make health improvement easier as communities develop their own health improvement strategies
- Reduce reliance on local authority services

The World Health Organisation has published a review of the role of empowerment in promoting health. It showed that empowerment projects were beneficial to health.

It has been shown that the strength of a person's social support networks is a major influence on their health. It influences not only minor levels of mental ill health such as depression or anxiety but also the chances of suffering a serious psychiatric reaction after a horrendous experience, the risks of complications of pregnancy, and all-causes mortality.

Evidence even suggests that the effect of poor social support is as strong as the effect of poverty. Moreover because the strength of the effect increases with the length of time exposed to poor social support, it appears to be a causal relationship, rather than being due to, say, people who are ill withdrawing from social contact. It is thought that the reason social support has this impact is that it provides protection against stress. There are many sources of social support including families, friends, networks of people with shared interests, and faith groups. Neighbours also provide social support and research has shown that they do so to a greater degree in lightly-trafficked streets than in heavily-trafficked streets.

Community development has an important role in enhancing community resilience. There is evidence that improving community and individual resilience can improve health and reduce demand although evidence for reduced demand is more limited than evidence for improved health.

2.20.   EARLIER DIAGNOSIS

The NHS offers screening for a number of conditions, including several cancer screening programmes. Screening takes a population and uses a test to divide that population into high risk or low risk groups, the high risk group receiving further tests to see if they really have the disease.

Services to screen a population for a disease are introduced only with great care and after considerable analysis as to whether they do more harm than good. When considering any screening programme there are a number of questions to be asked: about the screening test itself; how much we know about the disease in question; what treatments are available; and how well this might work as a programme for everyone.

Part of the decision making when introducing a screening programme is whether or not early diagnosis of the disease will actually benefit the patient. So, is it important to diagnose disease as early as possible? This depends on whether the course of the disease can be affected by early treatment.
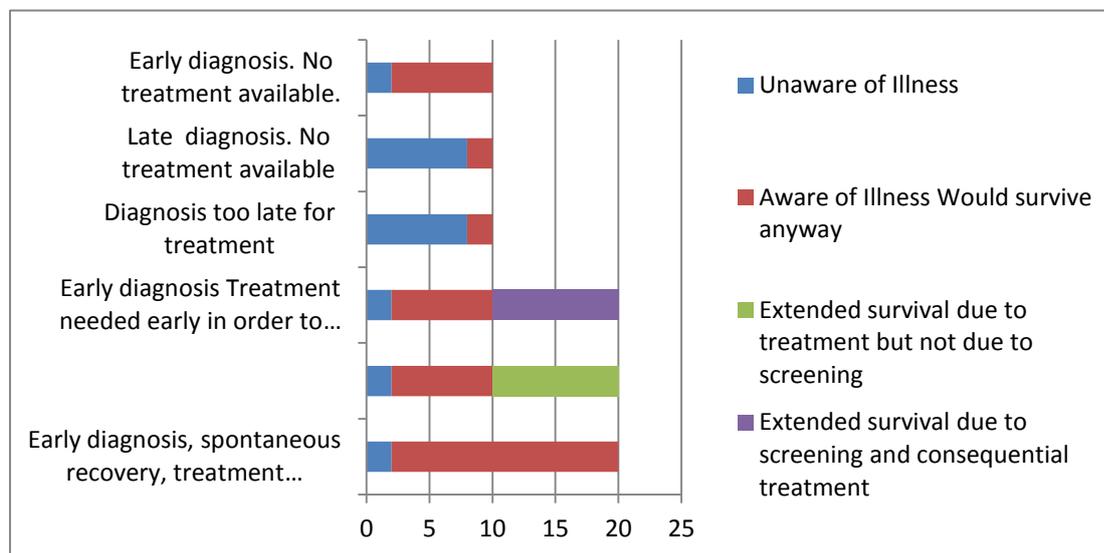
The red, green and purple bars represent the "survival time" of a patient with a disease. But only the green and purple bars represent *extended* survival due to treatment and only the purple bar represents extended survival due to screening.

In the top two examples on the diagram, early diagnosis seems to have extended survival because the red bar is 6 years longer than with later diagnosis, but all that really means is that the patient knew they had the disease for 6 more years. In the top example the screening has actually been pointless – it has simply extended the patient's suffering.

In the bottom three examples the screening test has been applied and has led to an apparent extended survival, but only in the one with the purple bar is this due to the screening. Unfortunately we often do not know precisely which of these three different scenarios applies.

So this demonstrates the point that screening services are introduced only after careful consideration of how the screening can benefit a population. All the screening services which are offered by the NHS have a sound scientific base to them and it is important to ensure good uptake.

2.21.   CHANGE IN THE HEALTH SERVICE

New Institutional Structures

The health service has been radically reshaped this year.

I particularly welcome:
- The transfer of public health to the local authority;
- The creation of the Health and Well Being Board as a committee of the local authority providing a single focus for strategic oversight within a democratically accountable context;
- The strong clinical input into commissioning and the extra power given to GPs.

I do however have six matters of concern.
- I am concerned that procurement bureaucracies may undermine the new structures.
- I am concerned that Health and Well Being Boards have inadequate powers.
- I have always believed that the distinction drawn between the health service and social care is artificial and that they would be better combined.
- I am deeply concerned at the absence of any local structure responsible for general practice.
- The Government has drawn a totally new distinction between "the health service" and "the NHS" with public health being described as part of the health service but not of the NHS. I believe this will cause confusion.
- Although clinical commissioning is a step back towards Nye Bevan's vision of a family of health professionals, there is no corresponding step in providers.

Commercialisation

For the last two decades a process of private sector involvement in the NHS has been under way, now institutionalised and accelerated in the Health & Social Care Act 2012, in a way which will inevitably accelerate it further. It doesn't matter to a person receiving care whether they get it from a state employee or a private company provided it is paid for by the state, is of good quality and is free at the time of use. Some private companies and charities undoubtedly make valuable contributions to the NHS. But competition to provide better care can only take place if quality can be measured in a contractual indicator, and the risk is that it will be easier to generate profit by distorting those indicators than by actually improving care, as has happened elsewhere in the world.

Moreover a commercial motive could diminish the commitment to other values, and hence destroy Nye Bevan's vision that the people, pursuing health as a social goal, would be supported by a family of professionals committed to that same goal. Indeed the health service, at least in the hospital service, is now suspicious of that vision, perceiving it as a restraint upon the labour market.

Financial Pressures

NHS funding is essentially static. Unlike most of the public sector it is not being cut but increases are very small. Demand for NHS care is rising at such a rate, due to a demographically ageing population, diminished self-reliance, and medical advances, that static funding represents a significant challenge. The so-called Nicholson Challenge states that the NHS needs to achieve 20% more benefit from static resources over a 5 year period. This challenge, rather than cuts in resources, is the basis of the present financial challenge to the NHS.

2.22. CHALLENGES FOR THE NHS

Quality of healthcare

The recent scandal at Winterbourne View, the Francis Report into the poor care at Mid Staffordshire Hospital have focused attention on NHS quality, and Sir Bruce Keogh, the Medical Director of NHS England, has written a report on how to address the problem. It is tempting to view these problems as aberrations that occurred elsewhere but the whole point of the Keogh Report is that the only way we can be certain that they will not happen here is if we focus actively on the pursuit of quality.

Rising demand on services

Despite improving health, demand for NHS services rises relentlessly. In part this results from an ageing population, especially to the extent that the ageing is due to demography rather than increased life expectancy. Partly it results from inefficiencies in the delivery of care, paradoxically often resulting from changes in care which were intended to promote efficiency – particularly striking is the greater use of Accident & Emergency departments as a first port of call because of nationally dictated changes in general practice which undermined continuity of care and the strength of the doctor/patient relationship. Partly however, it results from an increasing tendency to seek professional help for problems which in the past people would have dealt with themselves or to seek specialist care for problems which in the past would have been dealt with by GPs.

Areas of particular local attention include: the Emergency Department; care for children; follow-up hospital appointment; and the Healthier Together review of hospitals and their relationships to primary care.

The NHS Contribution to Prevention

Early Diagnosis - The ambition of the CCG is that everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisations, vaccinations and health checks.

Lifestyle Advice - It is important to ensure that opportunities are not lost to give lifestyle advice in the course of NHS care. There is evidence that brief interventions – simple messages from health professionals in the course of professional contacts – are valuable and effective and so the principle must be followed of "making every contact count".

Unifying health & social care into services based on need with prevention reducing rising demand

Health service resources are finite and are used to help people. It is not therefore ethical to waste them. The use of available resources to achieve as much as they can is, therefore, an essential part of managing the NHS.

To do this it is important to concentrate not on supply (the services currently provided and their problems) or demand (meeting what people think they want) but on need (that which has been shown by evidence to provide an important benefit) and to aim to reduce that through prevention. It is often said that prevention makes savings only in the long term but there are areas where prevention can make savings much more quickly. This is the only way to meet our immediate financial challenges. We must invest in these areas in 2014/15 to produce benefits for 2015/16..

2.23.   PREVENTION – THE CORNERSTONE OF PUBLIC SECTOR REFORM

The financial challenges facing the NHS and local government cannot be met by efficiency nor by service cuts (unless we are willing to dismantle essential services). They must be met by reform which reduces the need for services.

Across Greater Manchester, we have agreed a set of design principles which are being used as we design services for our populations.

- Focus on the outcomes to be achieved.
- Consider all the ways of achieving those outcomes.
- Prevent somebody needing a service:- this serves them better than supplying the service.
- A stitch in time saves nine - deliver support that prevents economic, social and health issues developing at their current rate and stops them becoming entrenched.
- Identify, as soon as practicable, those who are at an increased need for support and address these needs using state of the art evidenced-based services.
- Choose interventions on the strength of the evidence base.
- Integrate, co-ordinate and sequence interventions -the right order and right time for each family.
- Take a family or community based approach not focus on individuals, to best influence behaviour.
- Recognise the value of resilient communities and of independent individuals, of self-help and of mutual help, the role of social support and community spirit and the significance of civil society.
- Recognise that this does not happen merely by stepping back but requires active empowerment.

The aim is to prevent long-term issues of residents, better support their needs and enable them to live more independently and contribute to economic growth. Helping people to reduce their dependency on public services is the right moral choice – it also makes best sense to us as custodians of public resources. It would make sense even if there were no austerity – it is simply that austerity denies us the luxury of neglecting this duty.

Public Sector Reform starts with five themes:- early years, troubled families, health and social care integration, transforming justice and work & skills. These themes alone will not solve our problems, even in purely financial terms let alone in terms of enhancing wellbeing. The design principles must be applied to all public service. We need to accept that success can look like us doing less, not more, and that well served and supported communities need and indeed want less state intervention. This shift means a focus on intervening before crisis, in order to save the cost and pain of letting issues within the community build until levels are intolerable for both the individual and society.

Early identification and intervention is vital. We must not support interventions that have no evidential basis or theoretical support. At the heart of this is taking a holistic community and family approach in order to really understanding the citizen; their story and their circumstance, from their viewpoint.   All this hopes to develop a culture of resilience.

Resilient people don't just survive, they thrive. They do well and cope in good times and bad. They contribute to their community, both economically and socially. Resilient people have resources to call upon to support them, with strong personal skills and access to information and communication networks. Collectively the communities of resilient people are able to actively influence and manage economic, social and environmental change preventing large scale entrenched social issues forming.

2.24.   A COUNTRY CITY – TOWARDS A GREENER STOCKPORT

In 2000 I published 'A Country City' as part of my Annual Public Health Report and the most up to date version is available at:
http://www.stockport.gov.uk/services/environment/planningbuilding/planningpolicy/ldf/ldfevidence.
A review will take place in 2013/14 and the reissue of the original document, with only minor changes will launch that review.

"Country City" covers predominantly social and environmental aspects of issues including transport, open space, biodiversity and living as a community. This report describes an ideal of a Country City and Civilised City in which people live and work in peaceful and beautiful surroundings, with a focus on improving urban living and with many benefits for health. The Country City provides exercise opportunities and helps raise people's spirits by forming a city of village communities in natural surroundings. The Civilised City focuses on peacefulness and social support with an emphasis on the importance of social interaction, opportunities to enjoy peace and beauty, and community spirit.

The proposals are long term but I said 'the first step to creating something is the decision to create it. To solve a problem you must acknowledge that it must be solved. I have never said that the creation of the Country City will be easy. I say only that it must be done.' Timescales were examined acknowledging that a Country City cannot be created overnight. I cited   Reddish Vale Country Park as a success story of turning derelict land into breathing space where Kingfishers dive. I said: 'If 50 years ago councillors had said that the creation of a country park in that area was an unrealistic dream then it would not exist today. A succession of short term decisions would have reshaped the area instead. Instead councillors ensured that every decision made about the Vale pointed in the same direction. I hope that the borough is proud of that achievement. I hope that it also still has the confidence to repeat it. Does this generation have the same visionary civic pride that allowed our parents and grandparents to bequeath us this treasure? Will we and our children create further similar treasures for our grandchildren?'

I added : 'The report describes an ideal - a vision that I have called a Country City in which people live and work in peaceful and beautiful surroundings in balance with nature. The report asks that we start to work for it. I fully acknowledge that it will take time to achieve; that compromises will be made, and that parts of the vision will prove to be wrong and will be modified. But the determination to move in a particular direction must be summoned now.'

 Issues of significance involved in the above concepts are as follows:
- Tranquillity – stress reduced by quiet beautiful surroundings;
- Biophilia – health benefits from experience of nature;
- Aesthetics – beautiful surroundings raising the human spirit;
- Exercise – prevents heart disease and osteoporosis and promotes mental health;
- Transport – traffic destroys tranquillity and disrupts social interaction and community spirit. Walking and cycling are good exercises;
- Open space – Tranquillity; aesthetics, biophilia, exercise opportunities;
- Crime – Creates stress. Disturbs communities. Creates fear of walking, cycling, open space;
- Community Spirit – Social support is beneficial to health. Empowered people can make healthy changes. Poor community spirit can contribute to crime, loneliness and vandalism;
- Nature & Biodiversity – Contributes to tranquillity, biophilia and aesthetics. Biodiversity has ecological advantages.

2.25.   THE HEALTH AND WELL BEING STRATEGY

The Health & Well Being Strategy

This strategy, agreed by the NHS and the Council after an extensive process of consultation following the publication of the Joint Strategic Needs Assessment identifies a range of commitments ("we wills") directed at the following priority themes

- Early intervention with children and families
- Physical activity & healthy weight
- Mental wellbeing
- Alcohol
- Prevention and maximising independence
- Healthy ageing and quality of life for older people (Including complex needs and end of life care)

Inequalities are a cross-cutting theme which underpins all of these.

The Public Health Function Business Plan

This addresses the following strategic priorities and ensures their inclusion into staff objectives and into performance management

- To continue to reduce health inequalities in Stockport.
- To review public health commissioning and provision following the transitional process.
- To mainstream public health delivery in the Local Authority through the new 'Stockport Health Promise'
- To consolidate the delivery of the new Healthy Stockport service and public health services.
- To deliver the 'core offer' of public health advice, support and service delivery with Stockport GP Clinical Commissioning Group.
- To implement the Stockport Health and Well-being Strategy.
- To continue to protect the Health of the Stockport population.
- To provide robust programmes of Health Intelligence.
- To develop new Public Health programmes
- To contribute at the local and greater Manchester level to public health aspects of transport, spatial planning, workplace health and the economic strategy.

The Stockport Health Promise

Public health is not just something to be dealt with in specific specialist areas. Many of the activities of the Council and its partners contribute to the health of the people and the concept of the Stockport Health promise aims to capture that by asking all areas of the Council and its partner organisations to give commitments for activities that will improve health. Examples in the Council

might include improving the public realm in ways which enhance walking and cycling, developing the role of health in the school curriculum, or pursuing sustainable development strategies, developing preventive practice in social care, or enhancing the role of early intervention services for children and families. Much of the CCG's commissioning strategy is directed towards prevention, recognising that this is the only way to reduce the challenge of steadily growing need.

The Health Promise aims to record these commitments and hence ensure that we fully understand that prevention is not a specific activity but a goal to be pursued by everybody

The CCG Plan

Stockport CCGs vision and priorities as an organisation include:

'NHS Stockport Clinical Commissioning Group vision is to be known and respected for the reduction of inequalities in health outcomes. Working with you the public, we aim to:

- *Increase uptake of screening programmes, for example, bowel and breast screening.*
- *Increase the uptake of NHS Health checks.*
- *Exceed immunisation rates.*
- *Increase uptake of health lifestyles and reduction in harmful alcohol drinking. '*

The CCG has prioritised prevention and risk factor reduction as one of its five strategic aims. In 2013/14, the focus is on promoting the health check process that Stockport pioneered many year prior to the national drive for health checks. The scope of the checks includes assessment for multiple risk factors for future disease processes to reduce the burden of vascular disease as well as many cancers.

The CCGs ambition is that everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisations, vaccinations and health checks. The plan describes intentions, through investments, to ensure that people in more deprived areas are just as likely to uptake screening and have checks and vaccinations. The second main strand of work in the early phase of the CCG strategy is to support and encourage CCG members to fully utilise brief interventions and referral to the new Healthy Stockport lifestyle service for advice. Given Stockport's high levels of drinking much of the focus of this will be on alcohol.

2.26.   RECOMMENDATIONS

I welcome the strategies described in chapter 25 and recommend continuation. I recommend that all agencies intensify the process of developing a system of public sector reform focused on resilient communities and the principles set out in chapter 23. I recommend investment in 2014/15 in preventive programmes which will produce early results to ease the pressures in 2015/16. I welcome interagency work on integration of children's preventive services and of health and social care and recommend continuation.

I welcome Stockport CCG's planned work on detection of hypertension. I recommend continuation.

I recommend that Stockport CCG, Stockport MBC and Public Health England, in their respective areas of responsibility, vigorously pursue improved screening programme uptake in deprived areas.

I recommend that Stockport MBC signs the Local Government Declaration on Tobacco Control

I recommend that the relevant enforcement agencies prioritise the issue of illicit tobacco.

I urge people to declare their homes and cars smoke free. To support the continued denormalisation of tobacco use I recommend smoke free areas in parks.

I welcome Stockport's participation in the national 'Sustainable Food Cities Programme.' I recommend continuation

I recommend that Stockport MBC continue to pursue the development of linked-up walking and cycling networks and that walking and cycling be built into any strategic development proposal on the boroughs highway network.

I recommend that local MPs and political parties press for reversal of the Government's abandonment of a minimum unit price for alcohol and also for plain packaging of tobacco products.

I welcome Stockport MBC's intention in the coming year to enhance arrangements for public health input into planning applications and to review and renew Country City. I recommend continuation.

I recommend the development of an enhanced programme of work on healthy ageing by the Health and Well Being Board and its member agencies.

I recommend that all schools have a programme of SRE consistent with best practice guidance.

I recommend that the Council and the major local NHS organisations intensify programmes of workplace health and they include attention to issues of mental health and mental well-being by reducing stress, facilitating the adoption of the Five Ways to Well-Being, enhancing the arrangements to employ people with mental health problems, and enhancing the confidence and capacity of staff to integrate well-being into routine contacts with patients and clients.

I recommend the local NHS embed prevention and lifestyle into corporate and professional cultures.

I endorse the co-production approach to mental health, congratulate the Council on pursuing it, recommend continuation and urge that links be drawn between this programme and programmes of community well-being and resilience.

Advice to Individual Citizens of Stockport.

- **Follow the five ways to wellbeing**
  - ➢ **Connect** – with friends, family, colleagues and neighbours – think of these people as the cornerstones of your live and invest time in them
  - ➢ **Be active** – go for a walk, run. Step outside, play, garden or dance. Find an activity you enjoy and suits you make, being physical makes you feel good,
  - ➢ **Take notice** – be curious. Savour the moment and appreciate what matters to you.
  - ➢ **Keep learning** – try something new or rediscover an old interest. Learning new things is fun and boost confidence.
  - ➢ **Give** – do something nice for a friend, or a stranger. Smile. Volunteer your time.
- **Stop Smoking**

Use our smoking cessation service if you need help. If you can't give up on your own then try a Quit Smoking Group. If you are addicted to nicotine, consider other sources of nicotine, such as nicotine chewing gum or nicotine patches. You are more likely to successfully quit if you get help from the NHS Stop Smoking Service. Help is available at your GP practice, from some pharmacies in Stockport and also from our specialist advisers in the Healthy Stockport service. Visit http://www.healthystockport.co.uk/ for more information or call 0161 426 5085

- **Be physically active**

Adults should aim to be active daily. Over a week, activity should add up to a minimum of 150 minutes (2½ hours) of at least moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week. Use the stairs and walk those short journeys. Cycling is a great way to get more exercise over slightly longer journeys, consider using Stockport's leisure services for a swim or fitness class or go to a dance class with your friends. Children over walking age should be physically active for at least three hours a day, and 5-18 year olds should be physically active for at least an hour a day. Again, this should be at least moderate intensity. This activity can be achieved in different ways, visit http://www.healthystockport.co.uk/ for more information.

For babies not yet walking, physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.

Both adults and children should minimise the amount of time they spend being sedentary (e.g. sitting) for long periods (except when sleeping).

- **Eat a healthy diet**

Choose low-sugar, low-fat, high-fibre versions of the foods you eat and eat less red meat. Eat at least 5 portions of fruit & vegetables each day. You should also add less salt in cooking and at table.

- **Keep a healthy weight**

Maintain, or aim for, a healthy weight (adult BMI healthy weight range is 18.5-25kg/m2; healthy BMI for children is within the 2nd-90th percentile for their age and gender). BMI can be calculated by weight (kg) divided by height (m) squared (i.e.kg/m2).

- **Drink sensibly**

If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. Use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx. For example the following are all about 3 units: a pint of 5.2% lager; or a pint and a half of 3.2% beer; or a large (250ml) glass of 12% wine.

However a small amount of alcohol is beneficial for heart disease so after the age of 40, provided you don't have health or other problems related to alcohol or any problems with balance or stability, drink one small (125mls) glass of red wine most days but not every day.

- **Look after your sexual health**

Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both. Remember that having multiple sexual partners increases the risk of HIV/AIDS, gonorrhoea and syphilis, cervical cancer and pregnancy.

- **Use NHS screening services**

Take up all opportunities for screening whenever you are invited to participate in NHS screening programmes.

- **Take up opportunities for vaccination and immunisation**

Ensure children receive all the vaccinations recommended and keep your own vaccinations up to date – especially tetanus. Take health advice before overseas travel and have appropriate vaccinations, malarial protection etc. If you are over 65, if you are pregnant, or if you are under 65 and in an at-risk group, have your annual flu immunisation.

- **Protect yourself from sunburn**

Enjoy the sun safely. Protect yourself by using shade, clothing (including a hat, t-shirt and UV protective sunglasses) and high SPF (sun protection factor) sunscreen, and by avoiding the sun during the middle of the day. Avoid artificial ultraviolet radiation too – don't use sunbeds or sunlamps.

- **Reduce stress**

Talking things through, relaxation and physical activity can help. Find time to relax and share your worries with friends and partners. Demand training for responsibilities of which you are unsure.Try to plan your work to reduce pressure around deadlines. Developing interests outside of work can help reduce stress and improve productivity. You can also minimise stress by socialising and by contributing to your society. Release stress: Have fun. Take exercise. Maintain your social support networks with family and friends.

- **Avoid accidents**

Install and regularly check smoke alarms in your home. After drinking, allow one hour for each unit you have drunk before driving, using machinery or undertaking any other dangerous task requiring care. Drive at 20mph on side roads and wear seat belts in cars, crash helmets on motor cycles and cycle helmets on bicycles. Talk to your health visitor about preventing home accidents to toddlers. Always ask sales people about the safety features of products.

- **Protect the environment**

You can help to protect the environment by using public transport whenever possible (this also helps you get more physically active). Use environment-friendly products and recycle wherever possible. You can even refuse to accept unnecessary packaging on products you buy.

- **Avoid infectious diseases**

Keep up to date with all vaccinations, and wash your hands regularly when visiting or caring for sick people. You should observe good respiratory hygiene (when coughing or sneezing, catch those germs in your tissue and then bin it).

For more detail about staying healthy, visit: http://www.healthystockport.co.uk/ where you can access advice, tools to help you manage your own health, and free, confidential local support to make positive lifestyle changes.

21st ANNUAL PUBLIC HEALTH REPORT FOR STOCKPORT

2012/13

LEVEL 3

Full Analyses

LEVEL 3 (FULL ANALYSIS) INTRODUCTION

Since 1848 communities have had power to employ a doctor to treat the population as a collective patient, improving health by acting as a change agent wherever necessary. The first was Liverpool in 1847 (by a local Act ahead of national legislation) and it became mandatory in London in 1855 and throughout the country in 1872. It briefly became optional in 1985 with introduction of general management into the NHS but became compulsory again in 1989 via the Acheson Report. Since 1998 people without a primary medical qualification can directly enter postgraduate medical training for specialist recognition as a public health consultant so not all who now practise this medical specialty are doctors, although all have had postgraduate medical training and qualified as members of a medical Royal College.

From 1848 to 1974 this office was called Medical Officer of Health. It was Area Medical Officer from 1974- 1982 and District Medical Officer 1982-9. Since 1989 it has been Director of Public Health.

From 1848 until 1974 local authorities employed Medical Officers of Health. In 1948 they were incorporated into the National Health Service. A large part of the NHS was managed by local authorities, not just public health but also community health services. This was one of three wings of the NHS – hospitals and family health services (GPs, dentists, optometrists and pharmacists) being the other two. So Medical Officers of Health were still employed by local authorities within this wing of the NHS. Indeed they usually acted as general manager of this wing. In 1974 this wing of the NHS was removed from local government and integrated with the other two wings under the direction of health authorities. Those parts of the local authority Health Departments which had focussed on environmental and cultural determinants of health remained with local government and ceased to be part of the NHS. This 1974 redefinition of the NHS as a medical and nursing treatment-oriented service is often overlooked. It is sometimes said that the NHS never addressed the determinants of health but in its first quarter of a century it cleaned the air and cleared the slums.

On 1st April 2013 Directors of Public Health and their staff and functions returned to local government. They remain part of the health service, local government having regained the health service role lost in 1974 and the health service having regained its former wider vision of the pursuit of health as a social goal. This is a matter of celebration. For some reason, however, the Government has introduced different meanings for the terms "the health service" and "the NHS", reversing the 1974 redefinition of the former but not of the latter. Strictly, therefore, the health service now consists of the NHS, the local authority health service functions and Public Health England. Public health is part of the health service but not part of the NHS. I find this new terminology confusing.

Medical Officers of Health wrote an annual report on the health of the people of the borough. This duty was abolished in 1974, reinstated by guidance in 1989 and made statutory again from 2013. The Metropolitan Borough of Stockport was founded in 1974 by the merger of the County Borough of Stockport with surrounding urban district councils from Lancashire and Cheshire. The 1st Annual Public Health Report for that population – Health for Many but not for All – was written in 1989 by the Acting DPH, Dr. David Baxter. This is the 21st report in that series, 19 of them (since the 3rd onwards) being written under my authority, as I have held the office of Stockport DPH since 1990.

The first few reports described comprehensively the health of the Borough, each in greater depth and, from the 4th report onwards, with a special topic covered in greater depth still. However it is unnecessary to attempt a comprehensive description every year. This is now done periodically with

this role being played by the 7th, 10th, and 16th. This report fulfils that same function. One reason that for this is that it has been five years since the last comprehensive report and the 16th report was explicitly stated to start a five year cycle ending with the 20th report. Also organisational change requires summarising the public health messages for the tasks the new health service bodies face.

By its nature the report is quite long in those years when it is a comprehensive account but this year a new three-level structure allows us to summarise the message as well as comprehensively describe it. The report also links to the Joint Strategic Needs Assessment.

In the series from the 16th report special reports on particular topics were presented the PCT Board and then gathered together for publication. The annual report was effectively serialised. The start of a new series offers an opportunity to decide afresh what we want from the next few reports.

The report is written for health decision makers and others with an informed interest.

An annual public health report is a report by a DPH to the council, not a report of the council. Its contents are my personal professional opinions. Personal in that nobody tells me, or is entitled to tell me, what to write; responsibility for the opinions is mine. Professional in that the report is the advice of a doctor to the population which is my patient; it must be based on competent professional analysis of local information and the scientific body of knowledge. Where I address issues of political or philosophical controversy, I do so in accordance with Stockport's guidelines on public health advocacy which are set out on the next page.

STEPHEN J. WATKINS,

BSc, MB,ChB, MSc, FFPH, FFSRH, MILT

Director of Public Health for Stockport

Guidelines on Public Health Advocacy On Politically Contentious Issues

LEGITIMATE	ILLEGITIMATE	GUIDELINE
l. Stating public health facts, even if they embarrass the powerful.	l. Manipulating public health data in order to embarrass the powerful.	la. Have scientific justification for statements lb. Do not suppress facts
2. Making recommendations that will clearly benefit the health of the people.	2. Putting public health support behind political positions unrelated to promoting health.	2a. Be clear of the health objective 2b. Be open minded about alternative ways of achieving it.
3. Ensuring that advice is made public and reiterating it if necessary.	3. Using public resources to campaign for political causes or oppose government policy.	3. In highly contentious issues if there is a danger of over stepping this line use official mechanisms to place issues in the public domain where others can make what use of it they wish.
4. Advocating changes of policy.	4. Implementing unauthorised use of resources contrary to policy.	4. Distinguish advocacy of a position from its implement-action and recognise that authorities are entitled to reject your advice.
5. Offering scientific and professional support to those working for health promoting causes.	5. Using crown resources selectively for the benefit of a particular political group.	5a. Always be prepared to work with all political parties if working with any. 5b. Offer scientific and professional support directly but be careful about offering political parties any other resources. 5c. If working with any party see that it is open and that the others are free to use the same facility.
6. Facilitating a community identifying its own needs and campaigning for them.	6. Stirring up a community to do what you want.	When acting as a community developer – 6a. Don't dominate 6b. Don't lead. 6c. Provided you don't dominate or lead stand by the community you are working with.

LEVEL 3 (FULL ANALYSIS) SECTION A: THE HEALTH OF THE PEOPLE

3.1.   ILL HEALTH IN BRITAIN AND STOCKPORT

Stockport Wards	2010-12	Nearest matching country 2011	2011
Table 1.1 Life Expectancy for Men			
Bramhall North	84.6	Qatar	83
Bramhall South	85.0	Qatar	83
Bredbury & Woodley	78.6	UK /Netherlands/Japan/Spain	79
Bredbury Green & Romiley	80.0	Sweden/Canada/Italy/Singapore	80
Brinnington & Central	71.7	Mexico/Iran/Poland/Malaysia	72
Cheadle & Gatley	82.0	San Marino	82
Cheadle Hulme North	80.5	Sweden/Canada/Italy/Singapore	80
Cheadle Hulme South	82.0	San Marino	82
Davenport & Cale Green	76.5	Chile/USA/Cuba/Maldives	76
Edgeley & Cheadle Heath	76.8	Chile/USA/Cuba/Maldives	76
Hazel Grove	80.5	Sweden/Canada/Italy/Singapore	80
Heald Green	82.2	San Marino	82
Heatons North	79.1	UK /Netherlands/Japan/Spain	79
Heatons South	81.9	San Marino	82
Manor	79.7	Sweden/Canada/Italy/Singapore	80
Marple North	79.5	UK /Netherlands/Japan/Spain	79
Marple South	78.4	Germany/Greece/France/Bahrain	78
Offerton	80.0	Sweden/Canada/Italy/Singapore	80
Reddish North	79.4	UK /Netherlands/Japan/Spain	79
Reddish South	78.4	Germany/Greece/France/Bahrain	78
Stepping Hill	80.6	Germany/Greece/France/Bahrain	78
Table 1.2 – Life expectancy for women			
Bramhall North	84.1	Sweden/Canada/Greece/Iceland	84
Bramhall South	87.7	Japan	86
Bredbury & Woodley	81.8	UK/Denmark/Chile/Malta	82
Bredbury Green & Romiley	83.2	Germany/New Zealand/Ireland/Portugal	83
Brinnington & Central	76.9	Dominica/China/Serbia/Thailand	77
Cheadle & Gatley	85.3	Singapore/France/Italy/Spain	85
Cheadle Hulme North	85.3	Singapore/France/Italy/Spain	85
Cheadle Hulme South	87.0	Japan	86
Davenport & Cale Green	78.0	Mexico/Turkey/Latvia/Maldives	78
Edgeley & Cheadle Heath	82.6	Germany/New Zealand/Ireland/Portugal	83
Hazel Grove	85.8	Japan	86
Heald Green	85.2	Singapore/France/Italy/Spain	85
Heatons North	81.8	UK/Denmark/Chile/Malta	82
Heatons South	84.1	Sweden/Canada/Greece/Iceland	84
Manor	82.0	UK/Denmark/Chile/Malta	82
Marple North	83.3	Germany/New Zealand/Ireland/Portugal	83
Marple South	82.4	UK/Denmark/Chile/Malta	82
Offerton	82.8	Germany/New Zealand/Ireland/Portugal	83
Reddish North	83.5	Germany/New Zealand/Ireland/Portugal	83
Reddish South	84.0	Sweden/Canada/Greece/Iceland	84
Stepping Hill	82.5	Germany/New Zealand/Ireland/Portugal	83

The tables show life expectancy for men and women by ward linked to comparator countries across the world. The most affluent wards have life expectancies greater than the highest countries (Qatar for men, Japan for women); life expectancy in the most deprived areas of Stockport is better than the life expectancy in two-thirds of the world's countries. Stockport as a whole with a life expectancy

of 79.7 for men matches to Sweden, Canada, Italy and Singapore with life expectancy of 80. For women the life expectancy of 83 matches to Germany, New Zealand, Ireland and Portugal with life expectancy of 83. The following charts show the causes of death in the world, the European Union, England and Wales and Stockport.

Figure 1.3 – Causes of death – World
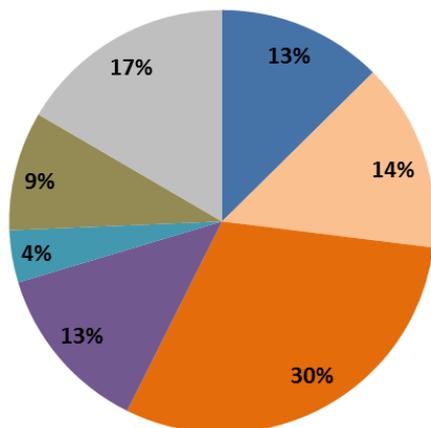
Data for 2011 Source: WHO

Figure 1.4 – Causes of death – European Union
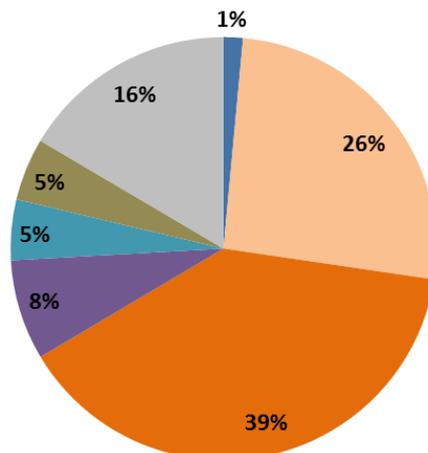
Data for 2010 Source: Eurostat

Figure 1.5 – Causes of death – England & Wales
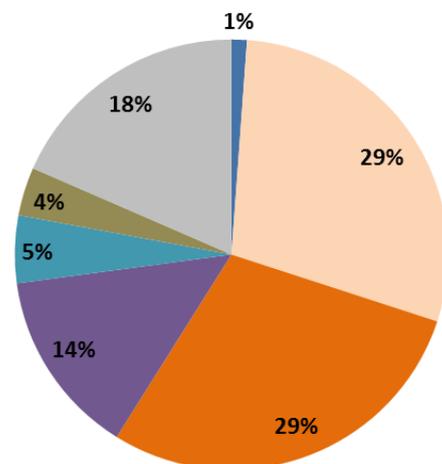
Data for 2011 Source: Vital Statistics

Figure 1.6 – Causes of death – Stockport

Data for 2011 Source: Vital Statistics
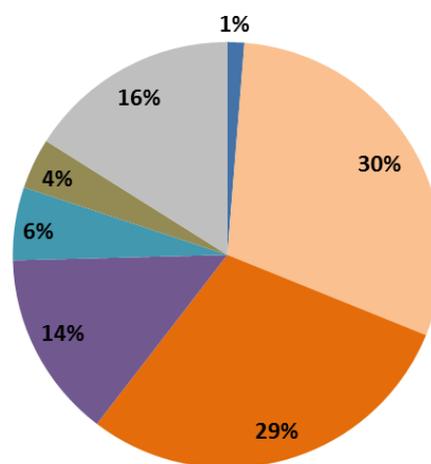
| ■ Cancer | ■ Respiratory | ■ Injury |
| ■ Infectious and parasitic diseases | ■ Circulatory | ■ Digestive | ■ All other causes |

These charts show that causes of death in Stockport are almost exactly comparable with the pattern across England and Wales; however there are difference between the national pattern and international patters. While infectious diseases are a major cause of death on a global scale, prevention and treatment have virtually eradicated these as a cause of death in Europe (including

England and Wales). Injuries and respiratory causes also account for a far lower proportion of deaths in Europe than they do worldwide, however while England and Wales follows European patterns for injuries, the proportion of deaths from respiratory causes nationally is much more similar to the global rather than European trend. Conversely England and Wales has a far lower proportion of deaths from circulatory disease than the European average; heart disease and cancer are the main causes of death in Stockport.

The above analysis could also be expressed instead in terms years of life lost, rather than just a proportional count. The measure "years of life lost to age 75" would count a person who died at 74 as having lost one year of life but a person who died at 55 as having lost 20 years of life. When we consider years of life lost, rather than just number of deaths, injuries join cancer and heart disease as major killers in Europe as well as internationally. This is because injuries are the commonest cause of death in young people.

Table1.7 - Prevalence rate per billion of moderate and severe disability, by leading health condition associated with disability, and by age and income status of countries								
Health condition (b, c)	**High-income countries (a)**			**Low and middle-income countries**			**World**		
	0–59 years	**60+ years**	**All ages**	**0–59 years**	**60+ years**	**All ages**	**0–59 years**	**60+ Years**	**All ages**
Hearing loss (d)	**9.4**	**96.9**	**26.5**	10.9	93.8	**18.0**	10.7	94.7	**19.3**
Refractive errors (e)	**9.8**	**33.5**	**14.4**	13.7	85.0	**19.8**	13.1	70.1	**18.9**
Depression	**20.1**	2.6	**16.7**	15.6	10.3	**15.1**	16.2	8.0	**15.3**
Cataracts	0.6	5.8	**1.6**	4.2	67.1	**9.6**	3.7	49.3	**8.4**
Unintentional injuries	3.6	5.8	**4.0**	7.1	12.2	**7.5**	6.6	10.3	**7.0**
Osteoarthritis	2.4	**42.4**	**10.2**	2.8	41.5	**6.1**	2.8	41.7	**6.7**
Alcohol dependence & problem use	**9.3**	2.1	**7.9**	6.2	3.8	**6.0**	6.6	3.3	**6.3**
Infertility (unsafe abortion & maternal sepsis)	1.0	0.0	**0.8**	6.5	0.0	**6.0**	5.8	0.0	**5.2**
Macular degeneration (f)	2.3	**31.4**	**8.0**	1.8	32.3	**4.4**	1.9	32.0	**5.0**
Chronic obstructive pulmonary disease	4.1	23.6	**7.9**	2.2	17.1	**3.5**	2.4	19.0	**4.1**
Ischaemic heart disease	1.3	11.5	**3.3**	1.6	25.4	**3.7**	1.6	21.4	**3.6**
Bipolar disorder	4.2	2.1	**3.8**	3.5	1.7	**3.4**	3.6	1.8	**3.4**
Asthma	3.7	2.6	**3.5**	3.0	1.9	**2.9**	3.1	2.1	**3.0**
Schizophrenia	2.8	2.1	**2.7**	2.6	2.1	**2.6**	2.6	2.1	**2.6**
Glaucoma	0.5	7.9	**1.9**	1.1	16.9	**2.5**	1.1	14.3	**2.4**
Alzheimer and other dementias	0.5	**32.5**	**6.7**	0.3	15.0	**1.5**	0.3	20.0	**2.3**
Panic disorder	2.4	0.5	**2.0**	2.3	0.6	**2.1**	2.3	0.6	**2.1**
Cerebrovascular disease	1.8	11.5	**3.7**	0.8	10.5	**1.6**	0.9	10.8	**2.0**
Rheumatoid arthritis	1.7	8.9	**3.1**	1.2	6.4	**1.6**	1.2	7.1	**1.8**
Drug dependence & problem use	4.7	0.5	**3.9**	1.6	0.2	**1.5**	2.0	0.3	**1.8**

Notes: Source: The Global Burden of Disease, 2004 update. Geneva, World Health Organization, 2008.

a. High-income countries have 2004 Gross National Income per capita of US$ 10 066 or more in 2004 per the World Bank (5).

b. GBD disability classes III and above.

c. Disease and injury associated with disability. Conditions are listed in descending order by global all-age prevalence.

d. Includes adult onset hearing loss, excluding that due to infectious causes; adjusted for availability of hearing aids.

e. Includes presenting refractive errors; adjusted for availability of glasses and other devices for correction.

f. Includes other age-related causes of vision loss apart from glaucoma, cataracts and refractive errors.

Health is not simply a matter of the length of life and causes of death; it is also a matter of quality - hence the public health slogan "**add years to life and life to years**"

Table 1.7 shows the leading causes of moderate and severe disability across the world, in descending order of prevalence for the total global population. This evidence suggests that the most significant

causes of disability for high income countries relate to mental health (depression, alcohol dependence and dementia) hearing, sight and musculoskeletal conditions (osteoarthritis).

Further analysis giving more detail of causes of death and disability in Stockport can be found on the JSNA hub (http://www.mystockport.org.uk/JSNA); however it is not possible to present a consistent estimate of the burden of disability in the borough by different causes as we rely on many different data sources.

Ideally we would look not just at the diseases that cause death and disability but at the factors that cause those diseases. How much of the burden of disease is due to smoking, alcohol, mental well-being.

One problem with this is that risk factors interact.

Thus smoking and diet both cause both cancer and heart disease.

Diet and stress both cause increased cholesterol which causes heart disease.

Stress causes high blood pressure (which is a cause of heart disease) as does obesity which is contributed to by diet and physical inactivity.

Stress and high blood pressure both cause heart disease.

Stress causes a depressed immunity and physical activity counters this. The depressed immunity causes cancer and infections.

Alcohol in excess can lead to heart disease and cancer but in moderation protects against heart disease.

This makes it difficult to attribute particular diseases to particular risk factors.

Some of the major interactions are shown in figure 1.8.
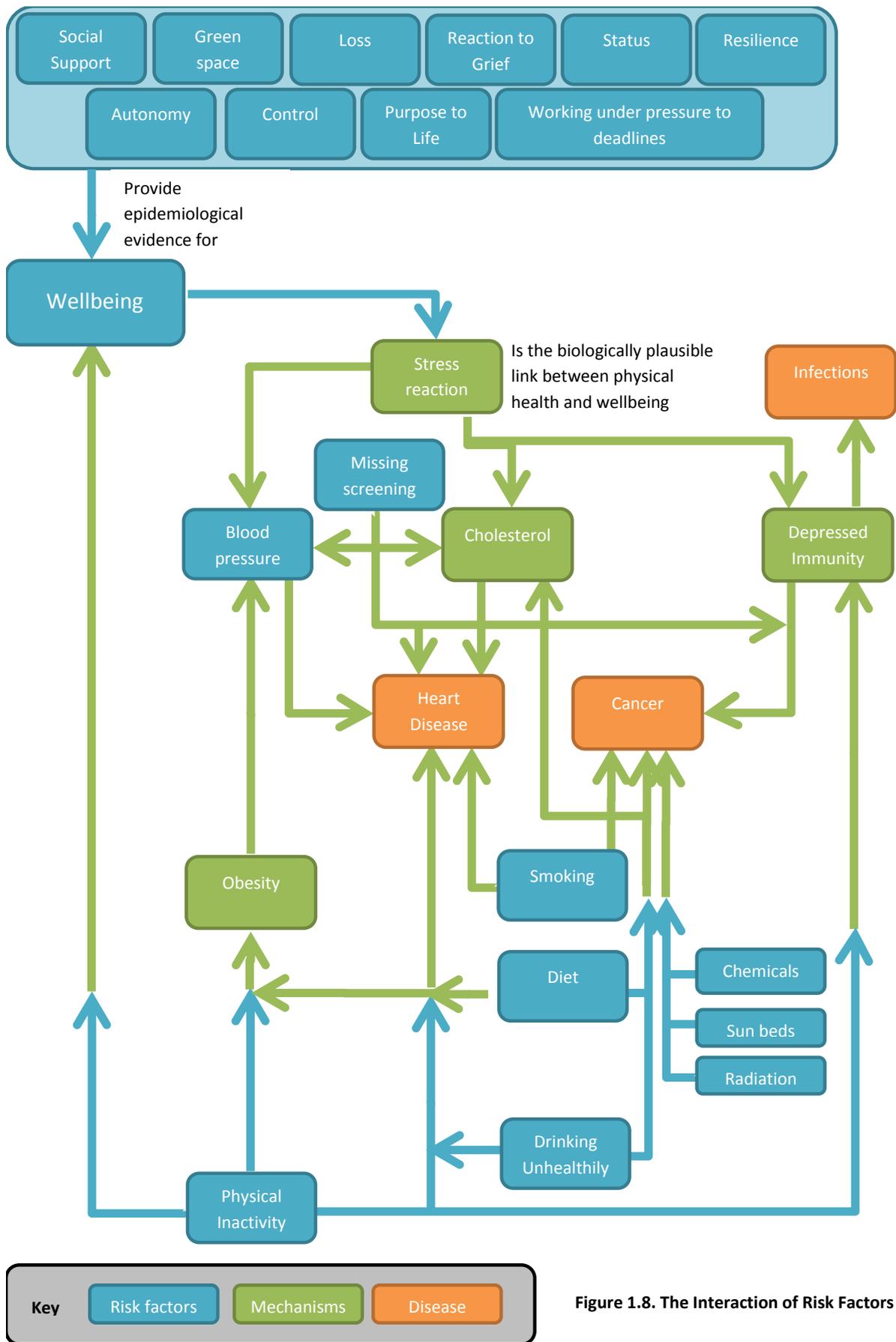
Figure 1.8. The Interaction of Risk Factors

Key:
- Risk factors
- Mechanisms
- Disease

Also scientists disagree about which associations can be regarded as causal for example, how much raised blood cholesterol is due to stress or to diet. Consider the following two different analyses.

Figure 1.9 – Burden of disease from UK risk factors – analysis by Murray et al
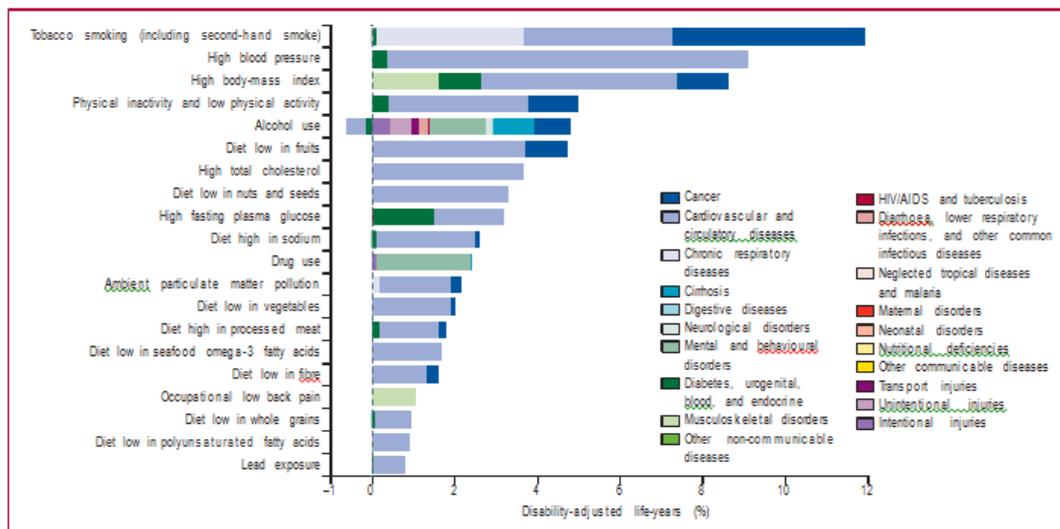
Figure 7: Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years
The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

Source: Murray CJL, Richards MAR, Newton JN, Fenton KA, et al. UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet. 2013 March 5; http://dx.doi.org/10.1016/S0140-6736(13)60355-4, figure 7.

Figure 1.10 – The relative value of social support/ social integration; a meta-analysis: comparative odds of decreased mortality
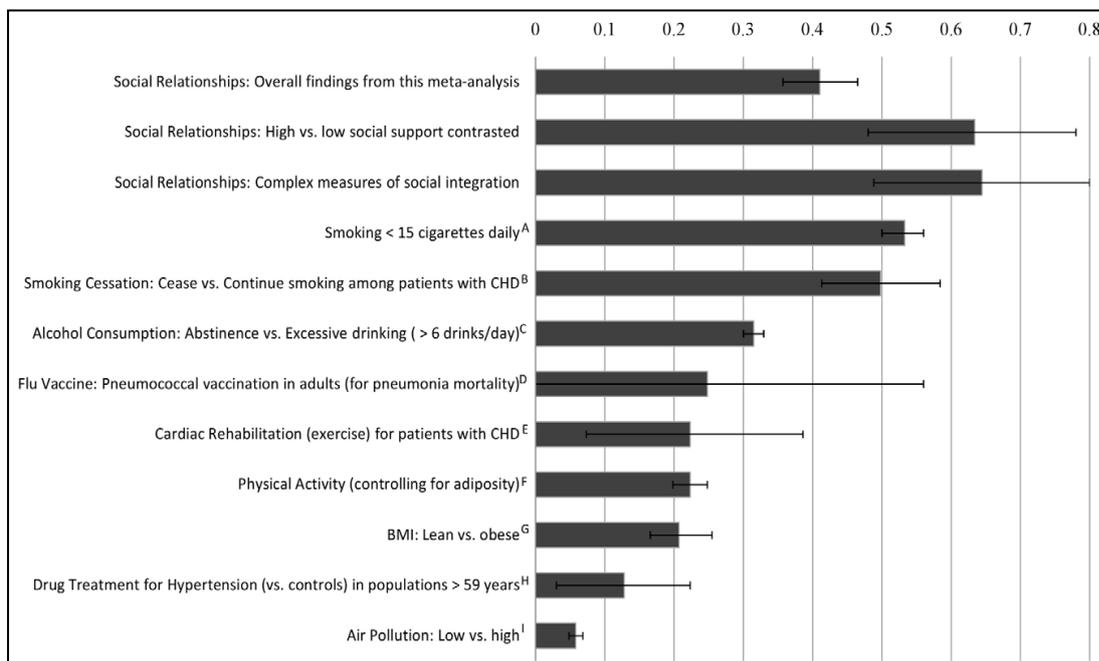
Source: Holt-Lundstad et al 2010

One would focus attention on hypertension and traditional lifestyle factors, the other on aspects of wellbeing. Both have scientific validity; they differ because of genuine scientific differences about stress. It is my personal professional scientific conclusion that figure 1.10 is the more valid. But there is scope for legitimate scientific debate on that.

3.2.   INEQUALITIES

In tables 1.1 and 1.2 we looked at life expectancy in various countries of the world and the various wards of Stockport. We saw how death rates in Bramhall are better than those in highest countries Qatar and Japan) and those in Brinnington & Central are more like those of Mexico or China.

Stockport has an unusual diversity of affluence and deprivation in its population. We are the third most polarised local authority in England, which means we have the third greatest gap between our most deprived and least deprived ward. This isn't the result of any local failure of policy or services. It simply results from the fact that our boundaries embrace some of the most affluent areas in the Country (three of the 190 LSOAs in Stockport rank in the 2% most affluent nationally) but also some of the most deprived areas (three of the 190 LSOAs in Stockport rank in the 2% most deprived nationally). Our polarisation measure is a context not an outcome.

It actually means that Stockport has a spread of affluence and deprivation similar to that of the country as a whole.

Table 2.1: Proportion of population by deciles of deprivation

Decile of deprivation	Stockport	Greater Manchester	North West	North	England
0-10% most deprived	7.7%	23.6%	20.5%	18.6%	10.0%
10-20%	4.3%	13.6%	11.4%	11.9%	9.9%
20-30%	10.8%	12.1%	10.5%	10.8%	9.9%
30-40%	6.9%	9.7%	9.1%	9.5%	9.9%
40-50% mid deprived	7.7%	8.3%	9.0%	8.8%	10.0%
50-60% mid deprived	12.3%	8.2%	8.9%	9.1%	10.0%
60-70%	11.3%	7.4%	8.5%	8.9%	10.1%
70-80%	10.6%	7.5%	8.7%	9.0%	10.0%
80-90%	13.8%	5.6%	8.0%	8.0%	10.2%
90-100% least deprived	14.5%	4.0%	5.5%	5.5%	10.0%

Source: ONS MYE 2007, DCLG IMD 2007

Table 2.1 shows that the deprivation profile of Greater Manchester, the North West and North are more deprived than the national average; the profile of Stockport however is less skewed and is similar to the national average.

