



STOCKPORT
METROPOLITAN BOROUGH COUNCIL

24th Annual Public Health **Report for Stockport** **2017/18**

SECTION E: The Strategic **Response**



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

24th Annual Public Health Report for Stockport - 2017/18

SECTION E: The Strategic Response

Contents

The report is broken down in to levels and sections.

There are now 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** sets out the recommendations for action by agencies and individuals within Stockport

This report presents the Section E of 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

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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SECTION E: The Strategic Response

LEVEL 1

Tweets

LEVEL 1 (TWEETS) SECTION E: THE STRATEGIC RESPONSE

1.1 RESILIENT COMMUNITIES

- In resilient communities self-reliant empowered individuals are healthier & strong social support networks ↑ health

1.2 EARLIER DIAGNOSIS

- #EarlierDiagnosis is important if treatment is more effective earlier rather than later #Stockport

1.3 NHS CHANGES

- Stockport and Gtr Mcr are linking #HealthAndSocialCare – they cannot be separated
- #PublicHealth is part of the health service under the NHS Acts not something separate #Stockport
- Its important the NHS is driven by professionals accountable to the people & not excessively commercialised #Stockport

1.4 NHS CHALLENGES

- Reducing demand thru prevention & proactive care is a key challenge for the NHS, as is resource optimisation #Stockport
- Quality of care must be a central concern for everyone in the #NHS #Stockport

1.5 PREVENTION – A CORNERSTONE OF “PUBLIC SECTOR REFORM”

- #PublicSectorReform must focus on intervening early, ↓ing need, & creating resilient thriving communities #Stockport

1.6 COUNTRY CITY

- Country City is a #Stockport spatial strategy focused on supportive sustainable communities in green environments
- #Stockport Country City will take many years to create so we must start now

1.7 BEHAVIOUR CHANGE

- Our behaviour is affected by 100+ well recognised predictable errors of perception, called cognitive biases.#Stockport
- People over assess risks they have often heard of & under assess risks that are imprecise & unclear. #Stockport
- People value things they have & might lose, 2X as much as they would value gaining them (loss aversion) #Stockport
- Loss aversion means that the downsides of change will be perceived more clearly than the benefits. #Stockport
- Asked if something is worth more or less than £x, people will subsequently value it more highly the higher £x is

- This is true even if they know £x to be random eg the last four digits of their telephone number
- We need to make healthier behaviours the norm because most of us like to do what everyone else is doing. #Stockport
- Role models & positive messages are key to making healthier ways of living the norm. #Stockport
- Making the healthier option the default helps avoid habitual unhealthy behaviours
- Michie's behaviour change wheel helps identify influences on behaviour (capability, opportunity & motivation)
- We must be as sophisticated in helping people do what's healthy as commercial marketers r in selling products #Stockport
- People may have a right to harm themselves. That doesn't create a commercial right to persuade them to do so #Stockport
- Rules can strengthen people's resolve to do what they know they ought to do #Stockport

1.8 HEALTH AND WELL BEING STRATEGY

- #Stockport health and wellbeing strategy is produced by the Council together with the rest of the NHS

1.9 LOCAL AUTHORITY RESOURCES

- NHS and Council resources are both under great pressure and must be used well #Stockport
- The Council & NHS cant balance books by efficiencies or service cuts but only by doing things differently #Stockport

1.10 PUBLIC HEALTH AND PUBLIC POLICY

- Disraeli said the health of the people is the 1st concern of Govt. #Stockport tweets this week call for Govt action
- #Stockport tweets this week are based on "Top Ten for Number Ten" by the North West Directors of Public Health
- Top 10 for no. 10 covers alcohol, sugar, poverty low pay & debt, physical activity & early years #Stockport
- Directors of Public Health call for 50p min per unit of #alcohol to tackle alcohol-related harm. #Stockport
- Public Health Directors called for a sugary drink duty to ↓tooth decay, #obesity, #diabetes etc .Thank you to govt
- DPHs call for ban on TV ads b4 9pm of foods high in fat, sugar & salt to protect children's health #Stockport
- Public Health Directors call for eradication of childhood #poverty to meet Child Poverty Act 2010 targets. #Stockport
- DPHs asked Govt to ↑minimum wage. Thankyou. DPHs ask Govt also to call employers to pay real living wage. #Stockport
- DPHs welcome tougher pay day loan company regulation to prevent people ending up with unmanageable #debts #Stockport

- DPHs back the 1001 Critical Days cross party report so all babies have the best possible start in life. #Stockport
- DPHs say all schools should provide a minimum of one hour of physical activity for all pupils everyday. #Stockport
- DPHs urge Govt to promote #activetravel & #publictransport to ↑physical activity & road safety, ↓emissions & pollution

1.11 LEISURE

- Leisure is good for health via physical activity, social networks and mental well-being.
- We should look at health and leisure together aiming at healthy living centres
- Stockport's Avondale Health Hub is a successful example of a leisure centre aiming at health.
- Greenery reduces stress, raises the human spirit and promotes wellbeing.
- Physical activity in green settings may have more benefits than it would indoors.

1.12 SUICIDE PREVENTION

- Suicide can be prevented. Stockport wants to be a place where people never see suicide as only option: <http://www.stockportsuicideprevention.org.uk/>
- In Stockport someone dies every 2 weeks from suicide, 20-30 every year. But death the tip of the iceberg & we must address all levels.
- Men; those age 35-59; those with prior attempt, or self-harm are among most at risk of suicide. Most not known to mental health services.
- We need to work together to reduce risk of suicide; be a catalyst for change; enhancing wellbeing & resilience in the population as a whole

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SECTION E: The Strategic Response

LEVEL 2

Overview

LEVEL 2 (OVERVIEW) SECTION E: THE STRATEGIC RESPONSE

2.1 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.

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

2.2 EARLIER DIAGNOSIS

It can be important to diagnose conditions early, 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.

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

2.3 NHS CHANGES

The health service was radically reshaped in 2013. I particularly welcomed 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 was concerned however about risks of fragmentation and commercialisation and the major financial challenges. The health service in Stockport has now addressed this through creating a partnership called Stockport Together.

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

2.4 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.

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

2.5 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.

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

2.6 COUNTRY CITY

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

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

2.7 BEHAVIOUR CHANGE

The psychologist Thomas Kahnemann won the Nobel Prize for Economics by showing that people have two systems of thought – a slow, precise, rational one that they use for careful considered problem solving and a quicker one, based on experience, perception and some hardwired evolutionary traits, which they use for most day to day decisions. The trouble is that the quicker one, which most people use most of the time for most things, contains some inbuilt errors of perception called cognitive biases of which over a hundred are listed in Wikipedia. These are often exploited by commercial marketing. We need to be equally aware of them when we pursue behaviour change advice.

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

2.8 HEALTH AND WELL BEING STRATEGY

Health and Wellbeing Strategy is a multi-agency strategy focused on improving the health of the population.

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

2.9 LOCAL AUTHORITY RESOURCES

Resources are tight in all organisations. The pressures on the NHS are considerable and far exceed the resources made available to it, generous though those resources are by the current standards of the public services. The Council faces very severe financial reductions and it would be untruthful to suggest that they can be achieved without adverse consequences.

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

2.10 PUBLIC HEALTH AND PUBLIC POLICY

Disraeli said that the health is the first concern of Government. Public health specialists must articulate the case for policies which will improve the health of the people. In July 2014 the Directors of Public Health produced a statement “Ten Points for Number Ten” which suggested measures that Government could take.

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

2.11 LEISURE

Leisure can benefit health by promoting social networking, providing opportunities for physical activity and addressing mental wellbeing and personal development in a number of ways.

The Health Hub at Avondale is an example of a new approach to organising a leisure centre in which it is seen not just as a facility to be made available, marketed and promoted, but as a centre for the promotion of physical activity which can serve as a base for organising events in the community and as a source of advice and promotion for other forms of physical activity such as active travel. We should see the creation of such networks as central to the promotion of physical activity and important components in the promotion of healthy living moving over time to the creation of Healthy Living Centres.

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

2.12 SUICIDE PREVENTION

Suicide can be prevented and in Stockport there is work underway to make Stockport a place in which people never see suicide as their only option: <http://www.stockportsuicideprevention.org.uk/>

In Stockport, someone dies every two weeks from suicide, between 20-30 people every year. Death lies at one end of a continuum of a common suicidal process which includes those bereaved by suicide, attempted suicides, self-harm, distress and contacts with The Samaritans. Those most at risk are men, people aged 35 to 49, people that have made previous attempt and people who have engaged in self-harm. Suicide is a significant inequality issue as there are marked differences in the suicide rates according to people's social and economic backgrounds. Our local suicide prevention strategy is working "to make Stockport a place in which people never see suicide as their only option".

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

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SECTION E: The Strategic Response

LEVEL 3

Key messages

LEVEL 3 (KEY MESSAGES) SECTION E: THE STRATEGIC RESPONSE

3.1 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.

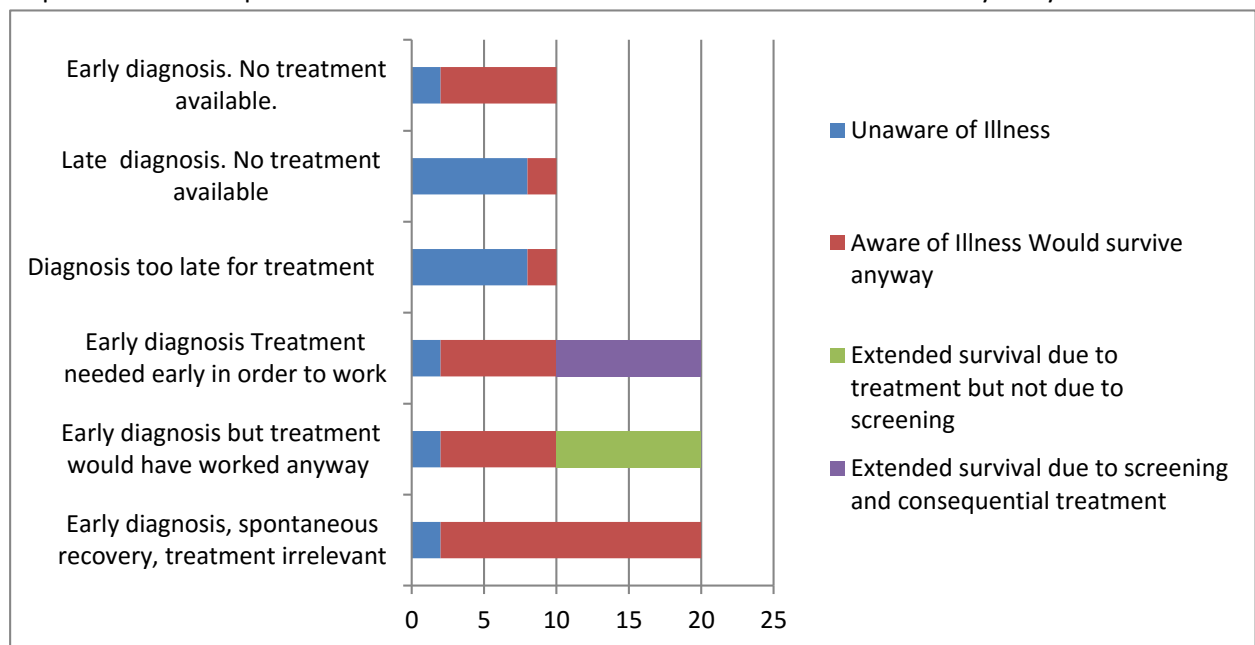
Community development has an important role in enhancing community resilience. There is evidence that improving community and individual resilience can improve health and reduce demand although evidence for reduced demand is more limited than evidence for improved health.

3.2 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. 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 example 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. 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.

3.3 CHANGE IN THE HEALTH SERVICE

2013 Structures

The health service was radically reshaped in 2013.

I particularly welcomed:

- 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 did 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 stated that the NHS needed to achieve 20% more benefit from static resources over a 5 year period. That challenge was a few years ago but in the current Parliament the equivalent is a £30bn shortfall of which the Government will fund £8bn leaving a

challenge of finding £22bn by obtaining more benefit from static resources.. This challenge, rather than cuts in resources, is the basis of the present financial challenge to the NHS.

