



STOCKPORT
METROPOLITAN BOROUGH COUNCIL

23rd Annual Public Health Report for Stockport 2016/17

INTRODUCTION



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

23rd Annual Public Health Report for Stockport – 2016/17

INTRODUCTION

Contents

The report is broken down in to levels and sections.

There are six 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.
- **Section F** contains recommendations

This report presents the Introduction to the report

Within each section there are five levels:

- [Level 1](#) are a series of tweets sent by @stockportdph over the autumn of 2015.
- [Level 2](#) is an overview in which each chapter of the report is summarised in a paragraph.
- [Level 3](#) gives key messages where each chapter is summarised in one or two pages.
- [Level 4](#) contains the full report and analysis.
- [Level 5](#) provides links to additional reports and analysis where needed

A full content list follows, and you can access any level 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.

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INTRODUCTION

LEVEL 1

Tweets

LEVEL 1 (TWEETS) INTRODUCTION

The following tweets were sent by @stockportdph during December 2016.

- Watch this space for the #Stockport (SK) 23rd Annual #PublicHealth Report (APHR) coming in tweets [overview](#)
- You can find more information about the #health of #Stockport in the Joint Strategic Needs Assessment [additional analysis](#)
- The #Stockport APHR is an independent professional report to the Council not a report of the Council [overview](#)
- Attached documents are sometimes new & sometimes from the 22nd #Stockport APHR report [overview](#)

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INTRODUCTION

LEVEL 2

Overview

LEVEL 2 (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 to the Council not a report of the Council and the views expressed are those of the DPH not necessarily a corporate view.

Go to [key messages](#) or go to [full analysis](#)

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INTRODUCTION

LEVEL 3

Key messages

LEVEL 3 (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 23rd report in that series, 21 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 builds on the 22nd which fulfilled 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 five levels. At level 1 I have composed a number of tweets to summarise the report. Level 2 is an overview with a paragraph on each of the major issues. At level 3 each paragraph expands to one or two pages. At level 4 it is expanded to a full analysis. At level 5 you can find relevant additional documents.

STEPHEN J. WATKINS

Director of Public Health

Go to [overview](#) or go to [full analysis](#)

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INTRODUCTION

LEVEL 4

Full Analyses

LEVEL 4 (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 23rd report in that series, 21 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. The 22nd report fulfilled 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 last year a new three-level structure allowed us to summarise the message as well as comprehensively describe it. The report also linked to the Joint Strategic Needs Assessment. This year, in the 23rd report, rather than producing a lot of new material I have concentrated on summarising the 22nd report in tweets and facilitating electronic links to information.

In the series from the 16th report special reports on particular topics were presented to 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.

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I am grateful to the following for the contribution they have made to this report:-, Angie Jukes, Andy Jones, Charlotte Nicholls, David Baxter, Duncan Welldrake, Eleanor Banister, Eleanor Hill, Emma Dowsing, Gill Dickinson, Jennifer Connolly, James Catania; Jennifer Kilheeny, Mary Brooks, Russ Boaler, Sarah Clarke, Sarah Newsam, Sarah Turner, Simon Armour, Sue Kardahji, Vicci Owen-Smith. Their contributions have enhanced the report. But they wrote at my invitation and to the remit I set and I approved the final text so the responsibility for any faults lies with me alone.

I am grateful to Jennifer Connolly, Vicci Owen-Smith, Donna Sager, Eleanor Banister, Gill Dickinson Laureen Donnan, Paul James and Mary Brooks for work on presentation.

I have written the leisure chapter personally. The smoking in pregnancy chapter was written by Donna Sager, the suicide prevention chapter by Jennifer Connolly, the diabetes chapter by Vicci Owen-Smith, and the summary update on Stockport Together by Simon Armour.

In the leisure chapter I acknowledge the considerable contribution of Denise Irving to editing, of Andrew Metcalfe to mapping, of Malcolm McPhail to inspiring thought and of Caroline Simpson to provision of essential background. Contributions to specific sections were also made by Michelle Childs, Russ Boaler, Ian Walmsley, Emily Brough, Janet Wood, Ian Dixon, Alex Fryans, Lucy Webster, and Peter Ashworth.

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I am also grateful to the following for commenting helpfully on the text, providing information or otherwise helping:- Aaron Esler, Alexander Bremner, Ian O'Donnell, Andrew Metcalfe, Arteth Gray, Ann-Marie McCullough, Jonathan Vali, Jo Wilson, Julie Sara King, Joanne Drummond, Karen Dyson, Liz Davies, Martin Ward, Melony Woods, Paul Graham, Peter Cooke, Samantha McNichol.

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
1. Stating public health facts, even if they embarrass the powerful.	1. Manipulating public health data in order to embarrass the powerful.	1a. Have scientific justification for statements 1b. 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 implementation 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 public 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.

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LEVEL 5

Additional Analysis

LEVEL 5 (ADDITIONAL ANALYSIS) INTRODUCTION

More detailed analysis of demographic patterns, trends in mortality, health status and inequalities, and the possible causes of these can be found on the JSNA hub (<http://www.mystockport.org.uk/JSNA>).

The JSNA is currently being refreshed and more detailed links to specific analysis will be added here in early 2016 once the revised JSNA hub is created. In the meantime draft analysis is available on request from the public health intelligence team at JSNA@stockport.gov.uk.