Life expectancy has improved in all wards in Stockport over the last 20 years (see table 2.2). The question is whether they have improved faster in deprived areas, narrowing inequalities, or whether they have diverged further.

By plotting the trends (figure 2.3) in the gap in life expectancy between the most deprived quintile and the Stockport average it can be seen that the gap narrowed in the 1990s for women but has since risen and then remained fairly steady with some fluctuations, overall there has been no significant change (R=0.0); for men the gap has risen (R=0.7) again with some fluctuations over the period.

Table 2.2 Life expectancies in Stockport wards 1990/92 and 2010/12

	Males			Females		
	1990-92	**2010-12**	**Change**	**1990-92**	**2010-12**	**Change**
Bramhall North	75.7	84.6	+8.9	81.8	84.1	+2.2
Bramhall South	80.2	85.0	+4.8	85.5	87.7	+2.2
Bredbury & Woodley	72.7	78.6	+5.9	80.2	81.8	+1.6
Bredbury Green & Romiley	74.4	80.0	+5.7	79.6	83.2	+3.6
Brinnington & Central	64.1	71.7	+7.5	70.3	76.9	+6.6
Cheadle & Gatley	76.4	82.0	+5.6	82.4	85.3	+2.9
Cheadle Hulme North	74.0	80.5	+6.5	81.5	85.3	+3.8
Cheadle Hulme South	75.8	82.0	+6.2	80.0	87.0	+6.9
Davenport & Cale Green	70.1	76.5	+6.4	76.3	78.0	+1.7
Edgeley & Cheadle Heath	70.0	76.8	+6.8	76.9	82.6	+5.6
Hazel Grove	75.5	80.5	+5.0	78.6	85.8	+7.2
Heald Green	76.9	82.2	+5.3	83.6	85.2	+1.6
Heatons North	73.1	79.1	+6.0	78.9	81.8	+2.9
Heatons South	74.7	81.9	+7.3	81.0	84.1	+3.1
Manor	74.0	79.7	+5.7	77.8	82.0	+4.2
Marple North	76.9	79.5	+2.5	80.9	83.3	+2.4
Marple South	74.4	78.4	+4.0	81.2	82.4	+1.2
Offerton	73.3	80.0	+6.7	78.5	82.8	+4.3
Reddish North	71.6	79.4	+7.8	78.8	83.5	+4.7
Reddish South	71.6	78.4	+6.8	78.5	84.0	+5.5
Stepping Hill	70.9	80.6	+9.7	78.2	82.5	+4.4
Stockport	**73.3**	**79.7**	**+6.4**	**79.1**	**83.0**	**+3.9**

For men there is no evidence of the more deprived wards improving more than the average for the whole borough, but for women such an improvement can be seen.

If we look more closely at when this improvement occurred, it has not been constant.

Figure 2.3 Trends in the gap in Life Expectancy

Trends in Inequalities - Gap in Life Expectancy between most deprived quintile and Stockport average
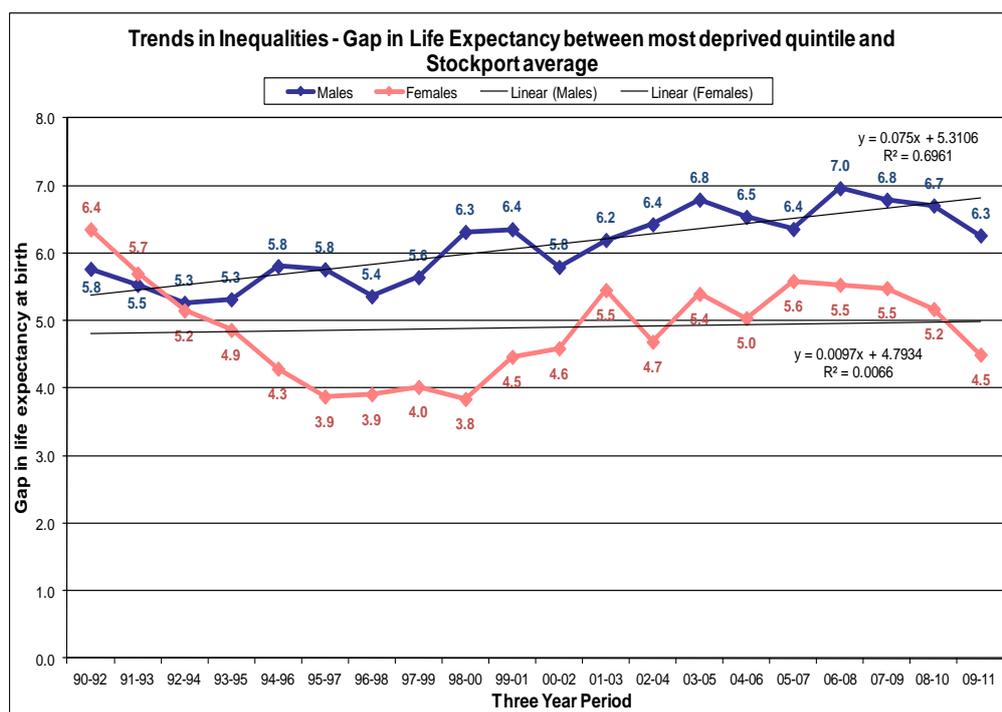
A more detailed paper analysing these trends and the possible causes of these can be found on the JSNA hub (http://www.mystockport.org.uk/JSNA) or obtained in paper form on request (Chapter B of this report). It can be seen however from the above graph that there was a considerable reduction in inequalities for women in the 1990s, followed by worsening.

of the situation in the first three years of the new century losing about two thirds of the gain, then a levelling off with an improving trend restoring itself from about 2008 onwards. For men the 1990s improvement did not occur and the gap has widened into this century although it has started to improve since 2008.

There was a great deal of new public health activity in Stockport in the 1990s, focussed on community development, cardiovascular risk factor screening, neighbourhood health strategies and the Stockport Health Promise (a series of commitments to take specific health-improving steps by a range of organisations). It may be that the reduction in the gap resulted from that activity and that the initiative simply ran out of steam around the turn of the century. Or it may be that there was some other cause for the narrowing of the gap, perhaps even a cohort effect of something that happened some years previously.

We therefore propose to see what the effect will be of reviving the Stockport Health Promise and revitalising the community development, screening uptake and neighbourhood projects. As we do this we will have to start in selected parts of the borough and comparison of those neighbourhoods with the rest of the inner city areas will help us see whether we are having an effect.

The worse trends for men will be addressed by programmes directed at healthy work.

A similar graph for directly standardised mortality shows a similar picture but with less loss of ground in the first few years of this century and with reduced inequalities in the 1990s extending to men as well as to women.

Figure 2.4 Alternative Trends in the gap in Life Expectancy

Trends in Inequalities - Gap in All Age All Cause Mortality between most deprived quintile and Stockport average

Males Females

Y-axis: Gap in the Directly Standardised Mortality Rate, All Age All Cause, per 100,000

X-axis: Three Year Period — 90-92, 91-93, 92-94, 93-95, 94-96, 95-97, 96-98, 97-99, 98-00, 99-01, 00-02, 01-03, 02-04, 03-05, 04-06, 05-07, 06-08, 07-09, 08-10, 09-11

Males: 626.1, 605.7, 557.0, 557.1, 512.8, 490.6, 435.8, 455.2, 509.9, 499.1, 481.5, 493.9, 519.3, 535.8, 505.2, 460.0, 471.5, 472.6, 457.9, 427.6

Females: 467.3, 417.4, 360.9, 342.8, 284.6, 258.3, 234.9, 220.8, 189.9, 214.4, 238.1, 286.0, 256.9, 297.7, 277.9, 284.7, 278.3, 265.7, 253.8, 203.1

$y = -6.1333x + 568.13$
$R^2 = 0.4809$

$y = -6.7345x + 352.39$
$R^2 = 0.3267$

The main difference between life expectancy and directly standardised mortality is that the former places a greater weighting on deaths of younger people.

Why did the gaps stop narrowing? Several hypotheses have been considered:

• Natural cycle – this might be the case if the changes were due to cohort effects,

• Loss of drive behind various programmes (such as those made as part of the Stockport Health Promise) when they were mainstreamed. This is the hypothesis that underpins the plans described above for piloting a reassertion of the 1990s initiatives.

• Heart disease becoming less of a driver for mortality, with less impact on overall mortality. Analysing inequalities in particular diseases those in heart disease continue to narrow but have been outweighed by other diseases especially cancer and gastrointestinal/liver diseases

• Deprived "Spearhead" PCTs funded to pursue intense inequalities programmes also had quick short term impact that were not sustained – explained as exhausting "heath gain"

The alcohol epidemic – the difference between life expectancy and directly standardised mortality and impact of cancer and gastrointestinal diseases suggest alcohol as a factor.

3.3. THE HEALTH OF STOCKPORT COMMUNITIES

The Health of the Council Areas and the CCG Localities

Generally a CCG Locality consists of two Council area committees but there are some discrepancies in boundaries in the Heatons-Reddish and Central Areas where CCG localities follow old Council Area Committee boundaries, as they were when the CCG localities were first agreed. The following maps show the differences, and the tables on the following tables show data for the eight 2004 area committees but with ward level analysis for Tame Valley and Victoria where the changes occurred.

Figure 3.1 CCG, Area Committees and Neighbourhood Management area maps
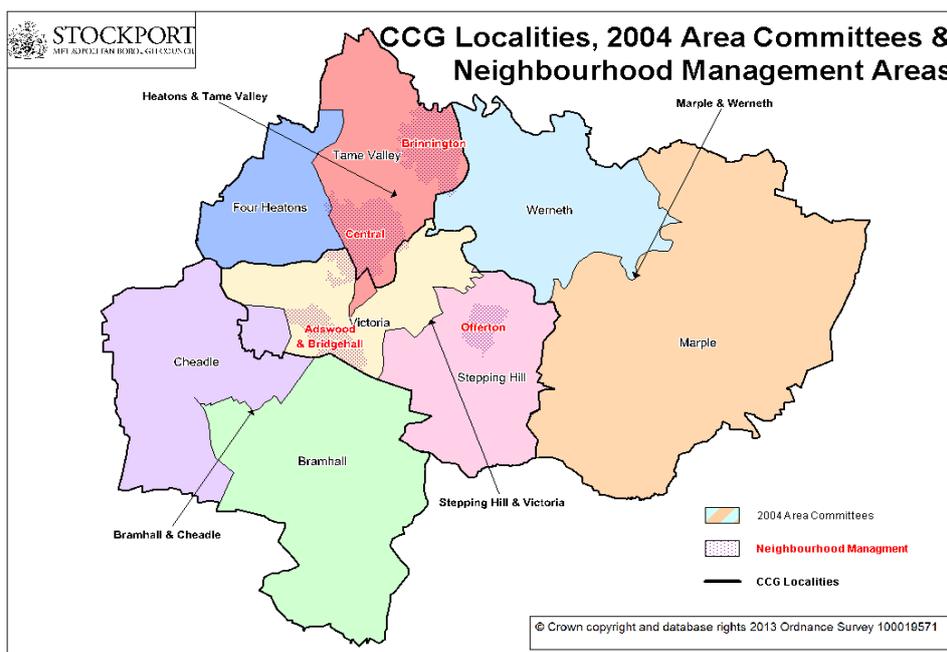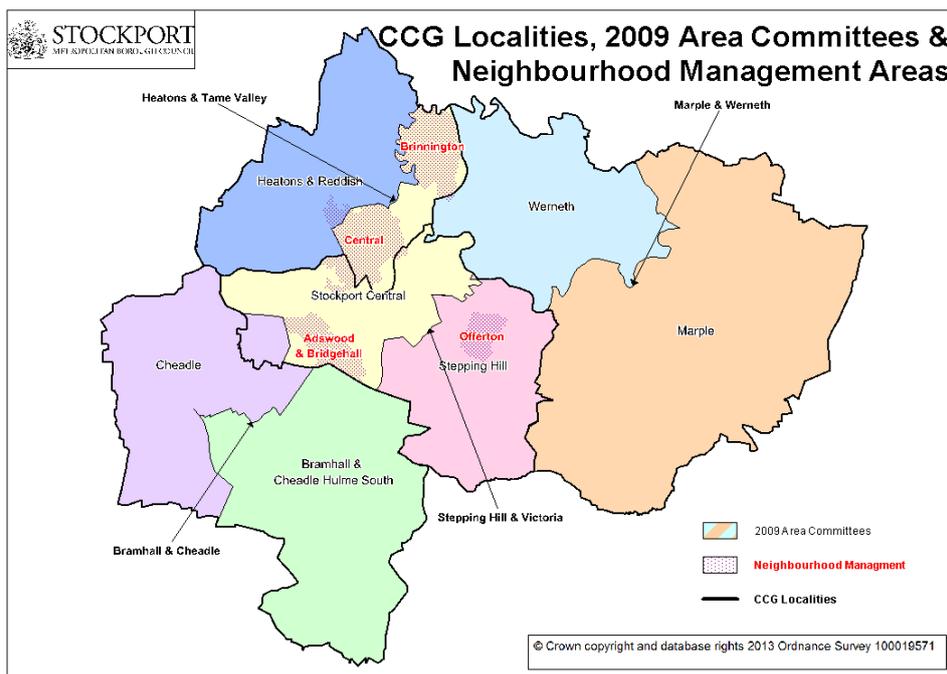
The Health of Bramhall

Bramhall Area consists of the villages of Bramhall and Woodford and Cheadle Hulme South Ward. It is an Area Committee of Stockport MBC and part of Cheadle & Bramhall Locality of Stockport CCG. It is an affluent area, one of the most affluent in Greater Manchester but there are some less affluent areas in the north west of Bramhall

Table 3.2	Bramhall Area	Stockport
Population (2011 Census)		
% aged 0-14	17.3%	17.6%
% aged 65+	21.2%	18.0%
Total population (number)	38529	283275
Life Expectancy in years (2010-2012)		
Males	83.8	79.7
Females	85.9	83.0
Self-reported health (2011 Census)		
% good / very good	84.5%	81.1%
% not good	14.6%	18.9%
Self-reported lifestyles in adults (2012)*		
% low mental wellbeing	8.9%	12.2%
% drinking – high risk	2.5%	2.9%
% non-drinkers	15.6%	21.4%
% smoking	9.0%	14.9%
% obese	13.3%	16.2%
% not physically active	75.0%	73.6%
% unhealthy diet	77.9%	82.1%
% multiple risks	30.4%	32.4%
Use of acute services (2012/13) crude rate per 1,000		
ED Attendances	273.0	313.8
Inpatient admissions	268.8	293.7
Emergency inpatient admissions	104.7	112.7

* Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence; however comparisons between areas are still valid

Bramhall is a lasagne-shaped village in which layers of housing and open space make up an attractive mix of village and country. Woodford is a rural village to the South of Bramhall where a major expansion of the village with a new garden village will more than double the size. This may help sustain village facilities but it will be especially important that the separation of Woodford and Bramhall is then maintained to avoid both being absorbed into urban sprawl. The Area is healthy. Its use of health service resources is disproportionately large when account is taken of its general good health. It is also noticeable that the percentage of people who are not physically active is higher than in Stockport as a whole. Given the attractive footpath network of the area and the availability both of Bramhall Park and of the Ladybrook Valley this is disappointing.

The Health of Cheadle

Cheadle Area includes Cheadle, Gatley, Heald Green and the Cheadle Hulme North Ward> It is generally quite affluent but includes some relatively deprived areas in Councillor Lane and Brookfield. Cheadle Area is an Area Committee of Stockport MBC and part of Cheadle & Bramhall Locality of Stockport CCG.

Table 3.3	Cheadle & Gatley Ward	Cheadle Hulme North Ward	Heald Green Ward	Cheadle Area Committee	Stockport
Population (2011 Census)					
% aged 0-14	17.8%	16.9%	16.4%	17.0%	17.6%
% aged 65+	20.5%	18.8%	20.7%	20.0%	18.0%
Total population (number)	14698	12954	12440	40092	283275
Life Expectancy in years (2010-2012)					
Males	82.0	80.5	82.2	81.6	79.7
Females	85.3	85.3	85.2	85.2	83.0
Self-reported health (2011 Census)					
% good / very good	82.4%	81.3%	81.0%	81.6%	81.1%
% not good	17.6%	18.7%	19.0%	18.4%	18.9%
Self-reported lifestyles in adults (2012)*					
% low mental wellbeing	11.7%	13.8%	10.2%	12.0%	12.2%
% drinking – high risk	1.9%	1.8%	3.9%	2.5%	2.9%
% non-drinkers	22.9%	21.2%	32.7%	25.2%	21.4%
% smoking	10.8%	13.1%	15.1%	12.8%	14.9%
% obese	14.6%	15.5%	16.7%	15.5%	16.2%
% not physically active	76.8%	77.7%	74.6%	76.5%	73.6%
% unhealthy diet	77.7%	81.9%	84.9%	81.2%	82.1%
% multiple risks	31.3%	32.4%	27.4%	30.9%	32.4%
Use of acute services (2012/13) crude rate per 1,000					
ED Attendances	329.6	319.0	329.3	326.0	313.8
Inpatient admissions	297.1	299.3	290.3	295.6	293.7
Emergency inpatient admissions	119.1	127.0	107.2	117.9	112.7

* Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence, however comparisons between areas are still valid

The area is adversely affected by aircraft noise from Manchester Airport. In much of the Area the natural patient flow is towards Wythenshawe Hospital rather than Stepping Hill. The large social housing areas of Councillor Lane and Brookfield are within the nationally most deprived quintile but not within the most deprived decile. Overall its health is slightly better than the borough as a whole and its lifestyles slightly healthier but it makes slightly more use of health services and less than a quarter of its population are physically active.

The Health of Heatons

When the CCG devised its boundaries and mapped on to the Area boundaries of Stockport MBC, Heatons was an Area Committee covering the areas of Heaton Moor, Heaton Chapel, Heaton Norris and Heaton Mersey (the Four Heatons). This former Area became part of the Heatons & Tame Valley Locality of Stockport CCG but Council area boundaries have now changed and it is no longer a separate area, being instead part of the Heatons & Reddish Area.

Table 3.4	Heatons	Stockport
Population (2011 Census)		
% aged 0-14	17.5%	17.6%
% aged 65+	16.6%	18.0%
Total population (number)	27454	283275
Life Expectancy in years (2010-2012)		
Males	80.4	79.7
Females	82.8	83.0
Self-reported health (2011 Census)		
% good / very good	83.7%	81.1%
% not good	16.3%	18.9%
Self-reported lifestyles in adults (2012)*		
% low mental wellbeing	12.7%	12.2%
% drinking – high risk	3.1%	2.9%
% non-drinkers	21.6%	21.4%
% smoking	12.8%	14.9%
% obese	12.6%	16.2%
% not physically active	72.8%	73.6%
% unhealthy diet	79.0%	82.1%
% multiple risks	29.6%	32.4%
Use of acute services (2012/13) crude rate per 1,000		
ED Attendances	279.8	313.8
Inpatient admissions	275.3	293.7
Emergency inpatient admissions	104.7	112.7

* Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence, however comparisons between areas are still valid

Heatons is a mixed area bordering Manchester. Its health is somewhat better than the Stockport average, apart from mental well-being which is slightly worse. It makes less use of health services than the Borough as a whole and lifestyles are generally healthier apart from drinking which is very slightly worse.

The Health of Tame Valley

Tame Valley covers Reddish, Brinnington and the Town Centre area. It no longer figures in the geography of the Council's Area Committees having been divided between the Heatons-Reddish Area and the Central Area. However CCG boundaries map onto the old boundaries and so it lies in the Heatons and Tame Valley Locality of the CCG.

Table 3.5	Brinnington & Central Ward	Reddish North Ward	Reddish South Ward	Tame Valley	Stockport
Population (2011 Census)					
% aged 0-14	19.6%	19.6%	16.7%	18.7%	17.6%
% aged 65+	12.3%	12.8%	14.8%	13.3%	18.0%
Total population (number)	14999	14458	13594	43051	283275
Life Expectancy in years (2010-2012)					
Males	71.7	79.4	78.4	76.0	79.7
Females	76.9	83.5	84.0	80.6	83.0
Self-reported health (2011 Census)					
% good / very good	72.0%	80.2%	79.8%	77.2%	81.1%
% not good	28.0%	19.8%	20.2%	22.8%	18.9%
Self-reported lifestyles in adults (2012)*					
% low mental wellbeing	17.9%	14.0%	11.6%	14.4%	12.2%
% drinking – high risk	5.5%	2.7%	2.5%	3.6%	2.9%
% non-drinkers	31.5%	28.4%	19.1%	26.1%	21.4%
% smoking	30.7%	24.5%	15.2%	23.2%	14.9%
% obese	22.0%	21.3%	19.1%	20.7%	16.2%
% not physically active	76.9%	75.5%	74.0%	75.4%	73.6%
% unhealthy diet	91.0%	88.0%	84.4%	87.7%	82.1%
% multiple risks	45.3%	42.2%	28.1%	38.2%	32.4%
Use of acute services (2012/13) crude rate per 1,000					
ED Attendances	455.4	364.6	332.9	386.3	313.8
Inpatient admissions	375.6	326.0	302.4	335.8	293.7
Emergency inpatient admissions	180.3	129.8	126.7	146.4	112.7

*Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence, however comparisons between areas are still valid

Brinnington & Central Ward has markedly lower life expectancy, markedly worse lifestyles and markedly worse health than Stockport as a whole. Brinnington is an attractive community with good facilities and ample greenspace set close to the town centre but still amidst countryside and with strong community spirit. It is possible that the health indicators are affected by the inclusion of the Town Centre within the ward and by the use of some housing in Brinnington for short term housing.

Reddish also shows worse life expectancy, health and lifestyles, especially in the North of the township, but to a much less marked extent than in Brinnington.

The Health of Victoria

Victoria is another former Council Area Committee which remains relevant to the geography of the CCG. It forms part of the Stepping Hill & Victoria Locality Committee of the CCG, but in Council geography it has been merged with part of Tame Valley to form the Central Area Committee.

It is a relatively deprived area including Edgeley, Cheadle Heath, Adswood and Bridge Hall.

Table 3.6	Victoria Area	Stockport
Population (2011 Census)		
% aged 0-14	19.4%	17.6%
% aged 65+	12.6%	18.0%
Total population (number)	42574	283275
Life Expectancy in years (2010-2012)		
Males	77.5	79.7
Females	80.4	83.0
Self-reported health (2011 Census)		
% good / very good	80.3%	81.1%
% not good	19.7%	18.9%
Self-reported lifestyles in adults (2012)*		
% low mental wellbeing	14.7%	12.2%
% drinking – high risk	1.8%	2.9%
% non-drinkers	25.1%	21.4%
% smoking	20.4%	14.9%
% obese	18.3%	16.2%
% not physically active	69.9%	73.6%
% unhealthy diet	85.1%	82.1%
% multiple risks	33.7%	32.4%
Use of acute services (2012/13) crude rate per 1,000		
ED Attendances	378.0	313.8
Inpatient admissions	334.3	293.7
Emergency inpatient admissions	150.4	112.7

* Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence, however comparisons between areas are still valid

Victoria is the other major deprived area of the borough. Life expectancy is intermediate between that of Brinnington and Reddish. It has shown marked improvements in lifestyles over the last decade to the point that it has one of the best levels of physical activity in the borough and low levels of high risk drinking. Its proportions of people with multiple risks are only slightly worse than the affluent areas.

The Health of Stepping Hill

Stepping Hill is an Area Committee of Stockport MBC and part of the Stepping Hill & Victoria Locality of Stockport CCG. It is a mixed area stretching out to the east of the Borough and including Offerton, and Hazel Grove.

Table 3.7	Hazel Grove Ward	Offerton Ward	Stepping Hill Ward	Stepping Hill Area Committee	Stockport
Population (2011 Census)					
% aged 0-14	17.6%	17.8%	16.8%	17.4%	17.6%
% aged 65+	20.3%	17.4%	20.1%	19.2%	18.0%
Total population (number)	14035	13720	12402	40157	283275
Life Expectancy in years (2010-2012)					
Males	80.5	80.0	80.6	80.4	79.7
Females	85.8	82.8	82.5	83.7	83.0
Self-reported health (2011 Census)					
% good / very good	82.2%	79.2%	82.6%	81.3%	81.1%
% not good	17.8%	20.8%	17.4%	18.7%	18.9%
Self-reported lifestyles in adults (2012)*					
% low mental wellbeing	10.0%	18.5%	12.1%	13.2%	12.2%
% drinking – high risk	3.5%	3.5%	2.6%	3.2%	2.9%
% non-drinkers	20.6%	20.1%	15.9%	18.9%	21.4%
% smoking	12.1%	16.7%	14.2%	14.2%	14.9%
% obese	18.0%	27.2%	14.7%	19.7%	16.2%
% not physically active	77.5%	70.1%	74.5%	74.3%	73.6%
% unhealthy diet	84.5%	83.6%	82.8%	83.7%	82.1%
% multiple risks	33.4%	34.6%	32.9%	33.5%	32.4%
Use of acute services (2012/13) crude rate per 1,000					
ED Attendances	328.2	373.5	318.8	340.8	313.8
Inpatient admissions	319.8	334.1	302.9	319.5	293.7
Emergency inpatient admissions	130.2	139.9	124.3	131.7	112.7

*Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence, however comparisons between areas are still valid

Life expectancy and self-reported health are slightly better than in the borough as a whole. Mental wellbeing is slightly better except in Offerton where it is markedly worse. Physical activity is better in Offerton and markedly worse in Hazel Grove. Diet is slightly worse, the alcohol epidemic slightly better. Use of health services is high, perhaps reflecting the proximity of Stepping Hill Hospital.

The Health of Marple

Marple is an Area Committee of Stockport MBC and part of the Marple & Werneth Locality of Stockport CCG. It consists of the township of Marple and the surrounding villages of Compstall, Mellor, Strines, and High Lane.

Table 3.8	Marple Area Committee	Stockport
Population (2011 Census)		
% aged 0-14	15.2%	17.6%
% aged 65+	24.9%	18.0%
Total population (number)	23686	283275
Life Expectancy in years (2010-2012)		
Males	78.9	79.7
Females	82.9	83.0
Self-reported health (2011 Census)		
% good / very good	81.9%	81.1%
% not good	18.1%	18.9%
Self-reported lifestyles in adults (2012)*		
% low mental wellbeing	8.9%	12.2%
% drinking – high risk	3.7%	2.9%
% non-drinkers	13.4%	21.4%
% smoking	11.4%	14.9%
% obese	11.9%	16.2%
% not physically active	72.1%	73.6%
% unhealthy diet	78.5%	82.1%
% multiple risks	31.1%	32.4%
Use of acute services (2012/13) crude rate per 1,000		
ED Attendances	277.0	313.8
Inpatient admissions	301.1	293.7
Emergency inpatient admissions	130.4	112.7

* Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence; however comparisons between areas are still valid

Disappointingly for an affluent rural area, life expectancy is slightly lower than in the Borough as a whole. Self-reported health is very slightly better. Smoking, diet and physical activity levels are better than in the rest of the borough but levels of high risk drinking are markedly worse and the levels of physical activity are not as high as might be expected from the excellent walking opportunities in the area. Use of health services is lower.

The Health of Werneth

Werneth is an Area Committee of Stockport MBC and part of the Marple & Werneth Locality of Stockport CCG. It consists of the townships of Bredbury, Romiley and Woodley.

Table 3.9	Werneth Area Committee	Stockport
Population (2011 Census)		
% aged 0-14	17.0%	17.6%
% aged 65+	20.1%	18.0%
Total population (number)	27732	283275
Life Expectancy in years (2010-2012)		
Males	79.3	79.7
Females	82.5	83.0
Self-reported health (2011 Census)		
% good / very good	78.2%	81.1%
% not good	21.8%	18.9%
Self-reported lifestyles in adults (2012)*		
% low mental wellbeing	11.7%	12.2%
% drinking – high risk	3.7%	2.9%
% non-drinkers	25.1%	21.4%
% smoking	15.6%	14.9%
% obese	16.4%	16.2%
% not physically active	72.1%	73.6%
% unhealthy diet	82.8%	82.1%
% multiple risks	32.0%	32.4%
Use of acute services (2012/13) crude rate per 1,000		
ED Attendances	332.3	313.8
Inpatient admissions	326.0	293.7
Emergency inpatient admissions	137.5	112.7

* Source: 2012 Adult Lifestyle Survey, NHS Stockport – please note that this survey is self-reported and underestimates true prevalence, however comparisons between areas are still valid

Life expectancy, self-reported health and mental well-being are slightly worse than in the borough as a whole. Rates of problem drinking are high. Rates of smoking, obesity and unhealthy diets are slightly higher than in the borough as a whole. Physical activity rates are slightly better.

The Health of the Neighbourhood Management Areas

In the PCT public health gave special attention to the most deprived quintile of the population via a process of community development and targeted resources. The Council took a similar approach through the process of neighbourhood management. The four neighbourhood management areas (NMAs) cover approximately 60% of the population of the most deprived quintile .The areas comprise Adswood & Bridgehall, 5,500 Population, Brinnington 7,500 Central   6,500 Offerton 3,550 30/06/12.

Since public health moved into the Council we are exploring how to reconcile these two approaches.

Life expectancy

Trends in life expectancy for the NMAs can be seen in figure 3.10 and shows a general increase since 1995/97:

Figure 3.10: Trend in Life Expectancy – all NMAs
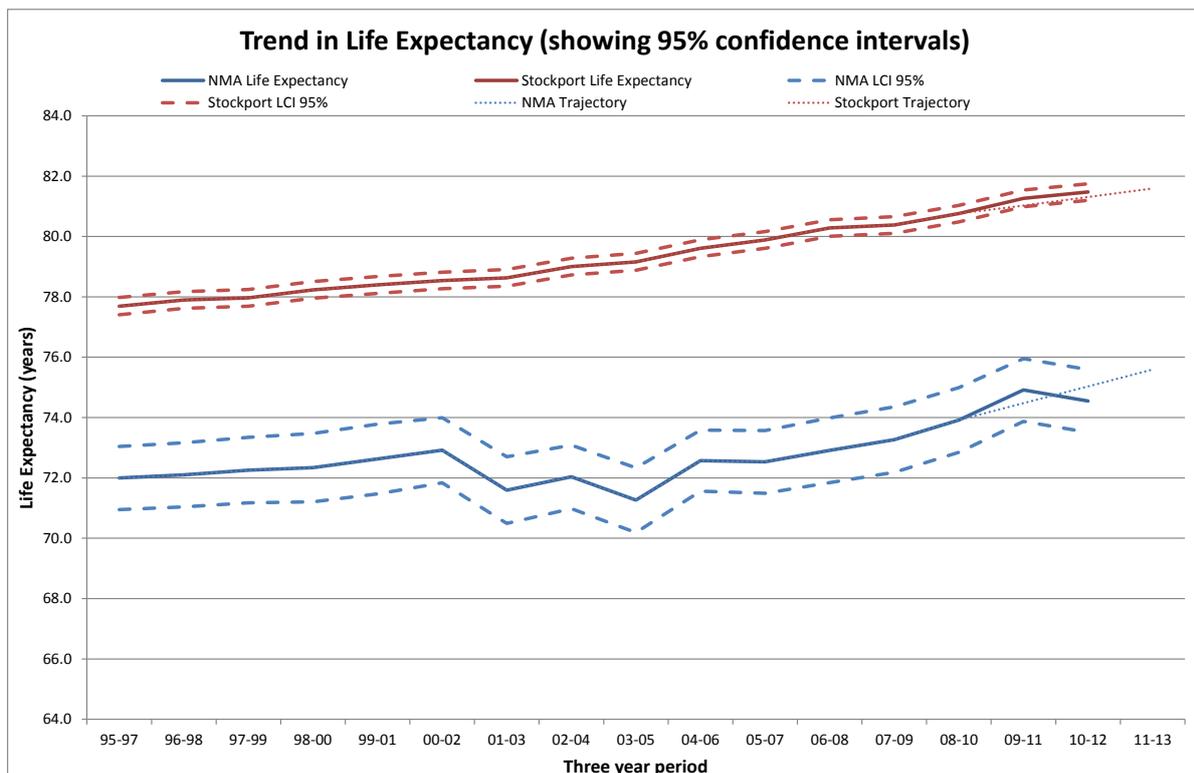
Source: PHMF, ONS & NHS Stockport

Trends suggest that during the early part of the last decade the rate of improvement stopped, and at this point the inequalities gap widened; since 2005/07 however the improvement in life expectancy has resumed and the gap has narrowed, though not back to the levels seen in the mid-nineties.

Trends in the inequalities gap in life expectancy have recently been re-examined and are discussed in chapter 2.

Life expectancy trends for each of the four NMAs individually need to be treated carefully, due to the small numbers involved, however key trends can be identified (see figure 3.11). Overall:

Brinnington has seen the most significant and consistent improvement in life expectancy rates since 1995/07 and is the only NMA where a statistically significant increase can be shown. Over the period between 1995/97 and 2002/04 rates in this area remained relatively stable; since 2002/04 life expectancy has increased by 3 years.

Adswood & Bridgehall and Offerton have overall seen increases in life expectancy since 1995/97; but these cannot be shown to be statistically significant. Both experienced a drop in life expectancy between 2000/02 and 2003/05 and since then have seen an increase in life expectancy.

Central neighbourhood management area has seen the least change, and life expectancy in this area has not improved since 1995/979. Rates in this area are falling behind the other NMAs.

Figure 3.11: Trend in Life Expectancy – by NMA
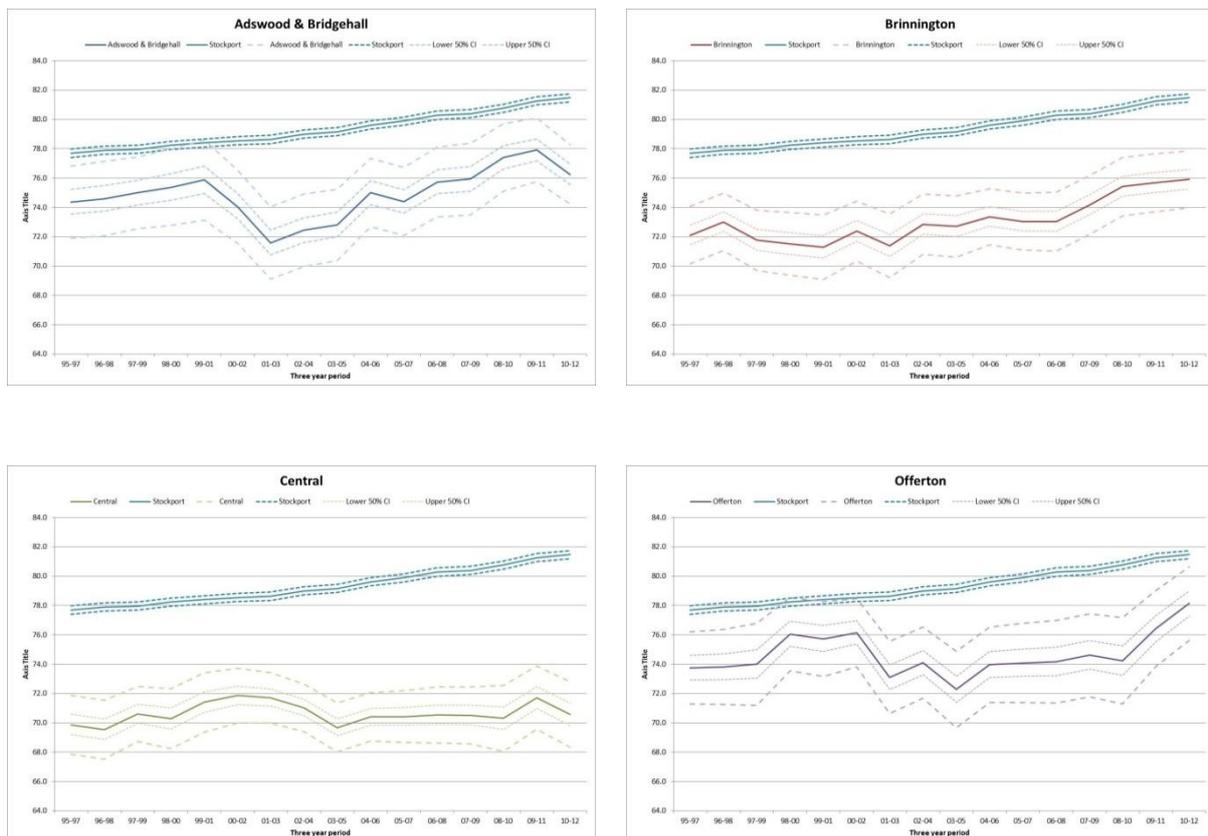
Source: PHMF, ONS & NHS Stockport

Table 3.12: Self-reported "good" or "very good" general health

	2009 Adult Lifestyle Survey (18+)		2012 Adult Lifestyle Survey (18+)		2011 Census (all ages)	
	Sample size	Rate	Sample size	Rate	Sample size	Rate
Adswood & Bridgehall	94	64.9%	88	55.7%	5,088	76.5%
Brinnington	96	54.2%	104	56.7%	6,686	72.7%
Central	175	62.3%	123	58.5%	6,488	67.4%
Offerton	71	54.9%	64	68.8%	2,738	71.4%
All NMAs	*436*	*59.9%*	*379*	*59.1%*	*21,000*	*71.8%*
Stockport	*7,456*	*73.8%*	*6,668*	*74.2%*	*283,275*	*81.1%*

Source: 2012 Adult Lifestyle Survey, NHS Stockport

2011 Census data relating to the general health of the population is now becoming available, full analysis and comparison with local surveys will not be possible until the full data is released later this year (when age breakdowns will be available). However early data from the Census (table 3.12) shows that rates of general health in the NMA s are lower than the Stockport average; rates are lowest in Central and highest in Adswood & Bridgehall. Unsurprising the Census data for all ages shows a better picture of health than local surveys of adults; but this will be skewed by the inclusion of children.

Alcohol

In depth analysis of local mortality data suggests that while smoking is still a major cause of early death some progress is being made in reducing prevalence; the impact of alcohol is however an emerging priority.

Table 3.13: 2012 Adult Lifestyle Survey – High and Increasing Risk Drinking

	Sample size	High risk	Increasing risk	Drank within weekly guideline	Didn't drink last week	Non drinker
Adswood & Bridgehall	86	0.0%	12.8%	45.3%	9.3%	**32.6%** [H]
Brinnington	103	**7.8%** [H]	**4.9%** [L]	47.6%	6.8%	**33.0%** [H]
Central	121	5.8%	13.2%	**41.3%** [L]	11.6%	28.1%
Offerton	63	1.6%	7.9%	60.3%	6.3%	23.8%
All NMAs	*373*	*4.3%*	*9.9%* [L]	*47.2%*	*8.8%*	*29.8%* [H]
Stockport	*6,635*	*2.9%*	*16.9%*	*52.0%*	*6.8%*	*21.4%*

Source: 2012 Adult Lifestyle Survey, NHS Stockport

Results from the 2012 Adult Lifestyle Survey (table 3.13) show that in both Adswood & Bridgehall and Brinnington there are significantly higher rate of adults reporting that they do not drink alcohol at all; further investigation suggests that these people tend to be older and in poorer health. Of those who do drink, Brinnington reported an especially high rate of drinking at high risk rates (35+ units for women and 50+ for men) and Central reported a lower proportion drinking within the weekly guidelines (14 units for women and 21 for men).

Figure 3.14: Alcohol Related Harm Admissions

Source: SUS, NHS Stockport
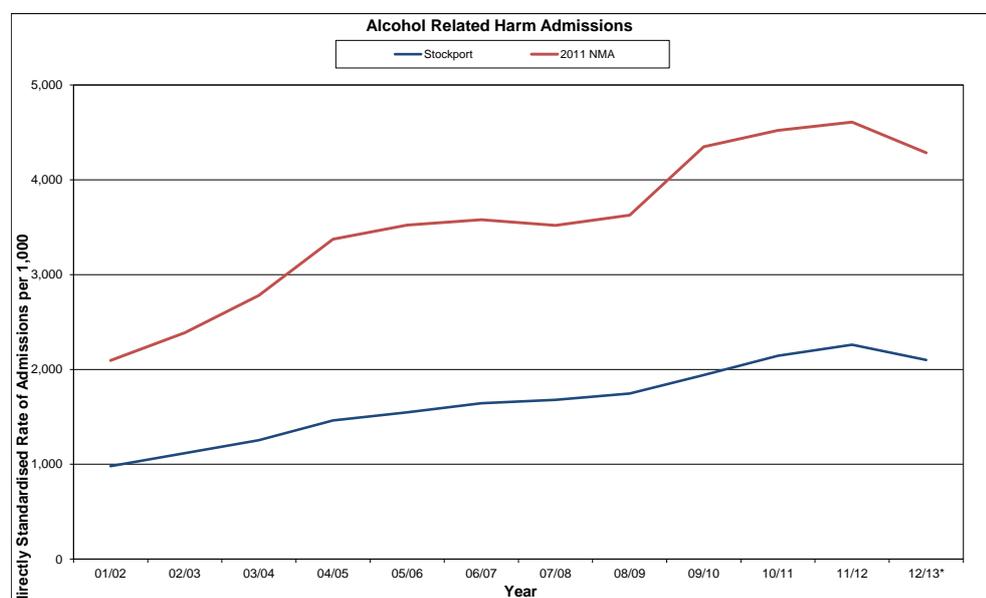
The impact of the unhealthy levels of drinking can be seen in the trends in hospital admissions for alcohol related conditions (figure 6.14), which have increased markedly since 2002/03; especially in the NMA areas where rates are more than double the Stockport average. In total around 1,000 alcohol related admissions are made each year from these areas and there is no real sign of a change in this trend.

Other lifestyle issues

Data from the 2012 Adult Lifestyle Survey shows how other key health behaviours vary across the areas (table 6.15)

Table 3.15: 2012 Adult Lifestyle Survey – Other key lifestyle issues

	Low Mental Wellbeing	Current Smokers	Obesity	Not Physically Active	Unhealthy diet	Multiple Risks
Adswood & Bridgehall	19.8%	**33.3%**[H]	**27.7%**[H]	74.4%	85.2%	38.8%
Brinnington	**20.8%**[H]	**38.6%**[H]	22.3%	83.5%	**93.3%**[H]	**55.6%**[H]
Central	**24.5%**[H]	**28.9%**[H]	23.1%	70.6%	**95.1%**[H]	37.9%
Offerton	**29.3%**[H]	**33.3%**[H]	**35.0%**[H]	65.5%	84.4%	**41.0%**[H]
All NMAs	**23.1%**[H]	**33.3%**[H]	**26.0%**[H]	**74.1%**	**90.5%**[H]	**43.5%**[H]
Stockport	12.2%	14.9%	16.2%	73.6%	82.1%	32.4%
Ratio NMA: Stockport	1.89x	2.23x	1.60x	1.01x	1.10x	1.34x

Source: 2012 Adult Lifestyle Survey, NHS Stockport

Smoking is the lifestyle behaviour with the steepest inequality gradient; rates of smoking in the NMAs are more than twice that of the Stockport average and are significantly higher in each of the four areas, but especially Brinnington. In 2011/12 275 people from NMAs were supported to quit smoking; 14.4% of the total number of quitters (7.5% of the total population live in these areas) but

a small figure when compared to the number of smokers (data from 2012/13 will be available at the end of June).

Mental wellbeing has the second steepest gradient; rates of poor mental wellbeing are 89% higher in the NMAs than in the rest of Stockport. Evidence suggests that mental wellbeing is a key determinant of health and underpins many poor health choices. Mental wellbeing is a priority of the Health and Wellbeing Strategy

Obesity rates are also significantly higher, with rates on average being 60% higher in the NMAs compared to the Stockport average. It should be noted that due to the self-reporting nature of this survey these rates are thought to be a significant underestimation of the issue (for example the Stockport average is thought to be 25% rather than 16%).

The only health behaviour which is not significantly worse across the NMAs as a whole is physical activity; where rates are similar to the Stockport average – however on average only 1 in 4 adults are active enough.

Over the last 2 years 295 residents of NMAs have been referred to the Stockport PARiS scheme (Physical Activity on Referral in Stockport).

In 2011/12 215 NMA residents received services from Stockport Health Trainers, who have now joined other lifestyle behaviour change services to become the Healthy Stockport Service. Over the last 2 years 25 frontline workers in the NMAs have undertaken Essential Public Health Training.

Use of acute health services

The use of these services is another key indicator of health and health care in local areas (table 6.16).

Table 3.16: Use of acute health services 2012/13

	Number of			Crude rate per 1,000		
	ED attendances	inpatient admissions	emergency inpatient admissions	ED attendance	inpatient admissions all emergency	
Adswood & BH	2,281	1,841	909	409.4	330.4	163.1
Brinnington	3,255	2,765	1,349	430.3	365.5	178.3
Central	3,321	2,664	1,329	513.8	412.2	204.5
Offerton	1,752	1,431	687	496.0	405.2	194.5
All NMAs	*10,609*	*8,701*	*4,274*	*458.6*	*376.2*	*184.8*
Stockport	*93,452*	*87,462*	*36,536*	*313.8*	*293.7*	*122.7*

Source: SUS, NHS Stockport

Rates of attendance at Emergency Departments (ED) and inpatient admissions are all higher in the NMAs than compared to the Stockport average; and are highest in the Central area.

Health Services

These communities are less likely to use primary care services or access opportunities to check their health e.g. screening which can result in them using more intensive or crisis services such as the

Emergency Department or receiving late diagnoses of conditions which make them more difficult to treat. Health inequalities also surface once people have been diagnosed with a condition, which may be due to people from a more disadvantaged background being less able to articulate their needs or be a confident self-advocate. NHS services are provided universally and the way they are provided and structured is generally not geared around socio-economic disadvantage, or a locality model of service provision. The development of processes to integrate health and social care, however, is leading to a locality model of provision. The CCG's priority to reduce health inequalities and establishment of locality footprint in addition to Stockport Health Promise and the proposed Health inequality pilot outlined elsewhere in this annual report may lead to increased proportion of resource directed towards more disadvantaged localities.

Most public health services are provided 'universally' to the whole of Stockport. The Healthy Stockport service combining the Health Trainer service, alcohol, smoking cessation and weight management is available to all Stockport residents but for residents living in the most disadvantaged parts of the borough more intensive contact and support is available. A number of community public health services focus on disadvantaged neighbourhoods or communities such as the Food and Health Team, the community stop smoking team; and the community development team. In addition a number of small schemes focus on the health and wider wellbeing of very vulnerable group including people who are homeless, people with alcohol addiction, refugee and asylum seekers, young people who are substance misusers, and vulnerable women / those at risk of domestic violence.

3.4.   HEART DISEASE AND CANCER

Heart disease and cancer are the two greatest killers of our time. Due to the recent decline in heart disease cancer has now taken over as the biggest killer. They can helpfully be thought of together as smoking, stress, physical inactivity and diet contribute to both heart disease and cancer so our preventive strategies focused on those factors benefit both diseases.

Cancer

Cancer arises when a cell starts to multiply out of control leading to tissues growing uncontrolled and ultimately spreading throughout the body interfering with other organs. This occurs as a result of factors that damage chromosomes, depress the immune system, or stimulate cell multiplication, such as

- old age,
- smoking,
- chemicals,
- radiation,
- stress,
- genetic predisposition
- diseases of the immune system such as HIV/AIDS

Over 80% of lung cancer is caused by smoking (including about 1 to 2 people in every thousand who die each year as a result of passive smoking). About 10% is caused by occupational exposure to chemicals. Smoking also increases the risk of many other cancers.

Breast cancer and testicular cancer are two of the very small number of diseases that are most common in the most affluent.

Delayed childbearing contributes to breast cancer.

Cervical cancer is commonest in women who have multiple sexual partners or who work in oily or dirty surroundings or with biological material or whose partner does any of these things.

Skin cancer is increased by overexposure to sun.

Gastrointestinal cancer is predisposed to by low fibre diets or by physical inactivity. Oesophageal cancer is increasing in incidence and is associated with reflux of stomach contents in the oesophagus whilst stomach cancer may be caused by an infection which also causes stomach ulcers and heart disease. Mouth cancers can be caused by smoking. All three of these cancers are also predisposed to by excessive consumption of alcohol or certain kinds of food

All age deaths from cancer have fallen by 15% in Stockport since 1995/97, currently 750 deaths a year in Stockport are due to cancer. Deaths from early cancer (aged under 75) have fallen by 19% in Stockport since 1995/97, currently 350 early deaths a year in Stockport are due to cancer (see figure below). Mortality rates are lower than the regional average and similar to the national average.

Figure 4.1 Trends in Cancer Mortality

Mortality rates for cancer for those aged under 75 years
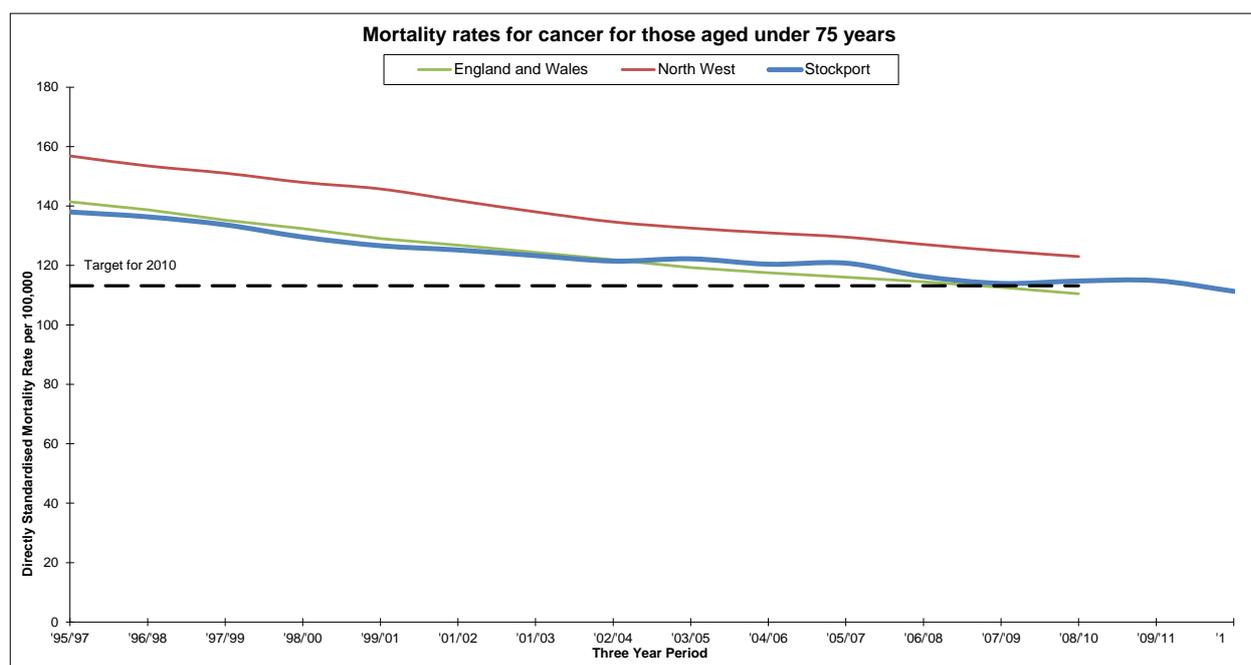
Over the same period the incidence of cancer has risen by 5% in Stockport, currently 1,700 people are diagnosed with malignant cancer each year. Incidence rates have risen fastest in the 50-64 age group, and have fallen for those aged 75+. Currently 1,100 people aged under 75 are diagnosed with malignant cancer each year in Stockport. Malignant cancer incidence rates in Stockport are lower than the regional average but higher than the national average.

Data for the incidence and number of deaths from the most common cancers or those with screening programmes are shown below.

Table 4.2 incidence and Mortality for key cancers

Stockport – Incidence and mortality numbers from key types of cancer

	Incidence (2010)		Deaths (2011)	
	All Ages	**Age <75**	**All Ages**	**Age <75**
All Malignant Cancers	1670	1090	750	370
Lung Cancer	220	110	170	80
Colorectal Cancer	180	110	80	40
Female Breast Cancer	260	200	50	20
Female Cervical Cancer	10	10	*	*
Male Prostate cancer	230	150	40	20

* less than 5

Source: Cancer information Service, PHE

Figure 4.3 Distribution of premature cancer mortality
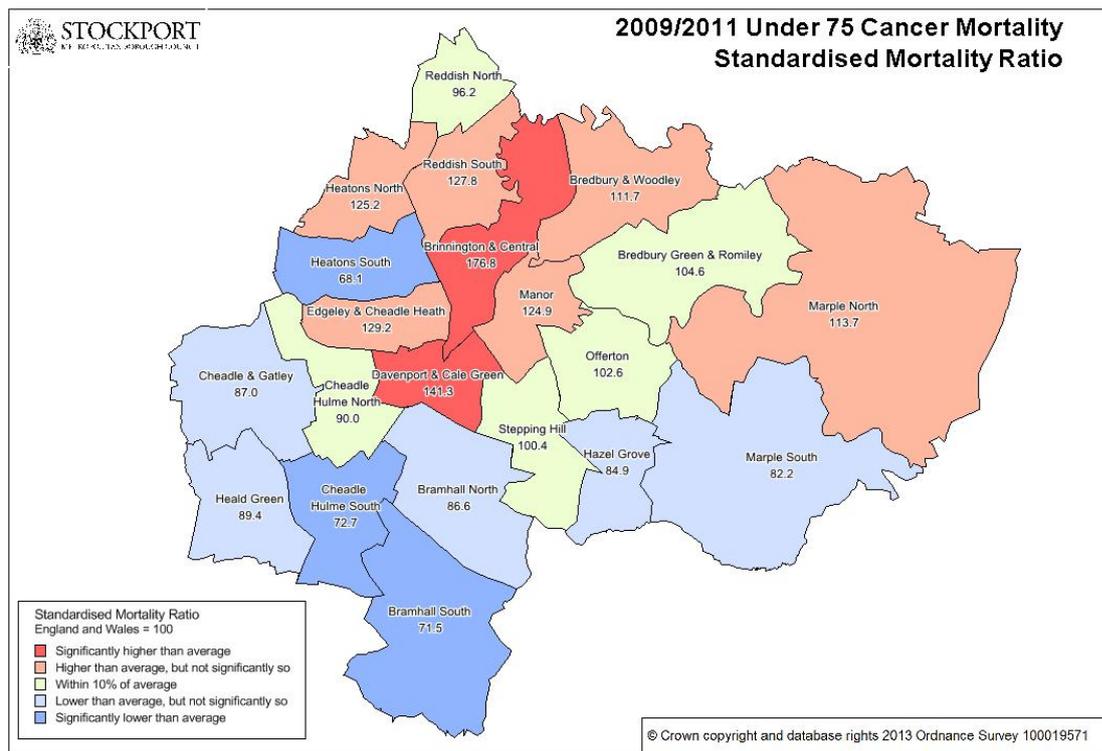
Heart Disease

Heart disease was the most common cause of death for many years until recently when cancer overtook it both locally and nationally.