The Distinction Between the Health Service and the NHS

Ever since 1948 the term “the NHS” has been the brand name of an entity legally called “the comprehensive health service”. In the first quarter of a century of the NHS this term included the Health Depts. of local authorities who were one of the three wings of the “tripartite” NHS. In 1974 local authorities ceased to manage any part of the comprehensive health service but in 2013 local authorities were made responsible again, as they had been between 1948 and 1974, for operating as part of the comprehensive health service the local public health function, including commissioning of drug and alcohol services, sexual health services and lifestyle services (including NHS health checks). In 2015 this was extended to include health visiting. However the Government did not simply use the terminology that was used between 1948 and 1974. Instead it referred to these services as being “part of the health service but not part of the NHS”. I said in my Annual Public Health Report at the time that I believed this terminology would be confusing and was philosophically and historically inaccurate. These fears have been proved right especially in relation to branding, access to information and, most importantly of all, funding. In the course of this Parliament funding of public health services will not rise in line with NHS funding but will instead be cut by 15%. This is at a time when containing demand through prevention is the cornerstone of the financial strategy of the NHS. NHS England and NHS bodies are faced with the choice of either abandoning that strategy, thereby undermining its potential to meet its own challenges, or to make good the cuts from its own funds, in which case those cuts will diminish the growth made available to them.

Stockport Together and Devomanc

Four of the areas in which I expressed concern in 2013 were

- 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.

In all four of those areas since 2013 progress has been made locally and at Greater Manchester through the creation of Stockport Together (a partnership between the local authority and local NHS bodies with pooled budgeting), through the pooling of health and social care budgets at Greater Manchester level as part of the devolution settlement, through the involvement of NHS providers in both of these initiatives, and through the application for devolution of general practice commissioning to the CCG from 1st April 2016 (result of application still awaited) .

3.4 CHALLENGES FOR THE NHS

Quality of healthcare

Health service organisations must maintain a strong commitment to quality if we are to avoid some of the problems that have happened elsewhere manifesting themselves here.

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.

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 now to produce benefits for the future.

3.5 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.

3.6 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.

3.7 BEHAVIOUR CHANGE

Most of our systems of politics, economics, governance and supportive advice have traditionally operated on the assumption that people behave rationally and that when they seem to be behaving irrationally it is because of constraints that prevent them making the sensible choice. This view was shown to be wrong by the psychologist Thomas Kahnemann. For this work he won a Nobel Prize. It launched an entire new branch of economics (behavioural economics).

He showed that human beings have two systems of thought. One of these is a rational system with which people engage in the figuring out of problems. This is mentally demanding. In fact it is so mentally demanding that people cannot both think in this mode and walk quickly at the same time. The other is a much quicker system based partly on some hard wired evolutionary traits, partly on experience and partly on perception. The problem is that this system contains some predictable perceptual inaccuracies which lead to people making incorrect decisions.

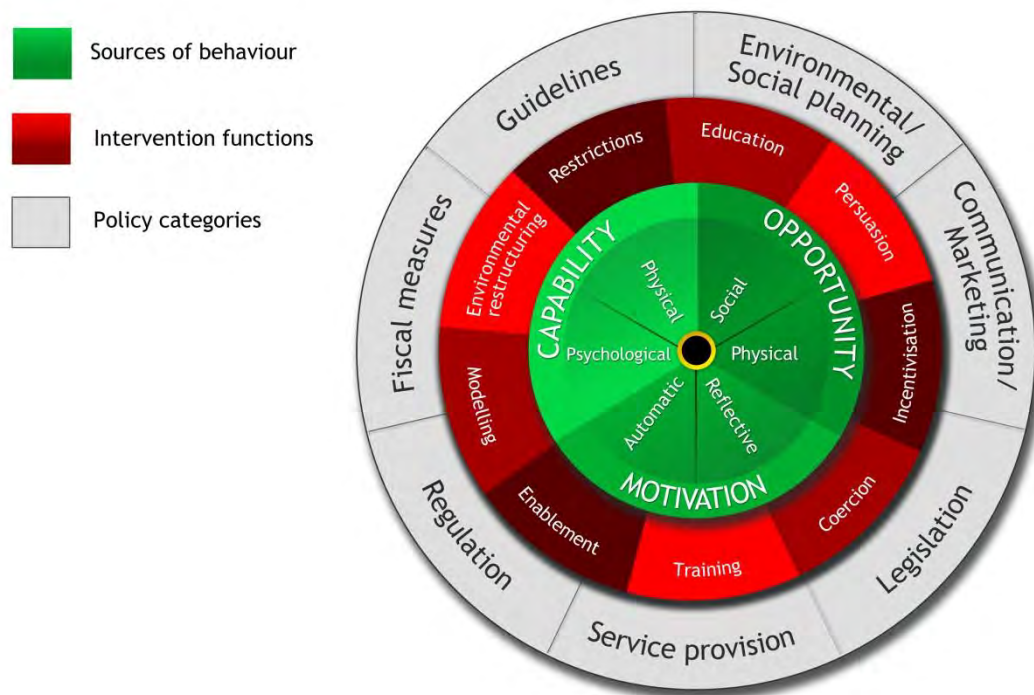
For example

- Asked to assess the likelihood of a flood killing more than 1,000 people in California due to an undersea earthquake and, later in the same questionnaire, the likelihood of a flood killing more than 1,000 people somewhere in America, people will assign a higher likelihood to the flood in California from a specific cause than they will to the flood anywhere in America from any cause. A moment's thought will reveal that this is irrational since every flood in California from an undersea earthquake is also part of the category "a flood somewhere in America from any cause." People over assess the likelihood of risks that they have heard of and are familiar with and underpasses risks that are imprecise and unclear.
- Asked firstly whether something is worth more or less than X and then what it is actually worth, the higher the value of X the higher people will value the object. This is true even if they know that X is a random number. It is true even if they were asked to use the last four numbers of their telephone number as X.
- Given £20 and told that you must either pay £5 or gamble on whether to lose £10, which would you do? Given £10 and told you can either be given another £5 for certain or can gamble on being given £10, which would you do? These are identical gambles – each is a choice between a certainty of £15 or a gamble between £10 and £20. But more people will gamble in the former formulation than in the latter. People are more averse to loss than they are receptive to the chance of gain. About twice as much.
- Monkeys were trained to trade tokens for food and provided with an expensive provider who sometimes gives more than they should have had or alternatively a cheap provider who sometimes gives them less. The occasional loss was more than made good by the cheaper price but they still chose the more expensive provider. Loss aversion is therefore a hard wired instinct that evolved tens of millions of years ago.

These are just three of the cognitive biases that have been described. There are over a hundred.

Most people would be able to recognise how these three cognitive biases are each used in marketing. Yet they would be hard put to name any instance of them being used in altruistically motivated public service behaviour change campaigns. We owe it to people to speak to them as they are, not as some theory tells us they should be.

Michie et al have linked the various influences on behaviour in a model called the Behaviour Change Wheel



Key points for us to remember are

- Loss aversion means that the downsides of change will be perceived more clearly than the benefits.
- It is important to present the preferred behaviour as normal. Most people most of the time on most issues do what they think is normal.
- Welcome messages can help do that – for example notices saying “You are welcome to breastfeed here” can help breastfeeding mothers overcome a sense of embarrassment.
- Conversely restrictions can help present an activity as abnormal.
- Rules which are difficult to enforce can nonetheless be highly effective if they push with the grain of what people know they ought to do (e.g. seat belt legislation, smoke free areas) because they normalise behaviour. However this doesn’t work if they don’t push with the grain and people think they are just irksome rules.
- Role models are also important in presenting behaviour as normal.
- Default arrangements which make the right choice normal and force people to make an active choice in order to behave differently are highly effective. This could be something as simple as providing the diet drink automatically unless the sugary version is requested, instead of the other way round. Or sending out public transport details for how to get to something with a note saying “Information for travel by car available on request.”
- Campaigns which help people see that they are not alone, and that they can make change, fulfil a number of purposes – normalisation, bandwagon creation, mutual support, opportunities for collaborative action

3.8 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 Strategy will be reviewed after the production of the new JSNA early next year. It will link to the strategy of Stockport Together.

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 years 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.

Increasingly the CCG Plan is being linked to the strategy of Stockport Together.

Stockport Together

Structurally Stockport Together is working to bring together the social care and public health commissioning processes of the local authority with the commissioning functions of the CCG, to combine the health and social care community services into a multispecialty community provider and to bridge the divide between commissioning and provision by outcome-based commissioning.

Its strategy is focussed on prevention and empowerment, expanded proactive care and reform of both planned and urgent care.

3.9 LOCAL AUTHORITY RESOURCES

Stockport MBC faces severe financial constraints.

It is important that health impact be taken into account in all of the steps that it takes to deal with this and I will make a recommendation to that effect.

I carried out a table top analysis of the health impact of the Council's Investing in Stockport proposals and submitted the following comments.

There will be a variety of impacts, some of them positive, some of them speculative, and some of them minor.

It isn't my wish to express any general unhappiness.

I appreciate of course that we are addressing a financial problem in which it would be foolish to pretend that there will be no adverse outcomes.

The following are issues which need attention to avoid problems

- Ensuring that digital by design does not increase inequalities
- Ensuring that the changes in leisure services do not adversely affect physical activity
- Ensuring that the health and social care system addresses the reduction in the Council's contribution as a problem affecting the whole of the system not just social care (or indeed community services)

I have no reason to doubt that those involved are fully alert to those issues.

Another big concern however is the impact of reductions in the public protection function on tobacco, alcohol and accidents. It is for example a matter of concern to see from the report on action to implement the Council's responses to the 21st Annual Public Health Report that work on illicit tobacco has been a casualty of resource constraints.

3.10 PUBLIC HEALTH AND PUBLIC POLICY

Disraeli said that the health of the people is the first concern of Government. The following is the list of Ten Points for Number Ten adopted by the North West Directors of Public Health in July 2014

Priority 1:

Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health and social outcomes

Priority 2:

Introduce a sugar sweetened beverage (SSB) duty at 20p per litre to help address poor dental health, obesity and related conditions

Priority 3:

Commit to the eradication of childhood poverty to meet targets set by the Child Poverty Act 2010 and improve the health and wellbeing of all children

Priority 4:

Work with employers to increase payment of the living wage and introduce a higher minimum wage to improve quality of life, happiness and productivity in work

Priority 5:

Ban the marketing on television of foods high in fat, sugar and salt (HFSS) before 9pm to reduce children's exposure to unhealthy food advertising and improve diet choices

Priority 6:

Implement the recommendations contained within the "1001 critical days" cross party report to ensure all babies have the best possible start in life

Priority 7:

Implement tougher regulation of payday loan companies to improve the health and wellbeing of people with debts

Priority 8:

Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds

Priority 9:

Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing

Priority 10:

Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption

3.11 A STRATEGY FOR HEALTHY LEISURE

Leisure can benefit health by promoting social networking, providing opportunities for physical activity and addressing mental wellbeing and personal development in a number of ways.

Sport, walking/ cycling and active leisure are important contributions to physical activity.

Physical activity addresses a number of health issues including diabetes, heart disease, stroke and osteoporosis. It is the best way for old people to reduce frailty. It makes people feel better and reduces depression.

Greenspace is important not only because of its contribution to opportunities for active leisure and active travel but also because physical activity in green surroundings appears to be more beneficial to health than activity in indoor or urban settings. In addition greenery appears to reduce stress, raises the human spirit and promotes wellbeing.

Libraries also make an important contribution to health, through helping disseminate information, provide sources of social networking and cultural development, and through the Self-Health scheme.

The Health Hub at Avondale is an example of a new approach to organising a leisure centre in which it is seen not just as a facility to be made available, marketed and promoted, but as a centre for the promotion of physical activity which can serve as a base for organising events in the community and as a source of advice and promotion for other forms of physical activity such as active travel.

The Hub has been outstandingly successful. In business terms it has dramatically reduced the deficit of the centre whilst still providing almost 1,000 free leisure access accounts for those receiving benefits and increasing uptake of physical activity in local communities. It has been nationally accredited as an exercise rehabilitation centre, the only non-clinical facility in the country to do so, and won an award for crowned Best National Exercise Rehabilitation Centre of the Year at the National Fitness Awards.

I believe that the Hub should be viewed as the way forward in leisure provision and that we should see the creation of such networks as central to the promotion of physical activity and important components in the promotion of healthy living.

There is value in considering the leisure estate and health estate together and moving over time to the creation of Healthy Living Centres.

3.12 PREVENTING SUICIDE: ITS NOT INEVITABLE

Suicide can be prevented and in Stockport there is plenty of work underway to make Stockport a place in which people never see suicide as their only option. In Stockport, someone dies every two weeks from suicide, between 20-30 people every year. For every person who dies by suicide, approximately nine people (adults and children) are directly impacted by the tragic event.

Death lies at one end of a continuum of a common suicidal process. On average, every month in Stockport 67 people attend Stepping Hill Hospital's emergency department with self-harm issues, 116 people attempt suicide, 275 people access the emergency department in suicidal distress, and 365 calls are received by The Samaritans which express suicidal thoughts and feelings. If we are to prevent suicide all aspects of the continuum are important.