Heart disease is caused by

- Smoking,
- Low fibre high fat diets,
- Lack of exercise
- High blood pressure and diabetes, both of which are contributed to by obesity which in turn is caused by diet and lack of exercise
- Salt.
- Genetic predisposition.
- Stress, in the precise sense discussed in the chapter on well being

Aspirin, statins and other measures to reduce cholesterol, and eating fish (especially oily fish also reduce the risk of heart disease

Moderate alcohol consumption is beneficial but the balance between healthy and unhealthy consumption is a fine one. Your first pint of beer, or your first two small glasses of wine, each day are good for you. The next pint or the next two glasses of wine cancels out the benefit of the first. After that it is harmful.

All age deaths from circulatory disease have fallen by 50% in Stockport since 1995/97, currently 750 deaths a year in Stockport are due to heart disease. Deaths from early heart disease have fallen by 59% in Stockport since 1995/97, currently 170 early deaths a year in Stockport are due to heart disease (see figure below). Mortality rates are lower than the regional average and similar to the national average.

Figure 4.4 Trends in Circulatory Mortality

Mortality rates for circulatory disease for those aged under 75 years
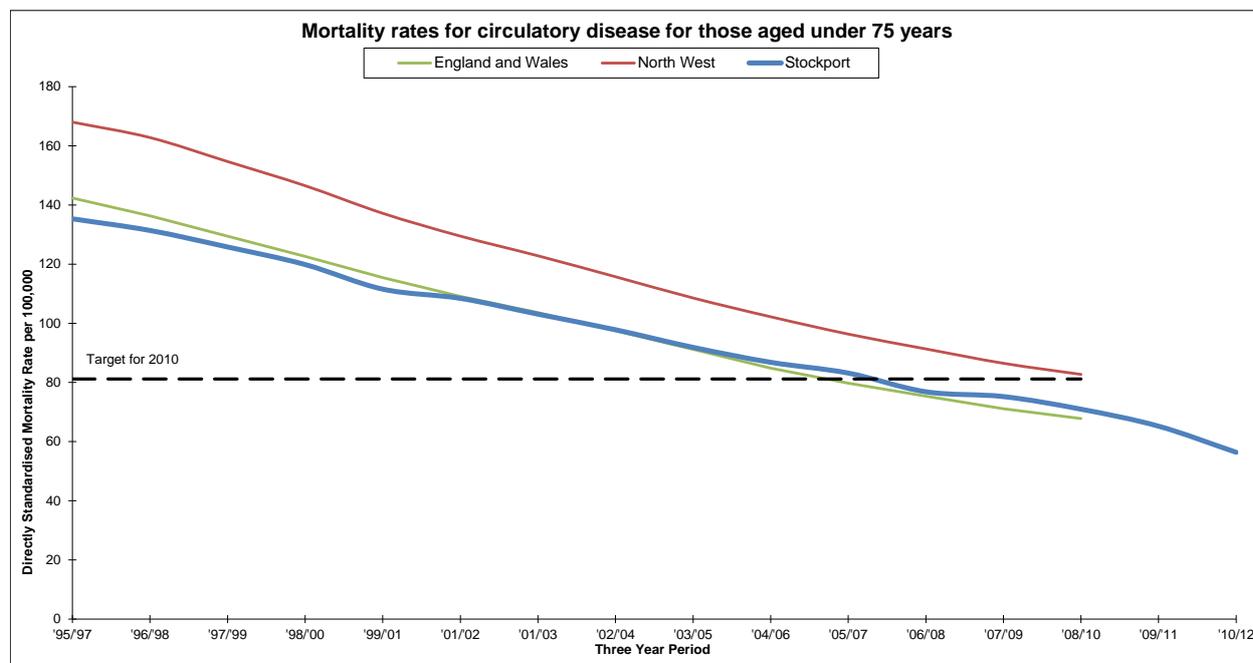
There are currently 11,900 people registered with a Stockport GP who have a diagnosis of coronary heart disease and 5,900 with a history of Stroke. Trends show that levels of diagnosed hypertension are rising, while levels of coronary heart disease and heart failure are falling.

Table 4.5 Morbidity of heart diseases

	Number with condition	Rate per 1,000
Hypertension	42,500	141.6
Coronary Heart Disease	11,900	39.7
Stroke / TIA	5,900	19.6
Heart Failure	2,400	8.1
Source: QoF		

Figure 4.6 Distribution of premature Circulatory mortality
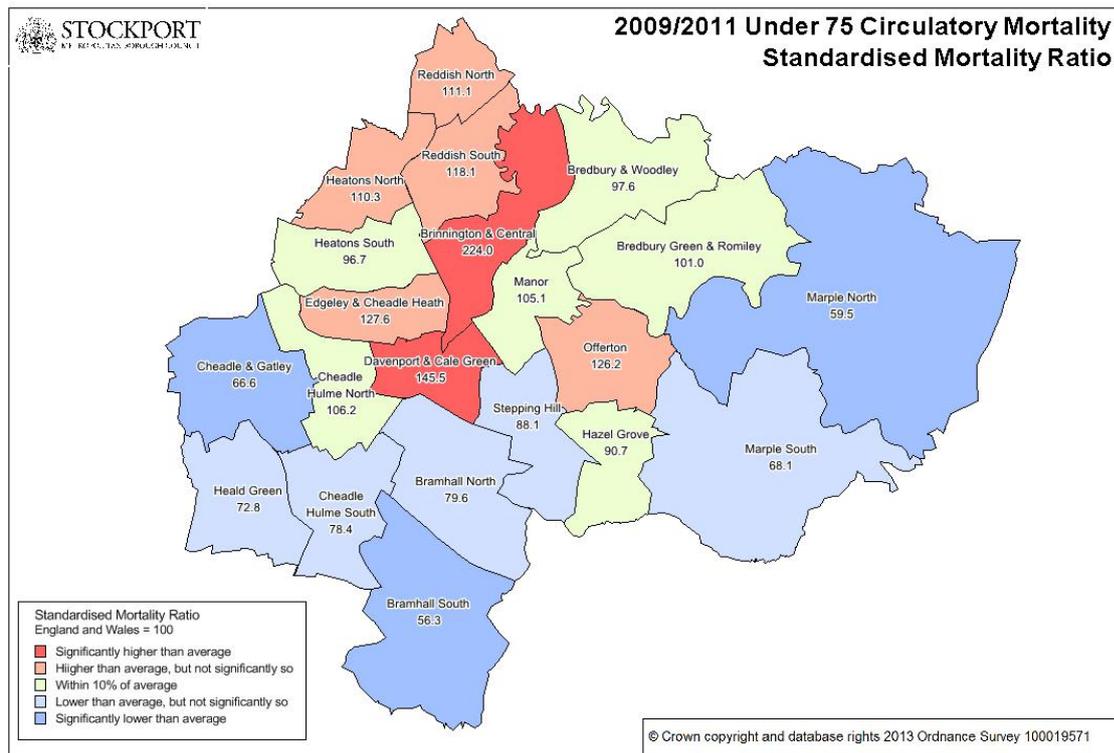
What Can We Do About Cancer and Heart Disease

The health service can help by providing services to screen for early disease or risk factors for disease and advise on healthy choices. It can diagnose and treat existing disease. It can sponsor and empower the community.

The wider local authority can *create safe and healthy communities, p*rotect and promote our environment and heritage, protect areas of peacefulness and tranquillity as refuges from a stressful world and promote exercise opportunities through leisure facilities, countryside management etc. They can develop a transport strategy that makes more provision for walking and cycling

Employers can encourage and reward healthy behaviours and have policies to reduce stress.

Caterers can adopt a pricing policy that encourages healthy choices, develop imaginative menus that make the healthier choices attractive and ensure that all food is cooked in the healthiest way possible for that particular food. They can also avoid excessively large portion sizes.

All organisations and businesses can help reduce the barriers to physical activity and can discourage smoking.

Schools can ensure that health is included as a cross curricular theme and that the school makes it easier for children to make healthy choices, thus laying the groundwork for a healthy lifestyle. School meals should be healthy – one sensible step to take is to find out what healthy food children like and provide that. Vending machines and tuck shops should also make it easier to choose healthy options.

Schools should promote physical activity and should try to encourage children to walk or cycle to school instead of coming by car.

<u>People</u>

You can help yourself avoid heart disease and cancer by

Drinking healthily (less than 14 units a week for women and 21 for men with no more than 6 units on any one day)

Not smoking

Maintaining a healthy shape (body mass index ideally less than 25 and certainly less than 30)

Taking at least moderate activity for at least 30 minutes on at least 5 days a week

Eating at least 5 portions of fruit & vegetables a day, and choose low salt, high fibre, low fat, and low saturated fat products.

Using stairs instead of lifts and making short journeys on foot instead of driving,

Covering up and using sun protection on holidays and when working in the open air in fine weather

Making full use of screening services.

3.5.   RESPIRATORY DISEASE

One of the major public health successes of the last 50 years has been the reduction in the rates of respiratory disease. This has been achieved by Clean Air, by tackling occupational causes of lung disease and by reductions in smoking.

However respiratory disease remains a significant problem.

COPD

1 person in 20 suffers from some degree of chronic obstructive pulmonary disease and it is important that this is recognised and steps taken to stop its continuing deterioration.

There are currently 6,400 people registered with a Stockport GP who have a diagnosis of chronic obstructive pulmonary disease; a rate of 21.4 per 1,000. Rates have risen steadily since 2004/05. This is about half of the predicted total.

All age deaths from COPD have fallen by 22% in Stockport since 1995/97, currently 150 deaths a year in Stockport are due to COPD; the majority in older age. All age deaths from all respiratory disease have also fallen, by 41%, in Stockport since 1995/97, currently 350 deaths a year in Stockport are due to respiratory disease.

Action is being taken by our local NHS bodies to address this disease.

Early identification

At the end of November a 'Know it, check it, treat it' day was organised at the Wellbeing Centre for people over 35, who are a smoker or have ever smoked to come down and have a screening test for COPD

The integration plan includes the development of indicators to promote and increase the diagnosis of COPD

Treatment

The Governing Body of the CCG heard an inspirational story from a patient with COPD who gave up smoking. This has been widely promoted.

http://www.youtube.com/watch?v=1-9mOS8SC_E&list=UUp2kjg2nAtAW0V3OmhuXlhg&index=15

The FT have been improving the pathway for COPD related to the CQUIN, which is to ensure optimal treatment and care planning of patients with COPD

The CCG have commissioned a process to review the medications of patients with asthma and COPD to check they are being managed correctly.

ASTHMA

Asthma is a disease of difficulty in breathing caused by contraction of the small air passages to the lungs. Sufferers are usually perfectly normal between attacks although some permanent damage can occur over time. Asthma attacks can range from severe coughing attacks (especially at night) through to totally obstructed breathing threatening life.

Asthma rates have increased considerably over the last few decades.

Asthma is caused by :

- genetic predisposition
- allergies to specific substances
- sensitisation to chemicals by repeated exposure, for example in an employment situation
- poor air quality caused by
- traffic
- other air pollutants
- meteorological conditions
- inhaling tobacco smoke from other people

As well as providing sufferers with good quality services and education about their disease we also need to address the fundamental causes of poor air quality.

There is a relationship to traffic density. It is usually said that asthma is not caused by traffic emissions but that they condition the airways to react more to the actual causal allergens. However if the effect of this is that people suffer regular attacks when they otherwise would not have done so then the distinction between causing asthma and predisposing to asthma may seem an artificial one.

There are currently 19,800 people registered with a Stockport GP who have a diagnosis of asthma; a rate of 66.0 per 1,000. Rates have been reasonably steady since 2004/05. Around 3,300 of these diagnoses are for children and young people.

Around 500 hospital admissions are made each year for asthma, around a half of which are for children and young people, admissions peak for this age group in the autumn as children return to school after the summer holidays. Around £1.9 million is spent on prescribing for asthma each year in Stockport

In the last few years Stockport Council's education service has introduced a robust programme of asthma management in schools. Working closely with school nurses and head teachers a training programme has been implemented that all head teachers have attended. In addition a range of in school training programs have been provided for staff. These include asthma management and also responding to asthma emergencies. Some schools have also used assemblies to promote asthma management to pupils

Each year school are asked to report on their asthma management policy and to report any areas of non-compliance. An audit of all schools is carried out by a self-completion questionnaire. Areas of good practice are highlighted and those schools who indicate areas where they need further support

are visited with the appropriate experts. Governors are also requested to assure themselves on an annual basis that the school asthma policy is current and robust.

The Stockport council policy has now been extended to include other issues of paediatric chronic disease management including diabetes and epilepsy. The school nurses have supported pupils in the schools with individual care plans which are shared with relevant staff members. The work we have progressed has been highlighted as good practice by Asthma UK

3.6.   INJURIES

Injuries account for a relatively small proportion of all deaths. However they cause very much the greatest proportion of deaths in young people, so they are the third largest cause of lost years of life.

Most injuries occur in one or other of five settings - on the road, at work, at leisure, at home or as a result of violence. There are some injuries in other settings – rail or air crashes or weather incidents for example - but the five main settings account for almost all of them.

A few accidents are genuinely unavoidable or are due to bad luck with the inherent risks in excitingly dangerous activities such as mountaineering or motor racing, and are avoidable only by constraining the human spirit. But most should not be called accidents as they have readily avoidable causes, such as:

- failure to warn about and protect against hazards
- unsafe systems of work
- alcohol
- defective equipment
- inadequate training
- inexperience in children and young people
- binge drinking in young people
- short cuts taken for convenience or profit
- people taking unnecessary risks out of bravado,   carelessness, lack of knowledge, misjudgement of risk, lack of self-worth, or familiarity breeding contempt
- absurdly risk averse safety procedures which discredit the concept of safety and lead people to ignore advice (the "cry wolf" syndrome)
- poor housekeeping in workplaces
- failure to appreciate hazards in the home, including
- fire risks
- unsafe storage of dangerous substances, including both prescription and non-prescription drugs
- unsafe equipment and furniture, especially where poor households buy cheaply

Injuries occur more commonly to the poor, because they are most likely to work in poor quality work settings, they are more exposed to risks as pedestrians and they often cannot afford safe equipment.

Health service statistics and traditional discourse divide injuries into intentional injuries and "accidents". This is a misleading terminology as most "accidents" have a cause and are potentially avoidable.

All age deaths from "accidents" have started falling in Stockport after an increase over the first decade of the millennium, currently 70 deaths a year in Stockport are due to "accidents". "Accidents" are one of the leading cause of deaths for people aged under 45, account for 20% of these very early deaths; the majority of accidental deaths however occur for those aged 80+; where falls cause around 30 deaths each year. Mortality rates are lower than the regional average and similar to the national average.

Figure 6.1 Trends in accidental mortality

Mortality rates for accidents

— England and Wales   — North West   — Stockport

y-axis: Directly Standardised Mortality Rate per 100,000 (0, 5, 10, 15, 20, 25)

Target for 2010

x-axis: Three Year Period ('95/'97, '96/'98, '97/'99, '98/'00, '99/'01, '01/'02, '01/'03, '02/'04, '03/'05, '04/'06, '05/'07, '06/'08, '07/'09, '08/'10, '09/'11, '10/1)

Injuries in Children

The most recent Ofsted inspection of arrangements for safeguarding children and young people took place in February 2012. The overall effectiveness was judged to be adequate which does not match the aspiration of partners. A comprehensive and robust joint children's social care and health action plan was put in place to address the OFSTED feedback and this has now been fully implemented.

The independent chair of the Stockport Safeguarding Children Board noted in a recent report, that referrals to social care had reduced in 2012 / 2013, which may be the result of demand being managed more intelligently through the Supporting Families Pathway and the recent introduction of the Early Help and Prevention Service. He also noted that despite the needs of organisations to make savings, commitment to safeguarding remains strong in Stockport.

There is an extensive training programme to support partner organisations to effectively safeguard children. There are concerns that elements of this may be at risk due to reductions in grant funding and reduced capacity for existing staff to deliver training.

A designated nurse for the Looked after Children post is now established following the Ofsted recommendations. Stockport health professionals are now achieving quality standards in relation to health assessments for children placed by Stockport Local Authority. Stockport continues to have excellent immunisation rates for looked after children. An action plan in relation to the mental wellbeing of looked after children is being implemented. There are some difficulties with access to mental health services for the 16+ group.

Unintentional Injury

Public Health England and the Royal Society for the Prevention of Accidents (ROSPA) published a report on delivering accident prevention at local level in 2013. This highlighted the impact that

accidents have on preventable death and injury and the huge costs to the economy as a result. The report stressed that accidents are eminently preventable and urged local authorities to give a higher priority to this issue than is currently the case. In particular the following priorities were highlighted:

- Accidents in the home in under 5s
- Leisure and road related accidents in 10 – 25 year olds
- Accidents in the home in the over 65 population, especially falls.

Hospital admissions for unintentional and deliberate injury in 0 -17s in Stockport are higher than the national average. Rates are highest in the early years of life and young people. There is no clear trend in the rate of hospital admissions caused by unintentional injury in 0 – 17s. There is also no clear trend for emergency department attendances caused by injury at Stepping Hill Hospital for the 0 – 17s.

There is a local unintentional injury strategy group which has developed a multi-agency action plan. The public health team is planning to invest more resource in this area in order to progress work. This will include:

- Developing and delivering a plan to prevent accidents in children aged 0 -5
- Developing and delivering a plan to prevent accidents in young people
- Further stakeholder engagement
- Development and delivery of a training plan
- Developing a communications plan
- Further development of the home safety equipment scheme which targets families with young children in priority areas.

Stockport currently has a home safety equipment scheme which aims to reduce injuries in the first 2 years of life. This is delivered in partnership with Stockport Homes. It is currently too small in scale to have a significant impact on accident rates.

It is acknowledged that accident in older people is also a priority. There are already well developed planning mechanisms in relation to falls prevention in older people but there are gaps in service delivery. Public health has agreed to provide some funding to support older people's accident prevention.

Health and Safety at Work *(Note- this section also appears in chapter 15)*

Improvements in health and safety at work are amongst the greatest achievements of our society in the 20th century and are one of the major reasons for the proportion of men reaching old age increasing towards the end of that century. It is easy today to laugh at some of the eccentricities of overzealous health and safety measures. Such overzealousness, which rarely results from a professional inspector, is indeed something we must tackle; health and safety is too important to be rendered a laughing stock. A couple of generations ago the image of ashen-faced families gathered for news at the gates of the factory or mine in which there had been a major accident was part of our cultural folk memory. If we have allowed it to fade we have done so at our peril.

Less than 50 years ago children burned alive in blazing nightdresses. Less than 25 years ago people choked in the poisonous smoke of burning foam-filled furniture.

If these things are to remain only history we must be careful how far we go in calling for deregulation or in laughing at "health and safety".

The important thing we must keep in mind is the distinction between a safe society and a risk-averse society. In a safe society people who climb mountains use the proper equipment, train properly, check the weather, inform others of their route and support a mountain rescue service. In a risk-averse society people do not climb mountains. When regulation strays into risk-aversion we must step back. Ultimately a risk averse culture is an unsafe culture because people lose patience with it and then have no parameters for safe behaviour, it absorbs resources which are needed to create a safer and healthier world, it limits human growth, creates dependency, and leaves people unfitted to handle risks when there are no regulations to direct them, people concentrate on documenting risk avoidance rather than on tackling hazards and it asks too much of people and they fail so that absurdly excessive levels of precaution coexist with blatant danger.

But we must oppose the siren calls of those who would neglect the genuine advancement of safety.

Unsafe Products and rogue traders

Trading Standards have a responsibility to enforce a wide variety of both general and product-specific legislation in the area of product safety. Enforcement of this legislation is achieved both proactively and reactively.

Some examples of these activities and the outcomes achieved are provided below:

Table 6.2 Examples on Enforcement

Activity	Number 2012/13	Summary
Business advice requests	17	Local businesses seeking advice on how to ensure compliance with relevant product safety requirements
Consumer complaints	43	Investigation of complaints from local consumers which indicate potential breaches of product safety legislation
Referrals about local businesses	22	Referrals from other TS departments regarding potential contraventions of product safety legislation by businesses based in Stockport
Product safety samples	41	Samples taken as a result of inspections, complaints etc. to monitor compliance with relevant product safety requirements in relation to areas of emerging risk
Routine Inspections	29	Risk based inspection programme covering businesses who make, import or sell goods to which product safety legislation applies
Surveys	5	Local and regional surveys targeting areas where compliance issues have been identified through local/regional/national intelligence

Advice was provided to local businesses on ensuring compliance with relevant safety requirements in a number of areas, including cosmetic products, toys, electrical equipment and electronic cigarettes.

Following a referral from another trading standards department after a consumer complaint, a business in Stockport was raided and thousands of imported phone chargers and associated equipment were seized. Samples were taken and submitted for analysis, and many of the items failed the relevant safety tests. A criminal investigation has been undertaken, with a prosecution pending.

Joint visits with the fire service during Electrical Safety Week to premises selling second hand electrical equipment, advising on appropriate testing provisions and safety requirements prior to sale,

Working with the Police, Fire Service and Anti-Social Behaviour team during the fireworks season, ensuring compliance with relevant safety requirements;

A protocol was developed with the Fire Service whereby information pertaining to electrical fires which may have been caused by faulty/unsafe products is shared and acted upon.

Regional projects undertaken during 2012/13 included:

Magnets and projectiles in toys: Each Authority purchased samples for each of the criteria. All samples were then submitted for analysis against the relevant safety standards, which resulted in a number of products being removed from sale/recalled by the manufacturer. This information was then reported on a national database (Memex) to alert and inform other trading standards departments of the product safety issues found and areas of concern

Importer project: Documentary checks carried out on businesses importing goods subject to product safety legislation (such as toys, electrical equipment and cosmetic products) from outside the EU, to ensure that traders were complying with relevant requirements, such as maintaining technical files for each product etc.

Targeted enforcement activity including prosecutions has been undertaken in Stockport for approximately 10 years to prevent the sales of age restricted products such as alcohol, tobacco, knives and sunbed use. The annual survey of young people carried out by Trading Standards NW has indicated that in Stockport fewer of them now believe that shops in Stockport will sell to those underage.

There is a multiagency prevention and response service in Stockport to provide information within communities about rogue trader activities and to respond in cases where rogue traders may actually be targeting vulnerable people.

Health and Safety at Work *(note this section also appears in chapter 15)*

The Health and Safety Executive (HSE) and Local Authorities (Las) are the principal Enforcing Authorities (EAs) for Health and Safety at Work etc. Act 1974 (HSWA) in Great Britain. The primary purpose of the HSWA is to control risks from work activities. The role of the EAs is to ensure that

duty holders manage and control these risks and thus prevent harm to employees and to the public. Regulation activity is split between the two authorities dependent upon work premises type.

In Stockport such work is carried out by Environmental Health. Proactive Inspections are restricted to those activities and issues detailed in the National Local Authority Enforcement Code and are also carried out at premises where Intelligence or history suggests poor compliance. Inspections are undertaken at all skin piercing premises prior to allowing registration under the Local Government (Miscellaneous Provisions) Act 1982. Investigations are carried out in respect of all accidents that result in a fatality of an employee or member of the public, if as a result of a workplace activity. All accidents that result in a serious injury to an employee or member of the public are investigated. The section has two officers trained as Family Liaison Officers. They liaise with bereaved families and injured parties in order to keep them updated on the progress of any investigations. Advice to small and medium sized business is via the council website and the 'Health & Safety that Works' pack. Service requests and complaints about premises from other enforcement agencies are also responded to.

The Section has responsibility for administering the annual Safety Certificate at Edgeley Park Football Stadium. This involves an annual ground inspection, match day inspections, chairing the Safety

Advisory Group meetings, ensuring compliance with the safety certificate and giving advice to the club. It has also entered into a Primary Authority (PA) partnership with National Tyres and Viking International. As part of this partnership the team provides PA advice to the company and responds to health and safety referrals from other LAs.

The section continues to work with Greater Manchester Police Crime Reduction Advisors in order visit premises that have suffered robberies. A member of the team attends the Retail Violence meetings.

In 2009 the section targeted young people to raise the profile of health and safety to reduce accidents / dangerous incidents prior to them going on work experience. During the session the students participate in various activities to spot workplace hazards and learn about occupational diseases. Some of the dangers highlighted include hazards in the construction, office, care, retail, horticulture and catering industries. These roadshows are supported by local businesses and the Health and Safety Executive. To date some 2550 year 10 children have attended our roadshows. This project will continue in 2013/2014 on request from schools.

"Smoke Free" legislation is also enforced by both Environmental Health and Trading Standards. Recent action has been taken to address smoking in taxis.

Recent cases:

- A fatality at a climbing centre, which resulted in evidence being given at the coroner's inquest.
- Fatality involving a member of the public who fell from height in a church whilst volunteering. This resulted in evidence being gathered for the coroner.
- A successful prosecution of a major high street building society for exposing employees and members of the public to asbestos fibres during a refurbishment.

- A successful prosecution of a woodworking company that had failed to adequately guard dangerous machinery and had exposed employees to potentially hazardous sawdust.
- Two prohibitions served to prevent tattooists from operating without the appropriate sterilisation procedures and exposing members of the public to risk of infection from HIV & hepatitis.

Preventing Injuries and Crashes – What we Can All Do to Help *(Note- this section also appears in chapter 15)*

- don't drink and drive
- after drinking, allow one hour for each unit you have drunk before driving, using machinery or undertaking any other dangerous tasks requiring care. This will keep the number of units in the bloodstream of a person of average size and build below one unit which should be safe. If you want to be completely alcohol free allow an extra hour. Also allow extra time if you are significantly below average height and weight (this includes many women). Traditionally a unit is a small glass of wine, a pub measure of spirits, or half a pint of beer. However this was based on 125 ml glasses of wine, 9% abv wine and 3% abv beer. Many glasses are now larger than this and most drinks served today are stronger, sometimes much stronger, so these traditional guidelines can be dangerously misleading. Check the size of the glass and the strength of the drink and adjust. Remember that drinks described as "low alcohol" rather than "alcohol free" do contain some alcohol.
- drive at no more than 20mph on side roads. This will add no more than a couple of minutes to most journeys, since you rarely travel far before you join the main road, and yet it would save most child pedestrian deaths.
- wear seat belts in cars, and crash helmets on motor cycles
- give cyclists space when driving past them
- learn advanced driving techniques - they not only protect you and other people, but they make driving more enjoyable

- fit smoke alarms and test them weekly to make sure they are working properly
- think about the safety of toys, furniture and domestic equipment
- talk to your health visitor about preventing home accidents to toddlers
- always ask sales people about the safety features of the product. Not only will the message eventually get through if enough people do it, but it's fun watching their reactions.

3.7.   MENTAL ILLNESS
__The Prevalence and Causes of Mental Illness__

Lifetime prevalence

1 person in 4 will suffer from mental illness at some time in their lives.

Point prevalence

In Stockport it is estimated from general practice disease registers in 2012-13 that 22,949 people aged 18+ suffered from depression and anxiety and 2,303 people suffered from schizophrenia, bipolar disorder or other psychoses. Across Stockport 27,000-31,000 adults report having low mental wellbeing (12.2%).

Causes

It is sometimes said that mental illness is merely one end of a continuum in which all of us have some abnormal thoughts, some mixed emotions and some irrational behaviours and these are socially labelled mental illness when we fail to conceal them and they impact on our functioning in society or become distressing. However others dispute that, arguing that there are specific biological factors that cause defined illnesses. Yet a third school of thought believes that both the other statements are correct because they perceive defined biological factors as being responsible for all our irrational behaviours and beliefs – for example research has been published suggesting differences in brain structure between people who hold left wing political beliefs and people who hold right wing belief. Those who seek to present mental illness as merely a social phenomenon sometimes argue that this must be the case since social circumstances figure prominently in its causes. However that is just as true of heart disease.

Whatever the merits of these theoretical arguments, mental illness is an observable abnormal state which has an adverse impact on those who suffer from it, which can kill people (by means of suicide) and which can be treated, so I find it distinctly unhelpful to regard it as anything other than a set of illnesses and disabilities. This is no way detracting from recognising its social causes or recognising that disability is a social concept and that it is social organisation which determines how disabling any particular impairment is.

There is much debate about the contribution to the predisposition to mental illness made by genetics, chemicals, nutrition, and upbringing. There is also debate about how far the association with lower social class is a causal relationship (the effect of poverty and low status on risk of mental illness) and how far it is due to reverse causality (the effect of mental illness on achievement) – both undoubtedly contribute.

It is clear however that low levels of well-being increase the risk of mental illness, that stress can be a precipitating factor in an incident of mental illness, and that strong social networks help provide protection.

Physical activity reduces the incidence of depression.

Overview of Mental Health in Stockport

Numbers of people in contact with various tiers of health services and estimated numbers with mental health needs in the general population

Number of people dying from suicide and undetermined causes (2009-11) — **75**
Years of life lost (under age 75) 2009-11 — **1,900**
Estimated attempted suicides a year[i] — **700+**

Number of adults in Secondary Care Mental Health Services — **700**

Number of people treated in hospitals for mental and behavioural disorders as Primary Diagnosis (F00-F99)
(Individual patients between 1st April 2011 and 31st March 2012 – 52% with Pennine Care) — **861**
Due to psychoactive substance use (F10-F19) — **271**
Schizophrenic, mood and neurotic disorders (F20-F48) — **400**

Number of people attending Stepping Hill Hospital ED given a self-harm diagnosis (2011-12)[ii] — **537**

Number of people treated for common mental health problems (anxiety & depression) — **3,000**

People attending outpatients for psychiatric consultation (2011-12 1st attendance only)[iii] — **1,483**

Estimated number of people self-harming[iv] (aged over 11) — **2,055 – 4,045**
Hospital admissions for intentional self-harm (2011-12) — **673**
Hospital admissions for intentional self-harm – poisoning (2011-12) — **587**

Claimants of benefit for mental disorders (Nov-2011)[v] — **3,570**

People suffering from schizophrenia, bipolar disorder & other psychoses[vi] — **2,247**

People (18+) with below average mental wellbeing[vii] — **27,654**

Number of people suffering from depression (QoF Register 2011-12) — **32,588**

Number and total cost of anti-depressant drugs prescribed (2011-12) — **328,344 (£1,568,144)**

Total expenditure on mental health disorders (10-11 Programme budget) — **£53,250,000**

Prevention

Community Development –Promotes social support and social solidarity which protects mental health. Increasing community participation and promoting resilience is a central element of preventing mental illness.

Stress Reduction –Stress can precipitate mental ill health. Programmes of stress reduction should take place in workplaces and in local communities.

Promoting Well Being – People with low well-being are at risk of developing mental ill health so the well-being programmes described in chapter 14 are valuable in preventing mental illness.

Counselling and Therapy –Can help diminish the consequences of stress and emotional ill health but providing this on the NHS poses a potentially limitless demand.

Supporting Stigmatised Groups –Stigma is an important cause of stress.

Self-esteem – Promoting self-esteem is an important contribution.

Supporting Isolated Groups –Mental ill health is known to occur in isolated groups such as, carers and parents of young children without links outside the home. This is presumably because of lack of social support. Maintaining social contacts and reducing isolation is of central importance.

Raising the Human Spirit –Measures which make the borough more aesthetically attractive and create areas of tranquillity contribute to easing stress.

Arts for Health –This project fulfils a number of roles, two of which are relevant to mental health. It contributes to raising the human spirit and it provides a key staging post in helping people with mental illness raise their self-esteem and return to employment.

Destigmatising Mental Illness – People with mental illness are themselves stigmatised and this is a vicious circle which creates stresses that cause recurrence as well as obstructing rehabilitation.

Promoting Physical Activity – see chapter 12

A New Approach to Mental illness

In about the last third of the 20th century the treatment of mental illness went through a shift from being based in institutions to being more fully integrated with the rest of the health service and with more care in the community. Around the turn of the century it went through a further shift towards the wider use of psychological therapies. It now needs to go through yet another shift – towards fuller integration of mentally ill people into society.

From Prejudice to Acceptance and Integration

Despite the high proportion of the population who suffer from mental illness at some time in their life, and the way that it can be perceived as an exaggeration of normal character traits, there is a very considerable stigma attached to the various mental illnesses. The old Victorian idea that mentally ill people should pull themselves together, and if they can't do that they should be sent to

an asylum, dies hard. Few would articulate it or indeed believe it, but many would behave as if they believed it, which for the sufferer is as bad.

This stigma worsens the experience of mental illness and constitutes a stress which exacerbates it. It often prevents people with mental illness from participating in activities which might ease their problems – physical activity or social networking for example.

It is therefore essential that we should take steps to reduce this prejudice and stigma associated with mental illness. In a recent Parliamentary debate a number of MPs, including some leading figures from all parties, declared that they had suffered from mental illness. This was a significant and much valued example of leadership.

Terminology

It is often said that one way to destigmatise mental illness is to abandon the term and refer to "people with mental distress" or to "people with mental health support needs". However it can be argued that these alternative terms are not precise, that "mental illness" is not in itself a stigmatising term but acquires stigma only because of social attitudes to it, and that we need to confront negative attitudes to mental illness not attempt to sidestep them by adopting a different term. The thinking behind the proposed change is also focused on the idea that we are dealing with a socially-created element of a continuum of normality, rather than an illness, although as I argued earlier this could be said just as much about many physical illnesses. A further argument for change is that the concept of illness implies lack of normality – this is a valid point but the concept of illness also has implications of a right to seek help and not be blamed and it can therefore be a supportive concept.

I find this a difficult debate. It is not helpful to abandon the concept of mental illness as a specific set of abnormalities and disabilities which are open to prevention, to epidemiological analysis and to treatment. However it would be helpful to find a way to combine that concept with one that emphasises the importance of avoiding stigma and prejudice and bringing about social change. A public health model of illness emphasises social and ecological causes of illness and the need for a social model of disability in dealing with their consequences. Such a model is no threat to a social model of mental health. However it seems that in the field of mental illness the concept of illness has become associated in many people's minds with a clinical model that neglects social causes and social consequences. It is not surprising therefore that there is a reaction to the very term "illness" but the danger is that imprecision may result.

Employment

Employment is of value to mentally ill people as a source of status, of social networking and of structure to the day. Often lack of employment creates needs for day care. It is unfortunate therefore that the stigma of mental illness extends very much to employment and creates high unemployment rates amongst mentally ill people.

Mental illness is a disability and its sufferers benefit from the Disability Discrimination Act. However much more help and support into work is needed if this right is to become a reality.

Coproduction

Coproduction is a method of organising services which allows users to participate in their design with a view to structuring them around supporting that individual in living as independently as possible.

Coproduction embodies a new relationship in the design and delivery of services, emphasising that the patients and people in the system are assets who can be enabled to support the recovery of their peers if their value is recognised. Reciprocity, the giving back to others, is so crucial for positive health and wellbeing and generates a win-win situation where both peer mentor and service user benefit. As well as creating this added value through peer support networks, coproduction stresses that more can be gained through collaboration than a more traditional clinician/patient (dependent and passive) relationship or indeed commissioner/provider (driven by competition and cost) relationship. What is crucial is the creation of resilient, mutually supportive communities in which people who experience mental distress can play a full part, defined by what they contribute rather than by their mental illness label.

Integral to coproduction is the involvement of the community in addressing issues of stigma and prejudice. This can be made part of a process of creating resilient mutually supportive communities and this would bring the issues of mental illness and mental well-being together into a truly comprehensive mental health process.

Suicide & Self Harm

Suicide

There were 75 deaths of Stockport residents due to suicide and undetermined intent in the three years 2009-11 The groups with the highest rates were young (20-34 years) and middle aged men (35-59 years) particularly living in deprived areas. Risk factors for suicide include: being male, unemployment, living alone, having a mental health problem and experiencing a recent significant life event, such as bereavement.

Figure 7.1 shows the mortality trends for the last twenty years, because of the low numbers of deaths and the impact of coroner's inquest timings the rates in Stockport fluctuate, but on the whole are lower than both the regional and national average. There is however no significant downward trend observable in Stockport, although national and regional rates appear to be reducing.

The most effective way to reduce suicides will be to improve mental health. We need a programme of work which plans accordingly. A multidisciplinary suicide prevention strategy for Stockport has been developed and is being implemented.

Figures 7.1 trends in mortality rates from suicide and deaths of undetermined intent

Trends in mortality rates for suicide and deaths of undetermined Intent

Legend: Stockport Rate — North West Rate* — England & Wales Rate* — Our Healthier Nation target for 2010

Y-axis: Mortality per 100,000 (3 year average)

X-axis: Three Year Period — 89/91, 90/92, 91/93, 92/94, 93/95, 94/96, 95/97, 96/98, 97/99, 98/00, 99/01, 00/02, 01/03, 02/04, 03/05, 04/06, 05/07, 06/08, 07/09, 08/10, 09/11

Sources: Department of Health: Compendium of Clinical and Health Indicators; Stockport PCT

Suicide in People Suffering from Mental Illness

Suicide in people suffering from mental illness is a mode of death which it may not always be possible to avoid. Sometimes, paradoxically, it occurs when recovery commences and people regain enough motivation to carry out the process of killing themselves.

Suicide in people suffering from mental illness needs to be addressed partly by measures to reduce the incidence of mental illness and partly by a programme of work aimed at improving the detection and prevention of suicide risk.

Self-harm

725 Stockport residents a year are admitted as an inpatient due to self-harm but this is the tip of an iceberg, more may attend other emergency or primary care services it is estimated that between 2,000 and 4,000 people a year self-harm

Parasuicide

It is important not to confuse suicide with parasuicide - self harm which looks as if it is intended to kill but which in fact is often a cry for help. Sometimes parasuicide goes too far and the person unintentionally "succeeds" in a "suicide attempt" which was intended to fail. This is only a very small proportion of parasuicides but as there are far more parasuicides than suicides (over 700 a year) so it represents a significant proportion of successful suicides.

One of the commonest methods of unintentionally successful parasuicide is paracetamol poisoning, where people are not aware of the liver damage that occurs a few days after the overdose.

If parasuicide were logical then more widespread knowledge about late effects of paracetamol poisoning might reduce these accidents. Unfortunately, the emotional turmoil that surrounds parasuicide is often such that the intention to fail in the attempt may be subconscious and conflicting trends of thought may lead people to go as close as possible to success in order to make the attempt more realistic - so if the danger of paracetamol were more widely known it may be seen as a particularly effective cry for help, but people may misjudge how much they could safely take. Ideally methionine, which prevents the liver damage, would be added to paracetamol tablets but this would raise the cost of a very common and useful medicine often bought over the counter.

Successful parasuicides can be reduced by reducing the availability of modes of parasuicide which carry a prospect of success so that instead people use safer methods. The replacement of coal gas by natural gas and the replacement of barbiturates by safer drugs both had this effect.

The beneficial effect of war on suicide rates – a case for social solidarity?

Social solidarity may reduce suicide. Suicides fell dramatically in both World Wars and have increased in Northern Ireland since the development of peace. The explanation often advanced for this is that periods of war or crisis induce social solidarity. If this is the case then other measures which induce social solidarity may also have the same effect. Our community development strategy may therefore reduce suicides. But what is the essence of this "social solidarity". Is it just sense of community and belonging, circles of support, having purpose and hope, usefulness and self-esteem, the strengthening of resilience from being part of a caring and mutually supportive network, all of them well-recognised and achievable contributors to mental well-being? Or is it also the sense of shared adversity in a co-ordinated effort to achieve a dangerous shared overriding communal priority – this would be much less easy to create in normal circumstances. Indeed is the observation of low suicide rates in war associated with social conditions at all. There are other possible explanations for the relationship between war and low suicide rates. For example, war offers other more socially acceptable (even socially honoured) opportunities for self-destruction.

Inexplicable single person accidents

Just as some cries for help masquerade as suicide, so some suicides are so carefully concealed that they appear to be accidents.

3.8. MUSCULOSKELETAL DISEASE

There is no additional material at level 3 in this chapter.

3.9.   HYPERTENSION

Hypertension is a persistently raised blood pressure.

Blood pressure goes up temporarily in exercise and under stress and this is perfectly normal. It is when it happens persistently that it is a serious health problem.

It is a serious health problem because it can damage blood vessels and thereby damage important organs such as the heart. It also considerably increases the risk of stroke.

Hypertension can be caused by kidney disease, various other diseases, high salt intake or persistent stress. It can also occur without apparent cause.

Hypertension is treatable but unfortunately it is often without symptoms and people can have it, and be damaged by it, without realising it.

It used to be said that only a third of people with high blood pressure knew that they suffer from it and that only a third of those were adequately treated. Much effort has been put in, especially by general practitioners, to ensure that this bleak statistic is improved. People are now screened for hypertension at health checks and opportunistically at visits to their GP. As a result things are now much better with far more cases of hypertension being recognised and the blood pressure successfully controlled.

There are still however a lot of people who slip through the net.

It is important that we continue to pursue the early diagnosis of hypertension vigorously.

The following is an extract from the slide set prepared by NICE:

Hypertension is common in the UK population.

Prevalence is influenced by age and lifestyle factors.

25% of the adult population in the UK have hypertension.

50% of those over 60 years have hypertension.

With an ageing population, the prevalence of hypertension and requirement for treatment will continue to increase.

High Blood Pressure is a major risk factor for stroke, myocardial infarction, heart failure, chronic kidney disease, cognitive decline and premature death.

Untreated hypertension can cause vascular and renal damage leading to a treatment-resistant state.

Each 2 mmHg rise in systolic blood pressure associated with increased risk of mortality: 7% from heart disease, 10% from stroke.

How big is the problem?

CVD accounts for 20% of Stockport deaths under 75 years and 33% over 75 years. These have fallen from 37% and 49% in 1995.

Overall, the prevalence of hypertension in the UK is estimated as 32% in men and 27% in women over 35 years increasing from 33% aged 45/54 to 73% aged 75+ in men from 25% to 64% in women.[2]

17% Stockport population have treated hypertension (compared with 11.3% nationally)

Recent data from the Framingham Heart Study suggest that individuals who are normotensive at age 55 have a 90% lifetime risk of developing hypertension

The relationship between BP and risk of CVD events is continuous, consistent, and independent of other risk factors.

The higher the BP, the greater is the chance of heart attack, heart failure, stroke, and kidney disease. For individuals 40–70 years of age, each increment of 20 mmHg in systolic BP (SBP) or 10 mmHg in diastolic BP (DBP) doubles the risk of CVD across the entire BP range from 115/75 to 185/115 mmHg

http://www.nhlbi.nih.gov/guidelines/hypertension/

How cost effective is treatment?

NICE analysis found that treating hypertension is highly cost-effective resulting in improved health outcomes (higher QALYs)

And with all of the (low cost generic) drug classes in the model actually resulted in overall cost savings compared to no treatment as the reduction in cardiovascular events led to savings that offsets the relatively low cost of antihypertensive medication

In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence averaging 35–40%; myocardial infarction, 20–25%; and heart failure, more than 50%

It is estimated that in patients with stage 1 hypertension (SBP 140–159 mmHg and/or DBP 90–99 mmHg) and additional cardiovascular risk factors, achieving a sustained 12 mmHg reduction in SBP over 10 years will prevent

1 death for every 11 patients treated.

In the presence of CVD or target organ damage, only 9 patients would require such BP reduction to prevent a death

http://www.nhlbi.nih.gov/guidelines/hypertension/

What can people do to help themselves?

Table 9.1: lifestyle Modifications

Lifestyle Modifications to Manage Hypertension*†

Modification	Recommendation	Approximate SBP Reduction (Range)
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m²).	5–20 mm Hg/10 kg weight loss[1,2]
Adopt DASH eating plan	Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat.	8–14 mm Hg[3,4]
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).	2–8 mm Hg[3,5]
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week).	4–9 mm Hg[6,7]
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks (1 oz or 30 mL ethanol; e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men and to no more than 1 drink per day in women and lighter weight persons.	2–4 mm Hg[8]

DASH, Dietary Approaches to Stop Hypertension.

* For overall cardiovascular risk reduction, stop smoking.

† The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.

What can Government do?

The following is an extract from the World Health organisation's report for World hypertension day, 2013

10 "best buys" - highly cost-effective, culturally acceptable, easy

Smoke-free workplaces and public places; warnings about the dangers of tobacco; comprehensive bans on tobacco advertising, promotion and sponsorship; raising excise taxes on tobacco and alcohol; restricting access to retail alcohol; enforcing bans on alcohol advertising; reducing salt and sugar content in packaged and prepared foods and drinks; replacing trans-fats with unsaturated fat in food; promoting public awareness about diet and physical activity through education and consumer information (including through mass media)

Other interventions thought to be effective, but slightly less cost-efficient, are referred to as "good buys":

Nicotine dependency treatment; enforcing drink–driving laws; promotion of adequate breastfeeding and complementary feeding; restrictions on the marketing of foods and beverages that are high in salt, fats, and sugar –especially to children; introduction of food taxes and subsidies to promote a healthy diet

What can health professionals do?

Promote healthy food and alcohol consumption and physical activity

Consistent messages - working with public health and communities

Systematically identify and effectively treat people with hypertension

In January 2014, the CCG intends to run a campaign to encourage the 11884 Stockport patients over 45 years who don't have a blood pressure recorded, to check their blood pressure: 'I know my numbers, do you?'. This will be run alongside a number of initiatives aimed at getting people more active.

3.10. SMOKING

Tobacco remains the main cause of preventable morbidity and premature death in England and Stockport. Beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and health inequalities. Smoking is the biggest cause of premature death and a major factor to the mortality divide between the most disadvantaged areas and affluent areas in Stockport.

Tobacco is the only lawful drug of addiction. The majority of smokers want to stop smoking but find this difficult. Typically people become addicted to tobacco whilst they are still at school and whilst they are under legal age for purchase, which is now 18, and then face a lifelong addiction. Were it not for the large number of addicts spread throughout all sectors of society there is little doubt that tobacco would be banned along with heroin and cocaine. Certainly it is every bit as addictive.

Tobacco is the only lawful product that kills people who use it in the way it is intended to be used. The only difference between smoking and playing Russian roulette is the delayed effect. A recent comprehensive Australia study has shown that smoking is directly linked to 2/3 of deaths in current smokers and cuts 10 years of life off the average smoker [1.] This is much higher than previous international estimates of 50% of deaths of smokers.

The cost of smoking to Stockport as a borough is considerable. Action for Smoking on Health estimate that the total cost is £78.9 million, the costs to the NHS alone being £15.5 million. It is estimated that Stockport residents spend £84.5 million on tobacco products, a cost that falls disproportionately on the most disadvantaged households. Poorer smokers proportionately spend five times as much of their weekly household budget on smoking than do richer smokers (Based on 2009 prices). A very low income smoker earning £10,000 and smoking one pack of 20 cigarettes a day will spend up to 27% of their net income.

Smoking prevalence data

Various data sources suggest that the prevalence of smoking in the borough is around 18-20%. Data sources which enable trend analysis suggest that the smoking prevalence rate in Stockport is falling – however in more recent years there is no evidence that it is falling in our most deprived areas.

Data from Stockport Adult Lifestyle Survey: 2012 Stockport's Adult Lifestyle Survey data is analysed by 2007 National IMD Quintile based on respondent's postcodes. Deprivation is closely linked with smoking rates with a steep in smoking rates in more deprived areas. People in the two most deprived quintiles are significantly more likely to smoke, and those in the two least deprived are significantly less likely to smoke.

Table 10.1 Smoking and Deprivation			
2007 National IMD Quintile	2012 Current smokers	2009 Current smokers*	2006 Current smokers
1 –most deprived	30.9%	29.5%	26.7%
2	21.3%	22.7%	18.9%
3	16.3%	17.0%	14.1%
4	12.2%	12.3%	14.0%
5 – least deprived	8.1%	8.3%	9.5%

*Note: 11.6% of responses in 2009 did not have postcodes so care should be given to interpretation

Data from Stockpot Health Record (SHR): This is a local system of querying GP practice held records for all but one Stockport GP practice; trend analysis is not yet possible.

Table 10.2 Smoking prevalence Age 15+ at Stockport GP Practices			
	10th May 2013	**3rd Jan 2013**	**16th Oct 2012**
Quintile of Deprivation	**Current smoker**	**Current smoker**	**Current smoker**
Most deprived 0-20%	35.1%	34.9%	34.6%
Second most deprived 20-40%	25.4%	24.9%	24.7%
Mid deprived 40-60%	18.8%	18.7%	18.6%
Second least deprived 60-80%	13.7%	13.6%	13.6%
Least deprived 80-100%	10.5%	10.1%	10.5%
Non Stockport	18.0%	17.0%	16.8%
Total	18.7%	18.3%	18.1%
Total Stockport residents	18.7%	18.4%	18.1%

Smoking Demographic

Nationally some 2/3 of current and ex smokers started smoking before they were 18 with 39% saying they started regularly before their 16th birthday.

Smoking prevalence is higher in certain groups:

- Routine and Manual workers
- Some Black and Ethnic groups
- People with a mental illness and addictions
- Prisoners

Sir Michael Marmot in his independent review of Health Inequalities in England in 2010 Fair Society Healthy Lives made the following recommendation

"Tobacco Control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income group. Smoking–related death rates are two to three times higher in low income groups than in wealthier groups" [2]

Wanless and NICE have also stated that reducing smoking prevalence in routine and manual groups will help reduce Health Inequalities more than any other public health measure

Stockport is the 3rd most polarised area in England in terms of Health Inequalities

Nationally some 2/3 of current smokers say they want to quit smoking with ¾ reporting they have attempted to quit smoking. On average smokers who die from a smoking-related illness lose around 16 years of life.

Nicotine is highly addictive; many people find quitting to be highly challenging. For the large majority of people quitting successfully can take many attempts. Levels of nicotine dependence vary with smokers from less affluent backgrounds smoking more and taking in more nicotine from the tobacco they smoke which means that people from less affluent backgrounds are less successful in quitting. [3]

In many disadvantaged areas smoking is perceived as the norm and is a habit that is copied by younger generations.

According to Dorsett's and Marsh's research on smoking and poverty high smoking prevalence and low quit rates are an effect of the socio-economic "poverty trap" that can be only addressed by a fundamental shift in income,[4] (Marmot has also stated that people at the lower end of the social spectrum are not listening to these messages because of the continued social inequalities. *It's not because they haven't heard or don't know that smoking is bad for you, it is because on their list of priorities, giving up smoking is way down and they have to turn their attention to more immediate matters* [5])

The Economic Downturn and Quitting Smoking

Paradoxically despite the rising cost of smoking the rate of quitting slowed down when recession hit the UK economy. Therefore the current challenging economic times, which are particularly being experienced by residents in our disadvantaged areas, may actually result in people being less motivated to quit. There is evidence emerging however that attempts to quit smoking have risen in the past year; this is being attributed due to the surge in popularity of E cigs as a quitting aid.

Professor Robert West, director of tobacco studies at the Cancer Research UK Health Behaviour Research Centre, has said "*While no-one can be sure about the cause and effect with data of this kind, this could be another very damaging impact of the financial crisis. Obviously we can only guess at a link, but we know that when people are under stress and have bad things going on in their lives they shorten their horizons and focus on getting through, day to day. "They don't have the mental energy to focus on doing things that are hard, like quitting smoking."* [6]

Action to impact on smoking prevalence therefore demands attention on the wider determinants of health, including in investing in community development to build resilience in communities not just merely funding stop smoking services. Tackling the circumstances in which people live by creating an environment which discourages uptake of smoking in the first place is therefore of paramount importance.

Tobacco control

The need for a comprehensive, multi stranded and sustained programme of tobacco control was recognised in the WHO Framework Convention on Tobacco control which was published in 2003. WHO has developed the MPOWER package of measures

- **M**onitor Tobacco use and prevention policies
- **P**rotect people from Tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising, promotion and sponsorship

- **R**aise taxes on tobacco and clamp down on illicit supplies

As a signatory to the Framework on Tobacco Control, the UK Government has reflected these measures in recent Tobacco Control Strategies These being

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second hand smoke
- Effective communications for tobacco control.

The Coalition Government published its Tobacco Control Plan for England in March 2011. In its strategy the Government acknowledges that smoking prevalence has fallen little since 2007 and that new action is needed to drive smoking rates down further and that tackling tobacco use is central to realising the Government's commitment to improve the health of the poorest fastest.

The strategy has 3 main ambitions

- To reduce the adult (aged 18 or over) smoking prevalence in England to18.5% or less by end of 2015.
- To reduce rates of regular smoking amongst 15 year olds in England to 12% or less by end of 2015.
- To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

The Government states that these ambitions will not translate into centrally driven targets for local authorities but local authorities, who now have the responsibility for leading local action to reduce smoking prevalence, will decide on their own priorities.

In January 2012 the Department of Health published 'Improving outcomes and supporting transparency–A public health outcome framework for England 2013-2016; three of the outcomes are related to smoking.

- Smoking prevalence in adults (over18)
- Smoking status at time of delivery
- Smoking prevalence rate amongst young people – to be measured amongst 15 year olds

Such is the importance of reducing tobacco prevalence to health of the population smoking is the only health behaviour which remains as a single issue health behaviour campaign by the Government and commands a separate marketing strategy. The importance of well-resourced national campaigns has been illustrated by the fall in quit attempts when the Government withdrew funding for a while. Funding was reinstated however there was a net fall in central funding for SmokeFree marketing from £15 million to £13.1M in the last financial year.

The Stoptober campaign was first run in 2012 and was reportedly very successful resulting in 160,000 people attempting to quit smoking for Stoptober. The campaign was repeated in Autumn

2013 with around a ¼ million attempting to quit. In Stockport around 1200 residents attempted to quit for Stoptober 2013, this was 2nd highest participation rate in Greater Manchester

What is the Evidence for what works?

In relation to Tobacco, there is a whole raft of NICE Guidance

Public Health Guidance No.1:Briefinterventions and referral for smoking cessation in primary care and other settings

Public Health GuidanceNo.5:Workplace interventions to promote smoking cessation

Public Health GuidanceNo.10:Smoking Cessation Services

Public HealthGuidanceNo.15:Identifying and supporting people most at risk of dying prematurely

Public Health Guidance No.14 Preventing the uptake of smoking by children and young people

Public Health Guidance No 23 School based Interventions to prevent smoking

Public Health Guidance No 26 Quitting Smoking in Pregnancy and Following Childbirth

Public Health Guidance No 39 Smokeless Tobacco Cessation

Public Health Guidance No 45 Tobacco Harm Reduction

Public Health Guidance no 48 Smoking Cessation in acute, maternity and mental health services

The recommendations contained in all the NICE Guidance are too numerous to highlight in this report but the Council in its commissioning and strategic decisions relating to tobacco will have regard to NICE guidance.

Smoking Cessation and Harm reduction

The relatively low cost of the intervention in comparison to additional years of life or quality of life measures gained by stopping smoking make smoking cessation and prevention of uptake of smoking one of the most effective public health and clinical interventions for individuals and for the population as a whole.

Of most recent significance for the commissioning of stop smoking services is the NICE guidance on tobacco harm reduction. Although existing evidence is not clear about the health benefits of smoking reduction, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products.

NICE recommend that for those smokers who do not want, or are not able or not ready, to stop smoking in one step they should be offered a harm reduction approach, with licenced Nicotine Replacement Therapy being used as a complete or partial substitute for tobacco either in the short or long term. In a change to previous recommendations NICE recommend that Smokers should be reassured that it is better to use these products and reduce the amount they smoke than to continue smoking at their current level.

Implementation of this guidance is likely to have an effect on prescribing costs however NICE have determined that the benefits outweigh the costs. A revision of existing pathways, training   and communications will be required to implement the guidance.

The Rise of the Electronic Cigarette- the next great public health gain or the next disaster?

Anecdotal evidence suggests that recently the numbers of people seeking smoking cessation support it has fallen. One theory being put forward is that this is due to the rise of the E Cigarette which is being marketed heavily. E Cigarettes act as Nicotine delivery devices. It has been reported that in the UK, 25% of all quit attempts are now made using e-cigarettes, making it the most popular quitting aid [7]. Action for Smoking on Health estimates that there are currently 1.3 million E-Cig Users in the UK. [8] At present E Cig s are not regulated. The Medicine and HealthCare Products Regulatory Agency (MHRA) has determined that they should be licenced as a medicine from 2016. There is a considerable debate amongst the medical profession on the merits of e cigarettes. Some argue that they could have a significant   harm reduction effect but others believe that they may sustain peoples smoking habit as they become dual users of the e cigarette and tobacco. There is also concern that they may become a gateway product to nicotine addiction, if taken up by young people, although there is no evidence that this is happening as yet.

The widespread use of e-cigarettes may undermine the denormalisation of smoking which is crucial to achieving a reduction in prevalence. There is a concern that the similarity to real cigarettes will create difficulties in enforcing the smoke free public places legislation, as the act of smoking an E Cigarette is difficult to distinguish from real smoking. This has led to many employers introducing policies not to permit them on their premises.

The tobacco industry is moving into the e cigarette manufacturing and distribution market, raising the ethical dilemma of whether we recommend products produced by a manufacturer who also profits from the sale of cigarettes. At present we are unable to recommend the use of e cigarettes as we do not know what they contain as they are not properly regulated. The MHRA state however that the current evidence is that electronic cigarettes have shown promise in helping smokers quit tobacco but that the quality of such unlicensed nicotine-containing products is such that they cannot be recommended for use at present.

E cigarettes do carry a risk of lipoid pneumonia.

Work by ASH has shown that under a third of e cigarette users are using them exclusively and more than twice as many users mix the use of e cigarettes with the continued use of cigarettes. This deepens fear that the use of e cigarettes will normalise and stabilise tobacco use rather than serve exclusively as a replacement. Out of about 1.2 million e cigarette users only 400,000 were using them as a total replacement for cigarettes and 55,000 were new users who had never previously used cigarettes.

Young people

The highest rates of smoking are among young adults. Around 26% of people in England aged 16-24 smoked in 2009. This is reflected locally, data from the Stockport Adult Lifestyle Survey (2012) indicated that 22.9% of 18-24yr olds were smokers.

Rates of smoking among children overall have continued to reduce (4% of secondary age Pupils 11-15 were categorised as regular smokers in 2012 compared to 13% in 1996.[9]This is also reflected locally, according to data from the Trading Standards NW survey, in 2009 11% of Stockport's young people aged 14-17 claimed to be smokers compared to 19% in 2009.

Every year an estimated 330,000 young people under the age of 16 try smoking for the first time. The continued initiation of young people into smoking is of great concern, as there is evidence that, although young people are less likely to start to smoke than previous generations, these smokers are subsequently less likely to give up. In recent years the Government have taken forward a number of initiatives to tackle the take up of smoking in young people e.g. increasing the age at which young people can buy tobacco from 16 to 18, stopping the sale of tobacco from vending machines, prohibiting the display of tobacco in large shops (to be implemented to other shops from 2015). It is however deeply regrettable that the current Government caved in to lobbying from the Tobacco Industry on the matter of **standardised packaging for cigarette**. Support for this proposal was strong amongst the major agencies in Stockport with the Council, Primary Care Trust, Stockport Link, the Shadow CCG and Children's Health Board supporting such a move. The recent announcement to review the evidence is welcome however we believe the evidence to be strong enough to warrant immediate implementation.

Smoking is dangerous at any age, but the younger people start, the more likely they are to smoke for longer and to die earlier from smoking. Those who start smoking at the youngest ages are more likely to smoke heavily and find it harder to give up. These smokers are at the greatest risk of developing smoking related diseases. Someone who starts smoking at 15 years is 3 times more likely to die of cancer due to smoking than someone who starts in their mid-20s.

Prevention of uptake of smoking in Children and Young People

NICE guidance on mass-media and point of sales measures was published in 2008 and recommends:

- Develop national, regional or local mass media campaigns to prevent the uptake of smoking among young people under 18
- Use a range of strategies as part of any campaign to reduce the attractiveness of tobacco and contribute to changing society's attitude towards tobacco use, so that smoking is not considered the norm by any group
- Ensure retailers comply with legislation prohibiting under-age tobacco sales
- Make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products
- NICE guidance on **school based interventions was published in 2010**. It recommends
- Whole-school or organizational wide smoke free policy
- Adult led interventions- integrate information about the health effects of tobacco into the curriculum, deliver interventions to prevent the uptakes as part of PSHE and activities related to Healthy Schools status etc.
- Consider offering evidence based peer led interventions
- Provide training for staff

- Ensure smoking prevention interventions in schools and other educational establishments are part of a local tobacco control strategy

Smoking in Pregnancy

Smoking in pregnancy is a priority area for Stockport; although (at 12.6% in 2012/13) smoking rates are lower in this group than in the population in general, the North West average (16.4%), and, this year, the national average (12.7%); the data still show a variable state rather than an improving trend. Smoking in pregnancy is a priority area for action and a more detailed commentary s available.

Nice Guidance on Quitting smoking in pregnancy and following childbirth was published in 2010 amongst its recommendations is to identify pregnant women who smoke and referring them to NHS Stop Smoking Services and assessing the woman's exposure to tobacco smoke through discussion and use of a CO test. Work continues with Stockport (NHS) Foundation T rust to ensure smoking cessation is embedded as a priority objective in contacts with pregnant women.

Local Tobacco Control strategy

The movement of public health to the Council has given us an opportunity to take stock as to how the borough is doing in relation to tobacco control. To this end the Council is taking part in the CLEAR assessment process developed by ASH (Action for Smoking on Health). The internal process has now been completed and an external verification process of the scores is to be undertaken early in 2014. There are strong regional and Greater Manchester tobacco networks which collaborate for Tobacco control initiatives and allow the sharing of good practice. Tobacco Free Futures, an organisation financially supported by northwest local authorities is an invaluable source of support and advice to local areas.

Action

We will seriously consider forthcoming recommendations from the external CLEAR assessment

We continue to promote compliance with tobacco legislation, for example by protecting the funding of activities carried out by Environmental Health and Trading Standards to stop under age sales of tobacco, ensuring compliance around displays and vending machines, enforcement of smoke free legislation and reducing the availability of illicit tobacco.

I have recommended Include the reduction of illicit tobacco as an objective in the Safe r Stockport Partnership Strategy

We continue to provide training and refresher sessions on Brief Interventions, particularly to frontline staff, ensuring that 'every contact counts".

We will continue to provide local stop smoking services in ways that maximise accessibility to smokers in disadvantaged areas of the borough.

We encourage local people to make their homes and cars smoke free

I have recommended consider implementing a voluntary code of smoke free play areas in parks in order to assist the de-normalisation of smoking

I have recommended that local politicians advocate for standardised plain packaging and engages with the Government on this matter

The GMPF has reduced its holdings in tobacco companies to be the lowest of any local government pension fund and has no direct equity investment. I trust that it will continue to review this issue and

That the Council adopts the Local Government Declaration on Tobacco Control

Encourage the Government to invest more heavily in comprehensive tobacco control as they have done in California which has shown dramatic drops in prevalence and youth uptake

Key Messages

Tackling smoking is the single most effective thing we can do to improve health in Stockport and tackle health inequalities

A multi-faceted tobacco control plan is necessary to tackle tobacco prevalence

The total cost to the NHS of smoking in Stockport is £15.5 million (ASH estimate)

At least 1 in 2 current smokers will die of a smoking related disease ,latest research suggest that this could be even higher around 2/3

Around a fifth of adults in Stockport are still smoking

Deaths from smoking are more numerous that the six next most common causes of preventable death and accounts for around 500 deaths in Stockport

Smoking prevalence is over 3x greater in our most disadvantaged than our affluent areas

Smoking in pregnancy is a priority for action. In 2012/3 Around 13% mothers smoke at the time of delivery this is close to the national average

Although Stockport has one of the lower smoking rates in Greater Manchester, the deprivation profile is steeper than in other boroughs

An estimated £84.5 million is spent on tobacco products by Stockport Residents

Tobacco is a significant factor in helping perpetuate poverty in our most disadvantaged areas with a significant amount of household income been spent on supporting the habit

Smokers need to be given the support to quit and must not be demonised for their addiction

Smoking cessation services are one of the most cost effective and evidence based health interventions – when we support people to quit we are not only saving (often the most disadvantaged) households money we are reducing the future demand on Health and Social Care services, reducing the costs on business due to reduced absenteeism and diverting money otherwise spent on tobacco into the local economy.

In tackling high smoking rates in our disadvantaged communities we need to consider additional support we can give, by supporting community initiatives to challenge the social norms of smoking by tackling the social and cultural determinants

Brief interventions are an effective way of encouraging people to attempt to quit

Tackling smoking needs commitment of Government to bring in appropriate legislation such as standardised packaging

1. Sax Institute (2013) 45 and up study https://www.saxinstitute.org.au/media/even-light-smokers-have-double-risk-of-early-death-australian-first-research-reveals/

2. Marmot (2010) Fair Society Healthy Lives
http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

3. DH 2011 Healthy Lives, Healthy People A Tobacco Control Plan for England
https://www.gov.uk/government/publications/the-tobacco-control-plan-for-England

4 . Dorsett, R., Marsh, A. (1998) The Health Trap: poverty, smoking and lone parenthood, (PSI research report 855). London: Policy Studies Institute.

5 Daily Telegraph 23rd June 2007 Poor People Ignore Health Campaigns
http://www.telegraph.co.uk/news/uknews/1555427/Poor-people-ignore-health-campaigns.html

6 BBC News (9th November 2010) Fewer People Quit Smoking in a recession figures suggest
http://www.bbc.co.uk/news/health-11713514

7 BBC News Magazine (6th July 2013) Is a smoking alternative being choked by regulation
http://www.bbc.co.uk/news/magazine-23196369

8 Ash Briefing (June 2013) Electronic Cigarettes http://ash.org.uk/files/documents/ASH_715.pdf

9. HSIC Statistics on Smoking in England 2013 https://catalogue.ic.nhs.uk/publications/public-health/smoking/smok-eng-2013/smok-eng-2013-rep.pdf

3.11.   DIET

Poor nutrition causes at least a third of heart disease and cancer deaths and also contributes to obesity, hypertension, diabetes, bowel disorders, tooth decay, mental illness and osteoporosis and increases hospital costs by delaying recovery. Generally poor nutrition contributes to the inadequate social, physical and mental development of people of all ages. There is evidence that poor nutrition contributes to behaviour disorders and impairs learning.

A low fat, low sugar, low salt, high fibre diet contributes to the prevention of heart disease, stroke, diabetes, obesity and cancer. The low fat, low sugar, low salt, high fibre message is a constant and scientifically well-established message and must not be confused with transient scares.

It is important to eat food which is nutrient dense rather than simply energy dense but over the last few decades the tendency has been towards energy-rich food and, along with declining physical activity, this has caused the obesity epidemic.

There are lots of simple ways to eat a more healthy diet www.healthystockport.co.uk and www.nhs.uk/change4life are useful resources. Simple steps include:

- **Eat more fruit and vegetables**. Aim for **at least** 5 portions a day.
- **Eat a balanced diet** in line with the Eatwell plate http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx
- **Eat regular meals.** Try to eat 3 meals a day plus 2 healthy snacks. Don't skip breakfast, it's a really important meal which makes maintaining weight easier and helps you concentrate better.
- **Look out for red, amber and green on food labels** making it easier to choose food that is lower in total fat, saturated fat, sugar and salt. Choose more greens and ambers and fewer reds.
- **Eat less salt.** About three-quarters of the salt we eat comes from processed foods we buy.
- **Eat less saturated fat**. It tends to come from animal sources e.g. butter, ghee and lard. Switch to unsaturated fats e.g. vegetable oils, oily fish and avocados. Remove fat from meats. Avoid trans fats (which are often found in fried fast food).
- **Eat less sugar** – sugar has no nutritional benefit and too many sugary foods can lead to excess weight gain. Excess sugar can cause tooth decay especially if eaten between meals. Cut down on cakes, biscuits, sweets, chocolate and fizzy drinks.

Most people know what a healthy diet is, although some confusion is caused by food fads and food scares. There are a number of reasons why people do not eat a healthy diet despite this.

By nature, humans are hardwired to be attracted to fatty and sweet foods and to over eat during times of plenty - to enable our species to survive periods of hunger and scarcity, during pre-historic times. However this is no longer useful in times of abundant cheap food!.

The food industry is powerful and the government have been reluctant to challenge them. This leads to difficulty obtaining healthy processed foods, especially low salt processed foods. Processed food is important under the time pressures of modern life. Families are buying processed ready meals without realising they aren't as nutritious or filling as home cooked foods. Trans fats are a major

health problem but have not been banned. The healthy food lobby can't compete with the huge marketing budgets of supermarkets and processed food companies.

Food manufacturers claim the British like high salt food. They provide it entirely as a matter of taste and nothing whatsoever to do with salt being a bulking agent. Interestingly Australians are of similar cultural heritage and genetic stock, but less willing politely to eat what they are given even if it kills them, demand and obtain healthier versions of processed foods.

The inertia of eating patterns. Enjoying the cloying sweetness of sugar and cream can give way to the crunch and tang of fruit and fibre. Food you now enjoy seems oppressively salty after a few weeks of subtler flavours. However people don't realise how quickly their tastes will change and adjust.

Lack of cooking and shopping skills. This expertise is no longer being passed down the generations. What used to be taught in schools as part of Home Economics is being revived but to a lesser extent. We spend more time watching celebrity chefs on telly than cooking ourselves.

Eating patterns are different. Regular meal times are being eroded. 1 in 4 households no longer have a table that everyone can eat round together. We graze constantly, expanding waistlines. We cook less and eat out far more than we used to.

We have been persuaded by powerful adverts to treat and reward using high fat, sugar and salt (HFSS) foods. Using such foods as rewards for children maintains their desirability as treats for adults. In addition, these highly processed foods are heavily advertised, with billions of pounds a year being spent in the UK creating an image that appeals to young people, whilst fruit and vegetables are not advertised at all to this market.

The popularity of local seasonal foods has given way to the expectation that foods should be available all year round flown from around the globe. We are still not achieving 5 portions of fruit and veg a day, especially in poorer families. We have lost touch with what tasty food actually tastes like and unlike the French resent paying for quality. Finding the cheapest food has become the most important issue for most people, hence the growth of supermarkets and the demise of local specialist food shops.

Parents allow children to dictate what they eat. This has resulted in children eating a very narrow range of often predominantly unhealthy foods. Instead of eating the 'family meal' children are given special 'children's foods' which are the polar opposite of the guidelines on the Eatwell plate! High in fat, salt and sugar (HFSS) a processed diet is now the norm for many children which causes cravings for more of the same. Feeding our children healthy meals seems to be no longer a priority.

Healthy food is more expensive to obtain easily. It is certainly possible to construct cheap healthy diets but the easy way to change from a traditional English diet to a healthier diet is to substitute healthier (low sugar, low salt, low fat, higher fibre) versions of traditional food, add elements of a Mediterranean diet, especially garlic (and leisurely meals) and add at least five portions a day of fruit, vegetable and salad. This simple way to change diet costs more money and preparation time. Such food is less likely to be sold at all in corner shops and the cheaper supermarkets whilst turnover and shelf time lead to a higher price. The price differential between healthy and unhealthy food is least in out of town hypermarkets readily accessible only by car. Driving to the hypermarket, and

buying bulk freezer purchases, spreading the cost on your credit card, may not be an option if on a low income

If we are to address these cultural and economic factors we need action at national level to tackle farming, food manufacture and advertising. Locally we need to address issues of availability, of the quality of institutional food (including school meals, hospital meals and other food supplied by, or sold from the premises of, public bodies) and of cooking skills. Growing food in local communities or establishing food cooperatives, all have their place. There is evidence for the effectiveness of such local projects. There are several initiatives across the borough that aim to tackle this problem.

- **Local fruit and vegetable schemes** operate at a variety of venues within the deprived areas of the district
- **Cook and Taste courses** run in a variety of venues across Stockport in collaboration with local community workers and groups.
- **Eat Better Live Longer** courses for carers
- **Weaning sessions** for families run in Children's Centres
- **Healthy Snacks and Drinks Policy** in Early Help and Prevention children's centres
- **Sustainable Food Strategy**
- **HENRY (Health Exercise and Nutrition for the Really Young)** Evidence-based, positive parenting approach to obesity for parents with young children. Runs in children's centres
- **Food Nutrition and Health Team have been awarded** £80k **"Big Lottery" project funding for** healthy eating interventions and weight management courses in Stockport between May 2013 and March 2015 targeting low income areas.
- **Healthy Stockport Service** focus on improving quality of diet rather than just calorie cutting e.g. Exploring Weight Loss course for targeted overweight / obese patients

3.12.   PHYSICAL ACTIVITY

Benefits of Physical Activity

"The potential health benefits of physical activity are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'."

(Sir Liam Donaldson, Chief Medical Officer for England, March 2010)

However, the benefits of physical activity are wider than just impacting on health and wellbeing alone. Increased levels of physical activity can also have positive effects on the environment, social cohesion, urban regeneration, community safety & the economy.

Health & Well Being – Physical inactivity is the 4th leading cause of global mortality. In the UK it accounts for over 35 000 deaths per year and 3.1% of morbidity and mortality in the UK.

Recent evidence shows that physical activity significantly reduces the risk of developing a range of long-term health conditions affecting society today, including:

- major non-communicable disease, including coronary heart disease (CHD), hypertension, type 2 diabetes, chronic kidney disease and some cancers (colon, breast [post-menopause] and endometrium);
- stroke, peripheral vascular disease and cardiovascular disease (CVD) risk factors such as high blood pressure;
- musculoskeletal health conditions, including osteoporosis, back pain and osteoarthritis;
- depression, stress and anxiety;
- overweight and obesity.
- In the UK, it is estimated that physical inactivity causes:
- 10.5% of coronary heart disease cases
- 18.7% of colon cancer cases
- 17.9% of breast cancer cases
- 13.0% of type 2 diabetes cases
- 16.9% of premature all-cause mortality

Environment - Cycling and walking are environmentally friendly and can lead to a reduction in traffic congestion and pollution.

Social Cohesion -The social benefits and interaction of casual participation, joining a group or sports club are also important for strong communities, cohesive and inclusive relationships.

Urban Regeneration - The development of sports facilities, parks and open spaces can play an important role in enhancing the image of an area and improving the built environment as part of urban regeneration programmes.

Community Safety – The importance of physical activity and sport has become increasingly apparent in recent years in acting as a diversionary activity in reducing the levels of crime and disorder,

especially among young people who are recognised as the most significant group in terms of offending.

Economy - In 2006/2007, physical inactivity cost the NHS an estimated £0.9 billion. More recently, data from 2009/2010 demonstrates that physical inactivity cost the primary care trusts (PCT) in England in excess of £940 million

UK Physical Activity Guidelines

In 2011 the Chief Medical Officers for England, Scotland, Wales and Northern Ireland produced new physical activity guidelines for all ages. This was the first time UK guidelines included recommendations for children under 5 and for minimising sedentary behaviour:

EARLY YEARS (under 5s)

Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.

Pre-school age children capable of walking unaided should be physically active daily for at least 180 minutes, spread throughout the day.

All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

CHILDREN AND YOUNG PEOPLE (5-18 years)

Should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.

Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least 3 days a week.

Should minimise the amount of time spent being sedentary (sitting) for extended periods.

ADULTS (19-64 years)

Should aim to be active daily. Over a week, activity should add up to at least 150 minutes of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.

Should also undertake physical activity to improve muscle strength on at least 2 days a week.

Should minimise the amount of time spent being sedentary (sitting) for extended periods.

OLDER ADULTS (65+ years)

Any amount of physical activity has some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.

Should aim to be active daily. Over a week, activity should add up to at least 150 minutes of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.

Should also undertake physical activity to improve muscle strength on at least 2 days a week.

Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least 2 days a week.

Should minimise the amount of time spent being sedentary (sitting) for extended periods.

Integrating Physical Activity into Daily Life

Even if it is felt that time pressures do not allow a 15 or 30 minute window to dedicate to ride a bike, go for a swim or have a game of badminton, physical activity can still form part of a daily routine. If individuals are not ready to commit to a structured exercise program, physical activity should be a lifestyle choice rather than a single task.

Even very small activities can add up over the course of a day when approached in a positive way.

Physical activity in and around the home

- cleaning the house
- washing the car
- gardening
- sweeping/mopping the floor

Physical activity at work and on the go

- cycling or walking to an appointment rather than drive
- walking to the shops
- avoiding the lift and using the stairs
- walking to the bus stop then getting off one stop early
- parking at the back of the car park and walking into the shop or office
- taking a vigorous walk during the coffee break
- avoiding prolonged periods at the desk by taking regular short breaks to walk around
- having short meetings standing up
- standing up and moving around whilst making a phone call
- cutting back on e-mail and delivering the message in person

Physical activity with friends or family

- playing with the children
- walking the dog together as a family
- going for a family walk after dinner
- going to the park
- taking up an activity as a family
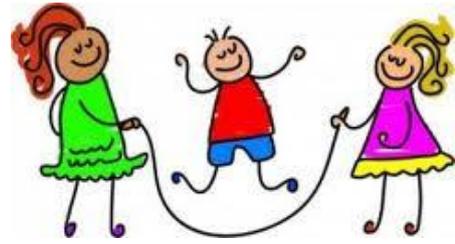
Physical activity while watching TV

- gently stretching while watching a favourite programme
- standing up during the commercial breaks
- watching TV while on the treadmill or stationary bike

Recreational Physical Activity

Recreational physical activity is pursued for enjoyment, is usually more purposeful and planned than play, but tends to be less organised than competitive sport. Nevertheless, some highly competitive sports are pursued as recreation, in which case the main motivation is taking part rather than to compete.

Many recreational activities require the movement of large muscle groups and can be aerobic, which improves cardiovascular health e.g. hiking, cycling, swimming, gardening and dancing.
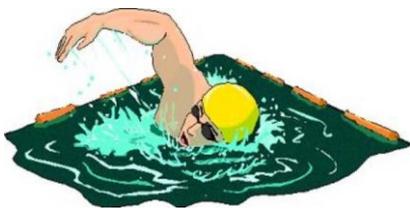
Physically active pastimes such as these are most beneficial if they are done routinely, and as well as promoting physical health, also play an important role in enhancing mental health and well-being by providing a buffer for stress and facilitating social interaction.

Recreational physical activity can be promoted by:

- ensuring opportunities for recreational exercise, through recreational footpaths, playing fields and open space, encouragement of sports clubs (especially community groups that may be attractive to the novice), promotion of walking, swimming, cycling and running
- specially organised activities to overcome barriers to recreational exercise e.g. women only swimming sessions
- encouraging mass participation events such as 'fun runs' or community bike rides
- building outdoor gyms in parks and open spaces
- the development of "green gyms" which provide opportunities for people to contribute to the environment through physically active voluntary work
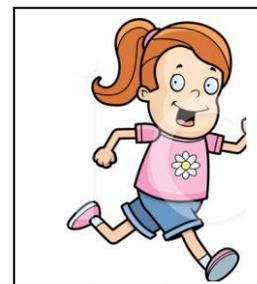
Currently, 71% of women (16+), 61% of men (16+), 76% of girls (2-15) and 68% of boys (2-15) in England do not meet the age relevant minimum physical activity recommendations. Opportunities to engage in high quality recreational physical activity can play an important role in increasing current levels of participation.

Physical Activity in Schools

It is widely accepted that children and young people today are less physically active than previous generations. In England 76% of girls (2-15) and 68% of boys (2-15) do not currently meet the minimum physical activity recommendations for children. Across the UK, boys are more likely than girls to be active at most ages Physical activity declines with age in both sexes, more steeply in girls.

The health and wider benefits of physical activity have long been recognised; but not only does physical activity play a significant role in preventing childhood obesity and reducing the risk of developing some common diseases such as coronary heart disease, type 2 diabetes, some types of cancer, osteoporosis and strokes in later life, it has a much broader impact on the life chances and quality of life for young people

"Physical activity is important for children and young people's health and wellbeing and contributes to their physical, social, emotional and psychological development."
(National Institute for Health and Clinical Excellence 2009)

Behaviours formed in childhood and adolescence have the potential to influence adult behaviours and health. Current guidelines for children aged 5-18 years recommend 60 minutes of physical activity on each day of the week, as well as reducing time spent sitting.

As children spend a large amount of time at school or travelling to and from school, this provides opportunities for the promotion of a physically active lifestyle. This can be done through:

Physical Education - Physical Education aims to develop physical competence so that all children are able to move efficiently, effectively and safely and understand what they are doing. The outcome, physical literacy, along with numeracy and literacy, is the essential basis for learners to access the whole range of competences and experiences.'

Extra-curricular sport - school sport clubs not only give pupils the opportunity to experience new sports and be active in school but also support them to move from school sport into community sport, so providing them with sustainable participation opportunities away from school

Extra-curricular active recreation - by offering alternative activities for pupils who are not 'sporty', schools can not only increase participation in physical activity but help address the drop-off in young people's participation levels in

the 14-18 year old age range.

Active play – providing opportunities for pupils to engage in both formal and informal physical activity at both playtimes and lunchtimes not only increases their levels of activity but can significantly reduce their levels of sedentary time during a day

Active travel to & from school – children who walk, cycle or scoot to school tend to be more physically active overall, indicating that children do not 'compensate' for more activity during travel by being more inactive at other times

Active Travel

Active transport is physical activity undertaken as a means of transport and not purely as a form of recreation. It is a great way to keep healthy and fit, save money and reduce impact on the environment.

Active transport can include walking, cycling, skating, skateboarding and any incidental activity associated with the use of public transport.

During the year ending October 2012, 10 per cent of adults in England cycled at least once per week. 3 per cent of adults cycled at least 5 times per week. The prevalence of cycling in England during the year ending mid-October 2012 has not changed significantly compared to the same period for the previous year.

Nearly all journeys involve walking, often to connect with other transport modes;

23% of all journeys in the UK are made entirely on foot

75% of journeys under 1 mile/1.6km are made entirely on foot

The average person travels 315km/197 miles a year on foot, or 3% of total distance travelled

The average length of a walk journey is 1km/0.6 miles. Only 5% of journeys are over 2 miles/3.2km

Active transport is an easy way to participate in physical activity and can help you to find 30 minutes of exercise in your daily routine.

The benefits of active transport include:

Improved community health – physical activity helps reduce numerous chronic health problems and can contribute positively to mental wellbeing;

Increased community safety – more people walking and cycling around the neighbourhood results in improved awareness of all road users, greater community contact and more 'eyes on the street';

Helping local businesses – people using active transport are more likely to shop locally;

Access for all – walking and cycling are low cost activities that are available to the whole community;

Improved environment – fewer car trips means reduced greenhouse gas emission, less noise and air pollution;

Reduction in local congestion;

Reduced pressure on road budgets – providing for, and maintaining infrastructure for motor vehicles consumes a significant proportion of a council budget.

Stockport Walking Strategy

The Stockport walking strategy encourages and promotes walking as a desirable method of transport in its own right as well as a means of accessing other modes of transport .Since people will walk further if it is pleasant to do so there is a need to maintain a network of aesthetically attractive roots, linking parks with country/riverside paths and aesthetically enhanced streets, enhanced perhaps by greenery or perhaps by art or perhaps by attractive architecture. There is also a need to address the barriers to walking, for instance:

- Perceptions of danger from personal attack and traffic accidents
- Personal characteristics such as age, gender and health
- Personal desires such as self-image and journey requirements
- Physical barriers such as a lack of crossing points, footway width and signage
- Maintenance issues such as surface standard, perceived lighting levels, litter and graffiti
- Time issues: the perceived time to make a trip on foot versus the real time taken.
- To remove these barriers, there is a need to:
- Improve pedestrian routes to key facilities such as education, health, employment and shops.
- Improve crossing facilities so the right facilities are available in the right place to reduce severance between communities.
- Implement new pedestrian routes for utility and recreational journeys and to complete the aesthetically attractive network.
- Adjust street lighting, street furniture and accessibility of route in line with the type of route that is being developed to ensure the highest level of usability possible in that location.
- Improve links to and from other modes of transport.
- Provide and promote user friendly information about walking.
- Improve signage to key facilities.
- Pursue the implementation of travel plans.

Draft Cycling Strategy

Following a long period of decline, the number of people making journeys by bike is now increasing, particularly away from busy roads. Across Greater Manchester, cycling levels have exceeded their target of a 6% increase over the last five years.

Cycling's potential for short and medium length journeys is clearly recognised, although this may be tempered by people's perceptions of their own ability to cycle or the hazards of doing so. Any decision to cycle and the distance cycled is affected by a range of factors including:

Quality of the general highway network, and any cycle facilities available

Personal ability to cycle and fitness

Dominance of motor traffic and perceptions of danger, balanced against understanding of health benefits and their own abilities to cycle.

Social acceptability, including perceptions linked to attire and travel mode.

Knowledge of routes and facilities available including the time the journey is likely to take.

These and other transport issues must be addressed in order to encourage cycling as a viable mode of transport. During 2012 and 2013, the public profile of cycling has been boosted through British successes at the Olympics and Tours de France. The August 2013 announcement of £77m of Cycle City Ambition Grant funding, including £20m for Greater Manchester, made reference to this and comes on the back of Local Sustainable Transport, Cycle Safety and Links to Communities funding packages. There is an increasing sense that the time has come for the beginnings of a cycling revival, with people having already got back on their bikes, or being closer to making a decision to do so.

3.13.   ALCOHOL

As noted previously the steady improvement of the health of Stockport, and especially its most deprived areas, faster than that of the country as a whole, faltered around the turn of the century and through the first decade of the century improved only in line with the rest of the country. Analysis showed that we were still achieving improvements in cardiovascular disease, which our 1990s strategy had been directed to, but that progress was undermined by emerging problems in cancer, digestive diseases and liver disease. These problems derived from a serious alcohol epidemic. Such an epidemic affected the whole country but it affected Stockport to an above average extent. At first it affected deprived areas most but later became more widespread across the Borough as a whole, paradoxically leading to improvements in inequalities showing themselves again.

Three major factors in this epidemic were

The drinking of stronger alcohol in larger measures. This led to many people underestimating what they drink. The idea that a glass of wine is 1 unit is based on a 125ml glass of 8%abv. A 175ml glass of wine at 13% is 2¼ units. A pint of 5% beer is 2.8 units not 2 units.

The emergence amongst young people in generations born from around the 1970s onwards of a culture which saw getting drunk on a night out as an essential part of the experience. In previous generations born post war it had been seen as an acceptable but unintended consequence of a night out and in generations born pre-war it was as an unacceptable consequence to be tolerated only on a few occasions due to inexperience.

Accompanying this cultural change was the emergence of the practice of pre-loading, drinking cheap alcohol bought at the supermarket at home before going out so that less more highly priced alcohol needed to be bought on the night out itself in order to become drunk.

Cheaper and more widely available alcohol, especially on off sales for home consumption.

The alcohol epidemic has somewhat abated from its height but not yet to such a degree as to regard it as a problem solved or indeed to be certain that the decline will continue.

A major element of the response to the epidemic needs to be policy measures intended to address the dysfunctional drinking culture. Stricter licensing laws are needed and licensing committees need to have more power but the root of the preloading culture is cheap sales by supermarkets and this needs to be tackled by a minimum unit price. It is deeply regrettable that Government has recently decided against this.

More information about the problem of stronger alcohol and larger glasses is another important issue, but awareness of this has probably increased over the last few years and may account for the abatement of the epidemic.

Local strategies cannot wholly pick up the slack of national neglect but nonetheless local action has an important contribution to make. The Stockport Alcohol Strategy 2011-14 emphasizes prevention of alcohol misuse and harm, through working with front-line services and communities, while improving access to support treatment and recovery, and for individuals and families affected by harmful and dependent use of alcohol.

The key indicator of impact of the strategy is alcohol-related hospital admissions.

Table 13.1 Alcohol related hospital admissions

Indicator	Baseline 2010-11	2011-12	2012-13	% change since 2010-11
Total alcohol attributable hospital admissions	7,421	7,870	8,036	8.3%
Admissions (as above) from priority neighbourhoods	985	1,003	995	1.0%
Alcohol specific hospital admissions	2,256	2,348	2,376	5.3%

The hospital figures indicate a slowing of the upward trend in admissions seen over the last ten years, with numbers falling in the last two quarters. The definition of alcohol-attributable admissions includes a range of health conditions that risky drinking contributes to, including high blood pressure, cardiac arrhythmias and epilepsy. It is difficult to measure whether the role of alcohol in such conditions is increasing or not, but the figure still provides the best estimate of the scale of admissions in which alcohol is a factor.

The alcohol-specific indicator is a more robust measure of the direct health impacts of alcohol, such as acute intoxication, dependency and withdrawal, but excludes many alcohol related admissions, such as those due to alcohol-related accidents or assaults. This increased less than the alcohol-attributable figure last year.

The proportion of admissions from priority neighbourhood has fallen from 14.2% in 2009-10 to 12.4% in 2012-13. However, the rate of admissions of residents in the most deprived quintile remains three times that of residents in the least deprived quintile.

North-West Public Health Observatory benchmarking data indicates that Stockport is within the highest quartile nationally in terms of the rate of alcohol-related admissions, though slightly lower than the North-west average. Notably, Stockport's ranking, for alcohol-specific hospital admissions, is worse for women (291/326) than for men (279/326).

The 2012 Stockport Lifestyle survey found 19% of respondents reported binge drinking at least once in the last week (6 + units for woman, 8+ units for men), while 3% drank at a high risk level (over 35 units for women or 50 unit for a men) over the week and a further 17% at increasing risk levels (more than 14(f) or 21(m) units). The number reporting high risk drinking has reduced, from 4% in 2009, while the other figures are not significantly different. Men are significantly more likely than women to either binge drink or exceed weekly guidelines.

The profile by age shows two peaks in binge drinking, first among 18-24 year olds and again among 40-44 year olds. Increasing risk drinking is most common in 45-54 year olds, and high risk drinking peaks in the 45-49 age range.

It should be noted that self-reported levels of consumption of alcohol only account for around half of the alcohol that is sold in the UK, according to Inland Revenue figures, indicating that such surveys tend to under-estimate true consumption levels across the population. This may be due to inaccurate responses as a result of poor recollection as well as heavier drinkers perhaps being less inclined to complete such surveys.

Three key priorities have been identified for 2013-14:

Review of treatment system

The transfer of Public Health into the Local Authority in April has brought about significant changes in the framework in which the alcohol strategy is delivered, including integration of substance misuse commissioning. While the Payment by Results pilot will continue throughout 2013-14, this an appropriate time to undertake a fundamental review of the treatment system in relation to changing needs, priorities and policies, in order to plan for the future.

Health & Well-being Capacity Development

The ambition of the Alcohol Strategy to make alcohol misuse prevention 'everyone's business', and to 'shift the focus of our efforts from treating the symptoms to tackling the causes of alcohol misuse' has proved challenging in the context of current public sector reforms. In the light of this experience, the Alcohol Misuse Prevention group has undertaken a review of its ways of working and concluded that alcohol misuse may be most effectively addressed as part of a broader 'prevention' agenda, which promotes resilience and well-being. While the group will continue to educate about the specific harms of alcohol and work to ensure it is effectively identified and addressed, it recognises that this may be best achieved as part of a broader public health oriented programme. Health promotion work needs to move beyond the 'topic silos' to embrace more holistic and asset-based approaches ("Assets are any resource, skill or knowledge which enhances the ability of individuals, families and neighbourhoods to sustain their health and wellbeing." Jane Foot 2012 *What Makes us Healthy?)* Such approaches develop the capacity of public services in relation to health improvement and empower individuals and communities to maintain and improve their own health and well-being, particularly focusing on deprived communities.

Domestic abuse and alcohol

The links between domestic abuse and alcohol were highlighted as an area for development in the current strategy and while some progress has been made, this issue has now risen up the agenda, as a result of recent developments in Stockport. The prioritisation of the issue by the Police and Crime Commissioner, and the work now starting at both local and Greater Manchester levels to review how we address domestic abuse, provide an opportunity to deliver system-wide improvements, especially in relation to prevention, early identification and intervention, and alcohol misuse prevention work will play a key part in this. Therefore, making the links in policy and practice will be a key area of work.

(d) The Contribution of Local Cultures

The cultures of local communities have important impacts on health choices and influencing those cultures through working with the communities is an important part of the strategy.

3.14.   WELL BEING

The Science - Key Messages

Various aspects of well-being have been shown to be associated with physical health.

Evidence is particularly strong for the following:

- A positive impact on mortality from strong social support networks
- A harmful impact, especially on heart disease, of working under pressure to deadlines
- Lower mortality in those who have considerable autonomy in their work
- Lower mortality in those of higher social status
- Increased sickness and mortality during processes of change affecting fundamental areas of life identity. This lasts from the time that change first starts to be anticipated until the individual is settled back into a secure new role. It applies to both positive and negative life changes but the impact of negative life changes is greater.

There is also evidence for:

- A beneficial effect on health of aesthetically attractive surroundings and greenspace
- An adverse effect from inequality (i.e. doing less well than others) quite independently of the actual level of deprivation
- An adverse effect of threats hanging over people
- A beneficial effect of striving for a challenging and meaningful goal
- A beneficial effect of a strong personal identity

The biologically plausible explanation for this relationship is the stress reaction

The stress reaction is the mechanism whereby an organism faced with a threat gears itself up to deal with the threat – the "flight or fight" response. It increases strength and agility and speeds up mental processing. However the bodily changes involved in the stress reaction also lead to a depressed immune system, changed gut function, high blood pressure and high blood cholesterol. This may not matter too much in the normal situation where the reaction is short-lived but if it becomes inappropriately long-lasting these bodily changes will lead to cancer, heart disease, gastrointestinal disease and increased susceptibility to infection. These are exactly the effects that have been seen in the above studies (although not all of them in all studies)

The psychological literature contains some detailed theoretical analyses of well being

These include Maslow's hierarchy of needs, Cooper's matrix of occupational stress, the recent "flourishing/languishing" classification, the salutogenesis theory and a range of others. They often place emphasis on social support and strong personal resilience.

It is plausible that the psychological literature and the epidemiological literature are describing the same phenomenon but this scientific link has never been clearly shown.

If this gap were to be bridged we would be able to have much more confidence in the use, as important public health measures, of well-being indicators that have been developed from the psychological literature, such as the WEMWEBBS indicator which is increasingly being used.

Key Messages for People and Organisations

People can build 5 *Ways to Wellbeing* into everyday patterns of life

- *Connect*: develop your social and friendship networks; spend time with other people
- *Be Active*: find physical activities that boost your heart-rate and you enjoy
- *Keep Learning*: be curious, explore new opportunities or ways of doing things
- *Take Notice*: think about patterns and cycles in your life, how you react to things around you focus on 'now' and take pleasure in the moment
- *Give*: your time, your energy, your attention to those around you in small ways or big ones

It is good for mental wellbeing to eat well, get out into natural green spaces and have fulfilling work.

Protective factors that policies and organisations can help create include

- *Control*: the feeling that we can manage our own lives and make our own decisions
- *Participation*: our belief that what we do matters, that we can make a difference
- *Inclusion*: our feeling that we belong, that there are people who care about us
- *Resilience*: our ability to cope with what life throws at us and bounce back
- *Assets*: personal, social and environmental resources we draw on for help and support

For those aged between 10 and 17 years factors include creative imaginative play, the balance of family conflict or harmony, the level of support (emotional and practical) within the family and the level of autonomy parents allow children. **Autonomy** and **achievement** are vital at this age.

Commissioning effective services National evidence reviews in 2012/2013 support the following

Starting Well – early years with parents and young children:

- Universal and targeted parenting support
- Focus on 'school-readiness' via the home-learning environment and pre-school programmes
- Whole-school approach to mental wellbeing support
- Enhancing the physical environment (green-space/nature; access routes/mobility)

Working Well – working age adults:

- Specific support for unemployed people with mental health problems
- Specific support for return to work of those with mental health problems
- General promotion of mental health in the workplace
- Early identification and screening for mental health problems in the workplace
- Support for volunteering in the workplace
- Action to reduce stigma and discrimination

Ageing Well – older adults:

- Specific physical activity programmes, including community-based walking groups
- Increasing social contact and reducing social isolation/loneliness
- Support for volunteering, including time-banking

- Psycho-social interventions, including CBT (cognitive behavioural therapy) initiatives
- Maintaining activities of daily living (occupational therapy; hearing aids; support for carers)
- Provision of/access to meaningful activities (informal learning/arts-based activities)

<u>Neighbourhoods and Communities.</u>

- Reducing financial difficulties (debt advice)
- Supporting independent living (including issues like fuel poverty and energy efficiency)
- Community capacity building (time-banks, skill-share, 'navigators' to help access services, social prescribing)
- Improved access to the natural environment
- Reducing stigma and discrimination
- Promoting active travel opportunities

Key Messages – Cultural determinants

Promoting social integration, which has been shown to be weaker in deprived areas, tackles health inequalities in addition to being beneficial to individual's physical and mental health

A starting point for developing social integration is encouraging the development and participation of local groups.

Social cohesion is led by communities coming together in their own interests .Community development programmes have a crucial role in facilitating this , particularly in more disadvantaged areas or amongst more disadvantaged individuals.

As well as substantial benefits to people's health and some wider social benefits, there is increasing evidence that impact of Community Development can be measured financially.

Within a broad approach that values communities coming together, however, measures still need to be taken to address the priority that individuals, and communities attach to healthy living.

The strategy for tackling the challenge of creating opportunities for individuals and communities to live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development- primary community development and purposive community development.

THE SCIENCE

The Scientific Evidence

In the 1950s the first evidence linking well-being and physical illness showed more heart disease in US accountants busy preparing accounts for the Internal Revenue Service. Work ensued on "type A", a behaviour pattern with increased coronary risk evoked working under pressure to deadlines.

Kasl, Cobb and Gore extensively studied self-reported health, physiological and biochemical parameters during losing a job, divorce, imprisonment, bereavement, entering a care home, moving

house, promotion, and getting married. Life changes affecting identity damage health when they begin to be anticipated until full adjustment to the change. This negative effect applies both to beneficial and negative life changes but beneficial changes have less impact and are adjusted to more rapidly.

A study in US Army wives showed social support networks influencing complications of pregnancy In the Granville Train Disaster in Australia weak levels of social support strongly predicted serious mental illness in survivors of this horrific crash where a train left the tracks and collided with the supports of a bridge bringing it crashing down on the train. In the Alameda County Study strength of social support associated with a fourfold difference in all causes mortality. This difference, comparable to the effect of poverty, was so great the researchers refused to believe it attributing it to reverse causality (illness causing deteriorating social networks) predicting it would decline as the cohort was followed for longer periods. It didn't. It strengthened as would a directly causal relationship. Ultimately researchers were convinced. It is now clear that strength of social support is a major contributor to good health. This creates concern at economic policies of labour flexibility with frequent job change and at the finding by Appleyard & Lintell in San Francisco, and Hart in Bristol, that traffic levels weaken residents' social support networks by diminishing neighbour interaction.

Various studies of occupational mortality, including Marmot's study of civil servants show social status a positive factor in maintaining health as is autonomous control of one's own work. Various studies of stress at work show responsibility as good for health if linked to the training, ability and resources to discharge it, but without training, ability and resources it is bad for health. There are also adverse effect of threats hanging over people, a beneficial effect of striving for a challenging and meaningful goal and a beneficial effect of a strong personal identity. So, science clearly shows aspects of well-being affecting susceptibility to disease and influencing death rates. Most of this was known 30 years ago but has only recently come to prominence in practical policies.

Much newer is the recognition that aesthetically attractive settings benefit health. The pioneering study demonstrated patients recovered quicker from a surgical operation if they could see trees from their window. Other studies confirm this including one suggesting greenspace diminishes inequalities.

More controversial is Wilkinson's work suggesting perceived inequality may be important and people may suffer health consequences if they feel they don't share the lifestyle opportunities of others.

The Stress Reaction

The stress reaction occurs in organisms faced with a threat. It prepares for fight or flight. Mental processing speeds up so time seems to slow. Blood flow and energy is directed to muscles making the individual faster and stronger – the person just chased by a bull has no idea how he vaulted that hedge. In this process metabolic and cardiovascular changes occur – e.g. blood pressure, heart rate and blood cholesterol increase. Systems not immediately essential are shut down- the immune system is depressed and gastrointestinal blood flow diminishes.

Used up in fight or flight the stress reaction is an essential mechanism and perfectly healthy. However if it becomes inappropriately persistent it is harmful. Persistent elevation of heart rate, blood pressure and cholesterol causes heart disease and stroke. Depression of the immune system causes cancer and infection. Reduced gastrointestinal function leads to gastrointestinal illness. Cancer, heart disease, gastrointestinal disorders and infection are the diseases most associated with the lack of psychological wellbeing described above. This is the biologically plausible link for the epidemiological observations. A threat hanging over people (a conventional threat, a life change, a deadline, entrapment in an unsatisfactory situation like low status, or a feeling that you can't discharge a responsibility) triggers the stress reaction. It cannot be used up in immediate action, becomes persistent and damages health. This plausibly explains well established epidemiological findings but is not proved. If it is correct social support and tranquil green settings may moderate the impact of stress or operate directly raising the human spirit so their absence creates unease.

The Psychological Perspective

There are a number of psychological approaches to well-being which are helpful to understanding it.

Maslow approached well-being through needs, describing five levels of need – physiological (air, water, food), safety, belongingness (love and friendship), ego-status (position, identity and standing), and self-actualisation (to "be oneself" and "have a task that you must do"). He presented a hierarchy, human beings motivated by the lowest level of needs to be under threat; a drowning man is motivated solely by finding air but later air no longer plays any part in his calculations. Maslow acknowledged that ego status and belongingness needs were sometimes met in the reverse order and some see them as part of the same need – for acceptance - with self-actualisation addressing security of acceptance as safety does to physiological needs. Maslow later added aesthetic and spiritual needs and divided self-actualisers by into transcenders (motivated by spiritual needs) and non-transcenders. He also recognised that needs could be met by deciding, in a greater cause, to accept their absence.

The four level hierarchy with ego status and belongingness as one tier fits Galbraith's four modes of motivation – compulsion (dig the ditch or be shot), compensation (dig the ditch and we'll pay you), identification (the ditch needs to be dug) and adaptation (diggers decide where the ditch goes). Maslow's additional tiers suggest additions to Galbraith's theory – sensualisation (digging ditches is great fun) or spiritualisation (gain one-ness with the earth/build character through hard labour/ counter pride from high status occupation/ make an opportunity for meditation).

Some say Maslow was wrong to see a hierarchy in his needs and they are just a taxonomy of equally important needs. A national advisory group suggested the following fundamental psychological needs

Secure stable ATTACHMENT & TRUST to somebody we can depend on who knows us well

EMPATHIC COMMUNICATION RELATIONSHIP - someone wants to understand our meaning

IDENTITY & BELONGING with identity and position in a family or care-giving social group

CONTAINMENT, SECURITY & DISCIPLINE, living within secure social boundaries and rules

ESTEEM, BELIEF & PURPOSE hope, belief, meaning, value and purposeful occupation

SELF-DETERMINATION understanding and influence over ourselves and our environment

RESILIENCE & HAPPINESS capacity to tolerate frustration and fully experience pleasure

RESPECT & RESPONSIBILITY reciprocal respect, regard and responsibility towards others

Others look at psychological environments in which people function. Cooper produced a matrix of factors to identify occupational stress. An Occupational Stress Indicator is constructed using a biographical questionnaire and six questionnaires on different dimensions of stress. These focus on sources of stress, individual characteristics, coping strategies and effects on the individual and organisation. Organisations use this in a stress audit then reduce or eliminate sources of stress.

Other approaches emphasise personal factors that create resilience. Keyes distinguishes flourishing individuals (with 'enthusiasm for life, actively and productively engaged) and languishing individuals with neither wellbeing nor mental illness. Data from the USA found 50% of the general population moderately mentally healthy, 17% were flourishing, 10% languishing and 23% meeting criteria for mental disorder. There is no comparable UK data. Flourishing individuals have less psychosocial impairment, better physical health, higher productivity, fewer limitations in daily living, lower risk of chronic physical disease with age, fewer missed days of work, less helplessness, clear goals, higher resilience), less cardiovascular disease, and less use of health care. Flourishing, therefore, fits with a healthy ageing strategy.

Salutogenesisis is a social theory epidemiologically associated with mortality. Antonovsky coined the phrase interviewing Israeli women with experiences from concentration camps who remained healthy. He sought "the origin of health" rather than the causes of disease, identifying sense of coherence, a pervasive sense in individuals, groups, populations or systems that was the overall mechanism of the process. He claimed sense of coherence (SOC) explains why people stay well and improve their health. A strong SOC is ability to assess your situation (comprehensibility), resources to cope (manageability) and finding meaning to move in a beneficial direction (meaningfulness). Longitudinal studies find SOC associates with perceived good health and reduced mortality regardless of age, sex, ethnicity, nationality and study design.

The Measurement of Well Being

If the stress reaction's biochemical and physiological features were associated with states postulated in psychological literature this would confirm the reaction as the causal link and validate well-being indicators so associated. This experiment has not been done. So how can we measure well-being?

Indicators discussed include emotional intelligence, spirituality, learning and development, measures of resilience including sense of coherence , a single "life satisfaction" survey question, questionnaires addressing dimensions of disability, functioning and/or wellbeing, composite indicators, participation, social networks, social support, trust, violence, physical environment, working life, stigma / discrimination, debt / financial security, social inclusion, equality, safety. EQ5D (5 questions measuring disability and functioning) % people who feel they belong to their neighbourhood, local civic participation, regular volunteering, sickness absence. The JSNA used self-reported well-being. The WEMWEBBS composite indicator is widely used.