Men are nearly three times more likely to die by suicide. Deaths from suicide and undetermined intent peak for both men and women in the 35 to 49 age range. Around two in three who die by suicide are not known to mental health services. 80% of people that take their own life have made previous attempt and at least half will have engaged in self-harm. Suicide is a significant inequality issue as there are marked differences in the suicide rates according to people's social and economic backgrounds. Other risk factors include those in criminal justice service, people with drug and alcohol problems (often not in touch with services), physical health conditions, and pain management issues. There are also people that take their own life who have none of these risk factors.

In Stockport, we have a multi-agency Stockport Suicide Prevention group. The group developed and designed a web resource which puts all local and national services and resources together in one accessible place to offer support for those in suicidal distress, offers help and support for anyone with suicidal thoughts, people who are concerned about others, and those bereaved by suicide.

<http://www.stockportsuicideprevention.org.uk/>

The group has developed a local suicide prevention strategy with the ambition "to make Stockport a place in which people never see suicide as their only option". The strategy has three main areas of action:

- Reduce the risk of suicide - using the evidence to target high risk groups.
- Be a catalyst for change - ensure individuals, communities and services are able to recognise and respond to suicidal distress, including the needs of those affected by suicide.
- Support action to enhance wellbeing and resilience in the population as a whole.

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SECTION E: The Strategic Response

LEVEL 4

Full Analyses

LEVEL 4 (FULL ANALYSIS) SECTION E: THE STRATEGIC RESPONSE

4.1 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.

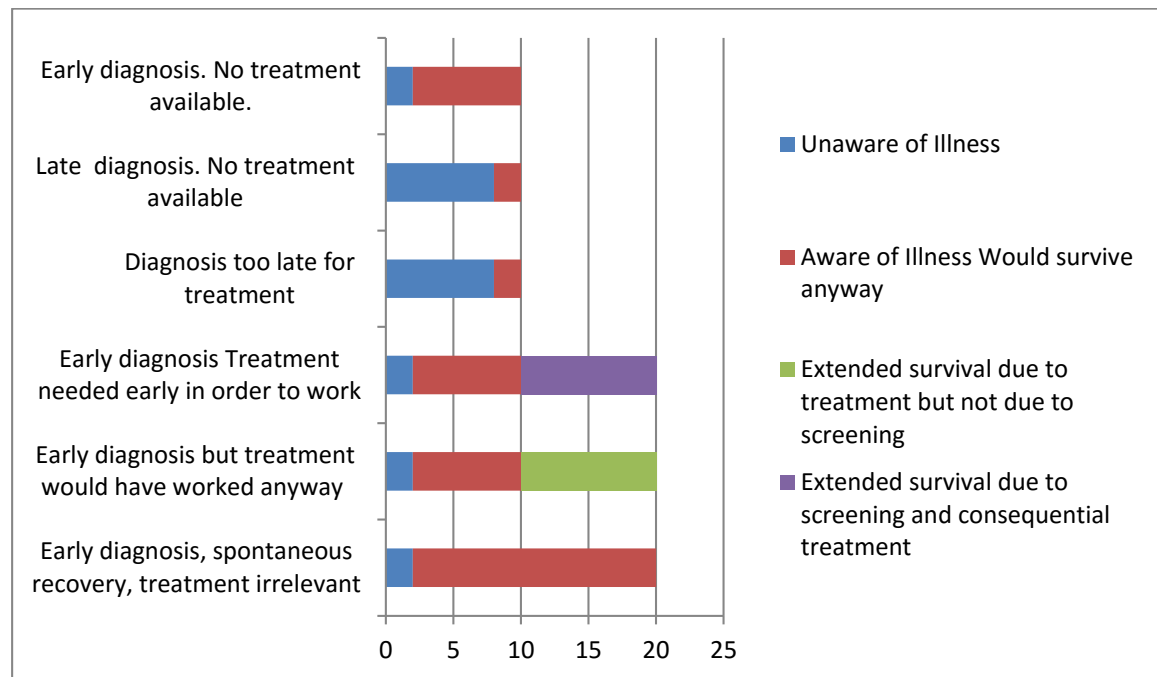
Thirdly, it can take a long time for people to become confident in their own capacities and for those in power to trust the judgements of others. Democracy is hard work, especially in the current climate where so many feel abandoned by politicians and without any real voice. Of course, this is precisely 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.

4.2 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
<i>Adult screening:</i>		
Abdominal Aortic Aneurysm	Men aged 65 and over. Men are invited in the year they turn 65.	48% reduction in risk of death
<i>Cancer screening programmes:</i>		
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
<i>Screening in pregnancy:</i>	
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
<i>Screening for babies and children:</i>	
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
<i>Adult screening:</i>	
Diabetic eye screening	2011/12 coverage: England – 73.9% 2011/12 uptake: Stockport – 75.8%

	2012/13 uptake: Stockport – 78.4%
Abdominal Aortic Aneurysm <i>Programme is still in roll out</i>	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 <i>Women aged 53-70:</i> 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 <i>Women aged 25-64 :</i> 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.

4.3 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.

The first four of these are now being addressed by various local initiatives.

- A move towards outcome-based commissioning with accountable care organisations that are tasked to achieve particular outcomes helps breakdown the bureaucratic arm’s length separation of commissioner and provider
- The development both in Stockport and at Greater Manchester level of a partnership between NHS bodies and local authorities extends the democratic input into the working of the NHS
- Health and social care is being integrated in Stockport within Stockport Together and at Greater Manchester level within the devolution agreement
- It is now possible for CCGs to have commissioning of general practice devolved to them and Stockport CCG has applied for this. The result of the application is awaited. If approved it would take effect from 1st April 2016.

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 Coalition Government has institutionalised this in the Health & Social Care Act 2012, in a way which will inevitably accelerate it

further, although the present Government actually seems somewhat less committed to this than the Coalition, probably because of the pressure of resource constraints.

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.

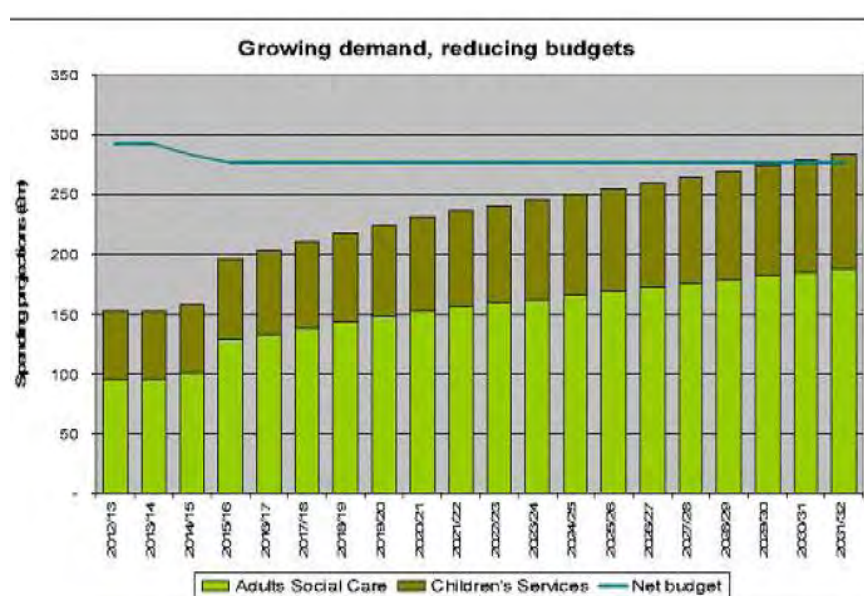
Underspending increased in the last Parliament. This was also very slight, but it slightly exceeded the increase in budgets so health service spending slightly decreased in real terms. Now, however, the situation has become one in which NHS bodies show significant deficits.

Although much was 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. The emergence of deficits however is a significant problem.

Local authority public health grants increased in the 2010 Parliament above the baseline public health spending of PCTs by more than the general increase in health service funding. This was 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 accorded 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. Unfortunately however this sensible move is now being abandoned with local authority public health grant facing a 15% cut in the current parliament.

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 in the last Parliament stated that the NHS needs to achieve 20% more benefit from static resources over a 5 year period. In this Parliament the equivalent challenge is that the NHS needs to achieve £30bn worth of increased activity (or reduced demand) with only £8bn of increased funding. 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 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.



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.

The Government is now to allow Councils partially to address this problem by increasing Council tax but this does not fully resolve the problem.

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. This is irrational since it is the gap between healthy life expectancy and life expectancy which creates demand, not life expectancy alone.

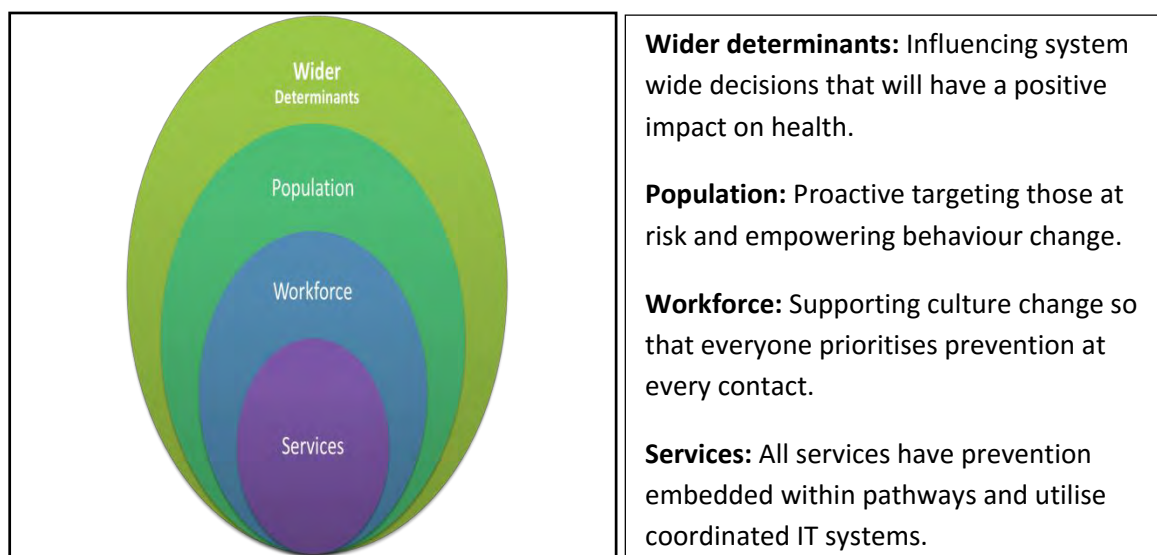
Stockport Together

Stockport Together is a collaboration of key health and social care partners in Stockport; there are four key programmes of work.

- Prevention and Empowerment - to prevent ill-health and empower residents to take control of their health
- Proactive Care – strengthening community capacity and improving health literacy, service quality, and outcomes of care for people such that fewer people will require hospital admission and consequently reduce demand
- Urgent Care – improving the quality, timeliness and clinical cost effectiveness of the urgent care system such that people avoid hospitalisation and/or return “home” more safely and more quickly
- Planned Care - improving the patient experience and outcomes across the planned care system whilst increasing efficiency and value for money

This section deals with the prevention and empowerment programme although there are preventative elements and a focus on self-care in each of the three other programmes

Prevention and Empowerment. Through a series of workshops and informed discussion we have identified 4 key themes.



The role of the preventative and empowering care system is to focus on preventing disease and illness before they occur and creating healthier homes, workplaces, schools and communities so that people can live longer, healthier and more productive lives and reduce the reliance on health and social care services.

To achieve this ambition we are committed to transforming and scaling up those programmes that have a strong evidence base, that are co-produced with local communities, that utilise new IT

opportunities and that are delivered by staff who understand what is motivating the health behaviours and needs of our residents.

It recognises that self-care and self-management are essential components of this new delivery model and that we can work proactively with local residents to improve their levels of activation, capacity and competence to address healthy behaviours and manage chronic long term conditions.

Looking specifically at each key theme

Wider Determinants: We will identify system wide factors that are currently contributing to poor health outcomes in Stockport and use our local knowledge and national evidence base to achieve sustainable change. Building on our work in the Stockport Health Promise and through such programmes as Feeding Stockport and the Tobacco Alliance we will make a public health contribution to policy decisions relating to employment, the local economy, infrastructure, education and housing to enable healthier behaviours to be built into everyday lives. We will pay specific attention to addressing wider determinants in our deprived communities using the intelligence and experiences of local residents.