The Role of Empowerment

The WHO has produced evidence that empowerment benefits health. This could be because it adds to the sense of status.

- People feel more in control of matters which might otherwise seem like an external threat
- Control of one's own work benefits health, and the same may apply in other settings
- If people often make decisions and risk-judgments they will seem less stressful when they occur.
- Making decisions together is socially supportive
- Involvement diminishes the fear of the unknown
- Involvement in decision making about a life change speeds the process of adjustment

People need to be involved in, decisions about their lives and in change processes, to express their opinions and dissent and work with others to bring change for their communities. This challenges politicians and leaders of representative organisations who see themselves as spokespeople for their constituents, leaders of enterprises and public agencies whose duty it is to chart their organisation's future and professionals who may be affronted if their advice is not accepted. An ancient Chinese proverb says "The leader the people love is the second best kind of leader. With the best kind of leader when the job is done the people say "We did it ourselves".

THE IMPLICATIONS FOR PEOPLE AND ORGANISATIONS

FIVE WAYS TO WELL BEING

A number of different elements have been described that enable people to maintain positive mental wellbeing. The 5 Ways to Wellbeing are simple actions that can be built into everyday patterns of life and are known to help people feel more positive about themselves and their place in the world.

Connect, be active, keep learning, take notice and give summarise the findings that to promote mental well-being you need to develop your social and friendship networks, spend time with other people, find physical activities that boost your heart-rate and you enjoy, be curious about your world, explore new opportunities or ways of doing things, think about the patterns and cycles in your life, the way you react to what happens around you, focus on 'now' and take pleasure in the moment and give your time, your energy, your attention to those around you in small ways or big ones

In addition to these five items, research shows that it is good for mental wellbeing to eat well, get out into natural green spaces and have work that is fulfilling. A recent report by the Children's Society (The Good Childhood Report, 2013) found that for those aged between 10 and 17 years creative imaginative play may be more relevant than giving to their mental wellbeing. For this group the balance of family conflict or harmony, the level of support (emotional and practical) within the family and the level of autonomy granted to children by their parents are vital to mental wellbeing. Autonomy and achievement are cross-cutting themes in the analysis of factors affecting mental wellbeing at this age (Children's Society, 2013).

How Organisations Can Help

In the Key Messages at the start of this chapter I listed some key factors that organisations can promote. These emerged from Mental Well Being Impact Assessment. I also listed services we should aim to commission according to an evidence review. There are clear implications for local authority functions-

Lifestyle Leisure	Libraries, arts, licensing
Community	Community development, youth and senior citizen groups, social cohesion
Local economy	Economic development, local government jobs, business grants
Activities	Benefits advice, play provision, schools programmes, adult learning
Built environment limits	Accessible cycle/walking routes, housing, street lighting, play spaces, speed
Natural environment	Green, open spaces, parks, air quality, sustainable development, allotments
Global ecosystem:	Home insulation, planning and development control

Strategic Principles

Mental wellbeing is the term used to describe how people **think, feel, function, make sense of and experience their lives**:

- how people **feel** about their lives (subjective wellbeing, happiness)
- how people **evaluate** their lives (life satisfaction, meaning)
- how people **function** (relationships, achievement of one's potential)
- **external factors** that can influence all the above (e.g. income, housing, social networks, crime, education, employment).

There is good quality evidence that improving wellbeing, including mental wellbeing, has a wide range of health, social and economic benefits. These include:

- reduced risk of mental illness and suicide
- improved physical health and life expectancy
- better educational achievement
- reduced health risk behaviours such as smoking, alcohol and drug use
- improved employment rates and productivity
- reduced antisocial behaviour and criminality, and
- higher levels of social interaction and participation.

Improvements in outcomes in all the areas influenced by mental health and wellbeing are associated with reduced costs and considerable savings across a wide range of public services, including health, social care, education, employment and criminal justice.

In 2012 the government published a new policy on mental health and wellbeing. ***No Health Without Mental Health*** (DH, 2012) sets out clear national ambitions and principles:

- Equal importance is given to mental and physical health
- Emphasis is placed on supporting the mental wellbeing of the whole population not just those with mental ill-health
- Application of a life-course approach (starting well, developing well, working well, living well and ageing well)
- Emphasis on early intervention (childhood/ teenage years) to support mental wellbeing and prevent mental ill-health
- Mental health and wellbeing are understood to be key to addressing inequalities in health
- Mental health and wellbeing are seen as a cross-departmental responsibility
- Consistent with the approach outlined in other main health policies:
- No decision about me without me
- Focus on outcomes
- Local decision making
- Personalisation
- Development of a national measure of wellbeing

Local action focused on mental wellbeing in Stockport

Stockport Health and Wellbeing Strategy states that mental wellbeing is a key priority. It is a central theme running throughout the document as well as the focus for an individual chapter. The strategy sets out clear objectives for local activity, as shown in the extract below.

"In order to improve the mental health and wellbeing of people in Stockport and keep people well, we will strengthen support for and the awareness of the effects of poor mental wellbeing in all services and activities, recognising this as the foundation for the health and wellbeing of individuals and communities.

We will do this through:

Establishing a clearly authorised forum through which this policy is implemented, including capacity to direct/affect resource allocation, for example by strengthening the terms of reference and adjusting membership of the Mental Wellbeing Strategic Planning Group (MWSPG);

Incorporating the Mental Wellbeing Impact Assessment process into legally required impact assessment processes for review of programmes and services and identifying responsibility for subsequent implementation by relevant stakeholders;

Promoting the "5 Ways to Wellbeing" as a simple mechanism to engage staff and public in addressing mental wellbeing and embedding this into working practices (part of MWSPG terms of reference + within staff development/training remit);

Providing specific training to strengthen the capacity of all staff and partners to address mental wellbeing issues with confidence and skill (part of MWSPG terms of reference + within staff development/training remit);

Applying the 'wellness service standards' as a quality benchmark for public health services: to the integrated lifestyle service (2012) and cultural determinants service (2013-2014) and for other services in the future.

We will take action to highlight these particular risks and opportunities to mental wellbeing;

Debt as an important risk factor points to the promotion of national and local debt advice resources and services,

Working through and with the CCG to promote early identification of poor mental wellbeing and alternatives to prescribing

Working with early years settings given the importance of maternal and early life mental wellbeing and BME groups in particular

Working with communities to develop local ideas for promoting good mental wellbeing

Working with the new carers centre to strengthen support for mental wellbeing.

In order to improve outcomes for people with mental health problems in Stockport through high quality services that are equally accessible to all we will;

Work in partnership to undertake the Stockport Mental Health Pathways Project**"**

A wide range of activities have been undertaken in the borough to ensure delivery against these objectives. These include:

Staff capacity building with a network of partners offering dedicated training programmes

Expansion of CBT support through community courses, computerised access and self-help booklets

Production of a handbook showcasing local opportunities to access the 5 Ways to Wellbeing

Social prescribing programmes such as Arts on Prescription, Mums In Art, Physical Activity on Referral in Stockport (PARiS) and bibliotherapy (self-health@your library - books on prescription)

Application of the Mental Wellbeing Impact Assessment Toolkit to a variety of policies and projects

The main focus of these activities is to expand access to wellbeing opportunities across the population. By providing a range of effective support options the intention is to address the extensive low-level needs relating to mental wellbeing and so reduce demand for more expensive, high-level interventions.

THE CULTURAL DETERMINANTS OF WELL-BEING

Promoting social integration, which has been shown to be weaker in deprived areas, tackles health inequalities in addition to being beneficial to individual's physical and mental health. A starting point for developing social integration is encouraging the development and participation of local groups

Social cohesion is led by communities coming together in their own interests .Community development programmes have a crucial role in facilitating this , particularly in more disadvantaged areas or amongst more disadvantaged individuals.

As well as substantial benefits to people's health and some wider social benefits, there is increasing evidence that impact of Community Development can be measured financially.

A social return analysis with imputed financial value was undertaken to track the activity of Community Development professionals in four local authorities It found that an investment of £233,655 would have a return of approximately £3.5 million: every hour spent by community members running groups and activities had 1:6 return on investment. Other examples were recorded evidence exists include Time banks and community based falls prevention for older people

Within a broad approach that values communities coming together, however, measures still need to be taken to address the priority that individuals, and communities attach to healthy living.

The strategy for tackling the challenge of creating opportunities for individuals and communities to live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development- primary community development and purposive community development.

Within a broad approach that values communities coming together, however, measures still need to be taken to address the priority that individuals, and communities, attach to healthy living.

People living in our deprived neighbourhoods have the greatest need to change lifestyle behaviours, as evidenced by the lifestyle survey, but they are the least likely to access lifestyle support services or make successful changes. Similarly our most vulnerable populations, homeless, refugees, asylum seekers, with mental health problems may struggle to prioritise good health amongst the challenges they face.

The strategy for tackling the challenge of creating opportunities for individuals and communities to live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development- primary community development and purposive community development.

Primary community development aims to develop the general strength of a community. It is important for two reasons firstly as a direct health promoting intervention in its own right because of the impact of social networks, empowerment and civil society as health determinants. Secondly it is a prerequisite for purposive community development. A metaphor used locally is that you cannot run the bus service before you have built the road.

Purposive means using CD methodology to address health related issues. It uses a unique approach to health improvement which encourages communities to identify their own health agenda and then assists them in developing strategies to create positive ways of addressing health issues. By encouraging genuine participation in the communities' agenda local people become more empowered. As people become a part of the decision making process they then become more willing to consider change because the impetus for change has come from within their own community.

Using these approaches a range of community based initiatives, that impact on the social and cultural determinants of health, need to be in place. The existence of a range of activities, support groups, self-help groups and the like can all help create a culture that values health and that encourages change.

In both primary and purposive community development an asset based approach is required   which focuses on the strengths that exist within the local community and builds on them rather than working from an assumption that the community has deficiencies that need to be tackled.

In communicating this strategy we need to find a framework for talking about the social determinants and cultural determinants of health to a non-professional public health audience. This is not just for people working in the field, but for policy-makers. We need to talk about the topic in a way that people can understand, that is meaningful, and that doesn't align the topic with any existing political perspective or agenda.

A good beginning is "Health starts where we live, learn, work and play"

Local action focused on cultural determinants in Stockport

A lifestyle strategy has three components. One component, the Healthy Stockport Service   provides individual support to achieve behaviour change, another component aims to change the environment so that healthier choices are easier to make and a third component – the cultural determinants component – aims to change social norms of behaviour within particular cultures so that healthy behaviour seems more natural. . For example our healthy Stockport service can provide individuals with tailored individual weight loss by creating the enabling conditions that facilitate change, development of cycling and walking facilities and availability of healthy food can make it easier for people to make changes which will improve their weight but the food and health team provide the community cookery skills training to help individuals and their neighbours cook healthier meals for themselves and their families.

Public health commissions a number of services that increase the capacity of people and communities to live healthy lives. Programmes include Food, Nutrition & Health, Health & Housing, Walking for health, Community Development, Arts and health and the Community stop smoking programme. Each of these services is small but together comprises a team of workers dedicated to addressing the social and cultural determinants.

The services provide a person centred, holistic approach to health. They work in partnership with individuals, families, carers, groups and other professionals in statutory, independent and voluntary sectors, utilising a range of tools and methods to assist people to maximise their quality of life, promote independence and interdependence, enhance the social networks and organised civil society in their communities and improve their health.

Social and cultural determinant work is carried out within the geographical areas of most disadvantage in Stockport. The areas currently worked in are Brinnington, South Reddish Lancashire Hill, Hillgate, Town Centre, Cheadle Heath, Adswood and Bridgehall and Offerton

Community Development workers work alongside people in communities, build relationships with key people and organisations to facilitate the identification of common concerns, and help build autonomous groups. They create opportunities for non-formal learning, which will help to increase the capacity of communities. By enabling people to act together, Community Development workers help to foster social inclusion and equality.

Communities of interest that are supported include Tenants and Community Associations, Friends of Parks, Health Walkers and a local children and families group , Marbury Minis People from a particular ethnic/cultural background, are also supported for example . Asian Heritage Group, A number of gender and Sexuality and age related groups are supported for example People Like Us Stockport, PLUS Exercise group, Brinnington Women's Group, SWAGGA Women's Group, Older people are brought together via Community café Lancashire Hill SK community café, Hillgate Millbrook community café.

Stockport wide and local groups where mental health issues are the common factor include Start the Week Drop In, Midweek Drop In, Start the Walk, Lancashire Hill (Penny Lane) Photography Group, Stockport Progress and Recovery Centre, Stockport User Friendly Forum, Service User Network Stockport, Hart Art Group, PEARL, Mums In Art, Beat the Blues, Inspire.

Purposive programmes provide targeted activities to increase the capacity of individuals and communities at high risk of health related harm to eat more healthily through the become physically active and create smoke free homes and communities

Outreach to some of the most disadvantaged populations in Stockport is also provided which includes homeless people, asylum seekers and refuges and travellers.

To enable CD workers to empower their target population the workers follow the public health advocacy policies set out at the start of this report which recognises that the prime responsibility of the worker is to the community that they serve and that the maintenance of the trust of that community must be a priority.

We aim to further develop our cultural determinants service to constructively challenge local culture and enable people to shift within that challenge. The ultimate aim is to develop further pool shared activities across different elements of service delivery to deliver our priorities. This would be particularly beneficial in training and capacity building for example increasing capacity to deliver more Health Defenders and Essential Public Health courses. There would still be some differentiation between different elements of service provision, however, as there are specialist functions that we would want to continue to be delivered.

3.15. SAFETY AND HEALTH PROTECTION

Control of Infection

The protection of the public from infectious diseases continues to be a major element of the public health process.

Infections may be spread by water, by air, by food, by close contact, by animals, or by infectious material coming into contact with bodily fluids (through sexual contacts, through unhygienic injections, or through wounds in accidents or in the course of healthcare).

Water-borne diseases such as typhoid and cholera once ravaged this country but have for many years now been virtually eradicated by the creation of safe water supplies. Legionnaire's disease occasionally develops in water stored in systems like cooling towers or air conditioning systems if the precautions to avoid this are neglected and then spreads by droplet. There have been a few outbreaks in the UK recently.

Air-borne diseases are largely addressed by two measures – respiratory hygiene and immunisation both to protect the individual and to halt the spread of the disease person to person.

Respiratory hygiene is important. Always cough or sneeze into a handkerchief or sleeve. Coughing or sneezing to the open atmosphere spreads disease and coughing onto your hand is not ideal either unless you wash it immediately afterwards. The recommendation is to cough into your sleeve at the inside of the elbow but many people find this embarrassing and the next best is a handkerchief.

Vaccination is the other main strategy for this group of diseases. Smallpox has been eradicated worldwide. Diphtheria has been almost eliminated in this country by immunisation. Polio is now unknown in this country and on the verge of worldwide eradication, although opposition to vaccination is preserving some islands of the disease in parts of Asia and Africa. Unfortunately personal decisions about vaccination can be complicated especially by scare stories. In this country measles, mumps and rubella were a problem which we thought we had contained until the MMR scare affected the uptake rates for vaccination, a problem we are only just recovering from. It is just as understandable that the populations of Pakistan, Sudan and Northern Nigeria have been scared by some equally misleading information about polio vaccine from some religious fanatics and this has delayed the world wide eradication of polio.

The common cold is the commonest air-borne disease but in terms of diseases causing serious harm flu is far and away the biggest threat amongst diseases in this category of spread.

Food-borne diseases remain a significant problem. Much food poisoning consists only of a short digestive upset, distressing and disruptive but not dangerous. However more serious forms of food poisoning kill. Meticulous food hygiene remains the defence.

Diseases spread only by close contact do not by their very nature break out as epidemics. Some forms of meningitis can spread within families.

Tetanus from the entry of dirt into accidental wounds has been reduced considerably by vaccination.

This country is free of the major insect-spread diseases such as malaria. However the numbers of notifications of Lyme disease continue to increase year on year with 1,040 individuals respectively notified in 2012 in England and Wales. Lyme disease is an infection caused by the bacterium *Borrelia burgdorferi* with humans becoming infected after being bitten by hard-bodied ticks (Ixodes *species*) that are infected with *B. burgdorferi*. Ticks become infected when they feed on birds or mammals that carry the bacterium in their blood. Lyme disease is one of the most important insect transmitted infections in the UK.

There are still cases of zoonoses, diseases spread by animals.

Food Hygiene and Standards.

Every producer and supplier of food has a responsibility to ensure the food they supply is safe and its composition is described accurately. Both Environmental Health and Trading Standards have key roles in enabling and supporting over 2400 premises in the food industry in Stockport to meet their legal responsibilities. This is mainly achieved through proactive targeted projects, unannounced inspections of premises, responding to complaints and by sampling programmes. Work is also carried out in preventing the supply of unsafe food such as illicit alcohol and tobacco through identification, seizure and destruction. Some examples of work and 2012/13 annual throughput include:

Food Hygiene Inspections – 647, Service Requests – 518, Written Warnings issued – 569, Voluntary Closure/ Procedure Notices – 11, Hygiene Improvement Notices – 19, Prosecutions – 2 pending, Food Bourne illness notifications – 87.

Healthy Catering Award - developed through the GM Food Liaison Group. The award recognises those catering businesses that have demonstrated a commitment to reducing the level of saturated fat, sugar and salt in the food and drinks they sell.

Food Safety in Schools– We have been working with a new provider of school meals for some of the opted-out schools. This input has led to a full review of the company's food safety policy and will help ensure that satisfactory standards of food hygiene in our schools are maintained.

Eat Better Start Better project) – EH and food safety guidance inclusion at events organised by the Council's Early Years Consultant aimed at nursery and pre-school groups.

Targeted listeria initiative – checking temps of hospital ward fridges and sampling of sandwiches in ward kitchens – negative results led to development of the FSA listeria policy

Salt shakers campaign – Stockport supported the FSA's national Salt Shakers campaign locally to help cut salt intake and reduce harmful health effects of excess salt consumption.

Hands up for Hygiene Campaign - officers teach good hand washing techniques, explaining how germs are spread through poor personal hygiene, in primary schools

The teams work closely with Public Health England – Greater Manchester Health Protection Team following notification of food borne illnesses or food poisoning outbreaks and with the Infection Control Team following liaison with schools, nurseries and residential care home if an outbreak is suspected to implement the appropriate controls.

Healthcare Associated Infections

The overuse of antibiotics has created multiply resistant organisms which are difficult to treat, especially (but not exclusively) in hospitals. This problem can only be tackled by using antibiotics more sparingly and only when needed combining this with meticulous cleanliness and hygiene in healthcare facilities.

Clostridium difficile – There were a total of 113 cases during 2012/13,

Tab 15.1	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	10	7	9	18	16	9	10	8	9	7	6	4	113

The health economy was set a challenging target of no more than 128 infections for 2012/13 and to be able to achieve less than this a number of actions were put into place, these included:

Performance management of the target on a biweekly basis

Incentive for GP's to examine their antibiotic prescribing habits for high risk antibiotics

Incentive for GP's to review and stop where possible patients on proton pump inhibitors

Development of a joint database with Stockport Foundation Trust to document Root Cause Analysis findings

Antibiotic stewardship ward rounds for patients in acute care

Review of both community and acute antibiotic policies

The target for 2013/14 is less than 99 cases and this is a challenging position for the health economy. A project team was developed prior to the end of March 2013 to ensure that this target was not breached.

MRSA Bacteraemia – There were a total of 7 cases during 2012/13

Tab 15.2	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	1	0	0	0	1	2	2	0	1	0	0	0	7

The health economy was set a target of no more than 6 cases of MRSA Bacteraemia (Bloodstream infection) for 2012/13. 4 of these cases were apportioned to acute medical care; however they were identified in acute trusts outside of Stockport Health Economy. The remaining 3 cases have been assigned to the community setting. The root cause analysis of these cases did not identify any significant issues.

MSSA Bacteraemia

Tab 15.3	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	5	4	4	5	5	1	5	5	7	7	5	6	59

EColi Bacteraemia

Tab 15.4	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	10	17	22	23	19	15	19	12	15	14	6	16	188

There are no national trajectories set for both MSSA and EColi Bacteraemia, however there is an expectation that acute trusts are actively working to reduce the incidence of these infections in these settings.

Infection Prevention and Control Assessments in General Practice

Since 2004, the Health Protection and Control of Infection Unit have undertaken assessments of infection prevention and control practices and procedures in all General Practices throughout Stockport. For the first time during 2011/12, for those Practices housed in former PCT premises, the assessment was divided in those aspects which are the responsibility of the Practice, and domestic & estates issues which were the responsibility of the PCT. The existing assessment tool is based upon one originally devised in 2003 by the Royal College of General Practitioners and the former Infection Control Nurses Association (now the Infection Prevention Society). It sets particularly rigorous standards which reflects the commitment of local general practitioners to ensuring high standards in this area but also implies the necessity not to panic when it produces a list of shortfalls from perfection.

In 2004/05 67% of Practices assessed achieved the required pass mark & 33% did not and it is a mark of the considerable effort at achieving high standards that by 2011/12, 95% achieved the required pass mark & 5% did not. Practices which fail are reviewed individually to see whether urgent action is needed to address patient safety. No practices required this in 2011/12.

As Practices have to be registered with the Care Quality Commission from April 2013, they will in future have to demonstrate steps taken to monitor & maintain their own infection control standards.

An electronic self-assessment tool, based on the Department of Health's "Essential Steps to Safe Clean Care" (DH 2006) has been devised, which will initially be piloted in 6 Practices across Stockport. It is intended that the Practice's nominated infection control lead will initially complete all sections of the self-assessment & compile a portfolio of evidence to demonstrate compliance. This will then be discussed with the Health Protection Nurse (Infection Control).

Infection Control and Inspection in Care Homes

During 2010/11 the Health Protection and Control of Infection Unit secured funding to create a temporary post (12 months) to undertake a specific project assessing infection prevention and control standards in nursing and care homes in readiness for CQC registration of these environments. This funding was withdrawn and the project came to an end. However over the duration of the project 64% of nursing and care homes within Stockport were visited, assessed, action plans drawn up and reviewed in conjunction with the home owners / managers.

This funding has since been renewed in conjunction with NHS Stockport Clinical Commissioning Group and a new project will commence from September 2013. The aims of this project are to

improve infection prevention and control standards within Nursing and Care Homes, with the ultimate aim of ensuring consistent standards across the health economy and to reduce the risk to vulnerable individuals of health and social care infections.

The current pre placement contract for placing individuals is currently under review by the Local Authority. Infection Prevention and Control has not previously been included in this contract. Therefore the Health Protection and Control of Infection Unit are working closely with Adult Social Care to ensure consistent standards are included in all pre placement contracts with nursing and care homes, ensuring consistency across the health economy for Stockport residents.

Infection Control in Stepping Hill Hospital

Stockport NHS Foundation Trust continues on its journey to zero avoidable Healthcare Acquired Infections (HCAI's), with its achievements in 2012-13.

The key areas of improvement in 2012-13 were MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia, further reductions in CDI (Clostridium difficile toxin associated disease) and Device related bacteraemia.

Zero MRSA Bacteraemia cases in 2012-13.

There was a continued reduction in the number of CDI cases in the year 2012-13. Numbers have fallen by 68.6% from 70 in 2011-12 to 48 in 2012-12.

There was a 34.2% reduction in the number of Trust Device Related Infections from 38 in 2011-2012 to 13 in 2012-13.

Zoonoses

Zoonoses are diseases and infections which are transmitted naturally between vertebrate animals and man.

Transmission may occur by a number of routes, from indirect contact through food or drink to direct contact through occupational exposure on farms, from pets or through leisure pursuits.

Twenty seven such diseases and infections are recognised as occurring in the UK and data on their frequency are obtained from national surveillance programmes.

The most commonly occurring zoonosis in England and Wales is Campylobacteriosis with 65,032 cases being notified (provisionally) in 2012: consumption of contaminated chicken would appear to be associated with the majority of campylobacter outbreaks. Non typhoidal salmonellosis is the second most frequent with 7,925 notifications, closely followed by Cryptosporidiosis (n= 5,722): one outbreak of cryptosporidiosis associated with the consumption of contaminated mixed salad leaves caused 300 cases. There were 795 notifications of VTEC 0157 – noteworthy because of its potential for causing Haemolytic Uraemic Syndrome.

The numbers of notifications of Hepatitis E continue to increase year on year with 579 individuals notified in 2012 in England and Wales: there is increasing evidence that Hepatitis E is a food borne zoonosis derived from inadequately cooked pork sausages.

Although cases of Toxoplasmosis appear to be falling from a high of 422 in 2009, nevertheless there were 311 identified through enhanced surveillance in 2012.

The first human UK case of Seoul hantavirus infection was confirmed in 2012 with isolation of the virus from wild rats in the North East of England: a new distinct hantavirus, designated Tatenale virus was isolated from a filed vole in Cheshire.

The occurrence of zoonoses, including those briefly mentioned above, emphasise the need for continued surveillance and collaboration between human and veterinary health practitioners.

Immunisation report 2012/3

Tab 15.5 Annual cover data 1/4/12-31/3/13

24 month cohort

Dtap/IVP/Hib	MMR	Men C	PCV
97.3%	94.1%	96.3%	93.9%

5 year cohort

Pre-school booster	MMR1	MMR2	Men C	PCV
97.6%	96.5%	91.1%	96.1%	93.3%

The WHO recommends vaccine rates to be over 95%. There is currently a GP lead catch up programme for MMR, due to the large number of measles cases across Greater Manchester. Although the figure for MMR 2 is not over 95% it remains higher than most areas, due to the hard work of the Immunisation and School Nursing Team catching the young people when they have their School Leavers Booster.

HPV

Human papilloma virus is the major cause of cervical cancer hence the reason for this immunisation programme. Provisional annual data for routine cohort as submitted by PCTs for first, second and third dose vaccine coverage by 31 August 2012. HPV coverage remains high and amongst the highest in the North West.

Table 15.6 HPV vaccinations

1st dose	2nd dose	3rd dose
94.5%	93.3%	92.0%

Season Influenza uptake 2012/13

Table 15.7	Over 65 yrs.	Clinical risk groups	Pregnant women
Stockport	80.3%	68.8%	74.5%
England	73.4%	51.3%	40.3%
North West	75.8%	55.3%	42.9%

The targets for 2012/3 were 70% for clinical at risk group and pregnant women and 75% of over 65 years. Although Stockport did not reach the target for clinical risk groups it is worth noting that Stockport had the highest uptake of seasonal influenza vaccine in all categories in the whole of England. This is an excellent achievement.

From the 1st April 2013, immunisation becomes the responsibility of Public Health England. We will be working closely with them to ensure that Stockport continues to improve on the already good immunisation uptake.

The Flu Strategy Group brings together stakeholders across the Health Economy to co-ordinate a seamless annual influenza vaccination campaign. Typically, the group meets three times during the year to plan and prepare for the forthcoming flu season. From mid-November through to the end of February the group 'meets' via telephone conference on a weekly/bi-weekly basis (dependent on influenza activity) to monitor levels of flu circulating in the community. The benefit of meeting so frequently over the flu season facilitates timely decisions/actions to be implemented in response to influenza levels.

Measles and Mumps

Measles is a disease which virtually everybody will catch unless they are immunised or fail to encounter it due to the immunisation of the population to a coverage level sufficient to stop spread. Bearing in mind the fact that a small number of people cannot be successfully immunised for various reasons there is very little scope for any significant number of people to free ride on the immunisations of others. It is for this reason that the cohort of children who were not vaccinated during the MMR scare are at significant risk.

The idea that measles is a minor disease is certainly true for many but by no means for all. It can cause death, disability or blindness and it is also the cause of a delayed neurological syndrome many years later causing disability and death.

There have been serious measles outbreaks in Greater Manchester which led to some cases in Stockport but these did not spread within the borough. We had formed the view from statistics of uptake levels that the Stockport population, although not immunised to a level of complete safety would probably not experience major outbreaks and these incidents bear that out. This situation has been achieved largely through catch-up campaigns and it is important that people who have not been immunised arrange to have an immunisation so as to protect themselves and strengthen further the protection of the Stockport population.

Mumps is an acute viral illness transmitted by direct contact with saliva or droplets from the saliva of an infected person. Humans are the only known host of the mumps virus. Mumps remains a notifiable disease (like Measles), which means that the Doctor who sees a patient whom they suspect has mumps is required by law to report it. There have been outbreaks of Mumps within Greater Manchester which led to some cases within Stockport as outlined in the figures below. Again the low numbers of infections is a reflection of the immunisation status within the borough.

Notification for Stockport LA from 01-Apr-2012 till 31-Mar-2013

Table 15.8	Confirmed	Probable	Possible	Discarded	Total Notification
Measles	3		20	27	50
Mumps	11		17	16	44

Mass Immunisation Plan**:**

The Mass Immunisation Plan exists to ensure that we could carry out mass vaccination should that be necessary in connection with any epidemic. It has been reviewed to ensure it remains fit for purpose following NHS Reforms. The review involves re-visiting venues previously identified for mass immunisation to ensure they continue to be suitable for this purpose & re-establishing links to access the necessary resources to facilitate such sessions (e.g. staff, equipment etc.). The Health Protection Team is working (in collaboration with Civil Resilience colleagues) to identify 'new' venues for Mass Immunisation to provide greater geographical spread across the borough.

Mass Vaccination Exercises take place periodically to test the plan and the revised plan will be tested later this year.

Sexually Transmitted Diseases

As well as the conventional infectious diseases, the major (although not only) cause of cervical cancer is sexually transmitted human papilloma virus.

Sexually transmitted diseases can be addressed by:

- Avoiding casual sex with a large number of partners
- Using barrier methods of contraception
- HPV immunisation
- Rapid attention to symptoms of sexually transmitted diseases at a sexual health clinic

Sexual Health - Nationally

The issue of sexual health embraces both avoidance of sexually transmitted diseases and avoidance of unwanted pregnancy.

Up to 50% of pregnancies are unplanned; these have a major impact on individuals, families and wider society.

In England during 2011, one person was diagnosed with HIV every 90 minutes.

Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment.

Rates of infectious syphilis are at their highest since the 1950s.

Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics.

In 2011, 36% of women overall, rising to 49% in black and black British women, having an abortion had had one before.

In 2011, just over half of women having an abortion had previously had a live or stillbirth, indicating that better support is needed to access contraception following childbirth.

Stockport Context re Sexually Transmitted Infections

1.   HIV Late diagnosis was 42% patients receiving a diagnosis of HIV for the first time with a CD4 count of less than 350 cells per mm3 within 91 days of their diagnosis. (2009 to 2011)

2.   Stockport HIV late diagnosis was second lowest across GM with 37% (2009 to 2011)

3.   Chlamydia diagnoses (15 to 24yr olds) 1755 per 100,000 (2012)

Meningitis

Invasive meningococcal disease presents usually as septicaemia, meningitis or more usually as a combination of both septicaemia and meningitis. It is a medical emergency and carries a mortality of approximately 10%.

There are 13 subgroups of Neisseria meningitidis classified on the basis of the capsular polysaccharide with type B being the most common in the UK.

During 2011/ 2012 there were 766 confirmed cases of invasive meningococcal disease in England and Wales with about 90% due to type B disease. In Stockport during 2012/ 2013 there were five confirmed cases with two resulting from type B disease - in the other three cases no typing result was available.

The majority of meningococcal disease occurs in infants less than five years of age, with a peak incidence in those under 1 year of age. There is a smaller, secondary peak in incidence in young adults aged between 15 - 19 years of age.

Meningococcal disease shows marked seasonal variation with a peak in winter and a low level in summer. The winter season coincides with that of influenza.

Since 1998 when the meningococcal C vaccine was introduced there has been a substantial reduction in numbers of individuals with confirmed disease.

The public health action (carried out by Public Health England) required after an individual is identified with confirmed/ probable invasive disease involves identification of close contacts and offering chemo prophylaxis with ciprofloxacin and vaccination with either a meningococcal C vaccine or a meningococcal A C W Y vaccine as dictated by the serotyping results. There is as yet no meningococcal B vaccine.

Some Significant Risks

Infection and Travel

The natural tendency of evolution is for parasites to become less harmful as natural selection favours the les virulent organisms (which do not suffer the disaster of their host dying) and the more resistant hosts (who survive the infection). One major example of this is scarlet fever which was once a killer disease but has now evolved into something much less significant. Evolution of the organism is more important to this process as millions of generations of evolution of the microorganism can occur in a single human generation but the two processes do converge.

Often contact with a disease early in life can produce a less severe disease than later in life so diseases which are widespread and to which people become immune from a mild attack in childhood may not b major problems.

When Europeans first visited yellow fever areas they found a disease which, for a combination of the above reasons was relatively mild in local people but was deadly to those arriving from a non-immune population. The opposite effect occurred when Europeans spread measles to the Pacific.

The mingling of previous separated ecosystems can therefore lead to outbreaks of disease. In isolated Arctic and Antarctic settlements an outbreak of the common cold commonly follows the arrival of the first supply ship after the winter – this phenomenon is called "the Spitsbergen cold" after the first community to describe it.

What therefore should we think of increasing international traffic? Some see in it more opportunities for these effects to occur. Certainly new viruses can now spread round the world more rapidly and it is essential that travellers pay attention to the vaccinations they need and to issues like malaria prophylaxis.

However the contrary effect is that as the world becomes more of a single ecosystem there are fewer totally separated populations to develop such situations.

The Risks of a Flu Pandemic

The flu virus changes its genetic make-up by mutation and this results in the creation of viruses to which people have reduced immunity. This explains why there is a flu outbreak each year and why we need to keep on being revaccinated. A flu pandemic occurs when a wholly new virus to which nobody is immune arises and spreads round the world before we have been able to develop a vaccine. The last such pandemic in 2009 and it was very mild, so much so that all the precautions taken seemed to have been an overreaction. The fear is of a pandemic which has a high fatality rate and kills millions, like that which occurred in 1918. With a very high fatality rate the disease cannot spread and often new viruses are not very transmissible anyway but the risk of a disease which is sufficiently virulent to kill large numbers of people, transmissible enough to spread and not virulent enough for the spread to peter out.

It is generally believed that someday the 1918 type of pandemic will happen again although I personally subscribe to a minority contrary point of view that the 1918 pandemic resulted from the

closed ecosystems of the First World War armies and the mingling that occurred on demobilisation so is unlikely to occur again unless there is a major disruption of international travel.

Sophisticated surveillance systems are in place around the world to detect a pandemic and in the recent pandemic they worked well, apart from overvaluing the virulence of the illness initially because of a failure to realise that the fatal cases seen in Mexican hospitals were the tip of an iceberg with most mild cases being dealt with outside the health care system.

The Risks of Losing Antibiotics

The Chief Medical Officer has recently warned of the fact that new antibiotics are not being discovered and so there is a danger that increasing resistance to existing antibiotics might leave us with no reliable antibiotics in which case people might again die from infections of minor wounds and some forms of surgery might become too dangerous to contemplate.

The misuse of antibiotics is fundamentally irresponsible.

Chemical Hazards

Hazardous Substances

The control of hazardous substances emitted to the outside environment is addressed at a multi-agency level whether through routine inspection of industrial premises or in response to an incident.

Response to a major incident is usually instigated by the fire service in the first instance, and where appropriate they will request the assistance of other agencies.

If the incident involved the pollution of a water course, then the responsible agency for this would be the environment agency. The environmental health department are generally responsible for emissions to air or land.

Where a spill or emission arises on private land and it is prejudicial to health, then Environmental Health can serve a notice on that person under the provisions of the Environmental Protection Act 1990 requiring them to carry out the necessary steps to remove the health risk. In most cases these works are carried out by the Council's contractors and the owner or occupier of the premises is recharged for the costs incurred.

A relatively common incident that is dealt with in this way is asbestos fires. The fire service attends the site to extinguish the fire and remove the immediate risk. If fallout from the asbestos fire is likely to affect the nearby population they will request our assistance in the service of a notice on the organisation of a clean-up. This can happen any time day or night.

Land Contamination

Land contamination is dealt with under the planning regime and also under the provisions of Part 2A of the Environmental Protection Act 1990.

Under the planning regime, a developer is required to assess land for potential contaminants and to make sure that the final development is suitable for the end user.

Under Part 2A the Council is required to have a contaminated land strategy and to prioritise any potentially contaminated sites for investigation. Where land is found to be statutorily contaminated it is included on the Council's Contaminated Land Register. The legal test to determine land as contaminated is that it must be shown that there is 'significant possibility of significant harm'.

Air Quality

Pollution from the increasing number of motor vehicles using our roads provides the greatest threat to air quality in Stockport and across the UK. Harmful vehicle emissions contribute to breathing and lung problems in susceptible people, and contribute to greenhouse gases which cause climate change.

Local air quality monitoring is carried out by Environmental Health which forms part of the Greater Manchester air quality network. The main pollutants that are analysed are particulates, carbon dioxide and nitrogen oxides. In Stockport along main road transport routes where monitoring and modelling of air quality has shown that exceedances are likely, the Council has declared Air Quality Management Areas.   Stockport is included in the Greater Manchester Air Quality Action Plan.

Where there are major incidents that may affect air quality, DEFRA recommend that a multi-agency 'Air Quality Cell' (AQC) should be convened. This is co-ordinated by the Environment Agency in consultation with Public Health England. Other agencies such as the Met Office, Food Standards Agency and local authority representative can join the AQC. The Council were recently involved in an AQC following a large fire at a waste recycling plant in the Bredbury area. The Council took over the air quality monitoring after the agency stepped down and continued to assess the situation over several days until we were satisfied that conditions on the ground were stabilised and were not going to worsen. Throughout the incident we liaised with Public Health England to ensure the correct messages were given to the local community.

Noise and Nuisance

The impact on health and wellbeing as a result of noise or other nuisance in the neighbourhoods of Stockport is potentially significant. Environmental Health dealt with 2300 complaints about noise or other nuisance in annual year 2012/13. Such issues not only have the potential to affect physical health but also impact in most cases on mental health and wellbeing. Noise and other issues e.g. smoke, fumes, premises, animals, odour, accumulations, deemed to be prejudicial to health or a nuisance are addressed utilising The Environmental Protection Act 1990.

 Health and Safety

Improvements in health and safety at work are amongst the greatest achievements of our society in the 20th century and are one of the major reasons for the proportion of men reaching old age increasing towards the end of that century. It is easy today to laugh at some of the eccentricities of overzealous health and safety measures. Such overzealousness, which rarely results from a professional inspector, is indeed something we must tackle for health and safety is too important to be rendered a laughing stock. A couple of generations ago the image of ashen-faced families

gathered for news at the gates of the factory or mine in which there had been a major accident was part of our cultural folk memory. If we have allowed it to fade we have done so at our peril.

Less than 50 years ago children burned alive in blazing nightdresses. Less than 25 years ago people choked in the poisonous smoke of burning foam-filled furniture.

If these things are to remain only history we must be careful how far we go in calling for deregulation or in laughing at "health and safety".

The important thing we must keep in mind is the distinction between a safe society and a risk-averse society. In a safe society people who climb mountains use the proper equipment, train properly, check the weather, inform others of their route and support a mountain rescue service. In a risk-averse society people do not climb mountains. When regulation strays into risk-aversion we must step back. Ultimately a risk averse culture is an unsafe culture because people lose patience with it and then have no parameters for safe behaviour, it absorbs resources which are needed to create a safer and healthier world, it limits human growth, creates dependency, and leaves people unfitted to handle risks when there are no regulations to direct them, people concentrate on documenting risk avoidance rather than on tackling hazards and it asks too much of people and they fail so that absurdly excessive levels of precaution coexist with blatant danger.

But we must oppose the siren calls of those who would neglect the genuine advancement of safety.

Unsafe Products and rogue traders

Trading Standards have a responsibility to enforce a wide variety of both general and product-specific legislation in the area of product safety. Enforcement of this legislation is achieved both proactively and reactively.

Some examples of these activities and the outcomes achieved are provided below:

Table 15.9

Activity	Number 2012/13	Summary
Business advice requests	17	Local businesses seeking advice on how to ensure compliance with relevant product safety requirements
Consumer complaints	43	Investigation of complaints from local consumers which indicate potential breaches of product safety legislation
Referrals about local businesses	22	Referrals from other TS departments regarding potential contraventions of product safety legislation by businesses based in Stockport
Product safety samples	41	Samples taken as a result of inspections, complaints etc. to monitor compliance with relevant product safety requirements in relation to areas of emerging risk
Routine Inspections	29	Risk based inspection programme covering businesses who make, import or sell goods to which product safety legislation applies
Surveys	5	Local and regional surveys targeting areas where compliance issues have been identified through local/regional/national intelligence

Advice was provided to local businesses on ensuring compliance with relevant safety requirements in a number of areas, including cosmetic products, toys, electrical equipment and electronic cigarettes.

Following a referral from another trading standards department after a consumer complaint, a business in Stockport was raided and thousands of imported phone chargers and associated equipment were seized. Samples were taken and submitted for analysis, and many of the items failed the relevant safety tests. A criminal investigation has been undertaken, with a prosecution pending.

Joint visits with the fire service during Electrical Safety Week to premises selling second hand electrical equipment, advising on appropriate testing provisions and safety requirements prior to sale,

Working with the Police, Fire Service and Anti-Social Behaviour team during the fireworks season, ensuring compliance with relevant safety requirements;

A protocol was developed with the Fire Service whereby information pertaining to electrical fires which may have been caused by faulty/unsafe products is shared and acted upon.

Regional projects undertaken during 2012/13 included:

Magnets and projectiles in toys: Each Authority purchased samples for each of the criteria. All samples were then submitted for analysis against the relevant safety standards, which resulted in a number of products being removed from sale/recalled by the manufacturer. This information was then reported on a national database (Memex) to alert and inform other trading standards departments of the product safety issues found and areas of concern

Importer project: Documentary checks carried out on businesses importing goods subject to product safety legislation (such as toys, electrical equipment and cosmetic products) from outside the EU, to ensure that traders were complying with relevant requirements, such as maintaining technical files for each product etc.

Targeted enforcement activity including prosecutions has been undertaken in Stockport for approximately 10 years to prevent the sales of age restricted products such as alcohol, tobacco, knives and sunbed use. The annual survey of young people carried out by Trading Standards NW has indicated that in Stockport fewer of them now believe that shops in Stockport will sell to those underage.

There is a multiagency prevention and response service in Stockport to provide information within communities about rogue trader activities and to respond in cases where rogue traders may actually be targeting vulnerable people.

Health and Safety at Work

The Health and Safety Executive (HSE) and Local Authorities (Las) are the principal Enforcing Authorities (EAs) for Health and Safety at Work etc. Act 1974 (HSWA) in Great Britain. The primary purpose of the HSWA is to control risks from work activities. The role of the EAs is to ensure that

duty holders manage and control these risks and thus prevent harm to employees and to the public. Regulation activity is split between the two authorities dependent upon work premises type.

In Stockport such work is carried out by Environmental Health. Proactive Inspections are restricted to those activities and issues detailed in the National Local Authority Enforcement Code and are also carried out at premises where Intelligence or history suggests poor compliance. Inspections are undertaken at all skin piercing premises prior to allowing registration under the Local Government (Miscellaneous Provisions) Act 1982. Investigations are carried out in respect of all accidents that result in a fatality of an employee or member of the public, if as a result of a workplace activity. All accidents that result in a serious injury to an employee or member of the public are investigated. The section has two officers trained as Family Liaison Officers. They liaise with bereaved families and injured parties in order to keep them updated on the progress of any investigations. Advice to small and medium sized business is via the council website and the 'Health & Safety that Works' pack. Service requests and complaints about premises from other enforcement agencies are also responded to.

The Section has responsibility for administering the annual Safety Certificate at Edgeley Park Football Stadium. This involves an annual ground inspection, match day inspections, chairing the Safety

Advisory Group meetings, ensuring compliance with the safety certificate and giving advice to the club. It has also entered into a Primary Authority (PA) partnership with National Tyres and Viking International. As part of this partnership the team provides PA advice to the company and responds to health and safety referrals from other LAs.

The section continues to work with Greater Manchester Police Crime Reduction Advisors in order visit premises that have suffered robberies. A member of the team attends the Retail Violence meetings.

In 2009 the section targeted young people to raise the profile of health and safety to reduce accidents / dangerous incidents prior to them going on work experience. During the session the students participate in various activities to spot workplace hazards and learn about occupational diseases. Some of the dangers highlighted include hazards in the construction, office, care, retail, horticulture and catering industries. These roadshows are supported by local businesses and the Health and Safety Executive. To date some 2550 year 10 children have attended our roadshows. This project will continue in 2013/2014 on request from schools.

"Smoke Free" legislation is also enforced by both Environmental Health and Trading Standards. Recent action has been taken to address smoking in taxis.

Recent cases:

- A fatality at a climbing centre, which resulted in evidence being given at the coroner's inquest.
- Fatality involving a member of the public who fell from height in a church whilst volunteering. This resulted in evidence being gathered for the coroner.
- A successful prosecution of a major high street building society for exposing employees and members of the public to asbestos fibres during a refurbishment.

- A successful prosecution of a woodworking company that had failed to adequately guard dangerous machinery and had exposed employees to potentially hazardous sawdust.
- Two prohibitions served to prevent tattooists from operating without the appropriate sterilisation procedures and exposing members of the public to risk of infection from HIV & hepatitis.

Housing Standards

Housing should provide an environment that is as safe and healthy as possible. Poor housing conditions can be a major cause of accidents and ill health. The quality of the home has a substantial impact on health; a warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors that help to improve well-being include the neighbourhood, security of tenure and modifications for those with disabilities. Research has shown that poor housing costs the NHS a substantial amount each year.

Various sources of housing and health data suggests that poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. Housing-related hazards that increase the risk of illness include damp, mould, excess cold and some structural defects that increase the risk of an accident, such as poor lighting, or lack of stair handrails.

Tackling problems of poor housing to protect the health, safety and welfare of the occupants is a key environmental health priority. The introduction of the Housing Act 2004 enables the Environmental Health profession to ensure that everyone has a decent home to live in. The Act allows Local Authorities to focus on helping tenants living in private sector housing, by requiring landlords to carry out necessary repair or improvement works.

Powers are also available under The Environmental Protection Act 1990 and the Public Health Act 1936 to ensure housing provision is of a satisfactory standard. The Environmental Protection Act concentrates on ensuring premises are not in such a state as to be prejudicial to health or a nuisance whereas the Public Health Act allows the LA to take action where a premise are in such a filthy and unwholesome condition as to be prejudicial to health or, are verminous.

The Housing Standards Team deal with a range of housing related duties. The team investigate requests for service relating to:

- Conditions in privately rented homes
- Filthy and verminous premises
- Poorly maintained privately owned dwellings
- Harassment and illegal eviction of private tenants
- Licensing of Houses in Multiple Occupation
- Empty Domestic Properties
- Immigration inspections

All of the above are statutory functions with the exception of bringing empty properties back to use.

The team deal with empty properties in the borough by implementing the Council's Empty Property Strategy.

Emergency Planning

Emergency plans are maintained, reviewed and tested under the auspices of the Health Economy Resilience Group for the health service and the Local Resilience Forum for multi-agency work. The HERG operates at local level. The LRF operates at Greater Manchester level but has a local group. A core group of key individuals serve on both groups and provide a reference group giving assurance to the Health & Well Being Board.

Preventing Injuries and Crashes – What we Can All Do to Help

- don't drink and drive
- after drinking, allow one hour for each unit you have drunk before driving, using machinery or undertaking any other dangerous tasks requiring care. This will keep the number of units in the bloodstream of a person of average size and build below one unit which should be safe. If you want to be completely alcohol free allow an extra hour. Also allow extra time if you are significantly below average height and weight (this includes many women). Traditionally a unit is a small glass of wine, a pub measure of spirits, or half a pint of beer. However this was based on 125 ml glasses of wine, 9% abv wine and 3% abv beer. Many glasses are now larger than this and most drinks served today are stronger, sometimes much stronger, so these traditional guidelines can be dangerously misleading. Check the size of the glass and the strength of the drink and adjust. Remember that drinks described as "low alcohol" rather than "alcohol free" do contain some alcohol.
- drive at no more than 20mph on side roads. This will add no more than a couple of minutes to most journeys, since you rarely travel far before you join the main road, and yet it would save most child pedestrian deaths.
- wear seat belts in cars, and crash helmets on motor cycles
- give cyclists space when driving past them
- learn advanced driving techniques - they not only protect you and other people, but they make driving more enjoyable

- fit smoke alarms and test them weekly to make sure they are working properly
- think about the safety of toys, furniture and domestic equipment
- talk to your health visitor about preventing home accidents to toddlers
- always ask sales people about the safety features of the product. Not only will the message eventually get through if enough people do it, but it's fun watching their reactions.

3.16.   HEALTH OF CHILDREN AND YOUNG PEOPLE

Indicators of the Health of Children and Young People

The health and wellbeing of children in Stockport is mixed compared to the England average.

Table 16.1 – Comparison between Stockport's performance on key indicators and the England average

Indicators where Stockport performs better than the England average	Indicators where Stockport is similar to the England average	Indicators where Stockpot performs worse than the England average
Immunisations **Children in care immunisations** **Acute sexually transmitted infections** **Low birthweight** **Obese children (age 4 – 5)** **Breastfeeding at 6 – 8 weeks** **A & E attendances (age 0 – 4)**	Infant mortality Child mortality (age 1 – 17) Obese children (age 10 – 11) Participation in sport / PE Teenage conceptions Admissions due to substance use Admissions for mental health	Children's tooth decay Admissions due to oral cavity disease Admissions due to alcohol Maternal smoking Breastfeeding initiation Admissions due to injury Admissions due to asthma Admissions for self-harm

The information in table 16.1 was taken from the 2013 ChiMat Child Health profile for Stockport with some additional analysis from Stockport Councils public health data team. The comparisons are largely based on 2012 data.

Stockport benchmarks very well against North West averages; rates for virtually all the above indicators are similar to, or better than, the North West average. One exception to this is hospital admissions for asthma where Stockport rates are worse than the North West average.

Hospital admission rates for several conditions are worse than the England average. This is the case for injury, asthma and self-harm; injury and self-harm are highlighted elsewhere in this report. There is also evidence that admissions rates are high for oral cavity disease and diabetes. The reasons for these high admission rates merit investigation. The CCG is currently progressing joint work on asthma management. The reasons for high admission rates are often complex and may not necessarily be because of higher prevalence. Coding issues and the way that services are funded and delivered may also have an impact.

Table 16 2 – Trends for key indicators

Indicator	Most recent value	Trend
Breastfeeding initiation	71.5%	No clear trends – small increase in 12/13
Breastfeeding at 6 weeks	47.2%	Trends were gradually increasing but decreased in 12/13
Maternal smoking	12.6%	No clear trend – decrease in 12/13
Hospital admissions for unintentional and deliberate injury 0 – 17s	13 per 1000	Gradual upward long term trend but small decrease in 12 / 13
Hospital admissions for unintentional and deliberate injury 0 – 5s	13.2 per 1000	Upward trend
Emergency department visits as a result of injury 0 – 17s	126.5 per 1000	Tentative evidence of an upward trend
Alcohol related hospital admissions 16 – 19	7.9 per 1000	Tentative downward trend
Children overweight or obese at reception class	19.5%	Upward trend
Children overweight or obese at year 10	33.4%	Upward trend

The rates for many of these indicators vary according to levels of deprivation. Despite concentred effort in priority areas significant inequalities remain and there isn't clear evidence that they are being narrowed. For example the breastfeeding rate in Brinnington at 6 weeks in 2012 / 2013 was 19% compared with 67% in Bramhall. Maternal smoking rates are also highly polarised with 43% of women smoking at time of delivery in Brinnington compared with 6% in Bramhall

Improving the Health of Children and Young People in Stockport

Stockport's Joint Health & Wellbeing Strategy identified 5 'We Wills'. This section of the report will review progress on these.

We will ensure children get the best, healthy start in life from conception to 5 years by enabling parents to access effective child care and advice, family support and quality early education and childcare provision

There is a clear sense of momentum in early year's services. Health visiting services are being strengthened through the Health Visitor Implementation Plan (2011 – 2015) in order to allow full delivery of the Healthy Child Programme (conception to 5 years). It is planned that Family Nurse Partnership (a programme targeting first time parents from conception until the child is 2) will be delivered in Stockport starting 2014 / 2015.

The model of Children's Centres delivery has been changed in order to meet the Council medium term financial plans but they continue to have a presence throughout Stockport and continue to be actively involved in supporting the Healthy Child Programme.

The Early Help and Prevention service is leading on the required increase in free high quality early learning places for two year olds. The Department for Education have indicated that in Stockport 550 two year olds will be eligible from September 2013 and 1100 two year olds from September 2014. There are currently 320 eligible two year olds accessing a free place. The Early Help and Prevention Service is also leading on improving the accessibility and quality of information available via the Council website in relation to early learning and childcare places for parents.

Stockport Council and the Stockport Foundation Trust are working closely together to develop integrated delivery models in early years in order to maximise use of resources. This is supported by a robust AGMA programme in which Stockport is actively involved.

Breastfeeding initiation rates rose to 71.5% in 2012 / 2013. The rate at 6 weeks fell to 47.2% which is disappointing. This fall coincided with a change in data collection methods, so it may be in part due to improved data quality. There are very stark inequalities in relation to breastfeeding in Stockport. Stepping Hill Hospital has achieved the UNICEF Baby Friendly award. Plans are currently being progressed to appoint a community infant feeding specialist and work towards achievement of the community Baby Friendly award.

The maternal smoking rate reduced to 12.6% in 2012 / 2013 which is similar to the England average. There are however very significant inequalities which we are not making a sufficient impact on and further work is needed in this area.

Promoting healthy weight continues to be a priority for stakeholders with ongoing investment in, and support for, the HENRY (Health, Exercise and nutrition for the Really Young).

Oral health remains a concern as Stockport's rates are worse than the national average. This is likely to be in part due to the lack of fluoridation in North West water but substantial inequalities point to other causes also being significant. It is suggested that that a greater focus is needed on this area with development of better partnerships with dental care, development of a prevention pathway and increasing our understanding of local data.

We will keep children safe from harm and reduce childhood injury

The most recent Ofsted inspection of arrangements for safeguarding children and young people took place in February 2012. The overall effectiveness was judged to be adequate which does not match the aspiration of partners. A comprehensive and robust joint children's social care and health action plan was put in place to address the OFSTED feedback and this has now been fully implemented.

The independent chair of the Stockport Safeguarding Children Board noted in a recent report, that referrals to social care had reduced in 2012 / 2013, which may be the result of demand being managed more intelligently through the Supporting Families Pathway and the recent introduction of the Early Help and Prevention Service. He also noted that despite the needs of organisations to make savings, commitment to safeguarding remains strong in Stockport.

There is an extensive training programme to support partner organisations to effectively safeguard children. There are concerns that elements of this may be at risk due to reductions in grant funding and reduced capacity for existing staff to deliver training.

A designated nurse for the Looked after Children post is now established following the Ofsted recommendations. Stockport health professionals are now achieving quality standards in relation to health assessments for children placed by Stockport Local Authority. Stockport continues to have excellent immunisation rates for looked after children. An action plan in relation to the mental wellbeing of looked after children is being implemented. There are some difficulties with access to mental health services for the 16+ group.

Hospital admissions for unintentional injury are higher than the national average. Rates are highest in the early years of life and the 15 – 17 age group. There has been a gradual upward trend in the last 4 years and there is evidence that emergency department attendances at Stepping Hill hospital for the 0 – 17s has increased over the same period. The public health team is working to develop an accident prevention co-ordinator post to progress work in this area. They will work across the ages focusing on early years, young people and older people. Stockport has a home safety equipment scheme which aims to reduce injuries in the first 2 years of life. This is delivered in partnership with Stockport Homes. It is currently too small in scale to have a significant impact on accident rates. It will be a key priority for the co-ordinator to develop the scheme.

We will support and promote healthy lifestyles for 5 – 19s through schools and other community settings

The majority of Stockport schools are well engaged with the health agenda with good links with Stockport Council facilitated by the schools health and well-being co-ordinator. Public health colleagues are working with the co-ordinator to explore how they can work together to develop a coherent health offer.

The capacity of the school nursing service remains a concern. Limited capacity means that the service is largely focussed on safeguarding and addressing the needs of children with high level needs rather that developing their public health role in schools. Mapping of school nurse funding is being progressed in the North West. Early indication is that spending per head in Stockport is below average. There are significant gaps in delivery of the Healthy Chid Programme (5 – 19s) because of these limitations. They include:

Little feedback is given to parents when their child is measured as part of the National Childhood Measurement Programme.

Links with independent schools. Stockport has many independent schools. The school nursing service has responsibility for all children living in Stockport but doesn't have the capacity to work

with independent schools to ensure the needs of Stockport children in these schools are being addressed.

Services for young people over 16. The school nursing service does not work with young people before the ages of 16. Services for young people over the age of 16 is a wider problem with concern being raised in relation to mental health support and support for Looked after Children. This issue was raised by the Local Authority peer review which reported in December 2012.

A team based approach to addressing public health in secondary schools has been effectively piloted in 3 secondary schools. The Local Authority and Foundation Trust are working in partnership to sustain and develop this programme with an aim for it to be delivered in all secondary schools.

Healthy weight remains a priority for the partnership. Stockport performs comparatively well in terms of obesity rates but the trend is upwards and there is also a large increase in overweight/obesity between ages 5 and 11. The gap between Stockport and England rates appears to be narrowing. There is a well-developed physical activity strategy and the Schools Sports Partnership works with 83% of Stockport schools. The government has recently announced further investment in physical education and schools sports. There is currently a focus on supporting and developing breakfast clubs in schools. New guidance on food in schools has recently been published and it will be a priority to roll this out in schools. Work is being progressed to scope and cost options for providing feedback to parents form the National Childhood Measurement Programme. The All Together (A2A) programme continues to report positive impacts. Weight management services for 13 – 16 year olds is a gap. Solutions to this are being explored.

The rate of alcohol related hospital admissions was higher than the national average in 2011 / 2012. The rate showed a fall in 2012 / 2013. The majority of schools continue to buy into the Mosaic service which is well developed in Stockport. A pathway has been developed for children and young people who present at the Stepping Hill emergency department with substance use issues. This has proved effective in terms of being able to offer support to this group. The Drug and Alcohol Awareness Weeks in schools have been partially funded from the Local Authority public health grant but not all schools have bought into these.

We will promote positive emotional health, self-esteem and wellbeing for children, young people, parents and carers

The Mental Health in Everyday Practice (MHEP) programme has been developed to support front line workers to address mental health needs in their work. Plans are progressing to deliver this programme to key staff in the children's workforce. This has been limited by capacity of staff to deliver courses but efforts are being made to develop the training pool. The Living Life to the Full course, a life skills course based on Cognitive Behavioural Therapy, is also being developed in Stockport. This is clarity relevant for parents.

The CAMHS strategy is currently being reviewed and there have recently been meetings to explore how the service can work more effectively with a range of stakeholders. Mental health services for under 5s are a concern. CAMHS does not provide services for this group. Work is ongoing to address this gap with plans to fund a child psychology post and develop more health visiting capacity to address early attachment problems. Services for children over 16 are a concern as is services for care

leavers. Stockport Council's Health Scrutiny Committee plans to do a review of CAMHS in Autumn 2013.

Stakeholders have identified that improving partnership working between adults mental health services and children should be a priority. Stakeholders have also expressed concern about self-harm and there may be a need to provide more training on prevention and management of self-harm. It is planned that this is discussed at the CAMHS Partnership in the near future.

We will work closely with families to provide early interventions and preventative programmes to reduce the development or impact of health or wellbeing problems

It is felt that progress in relation to this is covered in the narrative in the previous section

Some Priority Issues

The list below is a summary of pressures or areas where further developmental work is needed:

- Health inequalities on key indicators (e.g. breastfeeding, maternal smoking, hospital admission for unintentional injury)
- Mental health support for families with children under 5
- Joint working between children's and adult services
- School nursing capacity and development of the Healthy Child Programme public health offer for 5 – 19s
- Weight management – feedback from The National Childhood Measurement Programme and weight management services for 13 – 16's
- Services for 16 – 19 year olds
- Hospital admission rates for several conditions
- Development of a prevention pathway for oral health

3.17.   HEALTH AND WORK

WORKLESSNESS

One way of asking about the effect of work and health is to look at the opposite side of the coin and ask what the effect on health is of being without work.

There are over a thousand studies from the 1930s and 1980s about the effect of worklessness on health and more are being generated during the current recession. Yet only a handful of those are useful because certain common analytical errors continue to be made.
Unemployment correlates with poor health by time (when unemployment rises health deteriorates), by geographical area (health is worst in areas where unemployment is highest) and in individuals (unemployed people suffer worse health than employed people). People's health deteriorates when they lose their job.

But unemployment rate rises and falls with recession so the time relationship could be with recession not with worklessness. Unemployment rates are highest in areas of multiple deprivation so the geographical correlations could be documenting multiple deprivation not just worklessness. The fact that unemployed people are sicker than employed people could show only that sick people are more likely to be without work. If people's health deteriorates when they lose their job this is what we would expect from what we know of the health effects of life changes.

Another common analytical error is to say that most spells of unemployment are short. This is true but it only shows that there is an underlying rate of people changing jobs. What matters are the longer spells. The following diagram (fig 17.1) shows 12 people who change jobs in a year, one each month, being out of work for a month and 1 person who is unemployed for the whole year.

_ _ _ _ _ _ _ _ _ _ _ _   12 people unemployed for a month

_____ 1 person unemployed for a year.

Over 90% of the people shown in this diagram were unemployed for only a month. But at any given time 50% of those who were unemployed were unemployed for the whole year.

This diagram is, of course, only a theoretical example and reality is much more complex. But it does show how a study of spells of unemployed may be dominated by short spells of gaps between jobs when a large proportion of those without work at any given time are experiencing much longer unemployment.

For all these analytical problems we do indeed know that worklessness is bad for health. We know it from :

- Longitudinal studies following people over prolonged periods of time
- Studies which meticulously correct for the factors described in the above account
- A study which shows that people's health improves when they retire from worklessness.

THE IMPACT OF UNEMPLOYMENT ON COMMUNITIES

From work done by Brenner during the 1980s recession we know that each 1% increase in unemployment sustained for five years produces in the 5th year:

- a 1.9% increase in total mortality,
- a 4.3% increase in male mental hospital admissions,
- a 2.3% increase in female mental hospital admissions,
- a 4% increase in prison admissions,
- a 4.1% increase in suicide and
- a 5.7% increase in homicide.

This is greater than the effect shown by longitudinal studies which show that for every 100 men unemployed for five years there will be 2 extra deaths a year amongst those men and 1 extra death amongst their wives, implying an impact on the health of unemployed people themselves which is no greater than the impact which the above figures project for the whole community. Thus the effect of worklessness on the health of communities is greater than the sum of the effect of worklessness on the health of unemployed individuals and their families. This is because the effects of unemployment spread more widely – to those who fear losing their jobs, those who accept shorter hours or worse conditions, those who are affected by overwork in workforces that have been reduced, and those who lose the benefits of the work the unemployed could have done. These effects not only add to the ill health experienced by unemployed people themselves but they also affect the baseline set by the controls in the longitudinal studies.

MITIGATING WORKLESSNESS

The health damage of unemployment is

- greater the stronger the sense of commitment to the work ethic
- less in those whose work involved responsibility for structuring their own time
- reduced by strong supportive social networks
- affected by the stigma of unemployment. Health improves when unemployment is redefined as retirement.

WORK IS ALSO BAD FOR HEALTH

So if worklessness is bad for health then work must be good for it? Well not necessarily

In the 19th century recessions improved health

There have been some studies which show health improving on factory closures

One third of the social class inequality in health is work related according to a study from 1978. Although this study is old and has not been repeated it may well still be valid.

HOW CAN BOTH THESE STATEMENTS BE TRUE?

So how can we say that work is bad for health and worklessness is also bad for health?

The health damage of work and worklessness are not opposites

Some people securely enjoy good quality work

Some people enjoy good quality work when times are good but suffer poor quality work or insecurity when times are bad

Some people suffer poor quality work when the economy is booming and unemployment when it isn't

Some people, especially people with disabilities or other employment problems, rarely experience work and when they do it is of poor quality

Work provides

- Income
- Structure to the day
- Social contacts
- Status
- Sense of identity
- Sense of contributing to society

In good quality work these benefits are considerable and it is good quality work which is good for health.

It is good quality work which is good for health whilst poor quality work is harmful and falls on the same people as the harm of unemployment but at different times in their lives.

GOOD QUALITY WORK is

- Meaningful
- Enjoyable
- Able to be integrated into life
- Pleasant surroundings

And has

- Significant autonomy
- Resources, power and training appropriate to responsibilities
- No unnecessary deadlines
- Good social support
- No bullying

CHALLENGE 1 ALL PEOPLE IN STOCKPORT SHOULD ENJOY GOOD QUALITY WORK

The health service and local government are significant employers and can help create good quality work by

- Addressing worklessness and training through opportunities for disadvantaged groups
Improved occupational health support for employees

- Operating as best practice leaders and acting as exemplars
- Fostering understanding of the importance of good quality work and ensure this is understood by those working to attract jobs
- Strong political leadership on the need to create good quality work
- Encouraging exemplar businesses to emphasise the benefits in recruitment, retention, morale and productivity

CHALLENGE 2 DISABLED PEOPLE IN STOCKPORT SHOULD BE EMPLOYED FOR THEIR ABILITIES INSTEAD OF BEING REJECTED FOR THEIR DISABILITIES

Disabled people are often rejected when they would make good employees. Employers often have fears about attendance and sickness although in fact the evidence is that these fears are groundless.

Employers say that they need the best person for the job, but the important part of this statement is "for the job". It is not discrimination to reject visually impaired people for the job of cricket umpire. It is however utterly wrong to reject somebody for an office job that she would be perfectly capable of doing just because you don't want to buy a braille keypad (that is the meaning of "reasonable adjustment"). And it is positively foolish to reject a visually impaired person for a job that particularly depends on skills in other senses (a wine taster for example) as visually impaired people are likely to have developed those other senses in a compensatory way.

We must address the problem of exclusion of disabled people from the workforce by

- Moving people from incapacity benefit to work
- Using health and social care resources to create work rather than day care
- Statutory organisations acting as exemplars
- Political and business leadership to emphasise the good work record of disabled workers

Mental health investment is an important opportunity to focus on supporting people with mental health problems in work, rather than trying to replace the factors which work provides through some form of day care.

CHALLENGE 3 WE SHOULD SHAPE THE ECONOMY OF STOCKPORT SO THAT IT CREATES GOOD QUALITY WORK FOR EVERYBODY

A knowledge based economy creates good quality work

A knowledge based company can locate anywhere in the world. Why should it come to Stockport instead of Fiji or the Mull of Kintyre?

In this setting of mobile knowledge-based industries culture and environment are not drags on the economy – they become economic drivers instead.

A healthy economy would:

- Protect open space and create peace and beauty
- Reduce motor vehicle exhaust emissions
- Reduce unemployment
- Grow slowly and steadily rather than fitfully

- Provide security, relieve poverty and avoid pressures for geographical mobility
- Avoid chemical and physical hazards and noise and avoid accidents
- Provide pleasant working conditions
- Train people for the responsibilities they carry and avoid giving people responsibilities without resources and power
- Avoid overwork, underwork or working under pressure to deadlines
- Provide work that is meaningful and satisfying, under the control of the worker and flexible enough to accommodate other roles
- Avoid the disruption of communities
- Empower consumers to act to promote health and protect the environment
- Empower people to do not just to demand.

3.18.   HEALTHY AGEING

An Ageing Population

Stockport, like most of the country, has an ageing population. Indeed our population is ageing more than many parts of the country because we do not have the renewing effect of high levels of immigration.

Fig 18.1
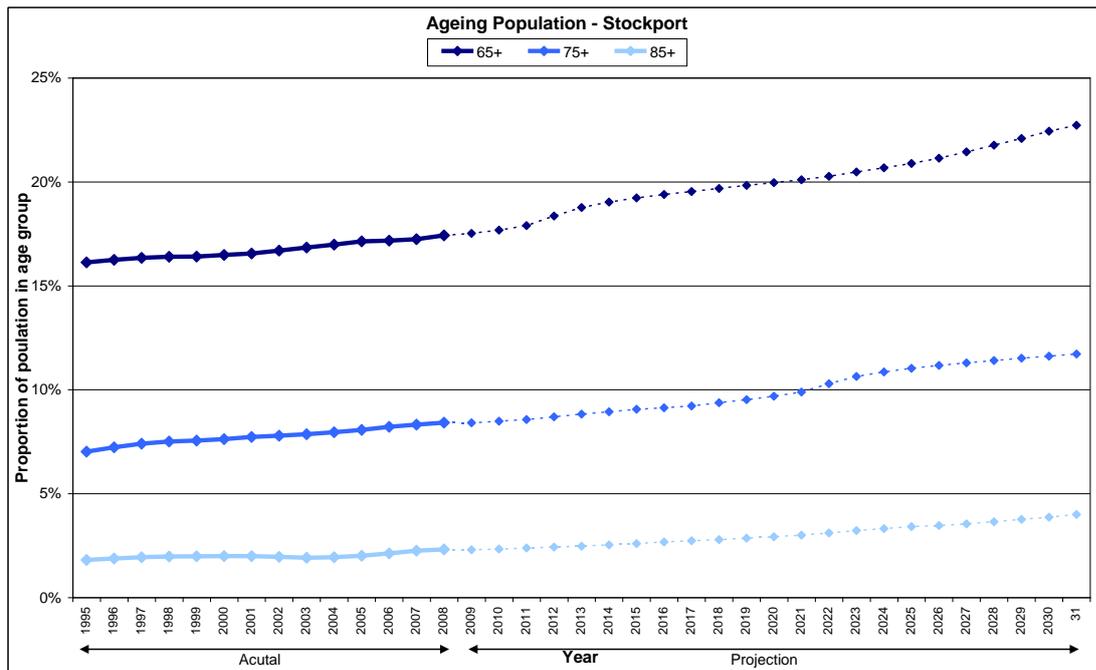
Further details can be found in the JSNA.

A population can age for a number of reasons

- for demographic reasons because a cohort of people, due to say a baby boom, comes into old age
- because fewer people die young
- because the age of death of people who survive to old age increases.

In the 1970s and 1980s the UK experienced an ageing population because a cohort of increasing population had reached old age. In the 19th century people used to have a lot of children so some would survive the high infant mortality. In the 20th century reproductive behaviour adjusted to much lower infant mortality. However there was a gap of about a generation whilst this happened and as a result there was a generation of large families most of whose children survived (although a lot of the men were killed in World War I). This generation grew into old age in the 1970s and 1980s. This was the largest ageing of the population the country had ever experienced so it conditioned our expectations of what an ageing population would bring.

Shortly after this the first generation of men to live their entire adult life in peacetime matured into old age. This also modified the gender ratio in old age so it became more common for old people to have a partner. The pressure of ageing then eased off for a few years but in 2016 the post war baby boom starts to reach the age of 70 and from that point on cyclical increases and decreases in numbers of old people will occur similar to those which have in the past affected the child population.

However in parallel to this process life expectancy is increasing.

Older people use more health and social care than younger people. Therefore it is often said that an ageing population must mean the cost of health and social care will rise. This was certainly true when the main factor ageing the population was demography. Does this change when increasing life expectancy is also a factor? Do older people use more health and social care resources because they are older or because they are closer to death. If it is the former then an ageing population will use more resources. If it is the latter they might not. Indeed a lengthening life expectancy might reduce the burden of an ageing population because a smaller proportion of the population will be in their last few years of life.

Scenarios for Health and Ageing

Let us assume that at the moment disability (and hence health care costs) occurs as follows:-
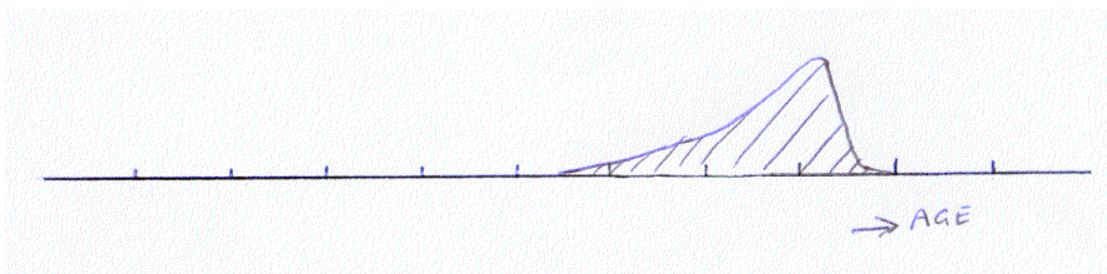
Fig 18.2A

The fear is that increasing life expectancy does not delay the onset of disability, it simply makes it last longer. For every extra year of life there is an extra year of woe. We live longer, but the extra time is spent taking longer to die.
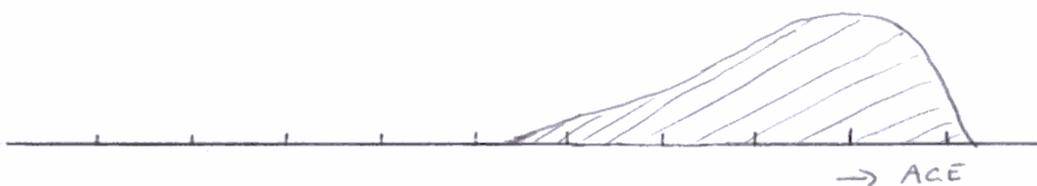
Fig 18.2B

In this case there will be a huge increase in disease burden for the individual (and hence health and social costs for the population) as a result of an increased life expectancy

Another possibility however is that all that happens is that disability and death are both delayed. For every extra year of life woe is delayed by a year but there is no change in the amount of woe. We

live longer and the extra time is spent living – we spend no extra time on dying.

Fig 18.2C

In this case there will be no increase in the disease burden incurred by the individual. At a population level the health and social care costs will be delayed and the proportion of the population incurring them at any one time may therefore be reduced.

An intermediate possibility is that disability may arise at the same time but may develop more slowly. Woe increases with the extra years but not by as much. We live longer and the extra time is partly spent enjoying more life and partly spent taking more time to die.
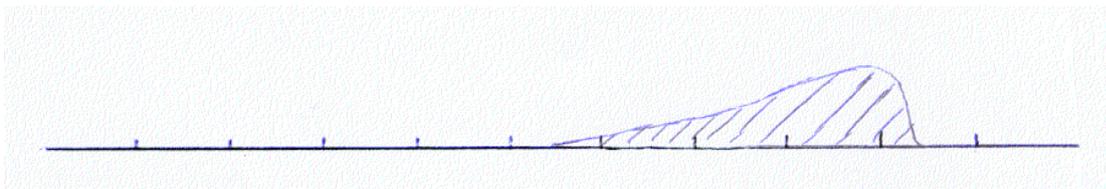
Fig 18.2D

In this case there will be some increase in the disease burden incurred by the individual and some increase in the health and social care costs incurred by the population, but it will not be anything like as great as in the first scenario.

The most optimistic scenario however is that we will live longer and we will spend less of that time ill. For each extra year of life there will be fewer years of woe. We will live longer and die quicker. My preferred mode of death is to be shot by a jealous lover at the age of 104.
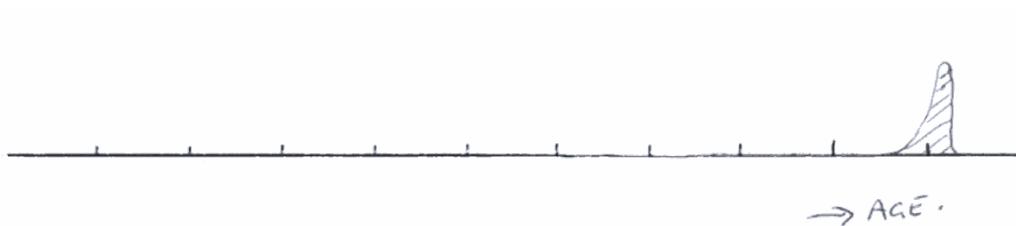
Fig 18.2E

If this scenario is correct then the lifetime disease burden on the individual becomes less as life expectancy increases – we have the double benefit of living longer and suffering less. Health and social care costs for the population are both diminished and delayed – again a double benefit.

The theoretical basis for the nightmare scenario (longer life more disease) is that as people avoid the causes of premature death – infections, accidents, heart disease, violence, famine – they come to live long enough to suffer from chronic diseases and as a result to suffer a greater and longer disease burden.

It is certainly true that people have to die of something and that diseases that are commoner in older people, such as cancer, increase in incidence as diseases that kill a lot of young people decline. But the theoretical basis for the delayed disease scenario (longer life, same amount of disease) is that there is no particular reason to suppose that these diseases will cause a greater burden. Most people make most use of health care in the year before their death. This is true whenever that death is. Therefore if most people die when they are old that is when most health care costs will occur. It has nothing to do with age – it is related to proximity to death.

The optimistic scenario (longer life less disease) was first put forward by Fries and became known as the compression of morbidity scenario. Fries believed that if death from disease were avoided people would eventually die of old age. He believed there was a natural age of death which varied for each individual but was normally distributed around an age that increased by a few months each generation, having been three score and ten in biblical times and now being four score and five. This was genetically programmed, probably in the part of the chromosome known as the telomere. We would not be able to increase this maximum longevity, apart from the few months by which it naturally increased each generation, until we were able to genetically re-engineer the telomere, at which time massive extensions of longevity would occur. Until then all increases in life expectancy would be achieved by increasing the proportion of the population who survive to the maximum longevity. Death from old age is, Fries argued, quick. Hence if more people survive to reach this maximum age the total amount of morbidity would be reduced.

An alternative theoretical perspective, without the concept of a maximum longevity, but still with the perspective of compressed morbidity, views ageing as a harmonious deterioration of organ systems which diminishes resilience and increases the probability of death. Old age brings "frailty" – a term used here with the particular meaning that people are fully healthy and fit but are less likely to recover from factors which disturb that health and fitness. Improving population health delays people experiencing the disease that will kill them. The older they are when they encounter that disease the less resilience they will have and the shorter their death will be. On this basis the compression of morbidity consists of somebody living on, fit and well, into old age until they die suddenly of a disease or injury which a younger person would have recovered from.

The Population Financial Implications of the Scenarios

In a theoretical population with no migration and a fertility rate that maintained a constant population the proportion of the population experiencing the need for health and social care associated with the disability and dependency of old age would be given by the formula:

<u>Life expectancy minus healthy life expectancy</u>

Life expectancy

As life expectancy appears in the denominator of this equation then an increase in life expectancy will in itself reduce the proportion, provided it is matched by an increase in healthy life expectancy so that the numerator doesn't increase.

For example:

Life expectancy	Healthy life expectancy	Proportion needing care
70	65	7.1%
80	75	6.25%
90	85	5.5%

Table 18.3A

The increasing 20 years life expectancy (from 70 to 90) with an unchanged gap between healthy life expectancy and life expectancy (5 years) has reduced the population burden by 1.6 percentage points out of 7.1 percentage points, a reduction of 22.5%

However changing healthy life expectancy affects the figures even more spectacularly:

Life expectancy	Healthy life expectancy	Proportion needing care
75	65	13.3%
75	68	9.3%
75	70	6.7%

Table 18.3B

An extra 5 years of healthy life expectancy with constant life expectancy of 75 reduces the population burden by half.

If compression of morbidity occurs these two effects would operate together reinforcing each other:

Life expectancy	Healthy life expectancy	Proportion needing care
75	65	13.3%
80	75	6.25%
90	87	3.3%

Table 18.3C

Applying this theoretical calculation to the figures for Stockport wards gives the figures in Table 18.4:

Table 18.4 2001 Ward	1999-2003 Life expectancy	1999-2003 Healthy life expectancy	Theoretical proportion needing care in a population which had these life expectancies, no migration no change in fertility and no cohort effects *
Brinnington	72.3	60.5	16.3%
Cale Green	75.0	65.1	13.3%
North Reddish	77.9	68.8	11.7%
South Reddish	73.8	65.2	11.7%
Edgeley	76.3	67.8	11.1%
Manor	76.1	67.7	11.0%
Great Moor	77.4	68.9	11.0%
Bredbury	78.3	70.0	10.7%
Davenport	75.9	68.1	10.3%
Romiley	79.0	71.0	10.1%
Cheadle Hulme North	77.7	70.5	9.3%
Heald Green	80.5	73.1	9.2%
Heaton Mersey	80.1	72.8	9.1%
Hazel Grove	80.0	72.9	8.9%
Cheadle	81.3	74.3	8.7%
South Marple	82.3	75.6	8.1%
North Marple	79.4	73.0	8.1%
Heaton Moor	78.9	72.7	7.9%
Cheadle Hulme South	81.2	74.9	7.8%
West Bramhall	81.7	75.8	7.2%
East Bramhall	82.3	76.8	6.7%

* the theoretical proportion in this theoretical population does not correspond to the actual proportion in the ward due to the impact of migration, fertility and cohort effects.

Although the theoretical population we are discussing in these calculations is a population isolated from issues of migration and fertility and not therefore an actual population at all, these calculations raise the rather startling prospect that the financial burden of an elderly population is actually greatest in those areas where people do not live as long and that increasing life expectancy reduces the cost of care for the elderly rather than increasing it, provided healthy life expectancy rises at least as fast.

What Can We Learn from Centenarians and Populations Where Ageing Well is Normal?

There are a number of populations in the world where it is much more common for people to live to over 100 and to remain healthy well into old age – Okinawa, Sardinia, some Seventh Day Adventist communities in California, Georgia, and some remote valleys in Ecuador and in Pakistan. These communities have been the subject of study as have centenarians in a number of different countries.

About two thirds of centenarians demonstrate compression of morbidity, remaining fit and active well into their 90s so these groups definitely demonstrate a desirable characteristic. About 30% of the chance of living to be over 100 seems to be genetic but about 70% seems to be environmental. The best documented environmental factors are a healthy diet, exercise (and especially remaining

active into old age), social support networks with a strong marriage and good friendships, a strong sense of personal identity with a goal to life, and some element of continuing challenge.

This is not exactly a surprising list. Indeed it could be said that years of careful scientific study of old people has shown that you are most likely to live to be old if you live a healthy life! The studies do however emphasise the prominent place in a healthy life of exercise and of various key forms of mental well-being.

A Healthy Ageing Strategy

A healthy ageing strategy must

- encourage people to live the kind of healthy life described in the preceding section, especially to remain active into old age, to maintain friendships and a purpose to life, and to continue with healthy lifestyles, such as healthy diets.
- ensure that people are not encouraged to accept that they suffer from old age when in fact they suffer from treatable illness.
- make it easier for old people to remain active and involved
- support people in staying independent when old age does begin to affect them

The Role of Healthy Lifestyles

The idea that it is too late to worry about good health when you are old is simply wrong. The drive to maintain healthy lifestyles must continue throughout life.

The Role of Expectations and Age Discrimination in the NHS

When I was 58 I began to develop some trouble with my ankle. I found it difficult to walk uphill. I commented to my wife that I felt like an old man when I walked up hill. I was fine when I walked on the flat or swam. However I did have two episodes where the ankle became swollen and painful.

I went to see a physiotherapist. She told me that there was restricted movement in the ankle probably as a result of an old injury in my twenties. She gave me exercises to carry me out. Most importantly she advised me to force the ankle to bend when I was walking uphill.

I carried out the exercises. The ankle got a lot better. It still isn't right. I still have to force it when walking uphill, and I still walk more slowly uphill than I would like. But my life is in no way restricted.

Imagine that I had had the idea that life ends somewhere in your 60s and that by your late 50s you are coming to the end of your life. Many people have that idea, especially in poorer areas. Being 58, I would just have accepted that I couldn't walk uphill. I would have stopped walking uphill. I would therefore have walked a lot less. I would have become less fit. I would fairly soon have stopped walking. A downward spiral would have gathered pace, all of it as a result of one eminently treatable and not very disabling start.

Suppose that the health professional I had gone to see had said "Oh, it's just your age". I would have been a bit distressed that I was wearing out so quickly. I would have felt upset to abandon my ambition to be shot by a jealous lover at 104. But I would undoubtedly have resignedly accepted

reality. Except that it wouldn't actually have been reality. Although it would rapidly have become so as I accepted it as such.

An immense amount of harm and premature ageing is caused by people accepting treatable illnesses as old age and restricting their lives instead of tackling the problem. Often people do this because of a culture that tells them that life ends in your 60s and you are lucky if you reach your three score and ten. We have to fight that attitude and substitute for it a culture which says that you shouldn't even consider being old until you have reached four score and five and even then think twice about it.

However people often abandon their active lives because the NHS has told them that a treatable condition is "just your age". This is something we have to root out and bring to an end. It is essential that we take steps to stop this error being made. It is a common error that has devastating effects and that we have to stop.

Experiential training of front line staff can assist with shifting cultural thinking.

The Role of Well Being

Of the five factors which the studies of centenarians and of long lived populations showed to be most strongly associated with a long healthy life, three are elements of well-being - social support networks with a strong marriage and good friendships, a strong sense of personal identity with a goal to life, and some element of continuing challenge. A fourth – exercise – is well known to be a factor which promotes a sense of well-being.

From an ageing well standpoint it is important that old people are encouraged to retain a place in the world and a goal in life. It is also important that old people maintain social networks, friendships and leisure activities.

From a standpoint of preparation for ageing it is important that these aspects of mental well-being play an important part in the Borough's health improvement programmes.

Supporting Older People Staying Independent

A key aspect of healthy ageing is the importance of sustaining functional independence so that older people, if they choose, can live in their own home environment for as long as possible. There are many different facets to independent living, the most immediate of which are being able to wash, dress and meet other basic nutritional and physical needs. But leading a satisfying and independent life also includes being able to regularly leave the home environment to see friends, take part in leisure activities, attend medical and other appointments, do light maintenance tasks around the home and garden, and keep in touch with family and community. The preservation of meaningful and productive social activity in particular has significant importance for the wellbeing and psychosocial health of older people and may, in itself, play a vital role in motivating and sustaining independent living at the individual level.

The opportunity to experience an independent and rewarding older age is of primary relevance to older people themselves, their families and carers, but it is increasingly important as a means of

managing the population impact of simultaneous increases in longevity and the ageing of the baby boom generation, who are now entering early older age.

This dual population effect is expected to create within the next 20 years an unprecedented demand on the UK health and social care system, on long-term care in particular. In demographic terms alone, ONS forecast that the 65+ age group is predicted to rise by 64% between 2007 and 2032, from 8M to 13.2M, with the 85+ population growing most rapidly by an average of 136%. This is coupled with expected ongoing increases in life expectancy but also increasing multiple morbidity and disability.

As already described, there are a number of possible scenarios for the impact of an ageing population on public service provision and society more generally. However, any of these scenarios will be positively influenced by taking action to ensure that years gained in life expectancy are healthy and productive ones, so as to minimise the negative effects of ageing and delay people's need for intensive (and unfortunately sometimes necessarily intrusive) formal health and social care support.

Achieving this will likely involve action across the public sector:

Implementing a financing system for long-term care which takes account of the anticipated rise in the volume and frequency of long-term care needs

Health, social and informal care working effectively and systematically in a community setting to achieve continuity of care for older people

Investing in healthy ageing and support which offers 'protection' against disability and dependence

Wider social recognition of the importance and value of older people within culture and society, including environments and communities which show increasing awareness of the daily challenges experienced by older people

Similarly, to tap into widest possible potential to improve health and wellbeing, the approach should address the risk factors which limit or reduce functional independence in older people and include:

- Environmental conditions
- Social circumstances – loneliness or the effects of living alone in particular
- Lifestyle - physical activity and nutrition in particular
- Psychosocial health
- Physical health
- Existing co-morbidity

In terms of the health and social care system specifically, there is evidence that when implemented systematically and consistently, community-based integrated health and social care can support and improve the quality of life, independence and psychosocial health of even very frail cohorts of older people i.e. those with established disability and chronic care needs.

Keeping people out of hospital is important to maintaining their independence since all too often a hospital admission can be the start of a process of decline.

Even when people finally need to go into residential care independence remains the driving value – the aim is not just to care for people but to enable them to live as fulfilling a life as possible.

However, as already indicated, the key to achieving success at both the individual and population level is to identify and address the multiple and co-existing risk factors which impinge on independence in older age as a key component of all elderly care. This should also form the basis of implementing 'Making Every Contact Count' starting with the younger older people and continuing through to the 85+ population.

3.19.   RESILIENT COMMUNITIES

If we can create resilient communities full of self-reliant individuals who feel empowered to address their own needs, and with a commitment to mutual help so that the community works together, we could potentially

- Improve health because self-reliant empowered individuals are healthier
- Improve health because strong social support networks improve health
- Reduce excessive reliance on the NHS and social care because of increased self-reliance
- Reduce excessive reliance on the NHS and social care because of more mutual help
- Make health improvement easier as communities develop their own health improvement strategies
- Reduce reliance on local authority services

Is this realistic? If it is, how can we do it?

Empowerment and health

The World Health Organisation has published a review of the role of empowerment in promoting health. It showed that empowerment projects were beneficial to health. This might have been because

The projects might have had other effects such as the promotion of social support

Empowerment of communities might have enabled them to address their health problems and address some of the factors that affect their health

Empowerment of individuals might lead them to make better health choices

Empowerment might be good for health in its own right by allowing people to address the stresses of life and treat them as challenges rather than threats. This would fit with

- work in occupational health which shows that people who have control of their own work experience lower mortality than those who do not,
- a randomised controlled trial of an educational instrument intended to increase personal autonomy in handling chronic diseases which showed improved outcomes
- work showing empowerment to affect the progress of various mental disorders.

Although there is a tendency to think of the liberty and empowerment of individuals as being in conflict with the power of the collective, there are many areas of life where the reverse is the case and where, if we are to control our own destiny we must have the right to make collective decisions about the general state of the environment.

The Tragedy of Commons, based on a hypothetical common where people each had the right to graze cows. As they gained the whole of the produce of each extra cow they grazed but suffered only part of the consequence of the overgrazing it was in their interest to graze as many cows as

possible but if everybody did that the common would be seriously overgrazed and the cows would die. This situation, which nobody wants, can be overcome only by a collective decision and the power to establish this is central to the empowerment of each individual to get what they want.

Social Support and Health

It has been shown that the strength of a person's social support networks is a major influence on their health. It influences not only minor levels of mental ill health such as depression or anxiety but also the chances of suffering a serious psychiatric reaction after a horrendous experience, the risks of complications of pregnancy, and all-causes mortality.

According to the Alameda County study in California the effect of poor social support is as strong as the effect of poverty. Moreover because the strength of the effect increases with the length of time exposed it appears to be a causal relationship, rather than being due to, say, people who are ill withdrawing from social contact.

It is thought that the reason social support has this impact is that it provides protection against stress.

There are many sources of social support including families, friends, networks of people with shared interests, and faith groups. Neighbours also provide social support and research has shown that they do so to a greater degree in lightly-trafficked streets than in heavily-trafficked streets.

This demonstrates the value of a relaxed social environment in which to develop friendships. Crowded, noisy, urban environments make the growth of informal relationships difficult.

These are the relationships which allow us to air problems and discuss solutions.

Opportunities for people to meet and discuss issues may need to be manufactured because these joint and informal approaches to problem solving help to nurture the social and organisational skills which many people lack.

In urban communities people often establish social networks on the basis of shared interests and such networks can often cover quite a wide geographical area.

However people with low self-esteem find it difficult to access the social opportunities that are based on common interests. Acquiring skills makes it easier to move towards greater self-reliance and self-respect.

So it appears that in urban communities it is very difficult for those who have fallen behind with social, organisational and educational skills, to get themselves back on the ladder. If they can be helped to do this, people can go on to acquire a range of skills which make them healthier and more productive. By overcoming these very fundamental barriers to social inclusion, community development workers help people to lead healthier and more productive lives.

However local communities are an important source of social support. Community spirit is an intangible but undoubtedly real factor and strong community spirit will not only increase social support levels in the community but it will also empower people, increasing the likelihood that

problems affecting the community will be seen as shared problems, and effectively addressed, instead of becoming causes of stress affecting individuals.

It is to enhance social support, community spirit and empowerment that the PCT and the local authority maintain a community development programme. Voluntary organisations also play an important role in achieving these objectives.

Community Development

There are clear links between the objectives of public health and those of community development. In particular these are strongest in the areas of community participation and addressing inequality and disadvantage.

Community development is concerned with strategies and mechanisms to enable people in disadvantaged communities to have a full say in the decisions made about their communities by local authorities and statutory bodies. It focuses on identifying and addressing the needs and priorities of community members and assisting them in communicating these to decision makers. The expectation is that the opinions and perspective of community members will be central to the decision making process. Community development is inherently involved in addressing inequality and exclusion and, as such, is a natural partner to public health.

It is helpful to think of different levels of community development work:

Primary or Generic Community Development – perhaps the most pure, but also most challenging – this works with communities to discuss and identify their needs and then seek ways to *help them to* meet these needs, either with agencies or through self-help. As the approach starts from the community and works outward, agencies are not the leading players. Where service providers become involved, the communities' expectation is that service provision will respond to meet the needs and priorities identified by the community. It is the community that sets the agenda and makes key decisions. In this regard, community development is concerned with the development of social capital and community assets, with multiplying the resources available within or to a community, as well as maximising its control over those resources.

Purposive Work – this is when a local authority organisation or statutory body seeks out the community's involvement in its programmes. The needs and priorities are identified by the organisation to meet its own targets, but may seek to increase community empowerment in running the project once it has been established by the agency. This is a more difficult process of empowerment, as the initiative comes from agencies and the community members start from a relatively passive position.

Community Engagement – this is when the community is approached by agencies to seek their views about an existing service to obtain feedback. There is no necessary follow-through to a change in the pattern of service delivery on the basis of what community members' say. The control and decision making rests with the organisations or statutory bodies seeking community support. The community role may be to endorse the decision made or bring about some adjustment to these but cannot affect the fundamental objectives or approach being applied.

Clearly there are challenges in working with a community development model. Firstly, identifying a 'community' can be difficult given the present levels of diversity in our society. Geographical definition may not be the most useful, and recent work has focused on 'communities of interest' as an alternative construction (see case studies).

Secondly, it can be hard to focus on the benefits of cooperation in the face of competitive threats, whether real or perceived. The case study on Stockport's joint credit union demonstrates how this can be true even within a community development activity itself.

Thirdly, it can take a long time for people to become confident in their own capacities and for those in power to trust the judgements of others. Democracy is hard work, especially in the current climate where so many feel abandoned by politicians and without any real voice. Of course, this is precisely why and where a primary community development approach can be so effective, but it is far from speedy in obtaining results and patience may be in short supply.

3.20.   EARLIER DIAGNOSIS

Is it important to diagnose disease as early as possible?

This depends on whether the course of the disease can be modified by early treatment.

Fig 20.1
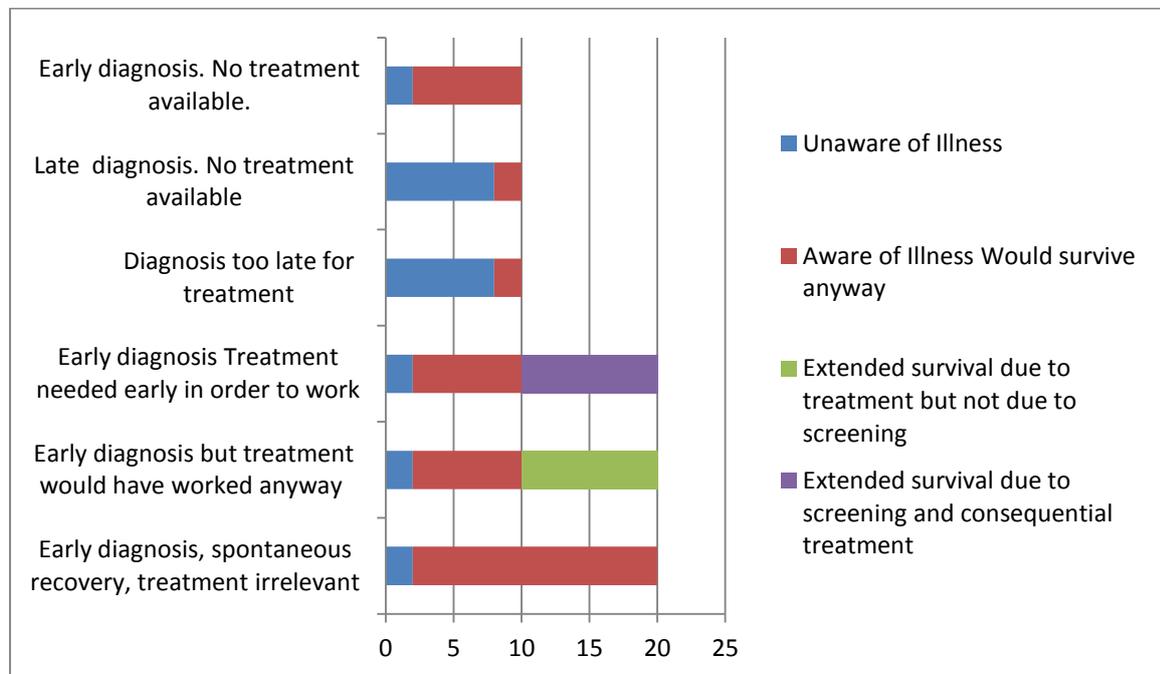
The red plus green plus purple bars are the "survival time" but only the green and purple bars represent extended survival due to treatment and only the purple bar represents extended survival due to screening. In the top two examples early diagnosis seems to have extended survival because the red bar is 6 years longer than with later diagnosis but all that means is that the patient knew they had the disease for 6 more years. In the top example the screening has actually been pointless – it has simply extended the patient's suffering. In the bottom three examples the screening test has been applied and has led to an apparent extended survival but only in the one with the purple bar is this due to the screening.

Unfortunately we often do not know precisely which of these three different scenarios applies.

For example prostate cancer is very common. About a third to a half of men in their 60s have it. It is usually very slow growing and has a high rate of spontaneous recovery. Sometimes it will grow quickly and cause serious illness and death. This is by no means an insignificant risk (indeed in 2012 47 Stockport males died as a result of prostate cancer, since 2000 the numbers have fluctuated between 40 and 50) but treating everybody who has the earliest form of the disease would cause far more harm than good. Scientists are working hard to see if they can find a way to determine which of the early cases will progress and which will not. If that problem can be solved a screening test for prostate cancer will be introduced. Until then it would be harmful to do this.

The same problem is present to a lesser extent with breast cancer. Out of four women diagnosed with early breast cancer and treated one would have suffered a disease that would have progressed

and killed her (the example with the purple bar) and three would not (the bottom example). So we deliver unpleasant treatment to three healthy women in order to save the life of a fourth. This balance of risk is thought to be beneficial on balance, although it is important that it is explained to the women and they are enabled to make their choice. All too often in the past women have been led to believe that the unpleasant treatment being recommended for them is to save them from imminent death when in fact it is to save them from a 1 in 4 risk of imminent death. They should make an informed decision as to whether they would rather take the risk.

The following table 20.2 shows for each of the major screening programmes that operate in this country the best current estimate of risk that early diagnosis averts

Table 20.2. Estimated reduction in risk achieved by screening for major screening programmes in England.

Screening Programme	Who is eligible?	Estimated reduction in risk
Screening in pregnancy:		
Sickle cell and Thalassaemia	All pregnant women offered Thalassaemia. Pregnant women offered sickle cell depends on family history.	This is genetic screening programme which helps parents identify the risk of them having a child with the condition, rather than identifying a condition for early treatment
Foetal anomaly screening (Down's Syndrome and other foetal anomalies)	All pregnant women	Not designed to reduce risk of the conditions, but instead enables actions to be planned for the arrival of the baby, which may include actions to reduce the risk of death from these conditions
Infection disease in pregnancy:	All pregnant women	
Hepatitis B		90% reduction in chance of baby developing Hepatitis B
HIV		Reduce the risk of a mother passing on HIV to her baby from 25% to less than 1%
Syphilis		Reduce the risk of the baby being born with syphilis by providing treatment for the mother.
Susceptibility to rubella		Reduce the risk of rubella-related harms to babies born in future pregnancies by offering vaccination to mothers after the birth
Screening for babies and children:		
Newborn Blood Spot screening:	All newborn babies	
Phenylketonuria		100% reduction in risk of severe brain damage
Congenital hypothyroidism		100% reduction in risk of severe

		physical and mental disability
Sickle cell disease		See above
Cystic fibrosis		Earlier diagnosis improves the management of the condition
Medium-chain acyl-CoA dehydrogenase deficiency (MCADD)		100% reduction in risk of serious illness and death
Newborn and infant physical examination screening	All newborn babies - within 72 hours of birth, and again at 6-8 weeks	This varies as the physical exam is designed to pick up several different conditions, all of which have improved outcomes the earlier they are detected
Newborn hearing screening programme	All newborn babies	This depends on the type of hearing loss that is identified, but early identification leads to better language acquisition and communication outcomes
Diabetic eye screening	All people aged 12 and over with diabetes (type 1 and 2) are offered annual screening appointments.	At least 30% reduction in risk of sight-loss
Adult screening:		
Abdominal Aortic Aneurysm	Men aged 65 and over. Men are invited in the year they turn 65.	48% reduction in risk of death
Cancer screening programmes:		
Breast cancer screening (mammography)	All women aged 50-70 are invited every three years (being extended to age 47-73).	25% reduction in risk of death
Bowel cancer screening (faecal occult blood test)	Men and women are offered bowel screening every two years from age 60 to 69 (being extended to age 74).	25% reduction in risk of death
Cervical pre-cancer (cytology - cervical "smear")	Women aged 25 to 64 are invited for cervical screening. Women aged 25 to 49 are invited every three years. After that women are invited every five years.	Scientists differ, and the figures differ according to age. The risk of death averted may be between 5% and 60%

Where early diagnosis is helpful it can be assisted by

- Awareness amongst GPs and other health professionals. For example it would be regarded as usual for patients to have their blood pressure measured on a visit to their GP
- Awareness of early symptoms by patients. The following are symptoms for which awareness campaigns currently operate

Table 20.3 Symptoms for which there are awareness campaigns

Symptoms/campaign message	Cancer being targeted	Specific target audience
If you are feeling bloated most days for 3 weeks or more, tell your doctor.	Ovarian cancer	Women aged 50 and over
If you have had a cough for 3 weeks or more, tell your doctor.	Lung cancer	Men and women aged 50 and over
If you've had blood in your poo or looser poo for 3 weeks, your doctor wants to know.	Bowel cancer	Men and women aged 50 and over
If you notice blood in your pee, even if it's 'just the once', tell your doctor straight away.	Bladder and kidney cancer	Men and women over the age of 50 from lower socioeconomic groups, and the key people who influence them – their friends and family.
1 in 3 women who get breast cancer are over 70, so don't assume you're past it. If you notice any changes in your breasts, it's important that you contact your doctor straight away.	Breast cancer	Women aged 70 and over.
When it comes to cancer, there are 4 key signs to look out for: 1. Unexplained blood that doesn't come from an obvious injury. 2. An unexplained lump. 3. Unexplained weight loss, which feels significant to you. 4. Any type of unexplained pain that doesn't go away.	A range of cancers	Men and women over the age of 50, and the key people who influence them – their friends and family.

A list of key signs and symptoms of cancer (advice is to visit your GP if you have any of the following)

Signs and symptoms for men and women:

- An unusual lump or swelling anywhere on your body
- A change in the size, shape or colour of a mole
- A sore that won't heal after several weeks
- A mouth or tongue ulcer that lasts longer than three weeks
- A cough or croaky voice that lasts longer than three weeks
- Persistent difficulty swallowing or indigestion
- Problems passing urine
- Blood in your urine
- Blood in your bowel motions
- A change to more frequent bowel motions that lasts longer than four to six weeks
- Unexplained weight loss or heavy night sweats
- An unexplained pain or ache that lasts longer than four weeks
- Breathlessness
- Coughing up blood

Signs of cancer for women:

- An unusual breast change
- Bleeding from the vagina after the menopause or between periods
- Persistent bloating

Table 20.4 Self-assessment that we encourage the general population to engage in

Self-assessment method	Cancer being targeted
Breast self-examination: Any changes including lumps	Breast cancer
Self-assessment of moles: Asymmetry Border Colour Diameter Enlargement or elevation	Skin cancer
Bowel self-assessment: Age Any rectal bleeding Any other symptoms (change of bowel habit; abdominal pain; another symptom)	Bowel cancer

Additional self-assessment tools exist for specific sub groups of the population.

Population wide screening programmes

The following are the uptake figures for the adult screening programmes

Table 20.5 Screening uptake for adult screening programmes

Screening Programme	Estimated uptake
Screening in pregnancy:	
Sickle cell and Thalassaemia	2012/13 uptake Stockport NHS FT Maternity Unit – 97.6% No national comparison available
Foetal anomaly screening (Down's Syndrome and other foetal anomalies)	2011 uptake England – 74% No local information available
Infection disease in pregnancy	2012/13 uptake Stockport NHS FT Maternity Unit Hep B – 94.7% HIV – 96.1% Syphilis – 96.1% Rubella – 96.1% No national comparison available
Screening for babies and children:	
Newborn Blood Spot screening:	2012/12 uptake Stockport – 92.6% No national comparison available
Newborn and infant physical examination screening	No robust data available for this programme
Newborn hearing screening programme	2012/13 uptake: Stockport – 96.3% No national comparison available
Adult screening:	
Diabetic eye screening	2011/12 coverage: England – 73.9% 2011/12 uptake: Stockport – 75.8%

	2012/13 uptake: Stockport – 78.4%
Abdominal Aortic Aneurysm *Programme is still in roll out*	2011/12 coverage: England – 69.5% Greater Manchester – 43.4% 2011/12 uptake: England – 75.0% Greater Manchester – 78.5% Stockport – 80.8% 2012/13 uptake: England – 77.0% Greater Manchester – 80.4% Stockport – 81.9%
Cancer screening programmes:	
Breast cancer screening (mammography)	2011/12 Coverage *Women aged 53-70:* England – 77.0% Stockport – 74.8%
Bowel cancer screening (faecal occult blood test)	2012/13 Uptake England – 57% Stockport– 53.8%
Cervical pre-cancer (cytology - cervical "smear")	2011/12 Coverage *Women aged 25-64 :* England – 78.6% Stockport – 81.3% 2012/13 uptake North West – 78.1% Stockport – 80.8%

Bowel screening

The NHS England Area Team have commissioned a Health Improvement Team in Greater Manchester to seek out inequalities in bowel screening and increase uptake in groups and areas where it is low. The team can be contacted on 0161 906 2851 or bowel.screening@nhs.net.