Population: Utilising GP, health, and social care records and other information sources we will extend our risk stratification approaches such as QRISK to proactively target those at risk such as patients with no recorded blood pressure (BP) readings, those at risk of diabetes, patients with raised liver function tests, smokers and those with respiratory conditions and those with mental health concerns. We will revise our Public Health Enhanced Services with GPs and provide them with training and additional equipment to proactively support such patients. We will utilise our innovative health inequalities programmes and our revised Healthy Stockport offer to develop alternative settings to deliver health checks, BP testing and roll out the 'Stockport String' community engagement tool. We will link with neighbourhood teams and the new Targeted Prevention Alliance of voluntary sector providers to enable prevention activity to be managed and delivered at a local level. We will expand our understanding of what the underlying issues are for each locality through listening, engaging and consulting with appropriate leaders and opinion formers in these communities. We will be flexible in how funding can be used to support localities to work with their communities to facilitate healthier lifestyles.

Workforce: We will train and empower the workforce to deliver positive and consistent health promoting messages, enabling the workforce to deliver primary prevention interventions proactively and holistically wrapped around the person's needs. This will build on Stockport Health Chat, and will develop more advanced behaviour change techniques incorporating motivational interviewing and patient activation that can be used in clinical settings. We will develop young people health chats training and extend our popular wellbeing programmes so that.

We will take the health of all our employees seriously and review and extend a range of activities that enable our staff to themselves make positive health choices and take control of their own health. We will challenge the current work environments that inhibit the health and well-being of their staff.

Services: We will continue to redesign, transform and procure our services such as Healthy Stockport (lifestyle advice and support), sexual health, early years and drug and alcohol services so that they

are consistent with our new prevention and empowerment models. We will extend programmes such as the 'Stop before your Op' which utilise clinicians as powerful change agents to promote key health messages to patients at key decision making times in the patient journey. We will work with colleagues in proactive, planned and urgent care to embed prevention within all pathways and coordinate IT systems so that all staff can use opportunities to promote health messages and address individual's healthy behaviours in their consultations.

Finally we will ensure that we integrate such ambitions within the Place Based Agreement in the Public Health and Prevention in Greater Manchester as part of the wider devolution deal.

4.4 CHALLENGES FOR THE NHS

Quality of healthcare

A relentless focus on quality is the cornerstone of a high performing provider organization. Providers that prioritise quality improvement in an open and transparent way ensure that the organizational culture has quality at its heart. Providers should encourage reporting cultures and systems that encourage reporting of near misses and prioritise actions to learn systematically from errors. Participation in national quality audits, procedure registers and benchmarking against NICE best practice are all vital to ensure that quality is maintained.

Commissioners need to ensure that they view quality through an enquiring lens, focusing on outcomes and capability and patient experience, ensuring that they intervene where they have concerns and don't simply spectate a poor quality system. As more providers enter the market, it is important to ensure that lead commissioners scrutinize quality on behalf of others.

Healthier Together has given Greater Manchester the opportunity to define a high quality provider system with the production of Healthy hospital and primary care standards. Devo Manc can build on this but should learn from leaders in quality improvement who demonstrate that a focus on patient experience of care drives quality improvement in clinical teams.

With the national focus on weekend mortality, it is vital that any redesign of the system takes into account current best practice around staffing levels.

Providers should ensure that priority is given to all staff being trained in safeguarding, deprivation of liberty and the mental capacity act and the duty of candour.

Problems have occurred elsewhere when 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 Sometimes 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. This is what the above processes are intended to achieve.

Rising demand on services

Despite improving health, demand for NHS services continues to rise 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 however, it results from an increasing tendency to seek professional help for problems, which in the past people would have dealt with themselves. Partly it results from inefficiencies in the delivery of care, and the national focus on new models of care has been designed to address this. The better care fund brought health and social care commissioners

together to focus on increased community capacity to reduce bed pressure in acute hospitals; the Vanguard pilots are testing different models of providing increased services out of hospital for older people and those with long term conditions. GP federations are working together to provide an increased range of services out of 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.

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. Despite the current financial pressures, we must invest in these areas to produce benefits for 2016/17 and beyond

The NHS as a healthy setting

It is imperative that NHS premises promote health to its staff, visitors and patients. An estate that facilitates:

- active travel and active working breaks
- healthy eating – in particular, not allowing the sale of food and drink high in refined sugars and unhealthy fats
- mental wellbeing for staff

and promotes health in a visible way that people can access advice about healthy behaviours.

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 within Stockport Together.

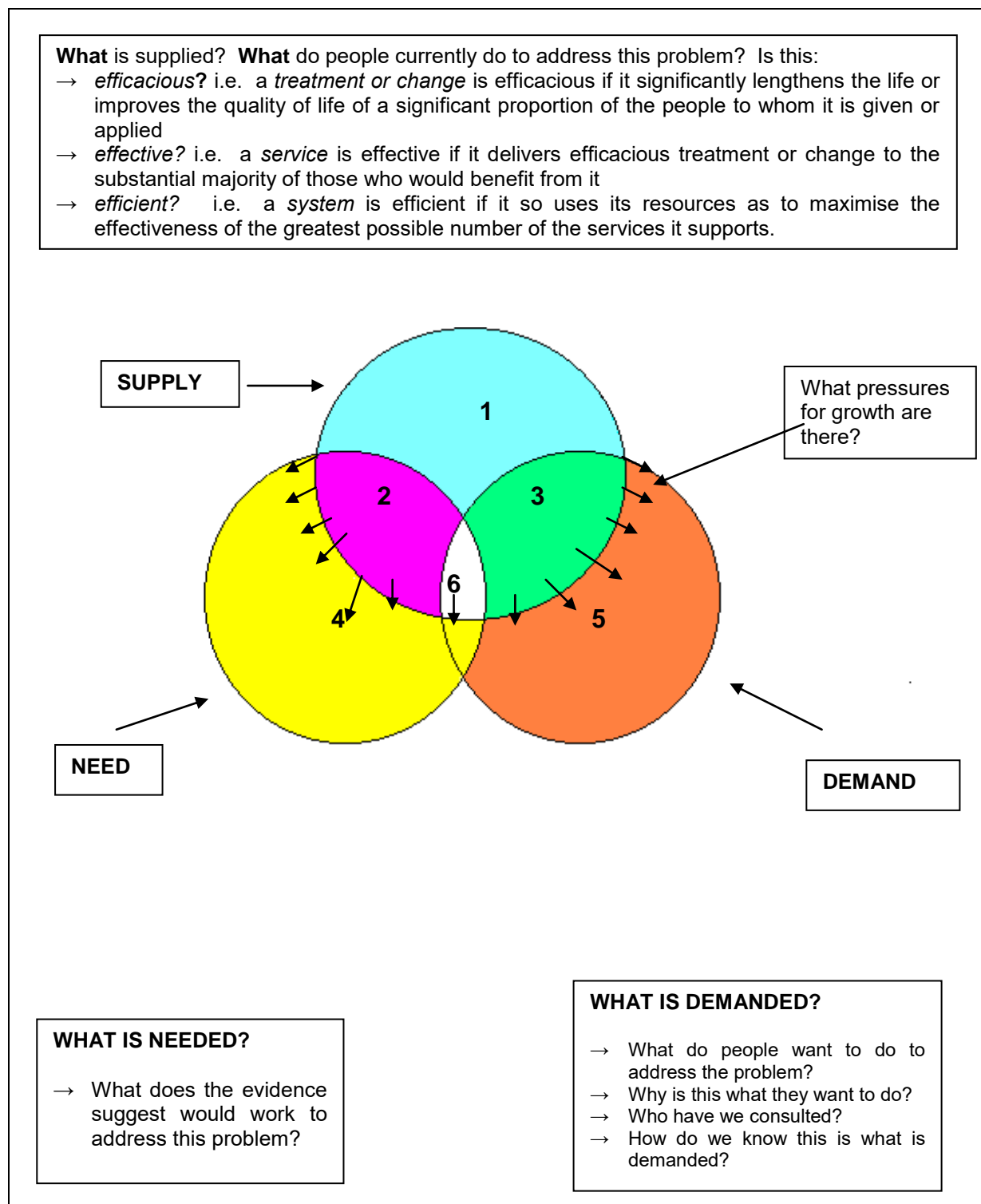
A Service Based on Need

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 22.1 Stevens and Gabbay



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 now to bring about benefit in the next few years.

4.5 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. Further cuts are to occur in the next few years. 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 Programme Plus 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.

4.6 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, and 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.

4.7 BEHAVIOUR CHANGE

Behaviour change is central to many health objectives. We need to persuade people to adopt healthier behaviours, to use health services more effectively, to act in ways which improve the environment and promote the health of others, to reduce the demand made on hard-pressed services, to help others.

Most of our systems of politics, economics, governance and supportive advice have traditionally operated on the assumption that people behave rationally and that when they seem to be behaving irrationally it is because of constraints that prevent them making the sensible choice. This view was shown to be wrong by the psychologist Thomas Kahnemann. For this work he won a Nobel Prize. It launched an entire new branch of economics (behavioural economics).

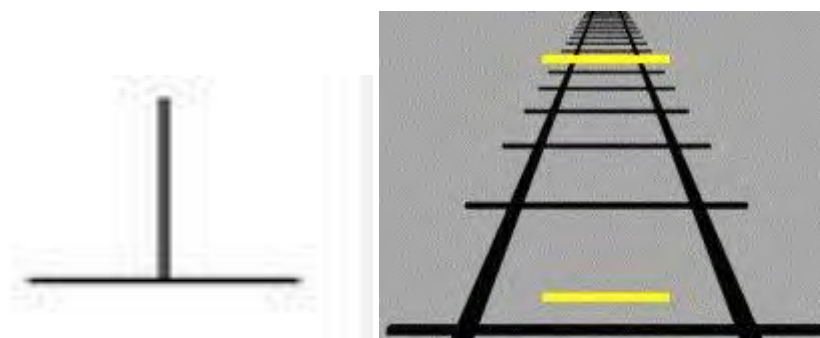
He showed that human beings have two systems of thought. One of these (system 1) is a rational system with which people engage in the figuring out of problems. This is mentally demanding. In fact it is so mentally demanding that people cannot both think in this mode and walk quickly at the same time. The other (system 2) is a much quicker system based partly on some hard wired evolutionary traits, partly on experience and partly on perception. The problem is that this system contains some predictable perceptual inaccuracies which lead to people making incorrect decisions.

Misperception

People can be misled by misperception.

Visual illusions are an example

On the left the vertical line looks longer than the horizontal one but in fact they are the same length.



On the right the upper line looks longer than the lower line because the brain thinks it is further away but in fact they are the same length.

From Misperception to Cognitive Bias

The misperceptions in system 2 are similar to these simple visual illusions but go much further and they affect the way people interpret and apply their experiences. This kind of misperception is called a cognitive bias.

For example

- Asked to assess the likelihood of a flood killing more than 1,000 people in California due to an undersea earthquake and, later in the same questionnaire, the likelihood of a flood killing more than 1,000 people somewhere in America, people will assign a higher likelihood to the flood in California from a specific cause than they will to the flood anywhere in America from any cause. A moment's thought will reveal that this is irrational since every flood in California from an undersea earthquake is also part of the category "a flood somewhere in America from any cause." People over assess the likelihood of risks that they have heard of and are familiar with and underpasses risks that are imprecise and unclear.
- Asked firstly whether something is worth more or less than X and then what it is actually worth, the higher the value of X the higher people will value the object. This is true even if they know that X is a random number. It is true even if they were asked to use the last four numbers of their telephone number as X.
- Given £20 and told that you must either pay £5 or gamble on whether to lose £10, which would you do? Given £10 and told you can either be given another £5 for certain or can gamble on being given £10, which would you do? These are identical gambles – each is a choice between a certainty of £15 or a gamble between £10 and £20. But more people will gamble in the former formulation than in the latter. People are more averse to loss than they are receptive to the chance of gain. About twice as much.
- Monkeys were trained to trade tokens for food and provided with an expensive provider who sometimes gives more than they should have had or alternatively a cheap provider who sometimes gives them less. The occasional loss was more than made good by the cheaper price but they still chose the more expensive provider. Loss aversion is therefore a hard wired instinct that evolved tens of millions of years ago.

These are just three of the cognitive biases that have been described. There are over a hundred.

A list of them extracted from Wikipedia appears in level 5 of this chapter

Behaviour Change

These cognitive biases lead people to make incorrect decisions. After every train crash there are people who switch to the car instead, because train crashes are so unusual that the media will focus on them. Moving to a system which is so much less safe that the media doesn't even report the daily accidents isn't rational, but it is entirely predictable. It is the "California flood".

Stockport Council saves on insurance premiums by not insuring against risks under £500,000. Rationally it is better for a large organisation to bear these losses than to pay an insurance premium to an insurer who will simply take a predictable rate of occurrence and add a profit to it. This rational calculation is unusual – loss aversion usually kicks in.

Most people would be able to recognise how the three cognitive biases with which we opened this section are each used in marketing.

Yet they would be hard put to name any instance of them being used in altruistically motivated public service behaviour change campaigns. We owe it to people to speak to them as they are, not as some theory tells us they should be.

It is sometimes suggested that for public service organisations to use such methods would be unethical. Why is it ethical to manipulate people into harming themselves for somebody else's commercial gain but unethical to manipulate people into benefiting themselves?

EAST

The name libertarian paternalism has been used to describe a model of behaviour change which leaves people free to act as they wish but puts in place arrangements which lead to most people doing the right thing most of the time. The EAST model summarises this.



Make it Easy

- Harness the power of defaults
- Reduce the 'hassle' factor
- Simplify messages



Make it Attractive

- Attract attention
- Design rewards and sanctions for maximum effect



Make it Social

- Show that most people perform the desired behaviour
- Use the power of networks
- Encourage people to make a commitment to others



Make it Timely

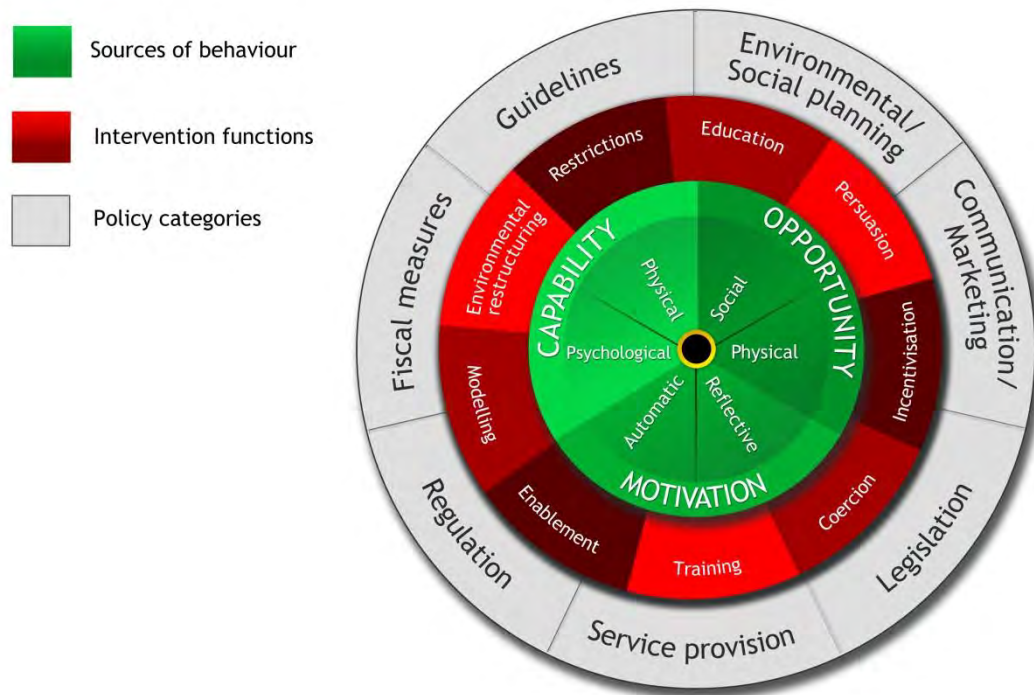
- Prompt people when they are most likely to be receptive
- Consider the immediate costs and benefits
- Help people plan their response to events



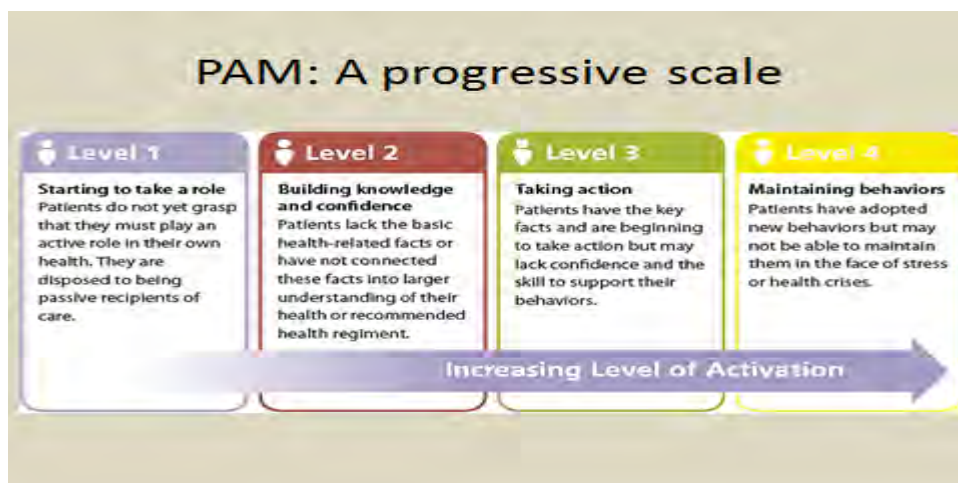
Other useful techniques favoured in this model include getting people to commit to something in the future rather than immediately (just as marketing offers free trials relying on the inertia selling of the post-dated direct debit), making sure that the best choices are most prominent (just as marketers pay for their brand to be prominently displayed in supermarkets) and creating bandwagons.

The Behaviour Change Wheel

Michie et al have linked the various influences on behaviour in a model called the Behaviour Change Wheel



Patient Activation



Measures which increase patient activation include developing skills and a sense of mastery, encouraging ownership of one's own health, stimulating autonomous motivation, using peer support, changes in social environment, coaching, education, and interventions tailored & targeted to PAM levels. This requires change in clinician perspectives and behaviour in relation to patients.

Technical or Adaptive Change



Technical: a tadpole can learn to swim faster and further around the pond (incremental change)

Adaptive: to come out of the pond a tadpole becomes a frog (radical change)

Personal and organisational development both require adaptive change to enable people to expand their horizons, respond to new situations and develop new understanding and skills...
... but our default is often to rely on technical changes

TECHNICAL PROBLEMS

1. Easy to identify
2. Often lend themselves to quick and easy (cut-and-dried) solutions
3. Often can be solved by an authority or expert
4. Require change in just one or a few places; often contained within organizational boundaries
5. People are generally receptive to technical solutions
6. Solutions can often be implemented quickly—even by edict

Implement electronic ordering and dispensing of medications in hospitals to reduce errors and drug interactions

ADAPTIVE CHALLENGES

1. Difficult to identify (easy to deny)
2. Require changes in values, beliefs, roles, relationships, and approaches to work
3. People with the problem do the work of solving it
4. Require change in numerous places; usually crossorganizational boundaries
5. People often resist even acknowledging adaptive challenges.
6. "Solutions" require experiments and new discoveries; they can take a long time to implement and cannot be implemented by edict

Encourage nurses and pharmacists to question and even challenge illegible or dangerous prescriptions by physicians

The Six Es

EDUCATION – ensuring people know the facts about the consequences of behaviour is essential but it is not in itself enough.

ENCOURAGEMENT - supporting change and positively reinforcing it

ENABLEMENT – we must make it easy to change. The healthy way should be the easy way.

EMPOWERMENT - we must empower people to change by normalisation and by creating communities committed to change

ENGINEERING – systems and environments can be changed to support healthy choices

ENFORCEMENT – rules have their place

Implications for Strategy

Key points for us to remember are

- Loss aversion means that the downsides of change will be perceived more clearly than the benefits.
- It is important to present the preferred behaviour as normal. Most people most of the time on most issues do what they think is normal.
- Welcome messages can help do that – for example notices saying “You are welcome to breastfeed here” can help breastfeeding mothers overcome a sense of embarrassment.
- Conversely restrictions can help present an activity as abnormal.
- Rules which are difficult to enforce can nonetheless be highly effective if they push with the grain of what people know they ought to do (e.g. seat belt legislation, smoke free areas) because they normalise behaviour. However this doesn’t work if they don’t push with the grain and people think they are just irksome rules.
- Role models are also important in presenting behaviour as normal.
- Default arrangements which make the right choice normal and force people to make an active choice in order to behave differently are highly effective. This could be something as simple as providing the diet drink automatically unless the sugary version is requested, instead of the other way round. Or sending out public transport details for how to get to something with a note saying “Information for travel by car available on request.”
- Campaigns which help people see that they are not alone and that they can make change fulfil a number of purposes – normalisation, bandwagon creation, mutual support, opportunities for collaborative action.

The difference between technical and adaptive change needs to be understood. Many of the major successes of public health have been adaptive changes which were ridiculed in their inception. Sewers were highly controversial – “The Times” once said that it would rather have the cholera than the hectoring of Dr. Snow. Children had always died in infancy – you just had more of them to make up for it. Women had always died in childbirth – just read any Victorian novel. Clean air was a ridiculous idea in the 1930s. Adaptive change needs to be pursued over a long time period beginning with making the case, then with encouraging experiment, then with generalising those experiments

and making new norms. A focus on short term immediate achievements, although important, must not lead us to fail to take the early steps towards the creation of future adaptive change. It is important that public health professionals are free to prepare the ground for future developments in policy, as our predecessors did. Here in Stockport that is fully understood, welcomed and defended. It is almost an uncontroversial statement. It deeply concerns me that there are many local authorities where this is not the case and there are serious concerns about whether it is the case in Public Health England.

4.8 THE HEALTH AND WELL BEING STRATEGY

Stockport's Public Health Goals

Table 26.1 shows how the various goals by public health in Stockport relate to the various outcomes we are seeking to achieve.

Table 26.1 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 & Young People	✓	✓	✓	✓	✓			✓	✓	✓	✓
Improve the Health of Older People	✓	✓	✓	✓	✓		✓			✓	
Provide Screening Programmes	✓	✓	✓	✓						✓	
Improve Sexual Health	✓	✓		✓							

The Health & Well Being Strategy 2012-2015

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** 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.

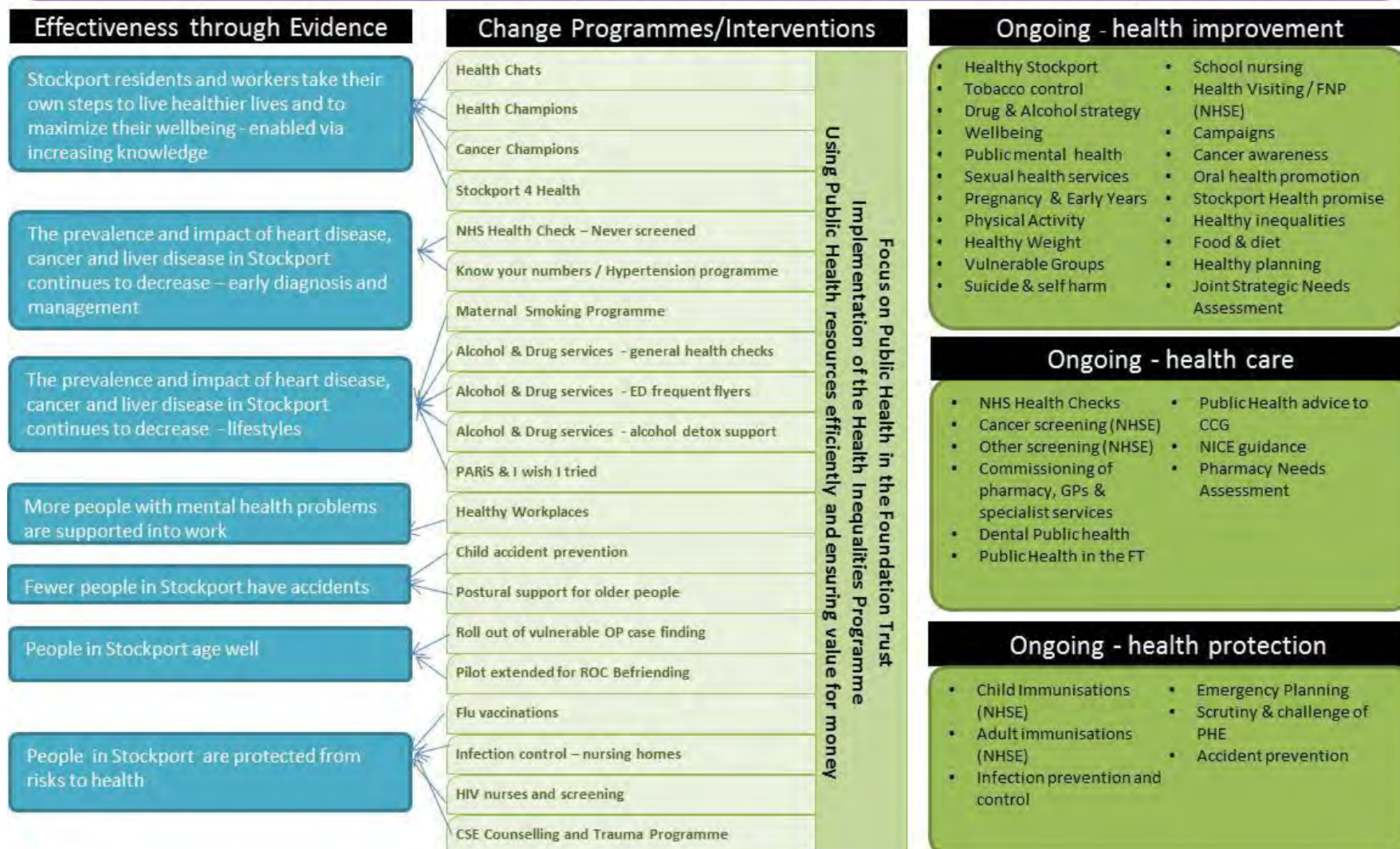
Alcohol The main focus of this section is on understanding how alcohol can affect our health and wellbeing. This might involve finding other ways to relieve stress, cutting back if you drink a lot of alcohol and believing that you can change - with help if you need it. The section sets out the local 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.