The service in Stockport is delivered as part of GM south sector programme. No CCG area is yet achieving the 60% standard. Uptake appears to have decreased due to change in data capture of over 74year olds opting in to programme

Breast screening

East Cheshire breast screening programme delivers the service in Stockport.Coverage remains consistent and is achieving minimum standard but the service is not achieving the target for 36 month round length or delivering a fully digital service. A Quality Assurance visit in June 2103

identified areas for immediate improvement. Action plans are in place to rectify these three areas. The service is delivered across the whole of Greater Manchester by one provider

AAA

National rollout completed April 2013 – KPIs now established and will be collected 2013/14 but not published until 2014/15

Local Programme one of many not meeting time to operation quality standard – issue being explored nationally

Diabetic Eye

Part of South Manchester program, which is an Optometrist based service.

Achieving national target which is 70%.

Screening programmes targeted on specific groups.

There are screening programmes which are applied only to specific groups, for example various occupational programmes delivered by occupational health services to those exposed to a particular hazard, or tests applied regularly to people with a longstanding disease to detect complications of the disease.

Issues of current concern in Stockport include

Issues of current concern in Stockport include

- Low screening uptake in deprived areas
- Late diagnosis of cancer
- Missed cases of hypertension.

The ambition of the CCG is that everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisations, vaccinations and health checks.

The CCG intend through investments to ensure that people in more deprived areas are just as likely to uptake screening and have checks and vaccinations. One of the biggest drivers of health inequalities is cancer and in particular cancer survival rates.

Much of the differential in cancer survival is due to late presentation and identification and the CCG are working with their members to promote the uptake of bowel cancer screening. One of the patient story presentations to the Governing Body of the CCG was from a patient whose cancer was only picked up and treated because of the programme and we have shared this video widely to hopefully encourage others to send back their screens. The CCG and Local Authority are working together to promote the health check process that Stockport pioneered many years prior to the national drive for health checks. During 2013/14 we will focus on different ways to encourage people to come for screening and the 50,000 adults aged 35-74 who have never had a recorded screen. The Local Authority lifestyle services at www.healthystockport.co.uk offer a great resource for healthcare professionals and the public to access if their health check indicates that they could

reduce their chances of developing a chronic disease by modifying their lifestyle. A key local element in the screening process will be recording alcohol consumption complimenting what is done for newly registered patients. Alcohol screening will in addition be conducted in the group 16 to 35 who would not be attending the health check service and in the over 70 age group. High blood pressure is second only to smoking as a cause of early death and illness in the Western World. Next year, the CCG plan to ensure that everyone in Stockport knows whether their blood pressure is high or not. High blood pressure is second only to smoking as a cause of early death and illness in the Western World.

3.21.   CHANGE IN THE HEALTH SERVICE

The health service faces a number of challenges at the moment.

New Institutional Structures

New commissioning bodies have been established with the commissioning work previously carried out by the PCT divided between the local authority (most public health issues), Public Health England (some public health issues, most notably immunisation, screening and health protection), the Clinical Commissioning Group (most hospital and community services but not general practice) and NHS Greater Manchester, a local area team of NHS England (specialist commissioning, general practice, dentists, optometrists and pharmacists).

There is a very real question of whether these changes have been worth the time, energy and money spent on them, but now that they exist are they fit for purpose? Viewed from a historical and organisational public health perspective they are a curate's egg.

I particularly welcome

- The transfer of public health to the local authority. Public health was part of the local authority under Nye Bevan's original NHS (as indeed were community health services). Moving it from local authorities to health authorities in 1974 separated it from the capacity to influence social and environmental factors. This seriously undermined Nye Bevan's vision of the NHS as an organisation which would improve the health of the people not only by providing treatment according to need rather than ability to pay but, of equal importance by addressing the determinants of health. It is often forgotten that the local authority Health Departments which cleared the slums and cleaned the air in the 1950s and 1960s were one of the three wings of Bevan's NHS. Those who have forgotten this often refer to his claims that the NHS would improve the health of the people as if they were an unrealistic overestimate of the power of medicine and nursing. They were nothing of the kind – they were amply borne out by the successes of the local authority Health Depts. Moving public health back into local government regains this vision.

- The strong clinical input into commissioning and the extra power given to GPs. An important element of Nye Bevan's original vision was the idea that in addressing the health of the people as a social goal the people would be supported by a family of health professionals dedicated to that vision. This vision has been undermined in recent years and the trust shown in GPs as commissioners is a step back in the right direction.

- The creation of the Health and Well Being Board as a committee of the local authority with statutory membership including professional and partnership representation alongside councillors and patient representatives. This provides for the first time a single focus for strategic oversight within a democratically accountable context. Under Bevan's original structure the only strategic oversight of the whole system was national, although the local bodies which ran the local service had strong democratic roots. The creation of health authorities in 1974 created a local strategic body but at the expense of the more limited perspective that was inevitable from the loss of the capacity to influence major determinants. The removal of local authority and community representatives from health authorities in the early 1990s created a

democratic deficit in the NHS. Health and Well Being Boards are another step back to earlier more idealistic visions.

 I do however have six matters of concern

- I am concerned that procurement bureaucracies may undermine the new structures.
- I am concerned that Health and Well Being Boards have inadequate powers
- I have always believed that the distinction drawn between the health service and social care is artificial and that they would be better combined. I am pleased at our local work on integration and at some recent national initiatives but think it would have been better if this had been built into the changes from the outset
- I am deeply concerned at the absence of any local structure responsible for general practice.
- For the first time ever the Government has drawn a distinction between "the health service" and "the NHS" with two of the new health service commissioning organisations – the local authority public health function and Public Health England – being described as part of the health service but not part of the NHS. I believe this will cause confusion. It seems to have been derived from the belief that the 1974 redefinition of the NHS as a treatment service had taken such a deep hold that any recovery of the earlier definition must be associated with a new nomenclature. I think that was a mistake. If we are recreating what Nye Bevan called "the NHS" the best name for it would have been "the NHS" and calling it "the health service" with the term "NHS" applied to a subset is confusing.
- Although clinical commissioning is a step back towards Nye Bevan's vision of a family of health professionals, there is no corresponding step in providers. On the contrary the strategy appears to be one of further erosion.

Commercialisation

For the last two decades a process of private sector involvement in the NHS has been under way, which began under the government of John Major, continued in the first term of Tony Blair and then accelerated in the second and third terms of that government. The present government has institutionalised this in the Health & Social Care Act 2012, in a way which will inevitably accelerate it further.

On the one hand it doesn't matter to a person receiving care whether they get it from a state employee or a private company provided it is paid for by the state, is of good quality and is free at the time of use. There are undoubtedly benefits to competition if it is competition to provide better care. Some private companies and charities undoubtedly make valuable contributions to the NHS.

On the other hand there are serious doubts as to whether commercial competition can indeed be competition to provide better care. Such competition can only take place if quality can be measured in a contractual indicator, and the risk is that it will be easier to generate profit by distorting those indicators than by actually improving care. Moreover a commercial motive could diminish the commitment to other values, and hence destroy Nye Bevan's vision that the people, pursuing health as a social goal, would be supported by a family of professionals committed to that same goal. Indeed the health service, at least in the hospital service, is now suspicious of that vision, perceiving it as a restraint upon the labour market.

It is important to appreciate that commercialisation does not only affect commercial providers. It affects NHS providers and social enterprises as well as they have to respond to actual or potential commercial competition.

Financial Pressures

The following are the basic facts concerning health service finances nationally.

Health service budgets have increased in real terms but very slightly.

Underspending has also increased. This is also very slight, but it slightly exceeds the increase in budgets so health service spending has slightly decreased in real terms.

Although much is made politically of these two figures, with the governing parties emphasising the first and opposition parties presenting the second as a contradiction to the first, the truth is that they do not contradict each other, both are insignificant and health service spending is essentially static.

Local authority public health grants have increased above the baseline public health spending of PCTs by more than the general increase in health service funding. This is the only part of the health service to experience noticeable growth (and the only part of the local authority not to be experiencing serious cuts). This accords with advice from the British Medical Association (well placed to see both sides of the story) that the benefit to the NHS of better prevention would ease its burdens more than a slight reduction in its financial difficulties. Spending on public health is such a small proportion of the health service budget that quite large proportionate increases can be made with only a small impact on NHS spending.

 Demand for NHS care is rising at such a rate, due to a demographically ageing population, diminished self-reliance, and medical advances, that static funding represents a significant challenge. The so-called Nicholson Challenge states that the NHS needs to achieve 20% more benefit from static resources over a 5 year period. This challenge, rather than cuts in resources, is the basis of the present financial challenge to the NHS.

Although health service spending has not been cut, social care spending has been affected by the serious cuts in local authority spending, where Government will have has cut support by 43%between 2010/11 and 2016/17. This is reflected in the Graph of Doom which shows that the combination of rising need for social care and diminishing local authority funding threatens, unless a way is found to curb social care spending, to eradicate all other local authority services.
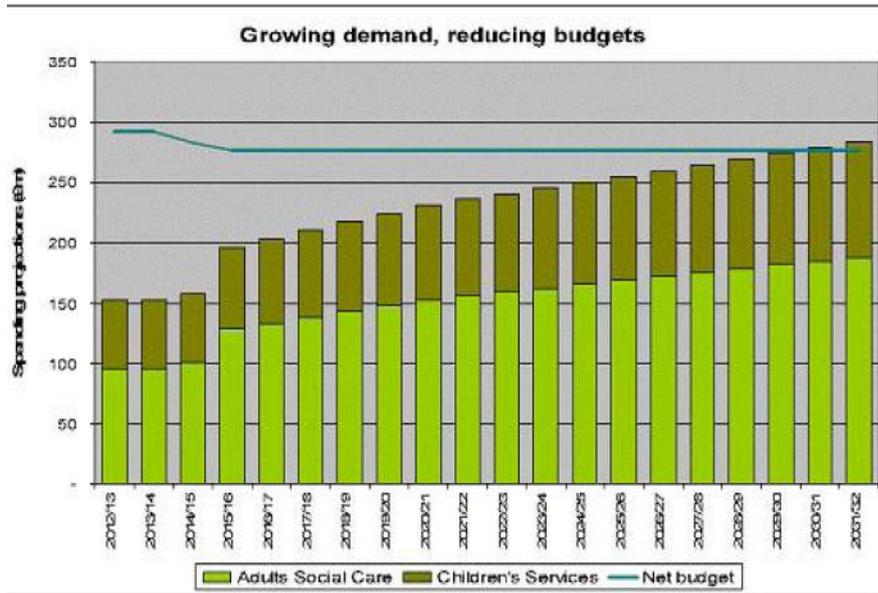
Fig 21.1 The Graph of Doom

This figure was originally produced by Barnet Council, but applies equally to all councils. It shows how the rising cost of social care and children's services coupled with a falling Council budget reaches a point at which the two figures meet.

Reduced social care spending inevitably adds to the burden on the health service.

As well as these overall changes there have been shifts in resource distribution which have benefitted areas with ageing populations at the expense of areas with deprived populations.

3.22.   CHALLENGES FOR THE NHS

Quality of healthcare

The recent scandal at Winterbourne View, the Francis Report into the poor care at Mid Staffordshire Hospital have focused attention on NHS quality, and Sir Bruce Keogh, the Medical Director of NHS England, has written a report on how to address the problem.

There are a number of interrelated problems. One is that the centrally driven target culture of the NHS has led local managements to concentrate on meeting targets, even artificially, rather than maintain good care – this was the problem a Mid Staffs. Another is that care has been undervalued relative to performance of tasks – even seen as getting in the way of efficiency. This has led to situations where in some parts of the country old people have been left hungry and thirsty because staff have not found the time to help them eat and drink. Such "efficiency" not only immediately undermines the whole purpose of an NHS but is even counter-productive in its own terms because it delays discharge and adds to treatment costs as the patient does not recover as quickly or as well. In some cases, as at Winterbourne View, this culture can develop further into a culture of self-serving casual cruelty.

It is tempting to view these problems as aberrations that occurred elsewhere but the whole point of the Keogh Report is that the only way we can be certain that they will not happen here is if we focus actively on the pursuit of quality.

The CCG's Quality and Provider Management Committee has reviewed these reports and is working with its staff, GP members, colleagues across health and social care and Healthwatch to ensure that we act on the lessons learnt, ensure best practice and continually drive up quality and in particular strive to enact the second ambition in the Keogh report 'the forensic pursuit of quality improvement'.

Of particular value in pursuing this goal is the epidemiological contribution of the consultant epidemiologist at Stockport NHS Foundation Trust who has made an important public health contribution to the Trust's Quality Strategy. Discussions are under way as to how to build on that in the future.

Rising demand on services

Despite improving health, demand for NHS services rises relentlessly. In part this results from an ageing population, especially to the extent that the ageing is due to demography rather than increased life expectancy (see the analysis in chapter 18 for the reason I draw this distinction between these two components of population ageing). Partly it results from inefficiencies in the delivery of care, paradoxically often resulting from changes in care which were intended to promote efficiency – particularly striking is the greater use of Accident & Emergency Depts. as a first port of call because of nationally dictated changes in general practice which undermined continuity of care and the strength of the doctor/patient relationship. Partly however it results from an increasing tendency to seek professional help for problems which in the past people would have dealt with themselves or to seek specialist care for problems which in the past would have been dealt with by GPs.

This problem manifests itself in a number of important elements of the work of our local CCG.

The Emergency Department

In January 2013, Monitor took regulatory action at Stockport NHS Foundation Trust to improve performance within the A&E department for the benefit of patients.

The action was taken to make sure the Trust takes immediate steps to improve its A&E performance and addresses underlying governance problems, so any future issues can be dealt with quickly and effectively.

Monitor asked the Trust to ensure there is an overarching action plan in place covering all urgent care projects. This plan should include the unscheduled care transformation programme, with defined timescales for improvements and the Trust will need to report regularly to Monitor on its progress against these milestones.

The Foundation Trust have introduced a number of pathway changes to improve the efficiency within the ED. The CCG and Local Authority are working with the Foundation Trust, through several strategic forums to introduce system change to reduce the demand on the service. Impacting on this urgent care reform are the Stockport One service and a model for integrated care, both of which are hoping to wrap services around patients in an out of hospital setting where appropriate.

Care for children

The CCG are also working to improve care pathways for paediatric urgent care, as we are an outlier. This programme is at heart a specification programme for paediatric urgent care. There are four steps to this. As a result of this programme we will achieve the following changes in 2013/14:

- Changes to counting processes by SNHSFT which will result in a reduction in the count of paediatric admissions. This will not require pathway changes and is expected to reflect greater consistency with standard admission thresholds in operation elsewhere in the NHS
- A review and re-specification of the Children's Community Nursing Team with a return to the original objectives of admission avoidance and the management of children's conditions outside hospital. This specification will be in the contract with Stockport NHS Foundation Trust.

This programme will work with local member practices and the NHS England area team to ensure that all children under 19 years old with asthma, diabetes or epilepsy have a care plan in place that is reviewed annually; that the pathways described above are fully embedded and followed; and that practices offer daily open access for children that are well advertised to patients, and aligned to new community nursing arrangements.

Follow-up hospital appointment pathway

This reform programme aims to address the issue of unnecessary follow up appointments. In many circumstances no follow up is necessary but the process is followed regardless of this. Some follow ups may be necessary within a hospital setting and others could be undertaken in a different way or in general practice at a much lower cost to the economy. Part of our approach will be to build on a model of good practice adopted within Tameside CCG which has realised cost savings. The intention

is to provide GPs with information regarding people waiting for follow ups whom they will then review. The programme will focus on specific specialities initially, including chest, hip and knee and breast clinics. As well as considering what work is unnecessary or can be undertaken by the GP, there will be a review of alternative approaches to those areas where follow-ups are necessary including the effective use of lifestyle support, care planning, tele-care and frequency.

Whilst it is essential that the resources of the NHS are used cost effectively and the CCG needs to reduce admissions and referrals, it is committed to high quality clinical care; "the right treatment, at the right time, at the right price, in the right place". Therefore in looking to correctly use outpatient and admission resources, the CCG will not set any form of cap on the number of referrals or admissions in a particular practice. The CCG is also committed to distributive leadership and therefore will give each of its four localities a stretch reduction goal and allow them using local knowledge, clinical expertise and innovation to determine how best to distribute and deliver the locality objective.

Healthier Together (https://healthiertogethergm.nhs.uk/)

Stockport CCG is actively participating in 'Healthier Together' and the following is an extract describing the ambition of the programme

"Healthier Together is one element of a wider public service system reform agenda seeking to improve outcomes for all Greater Manchester residents. It is set in the context of Health and Care service reform across Greater Manchester. The three elements are integrated care, primary care and hospital care, the latter being Healthier Together's focus, which is led by the Service Transformation team and is accountable to Greater Manchester's twelve Clinical Commissioning Groups (CCGs).

The Healthier Together programme aims to develop a model of care that will help the NHS and other care providers in Greater Manchester provide quality services that are safe, accessible and sustainable for future generations. It will consider how best to provide the right service, at the right time, in the right place to achieve the best outcomes within the resources available.

Greater Manchester is changing with vibrant communities growing and many people living longer. However, more people are living longer with multiple long term conditions such as diabetes and obesity, which increases the demand on the NHS and social care services.

Expectations of the NHS are also growing. The public expect more and higher quality services, but at the same time, resources for the public sector are reducing.

Greater Manchester has a good record of changing to meet these extra demands with many improvements in outcomes for patients. However, the current system was designed for the last century with a significant reliance on our hospital services.

This system needs to change to ensure more people can be cared for in the most appropriate place such as their home, primary or community care setting, while receiving specialist care in hospital when required.

Local health communities have made good progress in responding to local pressures, however it is recognised that in some cases the local system may achieve greater outcomes for patients by working with wider partners across Greater Manchester.

We need to do more to keep people well and help people take greater responsibility for their own health. We also need to shift the balance between services provided in our hospitals, in the community and in people's own homes to meet people's health needs.

This means improving access to GPs and other primary care staff, and providing better access to very specialist care in our hospitals. It also means better access to senior doctors who can improve your chances of a full recovery. This is not possible at the moment because services are spread too thinly across Greater Manchester, which leads to differences in the services available out of hours and at weekends, often leading to poorer outcomes for patients.

We also need to make services affordable for the future and make the best possible use of the resources we have available.

It is important however that we do not overcentralise. Research suggests that there are diseconomies of scale as well as economies and that the optimal size of a hospital is somewhere between 200 and 600 beds. Therefore rather than concentrating specialist facilities on a few very large hospitals it may be better for each hospital to do what it is good at.

The NHS Contribution to Prevention

Early Diagnosis

Issues of current concern in Stockport include

- Low screening uptake in deprived areas
- Late diagnosis of cancer
- Missed cases of hypertension.

The ambition of the CCG is that everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisations, vaccinations and health checks.

The CCG intend through investments to ensure that people in more deprived areas are just as likely to uptake screening and have checks and vaccinations. One of the biggest drivers of health inequalities is cancer and in particular cancer survival rates.

Much of the differential in cancer survival is due to late presentation and identification and the CCG are working with their members to promote the uptake of bowel cancer screening. One of the patient story presentations to the Governing Body of the CCG was from a patient whose cancer was only picked up and treated because of the programme and we have shared this video widely to hopefully encourage others to send back their screens. The CCG and Local Authority are working together to promote the health check process that Stockport pioneered many years prior to the national drive for health checks. During 2013/14 we will focus on different ways to encourage people to come for screening and the 50,000 adults aged 35-74 who have never had a recorded screen. The Local Authority lifestyle services at www.healthystockport.co.uk offer a great resource for healthcare professionals and the public to access if their health check indicates that they could

reduce their chances of developing a chronic disease by modifying their lifestyle. A key local element in the screening process will be recording alcohol consumption complimenting what is done for newly registered patients. Alcohol screening will in addition be conducted in the group 16 to 35 who would not be attending the health check service and in the over 70 age group. High blood pressure is second only to smoking as a cause of early death and illness in the Western World. Next year, the CCG plan to ensure that everyone in Stockport knows whether their blood pressure is high or not. High blood pressure is second only to smoking as a cause of early death and illness in the Western World.

Lifestyle Advice

It is important to ensure that opportunities are not lost to give lifestyle advice in the course of NHS care. There is evidence that brief interventions – simple messages from health professionals in the course of professional contacts – are valuable and effective and so the principle must be followed of "making every contact count".

Unifying Health and Social Care

The distinction between health and social care was drawn at the time the NHS was first founded and was rooted in the concept that what was needed to care for old people corresponded to the care the more affluent members of society purchased in private hotels. Nye Bevan referred to the new elderly people's homes that councils were establishing as "private hotels for the working class" and separated them from the NHS because he didn't want people to make a hospital bed their home. Indeed the Poor Law hospitals, newly nationalised and yet to find their place in the NHS, had still to throw off connotations of the workhouse.

Whatever may have been the merits of the distinction in that situation an ageing population, a focus on maintaining people in independence and a situation where the average person receives most of their lifetime healthcare expenditure in the last year of their life, all add up to a situation where unification is essential.

Stockport CCG and Stockport Social Services are pursuing this goal through the establishment of Locality Hubs.

A Service Based on Need

Health service resources are finite and are used to help people. It is not therefore ethical to waste them. The use of available resources to achieve as much as they can is, therefore, an essential part of managing the NHS.

To do this it is important to concentrate not on supply (the services currently provided and their problems) or demand (meeting what people think they want) but on need (that which has been shown by evidence to provide an important benefit).

The relationship is shown in the following diagram by Stevens and Gabbay:

Fig 22.2 Stevens and Gabbay

What is supplied? **What** do people currently do to address this problem? Is this:
→ *efficacious*? i.e. a *treatment or change* is efficacious if it significantly lengthens the life or improves the quality of life of a significant proportion of the people to whom it is given or applied
→ *effective?* i.e. a *service* is effective if it delivers efficacious treatment or change to the substantial majority of those who would benefit from it
→ *efficient?* i.e. a *system* is efficient if it so uses its resources as to maximise the effectiveness of the greatest possible number of the services it supports.

SUPPLY

What pressures for growth are there?

NEED

DEMAND

WHAT IS DEMANDED?

→ What do people want to do to address the problem?
→ Why is this what they want to do?
→ Who have we consulted?
→ How do we know this is what is demanded?

WHAT IS NEEDED?

→ What does the evidence suggest would work to address this problem?

In areas which are needed and supplied but not demanded (2 on the diagram) there may be problems of securing uptake. Unneeded supply (1 and 3) should be decommissioned as it wastes resources that could be used to meet unmet needs (4) but if it is wrongly perceived as valuable by the public (3).this will be harder. In meeting unmet needs we need to be careful not to confuse them

with demands which are not in fact evidence-based (5). The aim is to bring the three circles together so the public only demand what they actually need and that is supplied (6)

The main purpose of a healthcare system is to improve the health of the people.

Health gain is achieved when:

- **years are added to life**
- **life is added to years**

Health gain occurs through a wide range of activities, not just health care, which is why this report opened by asking what everybody can do to address the major health problems of Stockport. But health care services have the feature of being provided primarily for health gain – there is no purpose in carrying out a healthcare activity unless it lengthens somebody's life or increases somebody's capacity to enjoy the life they have.

Health care services are not unique in being provided primarily to provide health gain – the same could be said of environmental health, industrial health and safety services, certain regulatory systems and health protection services. All such services ought to subject themselves to the discipline of asking whether they are achieving, within their particular field, the maximum health gain that is possible from the resources they use.

This isn't a precise mathematical exercise because human reality is never precise, there is no easy way to value one kind of health gain against another in a single currency, we can't always measure health gain, one of the benefits the NHS provides is the peace of mind of knowing it will be there for you when you need it so it would be entirely wrong to write off certain activities entirely on harsh cost/benefit analyses which neglected equity and much experimental and research activity achieves little health gain at present but lays the ground work for developments which will achieve health gain in the future. Although it is not a precise mathematical exercise it must become a way of thinking. We must appreciate that we invest in health services in order to achieve health outcomes.

It is often said that both need and demand are infinite (or at any rate greater than society could possibly afford) so that a health service will always need to ration care either explicitly or implicitly. This may well be true in certain areas such as measures like cosmetic surgery which aim to perfect the patient rather than return them to normal, experimental treatments, last ditch treatments with very low prospects of success, treatments which have very small (often purely theoretical) benefits over cheaper treatments, treatments for minor aches and pains, one to one lifestyle advice and psychological counselling, and the substitution of professional care for the kind of advice and support which in the past would have been obtained from friends. In these fields it may well be that society needs to decide how much it can afford and the NHS must then prioritise. However in most fields of care there is a specific and definable volume of need and it could all be provided if society wished to afford it.

In many fields of care this specific and definable volume of need could be reduced by prevention and that is just as effective a way of achieving the health gain, and may well be cheaper.

It is often said that the health gain from prevention is delayed and long term. That can be true for some forms of prevention but others achieve early benefits. For example

Prevention of coronary heart disease in middle aged and elderly people has an immediate impact on heart attacks and angina attacks.

Reductions in smoking reduce health service utilisation within less than three years

Reductions in falls in the elderly reduce health service and social care costs immediately

Improved social integration of older people reduces progress to dependence and hence future social care costs. For a population of people within 5-10 years of their life expectancy this benefit would be felt within 3 years

Employment of people with mental health problems reduces health care and social care costs immediately

It is important that these early benefits of prevention are achieved as the health and social care system moves towards the financial crisis that I described in the previous chapter. Action is needed in 2014/15 to bring about benefit in 2015/16.

3.23.   PREVENTION – THE CORNERSTONE OF PUBLIC SECTOR REFORM

The Financial Challenge

By the end of 2015/16 Stockport MBC will have been required by Government to reduce its cash limited budget (the part of its budget which is not nationally earmarked for schools, public health or housing) to £134million. Had the budget grown in line with inflation from its figure in 2009/10 it would have been £90m greater. This reflects cuts in spending over 6 years of 40% on the services supported by the cash limit. Although service reductions to date have been modest achieving this has exhausted the scope for simple cost savings and it should be noted that half of the cuts have yet to be made and a third of the cuts have yet to be identified.

Similar financial challenges face the NHS although these are framed as a need to manage rising demand within static funding rather than as a need to cut spending.

There is no local choice about whether to make these savings. The decision that these will take place is made nationally. They flow from an economic consensus that Governments must balance their budget or borrow rather than create new money, that the country's debts are too high and that our economy is overbalanced towards collectively-purchased rather than individually-purchased goods and services. Each of those propositions can be challenged and within the public health literature "The Body Economic – Why Austerity Kills" by Stuckler & Basu published by Allen Lane ISBN 978-1-846-14783-8 makes the case against austerity both empirically and theoretically. Empirically it takes four instances where some states have followed economic orthodoxy and others have created money and in each case the latter have performed better both economically and in health terms. The comparisons it makes are between US states which enthusiastically adopted the New Deal in the 1930s and those which dragged their feet, between Malaysia and other South East Asian countries in the recession starting for those nations in 1997, between Hungary, Poland and Belarus on the one hand and other ex-Soviet countries following the collapse of the Soviet Union and between Greece and Iceland in the current recession. Theoretically this situation is explained by pointing out that for an individual or an organisation money is a personal share of society's resources and must be managed in the context of a need for financial balance, for a country money has a different purpose; it is a means of exchange and its purpose is to facilitate the making of viable transactions. If viable transactions cannot be made because of lack of money the solution is to create the money.

There are of course powerful arguments in favour of balanced budgets and one of the reasons I have set this dissenting case out is because the national consensus is such that this alternative is not heard as often or as clearly as the conventional case, and indeed is often ridiculed in comments like "You can't spend money you haven't got" which close down the debate about the nature of money in an economy.

However even if you are convinced by the case made by Stuckler & Basu, it doesn't make one iota of difference to the task facing the Council and the NHS for so long as the cross-party national consensus is for balanced budgets and the law requires us to follow that approach..

The task which we face is a difficult one. If it were to be tackled simply by a further round of service reductions these would bite deeply into the roots of our well-being and civilisation. It can only be

tackled either by making these deep and painful reductions or by finding radical new ways to achieve the outcomes the public sector exists to achieve. Currently public discourse is locked into resistance to cuts and the ridiculing of radical alternatives. That is an unsustainable discourse. One or other of those is going to have to give – hopefully we will stop ridiculing radical alternatives rather than succumbing to the acceptance of the dismantling of our well-being. There is no doubt that things will change. The question is whether they just get much much worse or whether we find new solutions. That is the challenge of public sector reform.

Public Health and Public Service Reform

Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, communities and individuals. However this prevention is complex and often more about the social conditions in which people live than about medical intervention.

This complexity makes prevention hard: issues must be prevented before they take hold, with society creating safe and nurturing environments for children and adults, helping them to reach their full potential. However society is equally complex and many children and adults develop problems and suffer disadvantage which create a cycle of dependency and the need for support. Prevention and wellbeing is at the heart of Public Health, and it is also at the heart of Public Service Reform (PSR). The goal is a society where we prevent problems occurring instead of allowing dependency to arise and then providing services to cope with it. If you state the desired outcome as being better well-being this is a public health process whilst if you state it to be to save money it is a process of public sector reform. Yet the two go hand in hand.

Public Sector Reform Programmes

Public Service Reform is a significant programme of work across the spatial footprint of the ten Greater Manchester (GM) Authorities. The work involves all public sector partners and the public in reshaping public services to be more evidenced-based, joined-up and prevention-focused.

It is a key objective of the Greater Manchester Strategy, and the Stockport PSR programme forms part of the wider Greater Manchester PSR programme. This joint working across the ten authorities is a significant challenge, opportunity and means to transform the sub-region over the next five years.

The objectives of this programme are:

- to ensure that residents in the Borough can benefit from future economic growth, by designing services that can better support them to make positive choices and be independent; and
- to meet the challenge of public sector austerity by reforming services collectively, such that outcomes for residents in the Borough are better than they would have been had reforms been undertaken solely by agencies acting alone.

Public Service Reform programme plays a key role in helping the public sector to face the unprecedented challenge of continuing to deliver effective and responsive services to the public with significantly reduced resources and, in many service areas, increasing demand.

Across the public sector in Stockport, as in the rest of GM, agencies have responded by working ever more efficiently to keep costs low; undergone significant internal restructures; sought opportunities to collaborate with each other, and across our respective sectors; reduced staff levels; and made some reductions in external service provision.

This has run its course and the next phase of transformation is reducing key causes of demand and creating a holistic public sector where benefits in one area can fund prevention in another. These new approaches are critical if we are to successfully meet the needs of Stockport residents within much more restricted available resources. Organisations and communities must prevent demand and become more resilient if we are to rise and thrive in the face of the challenges ahead. Public Sector Reform is currently focused on the five themes of early years, troubled families, health and social care integration, transforming justice and work & skills.

It is, however, unlikely that these five themes alone will solve our problems, even in purely financial terms let alone in terms of enhancing well-being. Therefore public sector reform must be seen as a set of design principles which underpin all services.

The Design Principles

The following are an expansion, for greater clarity, of the three principles agreed at Greater Manchester level.

1 Focus on the outcomes to be achieved.

2. Consider all the ways of achieving those outcomes.

3. Recognise that if you prevent somebody needing a service you serve that person as well as (perhaps better than) if you supply the service.

4. A stitch in time saves nine - deliver support that prevents economic, social and health issues developing at their current rate and stops them becoming entrenched.

5. Identify, as soon as practicable, those who are at an increased need for support and address these needs using state of the art evidenced-based services.

6. Choose interventions on the strength of the evidence base,

7. Integrate, co-ordinate and sequence interventions in the right order and at the right time for each family

8. Take a family or community based approach not just focus on individual, in order to best influence behaviour.

9. Recognise the value of resilient communities and of independent individuals, the value of self-help and of mutual help, the role of social support and community spirit and the significance of civil society.

10. Recognise that this does not come about merely by stepping back but requires active empowerment.

Commitment is high across Stockport and GM and central Government are playing a key role. The aim is to prevent long-term issues of residents, better support their needs and enable them to live more independently and contribute to economic growth. Helping people to reduce their dependency on public services is the right moral choice – it also makes best sense to us as custodians of public resources. It would make sense even if there were no austerity – it is simply that austerity denies us the luxury of neglecting this duty.

Developing such a place-based approach to PSR will be challenging, in particular to developing new models of support amidst the pessimistic climate which difficult finances always create, but opportunities exist in Stockport to:

Build on the integrated neighbourhood management model of place-based governance, joint working and innovation that currently exists in the Priority Neighbourhoods;

Consolidate, evaluate and expand the Supporting Families Programme infrastructure, to develop a whole-system approach to identification and assessment of need, and allocation of resource from a range of integrated delivery models;

Build on our cutting-edge pilots such the People Powered Health initiative and Problem Solving Courts; harness our residents' significant skills, experience and civic capacity; and work more closely with our community and voluntary sector partners to establish a meaningful dialogue with communities in the Borough that increase the supply of civic support to people that wish be more independent.

Recognise and use the positive features of Stockport culture which combines the solidarity of industrial Lancashire, the confidence of the Cheshire Plain, the openness of the Pennines and a decency which is a central feature of our culture.

Supporting people to deal with the key causal issues at the root of their problems will enable those people to then realise their potential, seize opportunities and collectively improve the economic productivity and growth, and the overall wellbeing of their families and their local communities.

The Early Years Theme

BACKGROUND 40% of children in Greater Manchester (GM) and 30% of children in Stockport are assessed in reception class each year as not being ready for school, by not attaining the expected level in the Early Years Foundation Stage (EYFS). This represents 16,000 GM children who set out on a poor life trajectory, unable to engage with the national curriculum effectively, at risk of never catching up to reach their full potential at school and, ultimately, less likely to be economically active and to live fulfilling lives and hence more likely to place a high demand on public services throughout their lives.

Stockport performs better than GM as a whole on EYFS performance, but is highly polarised; in 2011/2012 in the lowest performing area of Stockport 50% of children did not attain the expected level in EYFS as against 15% in the best performing area. As well as year on year improvements in EYFS, Stockport is also narrowing this gap.

AIM 1.Children with a 'good level of development' (GLD), arriving at school ready to learn.

AIM 2. Reduce future demand and dependency on expensive, acute public services.

FOCUS Centred on early identification and intervention, it aims to create strong families and school ready children preventing long term issues and consequential service demand and enabling those needing services to get the right support at the right time.

NEW DELIVERY MODEL Across Greater Manchester

A shared outcomes framework, across all local partners;

A common assessment pathway across GM: eight common assessment points for an integrated ('whole child' and 'whole family') assessment using evidence-based tools in crucial developmental windows, to identify early families reaching clinically diagnosable thresholds for intervention or with multiple risk factors leading to

Referral into an appropriate evidence-based targeted intervention sequenced alongside other public service interventions as a package of transformational support to families, with appropriate step-down packages of support rather than 'free fall', to help off-set the risk of re-entry to a high level of need in future.

Ensuring better use of day-care developing a new 'contract' with parents to drive engagement in education / employment / training / volunteering, and introducing new common terms and conditions to drive improvement in all day-care settings;

A new workforce culture enabling frontline professionals together in support of the whole family to reduce dependency and empower parents;

Better data systems to ensure the lead professional undertaking each assessment has access to the relevant data to see the whole picture, to reduce duplication and confusion, to track children's progress and in particular support the most vulnerable and disadvantaged;

Long-term evaluations to ensure families' needs are being addressed and add to national evidence for effective early intervention.

Health and Social Care

AIM 1. to respond to financial and quality challenges in health and social care

AIM 2. to improve citizens' experience

AIM 3. avoiding admissions to hospital and care institutions, especially in older people

FOCUS 1. "integrated care services" – joined up care based around the needs of people and carers putting them in control and delivering better outcomes for better value

FOCUS 2. financial frameworks investing in interventions for independence and resilience.

NEW DELIVERY MODEL

Accessible & Responsive - Enhancing primary care services and reducing variation so GPs are 'first port of call' particularly for people with Long Term Conditions

Health and social care providers working together particularly for the frail older people, people with Long Term Conditions and those with complex needs.

Integrated case management across health and social care

Single assessment process, with care co-ordination across agencies

Support for self-care and independence -Patients, individuals and their carers will be supported and empowered to take ownership of their care and wellbeing so that they are able to live independently so health and social care resources are targeted on the most vulnerable.

Patient education programmes

Expert patient programmes

Use of direct payments, personal budgets

Carers strategy

Assistive Technology

Quick response to urgent needs - Rapid access and response to urgent care needs to minimise the reliance on A&E and provide the most appropriate care.

Rapid Response/Intermediate Care teams, aligned to Reablement

Joint urgent response services across health and social care on a 24/7 basis

Planned pathways of care - Agreed care pathways and protocols will be in place to deliver standardised less variable care with fewer unnecessary attendances.

Outpatient clinic redesign

Community clinics

Appropriate specialist and hospital care only when required - Patients will receive appropriate specialist input in a timely manner when required spending only the appropriate time in hospital with planned discharge as early as possible.

Early supported discharge service

Integrated health team and Reablement

Integrated End of Life Care

Supporting Families

BACKGROUND Each family is unique, and is a primary influence on the behaviours of the people in the family. But currently, in the main, we deliver services without seeking to understand or respond to this context, leading to waste. Some of these families are huge repeat business for all public services. This is a bad outcome for families, especially children, a bad outcome for local neighbourhoods and a bad outcome for the public purse.

AIM: Reducing the number of families fitting the national Troubled Families definition;

FOCUS: the development of a whole-family way of working for public services; incorporating preventative work with families at risk of becoming troubled.

NEW DELIVERY MODELS

The delivery model for this theme also contributes, by enabling whole-family working to other themes such as Work and Skills, Early Years and Transforming Justice.

The new delivery model for Supporting Families employs a single key-worker that 'holds' a family on behalf of all agencies. Public service systems need to be re-designed so that this key-worker can 'pull' services towards a family in a sequenced manner at the time they will be most effective. This whole-family delivery model is characterised by:

- strong multi-agency governance at case and programme levels;
- key workers that are empowered to integrate, coordinate, prioritise and sequence support, informed by single, whole-family assessments;
- creating bespoke interventions for whole families, supported by mainstream resources;
- engaging the family in developing their action plans and identifying success – to promote self-reliance and responsibility; and
- high quality, common evidence and evaluation processes and tools, to show impact and allow comparison between different delivery models in GM.

Partners in Stockport have agreed to develop this way of working by re-engineering assessment procedures, referral pathways, and operating models across mainstream services, rather than establishing in parallel to mainstream services, a team or set of functions that are able to engage in a whole-family manner.

Transforming Justice

AIM: to reduce levels of crime, offending and reoffending across Greater Manchester by providing better, more coordinated support for offenders at the points of arrest, sentence and release and, through neighbourhood work, to prevent offending.

FOCUS: The work in this theme has focused initially on:

Youth and young people (aged 16-25), because the peak age of offending is 19, and this age group accounts for 40% of criminal justice costs; and

Women offenders, due to the whole system costs of female custody on families.

NEW DELIVERY MODELS

There are four proposed new delivery models within the GM Transforming Justice Theme. These require reforms to:

Youth triage – coordinated support at the point of arrest;

Intensive Community Orders (ICO) – scaling up an integrated support and control package for 18-25 year olds at risk of short-term custodial sentences;

Resettlement support – coordinated support for offenders in custody to discourage reoffending and promote employment when they are released;

Support for *Women offenders* – triage, ICOs and through the gate work.

Stockport will also incorporate:

the development of an approach to reduce the harm and cost of Domestic Abuse and the Cost Benefit Analysis of this [1] in conjunction with the AGMA work underway; and

the evaluation and further development of the current Problem Solving Courts and Neighbourhood Justice Panels pilot interventions

The development of an ICO and Women's offenders NDM that integrated with existing work in these areas (Problem Solving courts and the Stockport Women's Centre respectively).

Work and Skills

BACKGROUND

One of Stockport's greatest assets is the high skills levels of its residents, who support economic growth across the whole of Greater Manchester. The large number of successful, skilled, high earning residents in the borough is also a draw for businesses looking for suitable locations. Skilled residents are also more likely to create their own businesses, helping to stimulate the local economy. This Borough-wide strength masks significant variation, with low-skill levels and poor employment prospects clustered around our Priority Neighbourhoods and particular cohorts of people and families.

AIM: To ensure high quality work for more residents

FOCUS: Our work in Stockport on this Theme will primarily attempt to:

Build on existing work to integrate work and skills delivery by focusing on a small number of achievable improvements, as set out in the Theme plan below;

Ensure that Work and Skills outcomes are clearly positioned as a primary objective of the Supporting Families New Delivery Model.

The complexities and challenges of moving this agenda forward include:

Getting all relevant partners to work together effectively and not compete.

Achieving sufficient and effective data sharing to identify target individuals and to inform quality analysis of issues and impact.

Negotiating the sharing of costs and benefits.

NEW DELIVERY MODEL

the alignment of a clear Employment and Skills pathway with the wider Supporting Families Pathway, to ensure work and skills issues are raised and addressed early in a support conversation;

JCP direct investment in the Stockport Employment and Skills Advice service, and the fulltime secondment of a JCP Advisor, to create a dedicated Work and Skills resource within the Supporting Families Programme which may permit expanding that programme to include a small cohort of families with specific and significant employment support needs – for example, ESA claimants exiting the Work Programme. This would effectively be a pilot of the GM Work ProgrammePlus model.

Overall

It is clear that this is a comprehensive programme of work, however as said, it is unlikely that these five themes alone will solve our problems, even in purely financial terms let alone in terms of enhancing well-being. Therefore it is central to the success of this programme that the design principles be expanded from the original three and be seen as a set of design principles not just for Public Service Reform, but for all public service. This, alongside a relentless focus on the outcomes to be achieved and an approach to risk that enables us to work in new, imaginative and innovative ways will foster the spirit of resourcefulness and enterprise needed.

A significant culture shift is needed to enable the joint goals of the PSR and Public Health to be realised. We need to accept that success can look like us doing less, not more, and that well served and supported communities need and indeed want less state intervention. This shift means a focus on intervening before crisis, in order to save the cost and pain of letting issues within the community build until levels are intolerable for both the individual and society. This early identification and intervention is central to success, as is getting the basics of universal health and social support for the currently fit and well right first time.

An intellectual shift is also needed; to develop a system that does not support interventions that have no evidential basis or theoretical support. We must be equally rigorous as to when we deliver certain interventions, as too much for too long has been delivered at inappropriate times when citizens simply are not in a position to change or benefit. At the heart of this is taking a holistic community and family approach in order to really understanding the citizen; their story and their circumstance, from their viewpoint.

All this hopes to develop a culture of resilience. Resilient people don't just survive, they thrive. They do well and cope during good times and bad. They contribute positively to their community, both economically and socially. Resilient people have a myriad of resources to call upon to support them, with strong personal skills and access to information and communication networks. Collectively the communities of resilient people are able to actively influence and manage economic, social and environmental change preventing large scale entrenched social issues forming.

This goal must be infused into all our services using the five initial themes as examples but recognising that they cannot stand alone, nor can they be passed on our passive delivery, but require active and enduring support and empowerment.

3.24.   SUMMARY OF A COUNTRY CITY - TOWARDS A GREENER STOCKPORT

Background

In 2000 I published 'A Country City' as part of my Annual Public Health Report. A slightly updated and slightly revised version of Country City has been reissued and is available at: http://www.stockport.gov.uk/services/environment/planningbuilding/planningpolicy/ldf/ldfevidence. A review will take place in 2013/14 and the reissue of the original document, with only minor changes, is intended to launch that review. In reissuing it I have updated some of the analyses and have made slight changes. On the whole though the vision hasn't changed and there is no need to revise most of what was written 13 years ago. In the last 13 years the terminology both of planning law and of health service bodies has changed. "Country City" referred to "health authorities" and a "Unitary Development Plan". Both have been replaced and their replacements are now being replaced. In the following summary I have used new terminology. In chapter X (the reissue) I haven't bothered to make this change. That minority who keep up to date with these changes will readily translate. That substantial majority of the people who are bemused by such changes are as likely to understand the old terminology as the new. Perhaps likelier!

At the time Stockport Council was revising its Local Plan, which forms the policy basis for decisions on planning applications. It lays the basis of what kinds of development will be permitted and not permitted over a specified future period. In addition the Council was developing Community Transport Plans which determined how to effectively tackle the problem of traffic which is seriously damaging to health and wellbeing in Stockport.

In 2000 the report was aimed at those involved in the debate about future land use in Stockport, and in particular about transport policy and planning policy. However the powers of planners are limited and the proposed review during 2013/14 will acknowledge the need to widen the audience if some of the recommendations are to be achieved.

"Country City" covers predominantly social and environmental aspects of issues including transport, open space, biodiversity and living as a community. This report describes an ideal of a Country City and Civilised City in which people live and work in peaceful and beautiful surroundings, with a focus on improving urban living and with many benefits for health. The Country City provides exercise opportunities and helps raise people's spirits by forming a city of village communities in natural surroundings. The Civilised City focuses on peacefulness and social support with an emphasis on the importance of social interaction, opportunities to enjoy peace and beauty, and community spirit.

I acknowledged the long term nature of the proposals but said 'the first step to creating something is the decision to create it. To solve a problem you must acknowledge that it must be solved. I have never said that the creation of the Country City will be easy. I say only that it must be done.'

Timescales were examined acknowledging that a Country City cannot be created overnight. I cited Reddish Vale Country Park as a success story of turning derelict land into breathing space where Kingfishers dive. I said : 'If 50 years ago councillors had said that the creation of a country park in that area was an unrealistic dream then it would not exist today. A succession of short term decisions would have reshaped the area instead. Instead councillors ensured that every decision made about the Vale pointed in the same direction. I hope that the borough is proud of that achievement. I hope that it also still has the confidence to repeat it. Does this generation have the same visionary civic pride that allowed our parents and grandparents to bequeath us this treasure? Will we and our children create further similar treasures for our grandchildren?'

I added : 'The report describes an ideal - a vision that I have called a Country City in which people live and work in peaceful and beautiful surroundings in balance with nature. The report asks that we start to work for it. I fully acknowledge that it will take time to achieve, that compromises will be made, and that parts of the vision will prove to be wrong and will be modified. But the determination to move in a particular direction must be summoned now.'

A Country City – Towards a Greener Stockport was adopted by the Council as a 50 year strategy in that same year. The spirit of a 50 year strategy was not that the matter could be put to one side for the moment and returned to later. Rather the idea was that if it is going to take so long to bring to fruition we must start immediately. If I wanted to be in John O'Groats by this evening I wouldn't wait until after lunch before setting out.

In 2003 the Council carried out its first three year review of the strategy. This identified that heartening progress had been made and that many of the simpler first steps had been taken. It did not review progress again until 2012 and it was realised then that progress had slowed down. Whilst good progress has been made in integrating the principles of Country City into the planning and transport policies of the Council, it is questionable whether the vision of Country City can be delivered through those mechanisms alone. Plucking the low hanging fruit had not been a prelude to tackling the difficult longer term issues – rather when the low hanging fruit had been plucked progress slowed and many of the more difficult issues remain. The 2013/14 review will address these issues. We need to involve other areas of the Council and its arm's length bodies, and other actors, such as developers, employers, schools and the NHS if the vision is to be brought to fruition. We are about a quarter of the way into the 50 years of this vision. We have plucked the low hanging fruit. Real challenges lie ahead if we are to climb the rest of the tree.

The Concept Of A Country City

A Country City and a Civilised City are two concepts which are directed towards making urban life more tranquil. Both concepts are linked and complimentary and their practical implications in Stockport may be interchangeable.

Civilised City	Country City
Developed by the Royal Automobile Club – originates in the concept of traffic management	Developed in Stockport's 1995 APHR – originates in the concept of open space
A city where social interaction, opportunities to enjoy peace and beauty, community spirit and street life are prominent and the motor vehicle is controlled so it does not destroy them.	A city of village communities in natural surroundings with ready access both to urban facilities and to countryside
Emphasises human relationships - Short term, practical measures	Emphasises human relationships - Short term, practical measures
Promotes health through tranquillity and social support	Promotes health through exercise and raising the human spirit
Important to Stockport because our traffic problems create a major challenge to our quality of life	Important to Stockport because generations of protection of tongues of countryside reaching deep into the borough, create opportunities

Table 24.1

Issues of significance involved in the above concepts are as follows:

- Tranquillity – stress reduced by quiet beautiful surroundings;
- Biophilia – health benefits from experience of nature;
- Aesthetics – beautiful surroundings raising the human spirit;
- Exercise – prevents heart disease and osteoporosis and promotes mental health;
- Transport – traffic destroys tranquillity and disrupts social interaction and community spirit. Walking and cycling are good exercises;
- Open space – Tranquillity; aesthetics, biophilia, exercise opportunities;
- Crime – Creates stress. Disturbs enjoyment of local communities. Makes people afraid of walking, cycling, open space;
- Community Spirit – Social support is beneficial to health. Empowered people can make healthy changes. Poor community spirit can contribute to crime, loneliness and vandalism;
- Nature & Biodiversity – Contributes to tranquillity, biophilia and aesthetics. Biodiversity has ecological advantages.

Transport

The transport section of A Country City highlights the issues facing Stockport at the time of publication with regards to transport impacts on public health, including accidents, emissions, noise, stress, danger, loss of land and planning blight as well as severance of communities by roads.

Transport can help keep people healthy because it allows access to employment, education, shops selling healthy food, leisure activities, health services and the countryside, and it opens up social support networks. Walking and cycling are very healthy forms of transport and can help prevent heart disease. At the same time, however, it can damage people's health due to accidents, pollution, noise, stress and anxiety, and the replacement of open space with roads. Traffic is

responsible for a large amount of pollution in Stockport which, as well as damaging people's health, also contributes to acid rain and global warming.

New technology is expected to reduce the growth of traffic pollution in the future but traffic is predicted to grow to a greater extent than the benefit, so pollution will still get worse. People need to start using their cars less, and the only long-term solution to easing traffic congestion is to make walking, cycling and public transport in cities more attractive.

Replacing cars with public transport for long journeys and cycling and walking for shorter journeys would dramatically reduce traffic and improve health.

The document promotes active travel options such as walking and cycling as well as public transport, whilst highlighting inequities of transport health impacts which fall on the more deprived. . A section clearly lays out promotion of cycling including the networks to support such options with some suggestions for areas and approaches.

Heavy traffic reduces people's feeling of community and neighbourliness, and is a major cause of increasing limitations on children. Creating residential cells, areas without through traffic, would create opportunities for a cycle network and enable the use of streets for community purposes rather than just passing traffic. This includes examination of Home Zones based on the Netherlands approach of Woonerfen or 'Living Streets' as well as 20 mph zones. In Holland, "woonerfen" or "living streets" have trees, street furniture and play areas, but traffic is still allowed to use the street. Similar developments should seriously be considered in Stockport, together with more speed restrictions in streets to make them safer, particularly for children.

Recreational cycling is an important means of exercise and can also be used as a serious means of transport. It is currently perceived as a fairly dangerous form of transport because of pollution and the risk of accidents. These perceptions of danger are exaggerated and indeed for local journeys is as safe as the car (safer for young road users) but creating safe cycle networks could make it safer still and change this misperception. Trains are more effective at competing with cars, and the combination of frequent trains and cycling can be as flexible a means of transport as the car. Most of Stockport could be brought within 1km of a railway station by fairly minor changes to the rail system, including some new stations, orbital rail routes (at the time I advocated a Hayfield to Manchester Airport rail service but now the Orbit Tram proposal has developed that concept) and a funicular linking the station and the bus station. Bus service provision is also an important part of the public transport network and I cited bus networks (including dedicated bus lanes) as a way forward.

I queried development of new roads as likely only to increase the level of road traffic. Since I wrote this scientific knowledge of this effect has advanced and it is now understood that it results from the opening up of new opportunities for relocation. The Council has responded extremely positively to this advice by building into the SEMMS road scheme what are called "complementary measures" – measures which take the opportunities created by freed up road space and make use of them (perhaps for bus lanes or cycle lanes) in the gap before they fill. For those, like me, who are sceptical of road schemes, these measures make the SEMMS scheme one of the best designed road schemes in the entire national road building programme. Some of those who remember my original opposition to this road ask why I have abandoned this, and question whether I have been silenced. The explanation is very simple. My advice as to the problems the original proposals would have

caused has been accepted and the proposal modified so as to take account of them. This was recorded in my 17th Annual Public Health report in 2007/8.

Open Space

As I first wrote two decades ago in "Ginnels, Snickets and Leafy Lanes" Stockport is a beautiful town to walk around with distinctive communities and countryside but it is not so pleasant in a car. To enjoy this asset footpaths must remain accessible, safe and navigable, a pedestrian network was recommended and has since been designated, and recommendations were made for further development including protection and enhancement of the existing network considering surfaces, lighting, road crossings, security, hygiene and sign posting. Investment in off-road footpaths is needed to create a pleasant pedestrian network so that people can walk safely and pleasantly through the borough. Investment is also needed in aesthetic enhancement of key on-street links in the current network. At the time I believed that greening would be the best method of such enhancement but thinking has now shifted towards art trails.

Open space can make an important contribution to public health. It provides opportunities for exercise and a green rural environment helps people relax and raises spirits. Health promotion through parks, integrated and coordinated with other health strategies in Stockport, could make a substantial contribution to the 'Our Healthier Nation' targets, especially for heart disease and stress relief. There are many sources of country walk opportunities in Stockport and areas of open space suitable for exercise.