Public Health Plan-on-a-Page 2014-15

Stockport Public Health team takes the lead of improving health, co-ordinating local efforts to protect the public's health and ensuring health services promote population health. The team has strong links with directorates within Stockport MBC, Stockport CCG, Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust, NHS England, Public Health England and the third sector. The team contributes to Stockport's shared vision articulated in the Investing in Stockport Outcomes Framework priorities focussing on: **People are able to make informed choices and look after themselves, people who need support get it, communities in Stockport are safe and resilient within a thriving economy and Stockport is a place where people want to live.** The plan supports the CCG five year health priorities to: **reduce by 1000 the number of years of life lost and reducing the gap in life expectancy across the borough from 11 to 9 years.**



NHS STOCKPORT CCG – 2014-19 Plan on a Page

Stockport Health Economy is a system comprised of partners from Stockport CCG, Stockport NHS Foundation Trust, Stockport Council, Pennine Care NHS Foundation Trust and 3rd Sector partners who have come together to agree the following vision. This plan sets out how the CCG will play its part in delivering this vision:

Stockport will be a sustainable health & social care system that works together to:
consistently achieve and often exceed local and national standards for service quality and levels of public satisfaction;
deliver more care outside of hospital in locality settings in an integrated way; and
reduce the number of years of life lost whilst reducing the gap in life expectancy across the borough.

CCG Strategic Aims	CCG Objectives	Change Programmes / Interventions	System Success Criteria
Transform the experience of adults and children with long-term and complex conditions	1. To reduce unplanned hospitalisation of adults and children by 17% (admissions and bed days).	Unscheduled Care The goal of this major programme of work is to improve the way urgent presentation is handled; improving value for money, performance and the speed by which people are stabilised. Change Projects: <ul style="list-style-type: none">Reformed Front-EndAcute Ambulatory Care and Paediatric PathwaysNew Model Ambulance ServiceExpanded Range of Community Stabilisation Services Full alignment of discharge processes, diagnostic capacity, and mental health escalation will be essential business-as-usual improvements.	<i>Success will be measured as follows:</i> <ul style="list-style-type: none">No provider under enhanced regulatory scrutiny due to performance regimeAll constitutional requirements always metPatient experience in all areas in top quartileChange in spending profile as described1,000 fewer potential years of life lostHealth inequalities gap down to single figuresAll partner organisations with financial surplus in 2018-19.
Increase the clinical cost-effectiveness of elective treatment and prescribing	2. To improve the health related quality of life with people with long-term conditions to best in class .	Proactive Care The goal of this major programme is to reduce the number of people presenting with a real or perceived urgent need. The focus is on integrated, proactive and anticipatory care. Change Projects: <ul style="list-style-type: none">Integrated Complex Care Service including end of lifePeople Powered Health TeamProactive Care Home SupportRemodelled General PracticeLong Term Conditions Pathway Reform Alignment and strengthening of existing services such as IAPT, Falls, Patient Education, Carers Respite, Dementia and Minor Ailment schemes will be necessary.	System Governance <i>Overseen through following arrangements:</i> The Health & Wellbeing Board sign-off plans. Stockport Health & Social Care Reform Group meet monthly to oversee implementation supported by: <ul style="list-style-type: none">Full and proper public consultation of changesEconomy appointed PMO director and officeNamed organisation project accountability Major work programmes will be led and overseen by a jointly constituted programme board including lay members and dedicated change team.
Improve the quality, safety and performance of local services in line with local and national expectations	3. To improve access to mental health services including IAPT take-up to 20% & provide services for young people to 25	Parity of Esteem This is not a major programme of reform but is a significant expansion and improvement in the quality of and access to mental health services. It will in turn support other programmes above: IAPT expansion, CAMHS improvement, Dementia, ADHD and ASD improvement.	System Values & Principles <i>In the way we work together we will:</i> <ul style="list-style-type: none">Be obsessed by quality with a strong focus on continual improvement and by putting the people we serve at the heart of all our decisionsImprove outcomes by actively promoting prevention and anticipatory care in every settingDrive value for the public by looking for the best outcomes for every pound spentManage risks and benefits so as not to damage the sustainability of services for the publicHold each other to account in a transparent, constructive and supportive spirit.
Ensure better prevention and early identification of disease leading to reduced inequalities	4. To improve the efficiency of the elective system including outpatients by up to 30%.	Elective Care The goal of this major programme is improved efficiency and value for money of the elective care system, outpatients in particular. Change Projects: <ul style="list-style-type: none">GP referral project and peer reviewAlternate pathways including training thresholds and modelsModel clinics including GP Audit of follow upsIncreased Day Case treatment	
	5. To reduce the number of avoidable hospital deaths.	Acute Sector Reform This is encapsulated under the GM Healthier Together banner and describes the South Sector (CCG and Acute Provider) response to this wider work. This includes changes to the cardiology services in 14-15 and will expand to all acute surgery & medicine.	
	6. To increase patient satisfaction with all services to top quartile.	Local Quality This is more a focus on the continual improvement of standards and business-as-usual rather than system change. It includes work on a number of interventions collectively designed to improve safety and patient experience: Establish Shared Quality Charter, Shared Patient Safety Charter, Friends & Family Test, Continual Improvement and Compassionate Culture, Safeguarding Centre of Excellence	
	7. To reduce the years of life lost to causes amenable to health care by 1,000.	Health Literacy & Prevention This is a major programme focussed on preventing ill health developing and has a particular emphasis on the health literacy of the population. Change Projects: Hypertension; Screening Uptake; Immunisation	
	8. To narrow the gap in life expectancy across the borough to single figures.		

Information Technology
This is a major programme focused on harnessing technology to enable major changes to the Health & Social Care system.
Change Projects: Digital Services to the Population • Integrated Records • Care Plan • Supporting People Remotely • Electronic Prescribing • Clinical System Maturity

For more information see <http://stockportccg.org/wp-content/uploads/2012/01/Strategic-Plan-2014-20191.pdf>

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.

The Prevention and Empowerment Strategy of Stockport Together.

Overall Prevention and Empowerment Vision for 2020

- Our purpose is to reduce health inequalities and enable more people to live healthy lives for longer
- Our approach will build and strengthen individual and community assets and resilience through:
 - Increasing the availability and take up of support for adopting healthier ways of living, addressing both mental and physical aspects of health
 - Working with communities and organisations to develop social, economic and physical environments that are more conducive to health and well-being.
- This will lead to reduction in both the overall prevalence and the inequalities in illness, disability and premature mortality

Design Challenges

1. Increase the range, capacity and accessibility of behaviour change support across 5 levels of intervention
 2. Develop effective ways to proactively seek out people with undiagnosed conditions or health-risk behaviours
 3. Increase numbers engaging with health behaviour change support
 4. Empower communities to gain more control over the drivers of their own health and wellbeing
 5. Support staff in embedding prevention in all their interactions with people using services
- Prevention and Empowerment

Financial Challenges

- There is considerable uncertainty about future financial resources for prevention and empowerment due to:

- Public Health grant reducing significantly in current and future years
 - Council financial settlement for next year not yet known
 - Unknown local impact of Devo Manc prevention work
 - Implications of NHS funding increase to be determined
- The proposals in this document are based on additional funding of £3M above current levels, as proposed in the original Stockport Together vision. The pace and scale of implementation will depend on the availability of such resources.

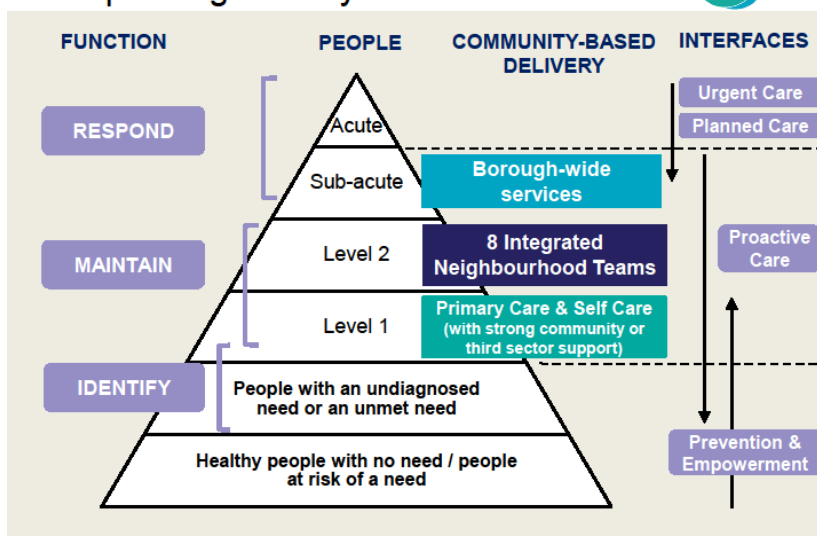
Overview of benefits

- The future model of care for Prevention and Empowerment is designed to
 - Prevent disease and illness before they occur by empowering the population to take control of their health as far as possible – giving them tools, skills and information to address unhealthy behaviours and manage their own health as far as possible.
 - Prevent premature death and chronic disability by increasing early identification
 - Build healthy communities, which improve social connections and support healthier ways of living
 - Reduce health inequalities within Stockport
 - Reduce reliance on the health and social care system.
- Delivery of the model requires a significant cultural shift in attitudes and behaviours from both the population and the workforce, and for prevention to be embedded across all health and social care pathways in Stockport.

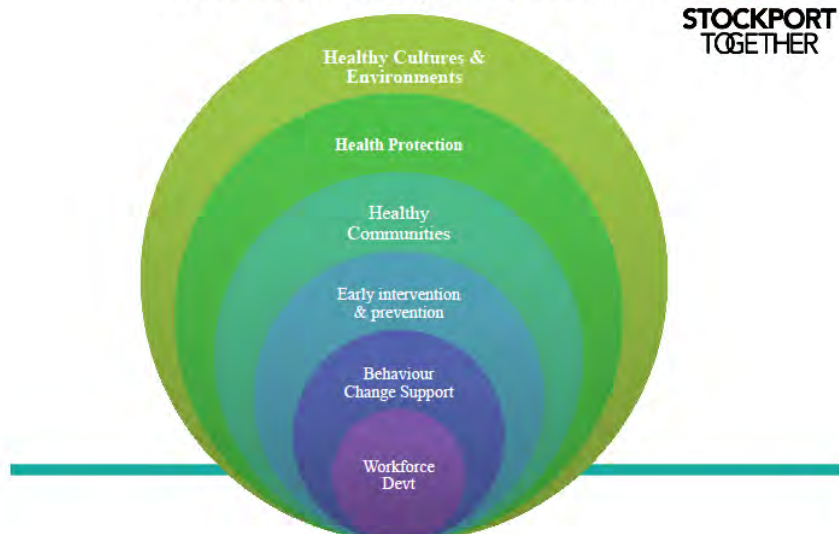
High level objectives

- Increase numbers of people engaging with individual lifestyle & wellbeing support to, and increase % of successful outcomes year on year
- Increase numbers of successful completions of alcohol and drug treatment and recovery interventions
- Increase numbers accessing online/app based lifestyle and well-being support
- Find and treat more people with previously undiagnosed hypertension, AF or pre-diabetes by 2017-18
- Increase rates of screening and immunisation

P&E in relation to Proactive Care & wider Stockport Together System:



Prevention & Empowerment Model



Overview description of model

The model includes five service components:

- Behaviour change support: we will increase the accessibility and capacity of support services to deliver individual and group support to address the lifestyle factors including smoking, alcohol misuse, diet, physical activity and mental well-being.
- Early intervention and prevention: building the capacity of front-line health, social care and other services to identify health behavioural risks and early symptoms, provide appropriate brief advice and facilitate access to further information and support, utilising ICT and skills development to embed prevention in every pathway
- Healthy Communities: we will work with communities of place or of interest to help develop the assets and networks which provide access to support and resources, thereby promoting healthier ways of living and increasing resilience at community as well as individual level.
- Health protection: enhanced immunisation and infection control activity to improve health at both individual and population level by preventing and controlling epidemics and outbreaks.
- Healthy cultures and environments: this component addresses the factors in our physical, social and cultural environment which impact on our health and well-being directly or through affecting our behaviours. This includes issues of inequalities and social exclusion as well as the built and natural environment and social norms.