Green gyms were in 2000 a new concept which brings together health, community empowerment and open space, through practical conservation activities undertaken by local residents to enhance their local community while improving their own physical and mental health. They still have not developed as much as I had hoped they would. Urban nature conservation improves the quality of life of people living in towns and cities and the attractiveness of local areas by adding trees and hedges, and roof gardens to preserve open space on land that has been built on. Traffic free estates could be an attractive addition to an area of open space, incorporating cycle ways, pedestrian networks and safe school routes.

Open Space is assessed for its wider contribution to health benefits, including raising the human spirit, the contribution of gardening both to physical activity and to nutrition, pleasant green views, and promoting exercise through walking and cycling or the establishment of Green Gyms. A programme for open space is outlined regarding maintenance of existing open space, clarification of the different roles of open space as well as the need for urban open space management. The preservation of open space in urban areas is cited as critical.

The conflict between open space and development was recognised as a problem even at the time and it is more serious a problem now. The solution put forward in "Country City" was greenspace-compatible development – development which aimed to identify the role of the open space and duplicate it in the development which is constructed. The role of green roofs and living wall to green urban areas and the use of greenery for security measures rather than hard fencing are also promoted. Large community buildings in the centre of parks are advocated and a preference is

stated for small new rural hamlets in the Green Belt rather than nibbling at the edges of existing Green Belt areas, indeed potentially enhancing rural transport networks through increased demand

Nature & Biodiversity

Within the consideration of open space, nature and biodiversity are highlighted as essential to continued good human health reflecting our place within the wider ecosystems. Well maintained natural environments enhance both physical and mental health and we have a moral duty to maintain them. It also makes economic sense to do so, given that this makes the Borough an attractive place that people want to live and work in, as well as visit. The need to protect our biodiversity is more important now than it has ever been. Without plants and animals we would not be able to survive, and our physical, mental and spiritual wellbeing are improved by contact with nature.

Living as a Community

Community spirit is important both as an end in itself (lack of social support is a powerful risk factor for death and ill health) and as a means to an end (working together to make things better). Community development, community streets, healthy living centres, tackling crime, and public involvement are all highly important factors for improving community spirit.

In a sustainable community people respect the local environment and value quality of life and future generations above short-term thinking and material consumption. Resources and energy are used efficiently, pollution is minimal, and nature is valued and protected. Facilities, services, goods and other people are easily accessible, but not at the expense of the environment; opportunities for leisure and recreation are readily available to all; spaces and places are attractive and valued; and everyone has access to good quality food, water, shelter and fuel at reasonable cost. These principles are being applied neighbourhood by neighbourhood throughout Stockport.

Community development includes co-operatives , credit unions and community efforts to regenerate areas. People can reclaim streets, volunteer, get involved in public actions and Healthy Living Centres which can provide information and advice to local residents.

Sustainable communities are cited as being a good way forward highlighting the Local Government Association checklist which was available at the time. This highlighted issues such as efficient resource use, pollution prevention and control, access to satisfying and rewarding work, valuing of unpaid work, access to necessary facilities and services (including leisure), protecting the diversity of nature, enhancing cultural assets (including heritage), reducing road traffic and enhancing opportunities to walk and cycle or access public transport. The management of crime and perceptions of crime were also determined as critical to enhancing community spirit.

Unrealistic Dream or Practical Necessity?

As we move into the technology-based culture of the future the economy will be centred around internet-based businesses, whose choice of location will be swayed by pleasant living conditions and an environment that feeds creativity. The Country City suggests a way to have the best of both

worlds – beautiful living conditions close to the entertainment and shopping opportunities of a city, and the creative energy of a vibrant community.

Sustainability is often seen as being in conflict with economic growth, arguing for the need for a balance. However I compared two scenarios for an internet-based future.

A is an accountant holding a major position as a commercial negotiator with a large company. From the large purpose built study in A's house, on the Mull of Kintyre, deals running into millions – sometimes billions – are negotiated daily by e-mail. The study has a beautiful view across the sea and allows her to keep one eye on the children playing on the beach. At five past six she closes a major deal, drinks a glass of champagne, calls to the children and still has over an hour to get ready for her dinner party at 7.30.

B and C live in a two bedroom terraced house in a northern industrial town. Because of the high technology home-working adopted by their employer, they have had to fill the sitting room with computers, fax machines and other office equipment, and have only the kitchen to live in. As C struggles to complete a long list of telephone calls, B changes the baby's nappy. B's computer bleeps insistently. The doorbell rings. The shopping that C ordered on the Internet late last night has arrived. As C opens the door to collect it, she realises that it is the first time the door has been opened in seven days. B notices that the order does not include any alcohol and shouts at C. B's computer bleeps again. The baby starts crying and B sticks the safety pin in himself. B hits the baby. There is an ominous silence.

How can we ensure that Stockport is the locus for the better quality work of the new economy rather than a reservoir of cheap labour?

The document acknowledges the constraints of the dangers of imposing ideas on communities where interests and values may be in conflict. However there was and is widespread concern around traffic and a desire for open space, including playing fields. It is acknowledged that a planning inspector might not welcome some of the more radical ideas put forward in A Country City, but there is a need to include these approaches in planning policy initially to foster debate and if attitudes to land use options are to change.

Stockport's successful defence of the requirement for commuted sums payments where open space is not provided on new development was a recent triumph at the time and I said that there were other areas where such battles were worth fighting.

Recommendations

A Country City builds up a series of options to inform decisions about land use that have associated benefits in terms of prevention of poor health. Recommendations from the original draft of A Country City will inform the review being undertaken during 2013/14. Progress has been made on many of them – others remain to be addressed.

These recommendations addressed greenspace-compatible development, pedestrian networks, an architecturally-significant building as a centrepiece of each park, residential cells, Home Zones and living streets, the creation of an urban forest with buildings in clearings, a cycle network, and the incorporation of health considerations into spatial planning.

I recommended that the Council resists the idea that land at the fringes of the Green Belt is less important than land deep within it. In many ways the reverse is true as eroding the fringes of the Green Belt puts the whole borough further from the countryside. For the same reason strategic open space within the urban envelope should be regarded as being as important as Green Belt. I suggested rural hamlets designed and designated for technology based homeworking within the Green Belt, but with this exception vigorous refusal to release land from Green Belt.

I recommended simple steps to render the workplace aesthetically attractive, that people and organisations be encouraged to aesthetically enhance their environment through the use of hanging baskets, green roofs, green walls, public art, and open space. Everybody should be asked to aesthetically improve any territory for which they are responsible. I recommended hedges as security barriers rather than fences and walls.

 I recommended that the Council opens discussion with the PTE, and the railway industry to establish a Hayfield Manchester Airport service including new Reddish and Gatley curves, the Greater Manchester Orbital Railway, the Metrolink to Stockport, twelve new stations on existing lines and a town centre funicular from the station to the bus station/Metrolink station. I recommended that the Council should press for active promotion of the combination of rail and cycling and should ensure cycle access to all stations is well designed and linked to the cycle network. I recommended Green Travel Plans and new mechanisms for ensuring that individual highways decisions accord with overall transport and health strategy.

I recommended that the Council explores the land use implications of a knowledge-based economy with a view to positioning Stockport to take full advantage of this, and that it urges the remainder of the region to do likewise so that the North West may become a centre for the new economy.

I recommended that local political parties debate the various trends that are loosening the roots of public services in local communities and also the issue of planning laws with a view to persuading their national parties to adopt a policy of expanding the powers of local authorities to promote coherent visions. I recommended that all agencies seriously debate the causes and consequences of deteriorating community spirit.

3.25. THE HEALTH AND WELL BEING STRATEGY

Stockport's Public Health Goals

Table 25.1 shows how the various goals by public health in Stockport relate to the various outcomes we are seeking to achieve.

Table 25.1 Stockport Public Health Goals and Outcomes

Goals	Outcomes										
Measures	**Reduce Inequalities in health**	**Reduce sickness and death from Heart Disease**	**Reduce sickness and death from Infections**	**Reduce sickness and death from Cancer**	**Reduce Sickness and death from injuries**	**Reduce sickness and disability from musculoskeletal diseases**	**Reduce disability and dependency from old age**	**Reduce disability and dependency from Mental ill health**	**Reduce disability and dependency from Learning Disabilities**	**Reduce disability and dependency from physical disability**	**Reduce disability and dependency from respiratory disease**
Public Health Outcomes – Domain 1: improving wider determinants of health											
Improve Air Quality				✔							✔
Improve Social Support, Community Spirit and Empowerment (resilience)	✔	✔	✔		✔		✔	✔	✔	✔	
Provide Community Development	✔	✔	✔	✔			✔	✔	✔	✔	✔
Reduce Discrimination & Social Exclusion	✔	✔	✔	✔				✔			
Creating Pleasant Restful Environments	✔	✔	✔	✔				✔		✔	
Improve Health in the Workplace	✔	✔		✔	✔	✔		✔	✔	✔	✔
Reduce Prevalence of Poverty	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔
Affordable Warmth	✔	✔	✔				✔				
Reduce Traffic Speeds	✔				✔						
Improve Safety for People who Live, Work and Play	✔			✔	✔					✔	
Reduce Impact of Crime & Fear of Crime	**Removes many barriers to healthy behaviour and addresses positive Mental Health**										

Public Health Outcomes – Domain 2: health improvement												
Improve Positive Mental Health	✔	✔	✔	✔	✔		✔	✔	✔	✔		
Reduction in Stress	✔	✔		✔			✔	✔	✔	✔		
Minimising Car Use & Increasing Walking & Cycling	✔	✔			✔	✔				✔		✔
Providing Life Change support		✔	✔	✔		✔				✔		
Improve the Health & Well-being of Children & Young People	✔	✔	✔	✔	✔				✔	✔	✔	✔
Improve the Health of Older People	✔	✔	✔	✔	✔			✔			✔	
Reduce Smoking	✔	✔		✔	✔						✔	✔
Improve Diets	✔	✔		✔								
Reduce Obesity	✔	✔				✔					✔	
Increase Physical Activity	✔	✔				✔	✔	✔			Osteoporosis	✔
Reduce Alcohol Misuse	✔	✔		✔	✔					✔		
Reduce Drug Misuse	✔		✔	✔	✔					✔		✔
Improve Rates of Breastfeeding	✔		✔	✔								
Public Health Outcomes – Domain 3: health protection												
Provide Health Protection			✔	✔	✔							
Public Health Outcomes – Domain 4: health care Public Health and preventing premature mortality												
Improve Services for Heart Disease, Diabetes & Strokes	✔							✔			✔	
Improve Services for Cancer		✔	✔	✔								
Improve the Health & Well-being of Children&YoungPeo	✔	✔	✔	✔	✔				✔	✔	✔	✔
Improve the Health of Older People	✔	✔	✔	✔	✔			✔			✔	
Provide Screening Programmes	✔	✔	✔	✔							✔	
Improve Sexual Health	✔	✔		✔								

Level 3 224

The Health & Well Being Strategy

The main themes of this strategy are:

- Early intervention with children and families
- Physical activity & healthy weight
- Mental wellbeing
- Alcohol
- Prevention and maximising independence
- Healthy ageing and quality of life for older people (Including complex needs and end of life care)

For each of these, the Strategy identifies at least five key commitments, or `we will' statements, summarised in chapter 26 of this Report to be progressed by 2015.

The starting point for the development of the joint strategy was the Joint Strategic Needs Assessment (JSNA). The themes were further developed through engagement events and partnership working with local people and other agencies.

The Stockport Health and Well Being Board meets approximately six times per year and each meeting will focus on at least one theme and consider progress against the key commitments outlined within the strategy. It will also monitor higher level outcomes such as key figures relating to healthy life expectancy and levels of equality across the borough.

The Board will also consider general issues such as:

- Opportunities for integrated working and improved efficiency
- Investing in health improvement and prevention in health and social care
- Shifting to community based care, linked to local needs and priorities with an Emphasis on effectiveness and service quality
- Identifying ways to encourage communities to provide mutual support
- Shared record keeping/reduced administration
- Linking to other work at regional and national level

The Main Themes

A fundamental commitment behind the joint strategy is the need to tackle inequalities in all its forms. We know that there are disadvantages facing certain groups and communities, whether social, economic or geographical. Improving health and wellbeing in Stockport requires separate, detailed consideration of issues relating to ethnicity, sexuality, disability and other issues which cut across all the main priority themes. This also relates to the broad range of issues affecting health and economic wellbeing as outlined above. The different areas within Stockport range from highly disadvantaged to highly affluent. Few boroughs in England are more varied. This is what it means when people say that Stockport is a polarised borough. It gives us a particular responsibility to tackle inequalities as it leads to very different opportunities or life chances. Disadvantaged Stockport residents are more likely to be exposed to the risks associated with poor health and wellbeing **and**

225

suffer higher levels of poor health and wellbeing within their lifetimes. Subject to this cross cutting theme there are six themed chapters

Early Intervention with children and families This part of the Strategy outlines the shared commitment to ensure that children and young people have a healthy start in life, that they are safe from harm, and that they grow up to be confident in themselves and have good emotional health. This includes giving young people the chance to learn about good health and wellbeing, to enjoy and do well at school, and to have the chance to have fun and to be children. This section also links to the local drive to make smoking history.

Physical Activity and healthy weight This part of the Strategy seeks to ensure that everyone, at any age, can have the opportunity to have fun and be active. This includes eating healthily on a budget, having the chance to grow, buy and cook healthy food and engaging in physical activity such as walking and cycling. There is a particular focus on exercise as a boost for both physical and mental wellbeing.

Mental Wellbeing The focus on mental wellbeing in the Strategy cuts across all the other themes and is relevant to everyone. It sets out a shared commitment to finding positive ways to improve wellbeing in Stockport, so that we can all connect with, and support, each other. It is also about ensuring that people who are using services have a real say in how they are provided, such as through the `people powered health' initiative so that people are helped to feel in charge of their lives and support.

Alcohol The main focus of this section is on understanding how alcohol can affect our health and wellbeing. This might involve finding other ways to relieve stress, cutting back if you drink a lot of alcohol and believing that you can change - with help if you need it. The section sets out the local strategy for tackling this significant local issue.

Prevention and maximising independence for everyone This theme also underpins much of the health and wellbeing strategy – the idea that we can help prevent many health and wellbeing issues and stay independent for longer. This section outlines preventative healthcare – regular checks, screening and immunisations – simple steps such as monitoring blood pressure and having regular dental checks have so many other health benefits. This section also looks at preventative health, social care and support services in the community, for example the commitment to ensure that people with disabilities have more choice and control, and that older people can live with greater independence in their own homes, if they wish to do so. This also relates to having a real choice and range of housing and support options, from supported living and home support schemes to extra care housing.

Healthy ageing and quality of life for older people (including complex needs and end of life care) This part of the Strategy draws together many of the themes relevant to all ages – supporting local communities to provide more social opportunities and networks, being a good friend and neighbour and looking out for each other, and a range of measures aimed at helping everyone to feel safe and well at home and in the community, from support for people with dementia to end of life care and dignity in care homes. It also highlights the need to respect people regardless of age and to value the role and experience of older people as those who often support others – as grandparents, carers

and friends- and to recognise that older people have many assets, such as a wealth of experience to bring to their local communities.

The Business Plan for the Stockport Public Health Function

Stockport Public Health Business Plan – Start Well Live Well Age Well   2013/4

Vision

Improving the health of people in Stockport, by increasing choice, control, independence and the adoption of healthy lifestyles as well as commissioning excellent services that offer value for money.

Outcomes

N:\Public Health Information Team\Performance Reports\Public Health Indicator Set v3.doc

Strategic Priorities	Strategic Objectives	
Continue to reduce health inequalities	Develop new pilot to reduce inequalities and health and strengthened programmes with Neighbourhood Management Board and area based initiatives	
Reviewing public health commissioning and provision following the transitional process	Complete Service Reviews:	Drugs and Alcohol Services,
		Sexual Health Services
		GP Health Checks
		Smoking LES
		Public Health in the FT
		Cultural Determinants
		Pharmacy LES
Mainstreaming public health delivery through the new 'Stockport Health Promise'	Develop Public Health offer and objectives in key council departments to ensure full integration of Public Health responsibilities	
Consolidating the delivery of the new Healthy Stockport service and public health services	Implement and monitor Healthy Stockport web resource and new integrated service	
	Develop new specification for PARIS	
	Develop Specialist Weight Management Specification	
	Extend the Essential public health Programme (linking to Making Every Contact Count) across front line workers (health & social care and voluntary sector)	
Delivery of public health advice, support and service delivery with Stockport GP clinical commissioning group, the 'core Offer'.	Develop individual relationships with GP practices covering deprived populations, build a network of prevention practices and scope the role of practice Marmot champion	
	Develop links with PHE contacts to increase screening uptake in low uptake practices.	
	Revise service delivery model for health checks and scope 'Prevention' accreditation for individual GP practices	
	Review and advise on NICE guidance/ best practice	
	Develop Pharmacy Commissioning and scope Healthy living pharmacies	
	Scope Public Health in optometry	
Implement the Health and Well-being Strategy	Early intervention with children and	Head commissioning of the including Healthy Child programme (5-19) including school nursing.
		Implement Public Health programmes in early years settings, schools and colleges, including focus on healthy eating,

	families.	breastfeeding, oral healthy , unintentional injury
		Work with NHS England to commission the healthy child programme (pregnancy to 5years) Health visitors and Family nurse partnerships.
	Physical activity & healthy weight	Develop Physical activity strategy
		Review and implement the healthy weight strategy
	Mental wellbeing	Ensure implementation of the 'we wills' from the H&WB Strategy through appropriate approaches, forums and partnerships.
		Support the use of MWIA linked to EIA within the Council and through identification of opportunities to offer it to external partners.
		Build capacity to support mental wellbeing for staff and residents via a specific training offer to Council colleagues and external partners (MHEP and LLTTF).
		Identify opportunities to promote the 5 Ways to Wellbeing with staff and public
		Ensure effective communication with Stockport Co-Design Forum (MHPP) through active membership of the Forum.
	Alcohol	Develop alcohol misuse prevention work
		Consolidate work relating to domestic abuse and alcohol
	Develop and co-ordinate a cross-sector approach capable of delivering the 'prevention and maximising independence' aspiration in the Health and Wellbeing Strategy	
	Lead the development of an integrated preventative approach within the Stockport integrated care model	
Continue to protect the Health of the Stockport population	Health protection	Ensure plans are in place to protect the health of the Borough's population from threats ranging from relatively minor diseases and outbreaks to full scale emergencies.
		Provide advice, guidance, support and training to SMBC partner organisations such as NHS, Stockport CCG and independent providers to discharge their infection prevention and control health protection functions.
Health Intelligence	Joint Strategic Needs Assessment	
	Develop support and analyses for new PH contracting responsibilities	
	Outcomes framework for Health and Wellbeing Strategy / Board / PPRA for Health Scrutiny Committee	
	Develop a public health analysis to support and inform the public sector reform programme	
Develop new Public Health programmes	Workforce	Confirm scope of work and personnel to engage in work. Organise seminar to bring together relevant staff and agree programme/action plan/next steps
		Agree key approaches/frameworks useful in managing and monitoring work.
		Further develop and improve workplace health provision within council and consider expansion of remit to external partners
	Review Accident prevention models and implement new programmes	
	Contribute to the development of the Leisure Strategy	
	Develop and implement new cycling and walking programmes	

Level 3   229

Develop, both locally and at Greater Manchester level, public health aspects of transport and spatial planning

Develop, both locally and at Greater Manchester level, public health aspects of economic strategy and of public health input to workplaces.

Tobacco Control	Complete CLEAR assessment
	Participate in national campaigns including Stoptober quit campaign
	Develop plans to reduce maternal smoking and prevalence of smoking by young people

Develop and run Lifestyle campaign's including cancer prevention and Change 4 life and promote screening programmes.

Sexual Health	Implement Teenage pregnancy strategy
	Monitor sexual health commissioned budget and activity
	Participate in GM Commissioning
Drugs and Alcohol	Develop integrated drug and alcohol strategy
	Monitor budget and activity
	Ensure the effective delivery of Year 2 of the Payment by Results pilot for Substance Misuse
	Participate in GM Commissioning
Cultural	Monitor budget and activity and develop strategy for cultural determinants services
	Deliver health related community development
Determinants	Support work in priority neighbourhoods
Locality working	Provide support and advice to area committees , CCG localities and Neighbourhood Management Boards

At the time of writing my Annual Report I am pleased to confirm that excellent progress is being made on the Business Plan. I am also pleased and welcome the active engagement of the Executive Member for Health and Wellbeing and the Health and Wellbeing Scrutiny Committee in monitoring our Business Plan.

NHS Stockport CCG Plan-on-a-Page 2013-14 Final

CONTEXT: Stockport has a practice population of just under 300,000. The population is older than average and in terms of deprivation whilst Stockport is a "prospering town" it is the third most polarised in health inequality terms. The CCG budget is c£350million and it is forecasting delivery of a small surplus in its shadow year. The CCG and Local Authority cover the same area, and there is one medium sized District General Hospital serving the borough. In terms of health Stockport has worse outcomes than expected for its peer group and is slightly below average. The area has much higher than expected hospitalisation of adults and children with ambulatory care sensitive conditions. Currently patient experience of GP and Out of Hours services is good and the CCG is meeting its NHS constitution requirements with the exception of significant protracted problems with A&E waiting times at the local hospital. The plan has been shared with the Health & Wellbeing Board and local partners, and agreement is documented in a Memorandum of Understanding describing the main reform programmes. The plan is designed to align to the Greater Manchester reform programme Healthier Together and in effect describes "Healthier Together Local", ensuring the local system is designed to support the regional changes.

COLLECTIVE AMBITION: Purpose: We exist so that Stockport's people will access high quality anticipatory health services that empower them to live healthier, longer and more independent lives
Vision: The CCG aims to be known and respected for: consistently achieving and often exceeding local and national quality and performance standards; delivering an increasing proportion of services out-of-hospital; being innovative and financially sustainable; reducing the gap in health outcomes; being an excellent membership organisation and great place to work.
Values: We will be quality obsessed, primary & community focussed, innovative, collaborative, distributive and professional

Strategic Aims	Three Year - Ambition	Strategic Outcomes	Key Work Programmes Running in 2013-14		Exec Lead
1. Transform the experience and care of adults with long-term and complex conditions	In each locality people with Long-term or Complex conditions will experience high quality anticipatory & integrated care. There will be improved access to 24/7 high quality primary care services & there will be a jointly commissioned single integrated 24/7 service with medical consultants, social care staff, nurses & allied health professionals proactively managing patients & able to rapidly draw on specialist support for example diagnostics or dementia. Patients requiring acute admission will be pulled along evidence based pathways by the locality team to return home as soon as possible. Shared electronic information systems and tele-care will underpin integration. Over three years this will result in 4100 fewer admissions (12%) and 3 fewer medical wards being needed, and 1200 fewer attendances at A&E (1.7%)	1. Reduce unplanned hospitalisation for Chronic ACS conditions (2.3i) & for acute conditions not usually requiring hospital admission (3a) 2. Reduce adult A&E attendances 3. Reduce all non-elective admissions (FFCE) 4. Increase proportion of people feeling supported to manage their condition (2.1) 5. Reduce emergency readmissions within 30 days of discharge from hospital (3b)	Stockport One Service	IM&T Strategy / OD Strategy (Inc Expanded Joint Commissioning, Membership, Organisational Forms) / Communications and Population Health Literacy	Dr Idoo
			Enhanced Primary Care (Part1) LTC,/GSF/Dem'		Dr Briggs
			Hospital Unscheduled Care		Dr Patel
			Specialist Community Services EOL, IV, Dementia		Dr Idoo
			Additional Primary Care Capacity		Dr Briggs
2. Improve the care of children and adolescents with long-term conditions and mental health needs	Children with long-term & complex conditions will be managed through enhanced access and review in primary care supported by specialist locality based community paediatric nursing teams. Children attending hospital will only be admitted when it is clinically necessary & coding will reflect nature of admission. Children's mental health services including access to psychological therapies will be expanded. Over the next three years this will result in 950 fewer admissions (12%) and 350 fewer attendances.	6. Reduce unplanned hospitalisation for asthma, diabetes, epilepsy in < 19's. (2.3ii) 7. Reduce emergency admissions for children with Lower Respiratory Tract Infections (3.2) 8. Reduce paediatric A&E attendances	Paediatric Pathway Review		Dr Patel
			Enhanced Primary Care (Part 2) - Children		Dr Briggs
3. Increase the clinical cost effectiveness of elective treatment and prescribing	In each locality patients will receive high quality clinically cost effective treatment & medication. GPs through a system of peer review, expert audit and feedback, enhanced access to diagnostics, and a network of practice referral and prescribing administrators will ensure latest guidelines & formularies are followed, & patients do not receive treatments or referrals that do not benefit them. Contract mechanisms will support clinically developed policies that only allow access to treatment of proven therapeutic value. The majority of follow-up activity will either take place remotely or in primary care. Over 3 years this will result in 6,600 fewer referrals (8%) , no further increase in elective surgery, only a moderate increase in the prescribing budget, & 20,000 (10%) fewer face-to-face follow-up procedures.	9 Reduced outpatient activity (GP referred & Follow up) 10. Continue to keep levels of prescribing spend below inflation 11 Reduce elective admission activity (FFCE)	GP Referral Management Scheme		Dr Briggs
			EUR & Thresholds		Dr Owen-Smith
			Follow-up reform		Dr Idoo
			Prescribing		Dr Briggs
4. Improve the quality, safety and performance of local services in line with local and national expectations	People will receive in full the performance & quality standards described in the NHS constitution. Reform of unscheduled care will have been completed to ensure waiting times in A&E are sustainable. Incidences of health-care related harm including HCAI's will have reduced significantly & in the case of MRSA been eradicated. Patient experience of local health services in terms of compassion, communication, dignity & respect, cancellations & reported out-comes will have improved significantly, & as result patient reported satisfaction will improve.	12. Reduce incidence of healthcare associated infections (5.2) 13. Full compliance with NHS constitution requirements & improvement in Friends & Family Test and Primary Care & Hospital Surveys (4.3).	Enhanced Primary Care (Part 3) – C Difficile		Dr Briggs
			Complete IAPT roll-out		Dr Patel
			Quality Strategy /Friends and Family		Dr Patel
			Duty to Promote Quality		Dr Briggs
5. Ensure better prevention and early identification of disease leading to reduced inequalities	Everywhere in Stockport there will be an increase in uptake rates for cancer screening, immunisation, vaccination, & health checks. People living in more deprived areas of Stockport will be just as likely to uptake screening, have their immunisations, & have a health check. There will be an increase in the numbers of patients being referred to & accessing lifestyle support & prevention services. Patients with harmful drinking wherever they are seen within the Health System will have a brief intervention & where appropriate referral to lifestyle services	14. Reduce Potential years of life lost (PYLL) from causes considered amenable to healthcare (Total and by locality) (1a) 15. Reduce < 75 mortality from cancer (1.4) 16. Slow the increase in admissions for alcohol related liver disease	Enhanced Primary Care (Part 4) - Early Identification & Alcohol		Dr Briggs

TOP 6 RISKS: Risk Description	Impact	Level	Controls and Mitigation
Additional demand above that anticipated through modelling historical data and current demography (such as accelerated birth rate)	Negative impact on investment plan with potential failure to deliver statutory duty	Red /Amber	Financial contingency set above national requirements / Risk share arrangements with providers / close monitoring and acceleration of CIP plans
The quality and timeliness of commissioned services is inadequate	Patient Care and Experience harmed. Reputational damage and resource redirected to addressing short-term goals	Red /Amber	Robust planning and performance management of providers/ resource flexibility (via CSU)
Organisational capacity and capability of local providers, the CSU and CCG itself insufficiently developed	Inability to flex workforce or address performance leading to slower delivery of significant dimensions of programme and business as usual	Red/Amber	Cyclical review of internal OD plan / CSU relationship management / provider development & market management
Financial imbalance caused by unforeseen additional costs (such as transition resource allocations, overhead requirements, trust over-performance and changes in national guidance)	Negative impact on investment plan with potential failure to deliver statutory duty	Red/Amber	Financial contingency set above national requirements / Horizon scanning process as part of risk management / Contract management of over-performance
Lack of membership engagement to support implementation of plans	Slower delivery of activity management plans and quality improvements	Amber	Locality committee and planning structure / distributive model / clear clinical engagement
Inadequate stakeholder engagement fails to take providers and public with us in transformation	Slower delivery of transformation plans	Amber	Partnership approach to planning / clinically-led public engagement

The Stockport Health Promise

Public health is not just something to be dealt with in specific specialist areas. Many of the activities of the Council and its partners contribute to the health of the people and the concept of the Stockport Health promise aims to capture that by asking all areas of the Council and its partner organisations to give commitments for activities that will improve health. Examples in the Council might include improving the public realm in ways which enhance walking and cycling, developing the role of health in the school curriculum, or pursuing sustainable development strategies, developing preventive practice in social care, or enhancing the role of early intervention services for children and families. Much of the CCG's commissioning strategy is directed towards prevention, recognising that this is the only way to reduce the challenge of steadily growing need.

The Health Promise aims to record these commitments and hence ensure that we fully understand that prevention is not a specific activity but a goal to be pursued by everybody.

Some promises record entirely new commitments, others record intentions to renew or expand work that is already under way. Some were developed specifically for the Promise but others were under consideration even before the idea of the Promise was developed. For some the idea originated in discussions between public health specialists and the department in question but for many others it originated in the commitment that many Council and NHS staff have anyway to further the public good and improve the people's health.

3.26   RECOMMENDATIONS

Recommendations From This Year's Report

I welcome the strategies described in chapter 25 and recommend continuation. I recommend that all agencies intensify the process of developing a system of public sector reform focused on resilient communities and the principles set out in chapter 23. I recommend investment in 2014/15 in preventive programmes which will produce early results to ease the pressures in 2015/16. I welcome interagency work on integration of children's preventive services and of health and social care and recommend continuation.

I welcome Stockport CCG's planned work on detection of hypertension. I recommend continuation.

I recommend that Stockport CCG, Stockport MBC and Public Health England, in their respective areas of responsibility, vigorously pursue improved screening programme uptake in deprived areas.

I recommend that Stockport MBC signs the Local Government Declaration on Tobacco Control

I recommend that the relevant enforcement agencies prioritise the issue of illicit tobacco.

I urge people to declare their homes and cars smoke free. To support the continued denormalisation of tobacco use I recommend smoke free areas in parks.

I welcome Stockport's participation in the national 'Sustainable Food Cities Programme.' I recommend continuation

I recommend that Stockport MBC continue to pursue the development of linked-up walking and cycling networks and that walking and cycling be built into any strategic development proposal on the boroughs highway network.

I recommend that local MPs and political parties press for reversal of the Government's abandonment of a minimum unit price for alcohol and also for plain packaging of tobacco products.

I welcome Stockport MBC's intention in the coming year to enhance arrangements for public health input into planning applications and to review and renew Country City. I recommend continuation.

I recommend the development of an enhanced programme of work on healthy ageing by the Health and Well Being Board and its member agencies.

I recommend that all schools have a programme of SRE consistent with best practice guidance.

I recommend that the Council and the major local NHS organisations intensify programmes of workplace health and they include attention to issues of mental health and mental well-

being by reducing stress, facilitating the adoption of the Five Ways to Well-Being, enhancing the arrangements to employ people with mental health problems, and enhancing the confidence and capacity of staff to integrate well-being into routine contacts with patients and clients.

I recommend the local NHS embed prevention and lifestyle into corporate and professional cultures.

I endorse the co-production approach to mental health, congratulate the Council on pursuing it, recommend continuation and urge that links be drawn between this programme and programmes of community well-being and resilience.

<ins>The We Wills from the Health and Well Being Strategy</ins>

The Council and the NHS have entered into important commitments as part of the Health and Well Being strategy and I welcome and endorse those commitments.

Table 26.1 STOCKPORT JOINT HEALTH AND WELLBEING STRATEGY 2012-2015 COMMITMENTS

Early intervention with children and families – We will-
- Ensure children get the best healthy start in life from conception to five years, by enabling parents to access effective child health care and advice, family support and quality early education and childcare provision.   - Keep children safe from harm and reduce childhood injury.   - Support and promote healthy lifestyles for 5-19s (reducing alcohol consumption, preventing smoking and drug use, promoting healthy eating, physical activity and healthy relationships) through schools and other community settings.   - Promote positive emotional health, self-esteem and wellbeing for children, young people and parents and carers.   - Work closely with families to provide early intervention and preventative programmes to reduce the development or impact of health or wellbeing problems.
Physical activity & healthy weight – We will-
- Develop a strategically co-ordinated approach to increasing levels of physical activity to get more Stockport people more active, more often, particularly focusing on reducing the numbers of sedentary people in the borough. This will include addressing gaps in our knowledge about local people's attitudes towards and preferences for being more active.   - Increase the numbers of families in Stockport signed up to the national Change4Life campaign.   - Increase the awareness and essential public health skills of those working with people facing multiple disadvantage and disadvantage, particularly those in priority areas where we know obesity is a greater issue.   - Increase the number of settings adopting policies to improve physical activity and healthy eating, especially settings affecting children in early years and primary school age, and workplaces where adults 35-45 are concentrated.   - Increase the practical support available to families for improving physical activity and healthy eating where one or more members are overweight or obese.

Mental wellbeing – We will-

- Strengthen support for and the awareness of the effects of poor mental wellbeing in all services and activities, recognising this as the foundation for the health and wellbeing of individuals and communities.
- We will do this through:
- Establishing a clearly authorised forum through which this policy is implemented, including capacity to direct/affect resource allocation, for example by strengthening the terms of reference and adjusting membership of the Mental Wellbeing Strategic Planning Group (MWSPG);
Incorporating the Mental Wellbeing Impact Assessment process into legally required impact assessment processes for review of programmes and services and identifying responsibility for subsequent implementation by relevant stakeholders;
Promoting the 'Five Ways to Wellbeing' as a simple mechanism to engage staff and public in addressing mental wellbeing and embedding this into working practices (part of MWSPG terms of reference and within staff development/training remit);
- Providing specific training to strengthen the capacity of all staff and partners to address mental wellbeing issues with confidence and skill (part of MWSPG terms of reference and within staff development/training remit);
Applying the 'wellness service standards' as a quality benchmark for public health services: to the integrated lifestyle service (2012) and cultural determinants service (2013-2014) and for other services in the future;
- We will take action to highlight these particular risks and opportunities to mental wellbeing;
Debt as an important risk factor points to the promotion of national and local debt advice resources and services;
Working through and with the CCG to promote early identification of poor mental wellbeing and alternatives to prescribing;
Working with early years settings given the importance of maternal and early life mental wellbeing and BME groups in particular;
Working with communities to develop local ideas for promoting good mental wellbeing;
Working with the new carers centre to strengthen support for mental wellbeing.
- In order to improve outcomes for people with mental health problems in Stockport through high quality services that are equally accessible to all we will:
- Work in partnership to undertake the Stockport Mental Health Pathways Project

Alcohol – We will -

- Deliver a three-year programme of training and support to front-line public services to develop the knowledge, skills and policies to enable staff to talk to their customers and clients (including children and young people) about alcohol, offering brief advice and referral where appropriate. Public Health, will lead delivery of this work through the Alcohol Misuse Prevention group, between now and March 2014.
- Work with services and service users to re-design the drug and alcohol treatment system to make it easier for people needing help to access it and to live a life free from dependency. This will include new investment in proactive work to engage those repeatedly attending hospital. The Substance Misuse Joint Commissioning Group will lead this work with implementation, starting in April 2012 and completed by April 2013.
- Improve information and support for families, especially the most vulnerable, to prevent harm to children and young people resulting from their own or family member's alcohol use. We will develop integrated services to support children and families, implement new protocols for joint working and continue investment in the Mosaic Family Service. This work is led by the Children's Trust and Young People's Substance Misuse Group.

- Work with communities in priority neighbourhoods to cultivate community assets that can help to address the social and cultural causes of alcohol misuse in their areas, delivering a number of locally developed projects and activities each year to 2014. The local Neighbourhood Management Boards are responsible and accountable to the Place Board for this work.
- Develop a new Lifestyles service and Healthy Stockport web-resource to improve access to information and advice for people drinking at risky but not dependent levels. This work is led by Public Health and will be implemented between January 2012 and March 2013.
- Investigate the connections between alcohol, drug use, mental health, domestic abuse and vulnerability in adults in order to identify how to provide more integrated support that is appropriate to the whole person, addressing their needs and their resources. This will involve Community Safety, Public Health and social care services and commissioners, and will be undertaken by June 2013.

Prevention and maximising independence – We will -

- Prioritise work with GP practices, especially in the Priority areas to identify their patients most at risk of developing preventable diseases to ensure they take up screening opportunities.
- Organise and deliver health campaigns highlighting the importance of making healthier choices, recognising early symptoms and seeking professional advice.
- Target public health resources to those areas where need is greatest in order to reduce health inequalities. As resources are limited, priority one neighbourhood areas will be prioritised in 2013.
- Deliver a holistic integrated wellness service to support people to make positive lifestyle changes by April 2013.
- Develop and implement methodologies which effectively engage with and empower communities to take a more proactive role in health improvement.
- Develop a clearer understanding of the issues that limit people's ability to live independently in their community and shape support services to target and meet those needs more effectively, including working with partners to explore housing options that maximise independence, such as extra care housing.
- Complete and implement the recommendations of the Disability Review in Stockport.

Enable people in later life and their carers to have choice, feel in control and connected, through:
- Services which are personalised, meet individual eligible needs, are safe, and respect people's dignity;
- Support for carers and effective contingency planning;
- Helping people to feel informed and empowered to manage their own care plan and their own budget;
- Long-term condition management including telehealthcare, information, education and lifestyle training;
- Helping to prevent social isolation and loneliness so that older people feel valued and stay engaged, connected and active in a way which is meaningful for each individual.

People receive support in ageing healthily and obtaining the best quality of life, through:
- Healthy lifestyle support from an early age, including recognising the importance and value of emotional and social health;
- Home and personal safety including a focus on falls prevention;
- Information, education and projects related to nutrition;
- Integrated health and social care services to offer a holistic approach;
- Responsive community services to prevent hospital admissions;

- Joined up working with third sector organisations.

Ensure people are encouraged and feel supported to stay independent and live longer in their preferred place, through a wide range of preventative services provided through all sectors.
- Reablement, assisting people to improve their physical, mental and emotional wellbeing, to learn or relearn skills to enable them to live as independently as possible in the community.
- Actions relating to specific areas of vulnerability including managing money, and winter warmth.
- Encouraging people to use telecare where appropriate and whilst recognising the importance of wider social contact.
- Links with neighbourhood developments, and of offering community focussed services.
- The extension of a single access point for older people seeking housing related support.
- Offering a range of housing options and housing related support.
- The development of a new community model for Supporting People services in relation to older people and exploration of personal budgets where appropriate.
- A review of options for the further development of Extra Care Housing.

Improve people's experience of end of life care and increase the opportunity for people to die in their preferred place.
- Improved end of life care in the person's preferred place to die.

Inequalities – (cutting across all the above themes) – We will -

- Continue the longstanding programmes addressing cardiovascular disease which are producing the underlying positive trends in health improvement;
- Implement the alcohol strategy thereby addressing the main countervailing negative trend;
- Improve uptake of cancer screening and awareness of cancer symptoms in areas of disadvantage;
- Pursue community-based initiatives to address local cultural factors and improve mental wellbeing;
- Vigorously address the issue of inequalities in children and young people;
- Strongly promote steps which mitigate the impact of inequalities on individuals and communities in the way we design and deliver health, social care and wider public services.

<u>The other key recommendations of the JSNA</u>

I endorse the recommendations of the Joint Strategic Needs Assessment which were as follows:-

Priorities for Health and Wellbeing

The overarching objectives for health and wellbeing in Stockport are to:

- Improve life expectancy and healthy life expectancy
- Reduce health inequalities

The priorities identified by the 2011 JSNA to help us achieve these objectives are to:

- **Reduce the consumption of and harm relating to alcohol**
- **Improve and promote mental wellbeing & resilience at all ages**
- **Reduce health inequalities**
- **Assess and respond to the increasing future need for complex packages of care at all ages**
- **Recognise the value of and support carers**

The first four of these objectives have been assessed using the lifecourse approach, and specific priorities for each age group have been identified, for example for alcohol there is a need to focus on reducing the consumption of alcohol for those who drink risky volumes in the 25-64 age group, but for the younger adults the focus should be on binge drinking. For children and young people the 2011 JSNA recommends that reducing smoking in pregnancy and child accidents and increasing breastfeeding as actions to deliver reductions in health inequalities, while for older people focus on healthy ageing, maintaining independence and social networks will improve mental wellbeing.

The final priority is the same for all ages and does not have specific sub priorities.

In addition further priorities relevant to only one lifecourse cohort have been identified:

- Reducing levels of child obesity, by focusing on healthy eating and physical activity
- Promoting effective sexual health in young adulthood
- Assess changes in trends for the use of illegal substances for young adults
- Reduce levels of obesity in adulthood
- Promote a planned and patient centred approach towards the end of life for older people
- Prevent falls in older people

The full list of priorities is shown in the table below.

For all these priorities **a focus on prevention for children and young people and healthy ageing for older people is vital**.

Priorities for the Wider Partnership to Support Health and Wellbeing

Priorities for health and wellbeing for other partnerships have also been identified in the JSNA, following the system wide approach recommended by Marmot. These priorities will enable colleagues in other partnerships to focus their attention on areas which can create the conditions needed to promote and improve health. Again a lifecourse approach has been taken to give priorities for each age group, at all ages the following priorities have been recommended:

- Focus on the wider determinants of health, especially deprivation & social exclusion
- Promote positive social networks and norms to challenge lifestyle culture
- Provide an environment which encourages healthy living
- Reduce the reliance on unscheduled health care

Again more specific priorities have been given for each lifecourse cohort; ranging from increasing educational attainment in deprived areas for children to providing accessible and affordable transport for older people.

The full list of priorities is shown in the table below.

Priorities for the Ways of Working

The 2011 JSNA priorities also include a section titled "ways of working" which have been generated from joint engagement with senior commissioning managers at the council and NHS as well as findings from Voice. Again a lifecourse approach has been taken to give priorities for each age group, at all ages the following strategic principals have been recommended:

- Focus on prevention, engage with individuals and the community to find the causes of issues and potential solutions, using social marketing approaches
- Work with individuals and families in a holistic way, so they are fully involved in decisions about their care
- Support communities to help themselves
- Ensure that the needs of vulnerable groups are fully acknowledged

Further specific priorities have been given for each lifecourse cohort; ranging from ensuring that prevention work for young adulthood is undertaken before they reach the age of 16, and therefore to be delivered in schools, to moving towards the provision of personal budgets to empower people to make decisions about their own care.

The full list of priorities is shown in the table below.

2011 Stockport JSNA for Health and Wellbeing – Priorities for Health and Wellbeing				
Our objective is to:	**Improve life expectancy and healthy life expectancy** **Reduce health inequalities**			
All Ages	**Childhood**	**Young adulthood**	**Healthy adulthood**	**Older people**
Reducing the consumption of and harm relating to alcohol	Safeguarding vulnerable children in families affected by alcohol	Reducing alcohol consumption, focusing on binge drinking	Reducing alcohol consumption, focusing on increasing and high risk drinking	Reduce the impact alcohol consumption has on older people.
Improving and promoting mental wellbeing & resilience at all ages	Promoting and supporting good parenting	Supporting service users in the transition from youth to adult mental health services	Promoting mental wellbeing in middle age Ensuring mental health services are culturally sensitive	Promoting independence and healthy ageing Maintaining social networks, targeting the most isolated
Reducing health inequalities	Reducing levels of smoking in pregnancy, especially in deprived areas Increasing rates of breastfeeding, especially in deprived areas Reducing the number of childhood accidents, especially in deprived areas	Reducing the number and rate of teenage conceptions, especially in deprived areas Supporting vulnerable young families to have positive health Reducing the number of young people who start to smoke, especially in deprived areas and minority groups	Preventing or detecting cancer early, especially in deprived areas and minority groups Identifying patients with undiagnosed long term conditions, especially in deprived areas and minority groups	Preventing early deaths or disability from circulatory disease, especially in deprived areas Identifying patients with undiagnosed long term conditions, especially in deprived areas and minority groups
Modelling and responding to increasing future need for complex packages of care at all ages	Model trends for the needs of children with long term and complex health needs, especially in CAMHS, ADHD and autism	Providing support towards becoming independent, especially at transitions	Model needs of adults with learning, physical and sensory disabilities, especially for mainstream services	Plan for an ageing population, especially frail elderly with complex needs, multiple conditions or elderly carers Promoting early detection and effective services for dementia
Recognising the value of and supporting carers	Recognising the value of and supporting carers whatever their age or whatever the age of the cared for person.			
Other priorities specific to lifestage:	Reducing levels of child obesity, by focusing on healthy eating and physical activity	Promoting effective sexual health Assess changes in trends for the use of illegal substances	Reducing levels of obesity, focusing on physical activity	Promoting a planned and patient centred approach towards the end of life Preventing falls

Priorities for Health & Wellbeing

Level 3

240

2011 Stockport JSNA for Health and Wellbeing – Priorities for the wider partnership and ways of working				
All Ages	**Childhood**	**Young adulthood**	**Healthy adulthood**	**Older people**

Priorities for wider partnership

All Ages	Childhood	Young adulthood	Healthy adulthood	Older people
Focusing on the wider determinants of health, especially deprivation & social exclusion Promoting positive social networks and norms to challenge lifestyle culture Providing an environment which encourages healthy living Reducing the reliance on unscheduled health care	Increasing educational attainment in deprived areas Reducing child poverty Health promoting schools and high quality PHSE	Providing opportunities to reduce the numbers who are not in education, employment or training Preventing crime Protecting victims of domestic violence	Providing opportunities for employment and skills Providing support to reduce dependence on disability and other benefits Exploiting the potential of the workplace as setting for health promotion	Promote and maintain social networks, targeting the most isolated Increasing housing quality and appropriately making adaptations. Maintain people in own homes or residence of choice. Reducing fuel poverty Provide accessible and affordable transport

Key focus through lifecourse	**PREVENTION**			**HEALTHY AGEING**

Ways of working

All Ages	Childhood	Young adulthood	Healthy adulthood	Older people
Focusing on prevention, engage with individuals and the community to find the causes of issues and potential solutions, using social marketing approaches Working with individuals and families in a holistic way, so are fully involved in decisions about their care Supporting communities to help themselves Ensuring that the needs of vulnerable groups are fully acknowledged	Focus especially on the early years Focus on families and parenting Involve children and young people in planning their health and social care. Ensure that staff working with these age group are fully trained in the specialist skills needed	Prevention for this age group needs to start early, school setting is key Continue focus on families and parenting Promote social responsibility Provision of affordable and popular activities Use of peer education, role models and real life examples	Provide fair and appropriate access to services Move towards the provision of personal budgets to empower people to make decisions about their own care Focusing on prevention and early detection of lower level health and social care needs Ensuring services are culturally appropriate Ensuring services are accessible and co-ordinated	Promoting independence and choice Empowerment of the vulnerable, maintain confidence by promoting activity and safety early Work with private sector care organisations to give excellent quality service Flexibility in services, designed for the individual not one size fits all

Copy of my para 171 letter on spatial planning

Para 171 of the National Planning Policy Framework requires the Council to seek the advice of its public health department on health implications of spatial planning and in May 2013 I was asked for this advice and submitted the following letter in response

I would suggest that

- A health impact assessment should be carried out for any major development. The methodology should be agreed in advance with the Director of Public Health.
- A health impact assessment should be carried out for any development which contravenes any of our health-relevant policies and where the developer argues that other considerations should be weighed in the balance to justify non-compliance. Again the methodology should be agreed in advance with the DPH. We probably ought to prepare a list of the policies that we regard as health-relevant.
- Best practice in relation to spatial planning and health should be viewed as a material consideration with a standing akin to that of a policy. This is likely to evolve over the next 12-18 months as various national bodies are working on this, but for the moment it should be regarded as embodied in the Greater Manchester Directors of Public Health document "Some Key Issues in Health and Spatial Planning, April 2013"
- We need to clarify the extent to which "Country City" is a material document. Over the next 12 months it will be revised.
- We need to work on developing policy in some areas of it, such as greenspace-compatible development. Planning Policy has for some years now advised against developing policy on this issue in case it was seen to be undermining the protection of open space. However we have recently granted two applications which bring about a net loss of open space and I was disappointed that it didn't occur to anybody to refer back to Country City.

I am not sure how far this advice becomes material merely by being presented pursuant to para 171, how far the council should follow some procedure of accepting it, and how far it would need to follow some process of making it known and seeking objections. There seems to be a lack of clarity here in the NPPF but it cannot be without significance that in a generally deregulatory document, health was added as a new policy.

<u>Advice to Individual Citizens of Stockport.</u>

Follow the five ways to wellbeing
- **Connect** – with friends, family, colleagues and neighbours – think of these people as the cornerstones of your live and invest time in them
- **Be active** – go for a walk, run. Step outside, play, garden or dance. Find an activity you enjoy and suits you make, being physical makes you feel good,
- **Take notice** – be curious. Savour the moment and appreciate what matters to you.
- **Keep learning** – try something new or rediscover an old interest. Learning new things is fun and boost confidence.
- **Give** – do something nice for a friend, or a stranger. Smile. Volunteer your time.

Stop Smoking
Use our smoking cessation service if you need help. If you can't give up on your own then try a Quit Smoking Group. If you are addicted to nicotine, consider other sources of nicotine, such as nicotine chewing gum or nicotine patches. You are more likely to successfully quit if you get help from the NHS Stop Smoking Service. Help is available at your GP practice, from some pharmacies in Stockport and also from our specialist advisers in the Healthy Stockport service. Visit http://www.healthystockport.co.uk/ for more information or call 0161 426 5085

Be physically active
Adults should aim to be active daily. Over a week, activity should add up to a minimum of 150 minutes (2½ hours) of at least moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week. Use the stairs and walk those short journeys. Cycling is a great way to get more exercise over slightly longer journeys, consider using Stockport's leisure services for a swim or fitness class or go to a dance class with your friends.

Children over walking age should be physically active for at least three hours a day, and 5-18 year olds should be physically active for at least an hour a day. Again, this should be at least moderate intensity. This activity can be achieved in different ways, visit http://www.healthystockport.co.uk/ for more information. For babies not yet walking, physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.

Both adults and children should minimise the amount of time they spend being sedentary (e.g. sitting) for long periods (except when sleeping).

Eat a healthy diet
Choose low-sugar, low-fat, high-fibre versions of the foods you eat and eat less red meat. Eat at least 5 portions of fruit & vegetables each day. You should also add less salt in cooking and at table.

Keep a healthy weight
Maintain, or aim for, a healthy weight (adult BMI healthy weight range is 18.5-25kg/m2; healthy BMI for children is within the 2nd-90th percentile for their age and gender). BMI can be calculated by weight (kg) divided by height (m) squared (i.e.kg/m2).

Drink sensibly

If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. Use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx. For example the following are all about 3 units: a pint of 5.2% lager; or a pint and a half of 3.2% beer; or a large (250ml) glass of 12% wine.

However a small amount of alcohol is beneficial for heart disease so after the age of 40, provided you don't have health or other problems related to alcohol or any problems with balance or stability, drink one small (125mls) glass of red wine most days but not every day.

Look after your sexual health

Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both. Remember that having multiple sexual partners increases the risk of HIV/AIDS, gonorrhoea and syphilis, cervical cancer and pregnancy.

Use NHS screening services

Take up all opportunities for screening whenever you are invited to participate in NHS screening programmes.

Take up opportunities for vaccination and immunisation

Ensure children receive all the vaccinations recommended and keep your own vaccinations up to date – especially tetanus. Take health advice before overseas travel and have appropriate vaccinations, malarial protection etc. If you are over 65, if you are pregnant, or if you are under 65 and in an at-risk group, have your annual flu immunisation.

Protect yourself from sunburn

Enjoy the sun safely. Protect yourself by using shade, clothing (including a hat, t-shirt and UV protective sunglasses) and high SPF (sun protection factor) sunscreen, and by avoiding the sun during the middle of the day. Avoid artificial ultraviolet radiation too – don't use sunbeds or sunlamps.

Reduce stress

Talking things through, relaxation and physical activity can help. Find time to relax and share your worries with friends and partners. Demand training for responsibilities of which you are unsure. Try to plan your work to reduce pressure around deadlines. Developing interests outside of work can help reduce stress and improve productivity. You can also minimise stress by socialising and by contributing to your society. **Release stress** Have fun. Take exercise Maintain your social support networks with family and friends.

Avoid accidents

Install and regularly check smoke alarms in your home. After drinking, allow one hour for each unit you have drunk before driving, using machinery or undertaking any other dangerous task requiring care. Drive at 20mph on side roads and wear seat belts in cars, crash helmets on motor cycles and

cycle helmets on bicycles. Talk to your health visitor about preventing home accidents to toddlers. Always ask sales people about the safety features of products.

Protect the environment

You can help to protect the environment by using public transport whenever possible (this also helps you get more physically active). Use environment-friendly products and recycle wherever possible. You can even refuse to accept unnecessary packaging on products you buy.

Avoid infectious diseases

Keep up to date with all vaccinations, and wash your hands regularly when visiting or caring for sick people. You should observe good respiratory hygiene (when coughing or sneezing, catch those germs in your tissue and then bin it).

For more detail about staying healthy, visit: http://www.healthystockport.co.uk/ where you can access advice, tools to help you manage your own health, and free, confidential local support to make positive lifestyle changes.