Delivery of these components will be founded on a strategic staff development programme which clearly articulates a consistent model for promoting health and facilitating behaviour change, including a range of levels and content tailored for different broad groups within the workforce. This will need to be underpinned by effective leadership and embedding of prevention in new and existing job roles and supervision.

Behaviour change support

This includes the following service components and developments

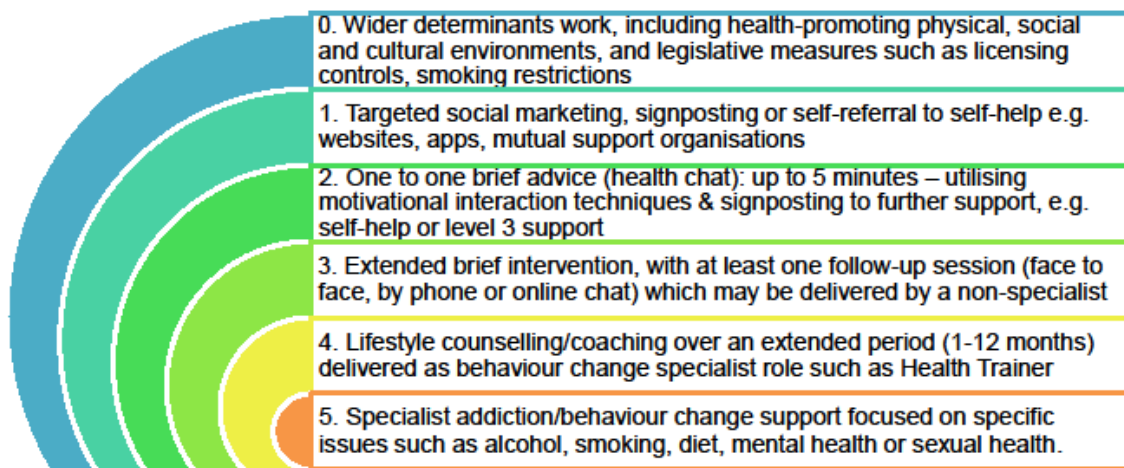
- Healthier living hub providing information, advice and referral, (face to face, by phone or online) on lifestyles and wellbeing issues
- Simple integrated electronic referral system to connect people to the healthier living and self-care hubs
- Healthy Living Pharmacies to provide enhanced support for prevention and self-care

- Renewed Healthy Stockport service, providing one to one and group support to help people address their lifestyle and behaviour issues. This will include new neighbourhood-based health trainer roles in all neighbourhoods, with provision weighted to more deprived areas
- Increased capacity for social prescribing, including Arts on Prescription, Walking for Health
- Promotion of cancer screening take up and early symptom checking
- Specialist support for people with entrenched behaviour issues including drug or alcohol dependency, low mental well-being, physical inactivity and eating disorders
- Increasing capacity of the Targeted Prevention Alliance of voluntary sector providers to enable prevention activity particularly for vulnerable people to be tailored to and delivered at a local level



**STOCKPORT
TOGETHER**

Levels of Behaviour Change Support



Early identification and prevention

Key to the P&E model is the identification of need and motivation of people to access preventive support and services and this will be delivered by means of:

- Prevention embedded in every pathway, facilitated by integrated IT, to facilitate the capture of opportunities for preventive advice and support. All health and social care services will be commissioned to include this as core business. This will require a holistic approach to the person which takes account of wider needs, circumstances and assets, to enable them to achieve better health.
- Find & Treat: Development and testing of risk modelling tools which utilise GP, health, and social care records to extend risk stratification approaches to proactively target those at risk such as people with no recorded blood pressure (BP) readings, those at risk of diabetes and those with mental health concerns
- Increasing the reach of the older people's health check questionnaire, which will help identify needs and opportunities for prevention

- Building the capacity and reach of the Know Your Numbers project, to deliver health checks, BP testing and brief advice in non-medical settings in the community.
- Targeted social marketing to engage identified segments of the population whose lifestyles are more likely to be risking their health, Promoting take up of appropriate screening programmes.
- We will also work in partnership with other public service providers such as housing providers, Benefits Agency, GMFRS and Police to engage people in health promotion and support.

Healthy Communities

Individual and community empowerment are interdependent and at community level engagement will support development of community assets, capacity and resilience across the borough, including volunteering. This will be integrated with the Proactive Care programme work including Targeted Prevention Alliance and Well-being and Independence Network, as well as the Investing In Stockport Locality Working model, and encompass:

- Settings based approaches, including workplaces, communities, hospitals, schools and public services, which have potential to combine individual, group and wider population approaches to health promotion and improvement, and in the process address issues such as social isolation and build capacity for promoting health.
- Community engagement activities may be targeted at population groups with increased risk of unhealthy behaviours or particular harms, to deliver changes in normative beliefs, attitudes and behaviours. This could include:
 - Activities and campaigns within workplaces: Stockport Together partners will seek to be exemplar employers, setting an example for others to follow in taking the health and well-being of all our employees seriously and reviewing and extending a range of activities that enable our staff to make positive health choices and take control of their own health.
 - Engaging target groups within communities to promote healthy lifestyles or participation in screening programmes by going to the places where they are, such as supermarkets, sports venues, religious institutions, community activities
 - Developing Champions for Health and peer supporters in communities and other settings
 - Campaigns, including: Know Your Numbers (hypertension)/ Stockport String/Diabetes/ Stop Before the Op etc.

Health Protection

- Immunisation and infection control work will be enhanced with additional capacity to undertake
 - Immunisations to prevent Flu, HPV, MMR etc. order to prevent outbreaks and epidemics
 - Infection control including work with residential and nursing care

Healthy Cultures and Environments

- This element will focus on creating healthier environments, including homes, workplaces, schools and communities so that people can live longer, healthier and more productive lives and ultimately reduce the reliance on health and social care services. The Stockport Health Promise is a vehicle for securing potential health promoting/protecting impacts of a range of council services. This work area will

- Identify system wide factors that are currently contributing to poor health outcomes in Stockport and use our local knowledge and (inter)national evidence base to achieve sustainable change.
- Ensure a public health contribution to policy decisions relating to employment, the local economy, infrastructure, education and housing to facilitate healthier ways of living and healthier social, economic and physical environments. Pay specific attention to addressing wider determinants in our deprived communities using the intelligence and experiences of local residents.

Workforce development

- Delivery of the prevention agenda depends on cultural change, including engagement of the Stockport Together agencies and other partners' workforces to develop the attitudes, skills and processes required to deliver an empowering, prevention-focussed approach to health and social care. This and will include:
 - Making Every Contact Count (Patient Activation): Train and empower the workforce to deliver positive and consistent health promoting messages, primary prevention interventions and motivational support proactively and holistically wrapped around the person's needs.
 - Building on Stockport Health Chat, Patient Activation model and Connect 5 and develop more advanced behaviour change techniques incorporating motivational interviewing and patient activation approaches that can be used in clinical and non-clinical settings, by appropriately trained staff, professionals or volunteers in health, social care and related fields such as housing or Police.
- This will be interdependent with the wider cultural change objectives of Stockport Together, as well as the workplace health initiatives, to create rewarding and engaging workplace cultures in which staff are empowered, skilled and motivated to actively capture opportunities for prevention and it is recognised as a core part of their role
- This will be supported with the identification of and support for a prevention and empowerment lead in every setting: neighbourhood/ practice/ team
- Taking a population approach means seeking to deliver wider social change which creates new norms of healthier ways of living. This involves addressing the wider determinants of health, such as:
 - Planning and environmental work to make active travel easier and more attractive
 - Housing conditions including heating and insulation and shared spaces
 - Promoting attitude and cultural changes including in our workplaces, in our relationships with food, alcohol and tobacco, attitudes to exercise, and looking after our own emotional health and well-being
 - Addressing the availability of goods and services that are health promoting (e.g. healthy food) and health harming (e.g. alcohol)

4.9 LOCAL AUTHORITY RESOURCES

Stockport MBC faces severe financial constraints.

It is important that health impact be taken into account in all of the steps that it takes to deal with this and I will make a recommendation to that effect.

I carried out a table top analysis of the health impact of the Council's Investing in Stockport proposals and submitted the following comments.

There will be a variety of impacts, some of them positive, some of them speculative, and some of them minor.

It isn't my wish to express any general unhappiness.

I appreciate of course that we are addressing a financial problem in which it would be foolish to pretend that there will be no adverse outcomes.

The following are issues which need attention to avoid problems

- Ensuring that digital by design does not increase inequalities
- Ensuring that the changes in leisure services do not adversely affect physical activity
- Ensuring that the health and social care system addresses the reduction in the Council's contribution as a problem affecting the whole of the system not just social care (or indeed community services)

I have no reason to doubt that those involved are fully alert to those issues.

Another big concern however is the impact of reductions in the public protection function on tobacco, alcohol and accidents. It is for example a matter of concern to see from the report on action to implement the Council's responses to the 21st Annual Public Health Report that work on illicit tobacco has been a casualty of resource constraints.

The following is the checklist that was used to produce the above analysis and that can be used to assess future proposals

1. Is the proposal an efficiency gain rather than a change in service provision?

2. Does the proposal impact directly negatively on one or more health behaviours?

- *Mental health*
- *Physical activity*
- *Alcohol / illegal substances*
- *Tobacco*
- *Nutrition / diet*
- *Violence / accidents*
- *Individual Resilience*

3. Does the proposal impact negatively on one or more determinants of health?

- *Green space*
- *Employment*

- *Housing*
- *Transport – especially active travel*
- *Environment*
- *Education*
- *Income*
- *Early years*
- *Leisure services*
- *Communities, wellbeing and resilience*
- *Public protection*
- *Crime*

4. Does the proposal impact on the provision of health and social care services?

5. What population groups will be affected by the proposal?

6. What is the geographical and population scale of the proposal?

7. Does this proposal DISADVANTAGE any groups in particular:

- *Digitally excluded*
- *Protected groups*
- *Inequalities*
- *Access to services*

8. Is it possible to change the proposal if necessary?

4.10 PUBLIC HEALTH AND PUBLIC POLICY

The manifesto of the Directors of Public Health for the North West Ten Points for Number Ten” is reproduced exactly in the words in which it was produced in July 2014 (except for references, which have been omitted here but will appear at level 5). However after each of the priorities I have added a personal comment.

Foreword (written by Abdul Razzaq, Chair, North West Directors of Public Health Group)

One of the key elements of the Director of Public Health role is to provide population advice on behalf of their populations, and to advocate for evidenced based interventions at both a local and national level.

Our aim is simple. Collectively we are working to improve the health and wellbeing of individuals, families, communities, towns and cities. We are striving to address health equity and ensure that everyone has a fair chance in achieving their maximum potential and contributing towards their own wellbeing and that of others around them. Social capital and asset-based approaches are being pioneered in the North West with local residents leading the movement for change and control over their lives. However substantial health inequalities still exist in the North West and so national policy is also really important in helping us drive improvements in health for our populations.

There has been significant work undertaken over the last ten years on improving public health, for example with the implementation of the smoking ban, a government commitment to implement standardised packaging for tobacco, increases in seasonal influenza immunisation, and improvements in MMR vaccination uptake. However, there is still more work to do, for example the implementation of standardised packaging, and with continued discussions around price and taxation policies for both tobacco and alcohol.

It is with this in mind, and with the 2015 General Election on the horizon, that the North West Directors of Public Health have developed this public health manifesto, to provide a coherent set of top ten priorities for Local Authorities, NHS, Public Health England, policy makers, advocacy organisations and Government departments to consider for immediate implementation. The development of this North West public health manifesto also allows us to formally input into the national Association of Directors of Public Health (ADPH) and Faculty of Public Health (FPH) manifesto discussions.

The top ten priorities are based on a robust evidence-based approach that if implemented in full will result in improving the physical and mental health and wellbeing of the population, and reducing health inequalities, further and faster than current trajectories. Investment and implementation in the ten priorities will not only save countless lives but build a better quality of life for a new generation.

I look forward to your support and further dialogue on how we transform the manifesto into a charter and mandate for change in the best interests of the Public’s Health.

Abdul Razzaq Chair, North West Directors of Public Health Group

Priority 1: Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health and social outcomes

Alcohol related harm is a major public health concern in the UK. In England alone, the cost to the NHS is estimated at £3.5 billion per year. Current statistics indicate that 16% of men and 9% of women in the UK drink on five days per week, and 9% of men and 5% of women drink every day.

National surveys show that 27% of men and 18% of women drink more than double the government's lower risk guidelines for alcohol on at least one day a week (8 and 6 units respectively).

The harms associated with alcohol consumption are well-established. In 2010, over 21,000 deaths were caused by alcohol consumption, 5% of all deaths in England but the harmful consequences of alcohol consumption impact on a range of health, mental wellbeing and social outcomes at both a personal and societal levels. Evidence suggests that implementing minimum unit pricing for alcohol is an effective policy tool for reducing population levels of alcohol consumption and related harm amongst heavier drinkers without penalising moderate drinkers. Modelling of the impact of a minimum price of 50p per unit suggests it would reduce consumption by 7% in England and by 6% in Scotland. In England it is predicted that over time this would reduce alcohol-related deaths (3,060) hospital admissions (97,700) and crimes (42,500).

My comment I support this entirely. Another possibility, theoretically preferable but probably impossible to organise, would be to issue people with a Smartcard allowing them to buy a healthy amount of alcohol tax free and then hugely increase the taxation on alcohol purchased beyond that.

Priority 2: Introduce a sugar sweetened beverage (SSB) duty at 20p per litre to help address poor dental health, obesity and related conditions

SSBs include any drink that has sugar added to it. SSBs make up 39% of all soft drink consumption in the UK, with overall consumption estimated at 92 litres per person per year. SSBs are the most frequently consumed beverage for those aged 4-18 years and intake is particularly high amongst adolescent. A range of poor health outcomes are strongly associated with intake of SSBs including being overweight and obesity, cardiovascular disease, type 2 diabetes, hypertension and dental caries. Childhood SSB consumption has been identified as a factor contributing to adult obesity.

There is evidence to suggest that a 20% price increase for SSBs would be acceptable to 52% of the population. Assuming that price rises are passed on to the consumer, it is predicted that a 20% tax on SSBs would lead to a reduction in purchases, and therefore in overall consumption and daily energy intake. In the UK it has been estimated that this would lead to reductions of 1.3% (180,000 people) in the prevalence of obesity and 0.9% (285,000 people) in the number of people overweight, with the greatest effects likely to be seen among young people. With additional anticipated benefits for dental health from reduced sugar consumption and no downsides for health from drinking less SSBs, a tax on SSBs has clear benefits as a policy tool for improving public health.

My comment I support this entirely. Concern has been expressed that such a tax would be regressive but this objection could be overcome if the proceeds were fed back into measures to improve low incomes.

Priority 3: 'commit to the eradication of childhood poverty to meet targets set by the Child Poverty Act 2010 and improve the health and wellbeing of all children

An estimated 3.5 million children in the UK, 27% of all children, live in poverty. An estimated 2.5 million live in damp housing, 1.5 million live in households that cannot afford to heat their home and over half a million are from families who cannot afford to feed them properly. Growing up in poverty impacts on life chances and is associated with delayed cognitive development, lower school achievement and unemployment, low income work and unskilled jobs in adulthood. Children in poverty are at increased risk of a range of poor health and social outcomes including adverse birth outcomes, obesity, diabetes, asthma, mental health problems and reduced access to healthcare. Children of persistently poor parents are at risk of becoming poor adults themselves and any children they have are at risk of growing up in poverty.

The Child Poverty Act (2010) includes two targets to be achieved in the UK by 2020:

- (i) less than 10% of children in relative poverty, and
- (ii) less than 5% of children in absolute poverty.

While the Government have introduced policies to improve outcomes for children in poverty, current evidence indicates that these targets will be not achieved and even with higher employment and benefit maximisation, projections suggest these targets could not be reached. It is clear that new ambitious actions across policy domains are needed to tackle child poverty to meet the targets of the 2010 Act and to improve health, wellbeing and social outcomes for children.

My comment. Since this was written the Government has recast these targets downwards. Child poverty has long-lasting impacts on the health of those affected. I am deeply concerned by these effects on future generations.

Priority 4: Work with employers to increase payment of the living wage and introduce a higher minimum wage to improve quality of life, happiness and productivity in work

The Living Wage is an hourly wage, calculated to provide an acceptable standard of living to employees and their families and it is currently optional for UK employers to pay a living wage. The Living Wage is set at £7.65 per hour outside of London in comparison to the National Minimum Wage of £6.31 per hour for workers aged over 21. It is estimated that over 5 million people in the UK, or one in five employees, earn less than the Living Wage. The proportion of UK workers in low-paid work is higher than the average for other OECD countries, behind only the USA.

Lower income leads to reduced ability to afford essential goods such as food, clothing and heating, reduced participation in social activities and increased debt. This can have a clear impact on the mental wellbeing and physical health of adults and children. Being paid the Living Wage has been associated with increased mental wellbeing and financial benefits in comparison to workers remaining on low pay. Employers also benefit from implementing the Living Wage through increased worker productivity and reduced staff turnover. Wider implementation of the Living Wage and raising the national minimum wage are therefore essential policy tools for improving the quality of life of the UK's lowest earners.

My comment:-

I would strongly congratulate the Government on increasing the National Minimum Wage.

The term "The Living Wage" in the above description was written before the term "the Living Wage" was appropriated to mean simply the National Minimum Wage. It is unhelpful when meaningful terms are redefined to have a different meaning, especially when there was already a term for the new meaning. The term The Real Living Wage is emerging to have the meaning that was used in this paragraph, although I would prefer it if a less value-laden term were available. I strongly support the idea that people should be paid the Real Living Wage.

Therefore whilst the Government is to be congratulated on the steps it has taken it needs to go further.

Priority 5: Ban the marketing on television of foods high in fat, sugar and salt (HFSS) before 9pm to reduce children's exposure to unhealthy food advertising and improve diet choices

The obesity crisis in the UK is well documented and likely to worsen in the future, with an estimated 50% obesity rate by 2050 at a cost of £50 billion a year. Currently around one third of 10-11 year olds are overweight with estimated obesity levels at 19%. Furthermore an estimated 9% of 4-5 year olds are thought to be obese Childhood obesity predicts obesity during adulthood and is associated with onset of diseases including diabetes, hypertension, heart disease and stroke.

Evidence supports the influential effect of food marketing on children's food preferences and consumption. Despite a UK ban on advertising HFSS foods in programmes made for children, a recent study showed that the level of exposure of children to television food advertising for HFSS foods has not reduce. One reason may be that children are likely to watch programmes that also attract an older audience where advertising of HFSS foods is still permitted.

Further measures are therefore required to reduce children's exposure to unhealthy food advertising. NICE guidance recommends that restrictions on the television advertising of HFSS foods be extended until 9pm, with evidence suggesting that such action could reduce exposure amongst children by 82%. A ban on advertising of HFSS foods on television before 9pm is therefore an essential policy priority in helping children make positive and healthy food preferences and choices.

My comment: - Proposals like this are sometimes described as “the nanny state” but protection of children raises quite different questions from those affecting adults and in any case a right to harm yourself does not give rise to a right, for purely commercial motives, to persuade other people to harm themselves.

Priority 6: Implement the recommendations contained within the “1001 critical days” cross party report to ensure all babies have the best possible start in life

The first few years of life are a critical period for a child’s development.

In 2013, over 5,500 children unborn or under the age of one in the UK were the subject of a child protection plan, and the NSPCC estimates that a quarter of all babies in the UK have a parent affected by domestic violence, mental health issues or drug and alcohol problems. Evidence indicates that half of all adults in England suffer at least one adverse childhood experience with 9% suffering four or more.

Between birth and two years of age, a baby’s brain grows from around 25% to 80% of its adult size. While there are many factors that influence brain development, one of the main drivers of this policy approach is the belief that infants that are neglected, abused or exposed to stress are less likely to develop connections in the brain that support healthy social, emotional and cognitive development. Exposure to adverse experiences in childhood is associated with a wide range of health-harming behaviours in later life and to poor physical and mental health outcomes.

Interventions that develop secure attachments between infants and their caregivers are viewed as the key tools in this policy area; evidence suggests they support maternal mental health, promote positive parenting and can generate long-term cost savings. Health visitors can reduce post-natal depression, while home visiting programmes (e.g. Nurse Family Partnership) for at risk mothers can improve health-related behaviours in pregnancy, reduce child maltreatment and childhood injuries, and reduce mental health problems, substance use and criminal behaviour in adolescence. Parenting programmes have shown positive impacts on both parent and child behaviours, particularly in reducing child conduct problems

My comment I entirely support these cross party proposals

Priority 7: Implement tougher regulation of payday loan companies to improve the health and wellbeing of people with debts

It is estimated that between 7.4 and 8.2 million payday loans were arranged in the UK in 2011/2012 at a value of £2-2.2billion. A payday loan is a short-term and unsecured loan repaid at a high interest rate in full on a fixed date. Such loans are seen as attractive due to very short approval periods from easily accessible lenders. The average cost of borrowing has been estimated at £25 per £100, but additional costs are accrued for transmission of funds and for late payments, which occur in approximately one in five loans.

Financial difficulty is a widespread issue for people who use payday lenders and being in debt is associated with the development of a range of mental health problems including anxiety, stress and depression.

In addition seekers of short-term loans are more likely to have a low income and be in poverty, which further compounds the negative health outcomes for these individuals and their families. For those borrowing money, high interest rates and additional costs are likely to increase debt and financial insecurity, which may create a cycle of further debt and use of money lenders.

The Government has recognised the problems caused by easily accessible and harmful payday loans and new regulations imposed by the Financial Conduct Authority are expected to reduce the number of payday lenders. It is important that the impact of new regulations is closely monitored and that tougher regulations are introduced in the future if required. While regulation of payday loans is an important policy tool, as options for payday loans are reduced it will be important to encourage responsible money lending across other sources of short term, high-cost credit, and to consider how other measures can improve access to credit and savings, and debt management advice, particularly for those on low incomes.

My comment: - As noted in the recommendation some progress has been made but needs to be monitored.

Priority 8: Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds

Current UK guidelines recommend that children participate in moderate activity for at least 60-minutes every day and vigorous activity on at least three days per week. Current data show that only 21% of boys and 16% of girls aged between 5 and 15 years in England reach the recommended level. Physical inactivity is a significant risk factor for obesity and several related chronic health diseases including type 2 diabetes, coronary heart disease, stroke and certain cancers. Being overweight in childhood is associated with a number of health problems, both during childhood and in later life.

Policy action is therefore required to reduce the future burden of ill health arising from physical inactivity. For each inactive child who reaches the recommended activity levels, savings are estimated at £40,000 over the lifetime through reduced healthcare costs⁴. For school-aged children, physical activity not only improves physical health, but has positive implications for behaviour, attitudes and academic achievement.

Children up to the age of 16 spend up to 45% of their waking time at school during term-time, and as a consequence schools provide the optimum opportunity for influencing and promoting health and health behaviours in children.

My comment It is especially important to note that physical activity improves educational attainment so eliminating it to “make more time for lessons” is wholly counterproductive.

Priority 9: Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing

Active travel incorporates physical activity into daily life. In 2012 only 39% of all urban trips under five miles made in England were by cycling or walking, with the average number of walking trips in the UK decreasing by 27% in 2012 from 1995/96. Cyclists and pedestrians in the UK can be deterred by lack of facilities and misperceptions of poor road safety, while a perception of expensive fares and inconvenience (in comparison to car use) reduces use of public transport. Transport methods are strongly linked with a wide range of public health outcomes.

In the UK an estimated 67% men and 57% women are overweight or obese and physical inactivity contributes to obesity and a number of chronic conditions.

Emissions from cars reduce air quality and contribute to noise pollution and climate change with 25% of the total

UK emissions of carbon dioxide estimated from road emissions.

Amongst young males, driving is associated with increased fatalities in comparison to methods of active transport.

Increasing levels of habitual physical activity by creating local environments where walking and cycling are safe and attractive, and facilitating use of public transport has therefore emerged as an important area of public health policy. Local policies can have a significant impact on the quality of the local environment as well as the health and wellbeing of residents. Nationally, a scenario of increased active travel, with subsequent reduced car use, produces estimated savings of £17 billion over 20 years through reduced spending on non-communicable diseases including type 2 diabetes, cardiovascular diseases, cancers, dementia and depression.

My comment I agree entirely.

Priority 10: Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption

Front of pack labelling is viewed as an effective means of providing consumers with information to help them make informed decisions about their diet. In the UK, food manufacturers and supermarkets can currently opt in to the 'traffic light' front of pack labelling system for pre-packed food. Back of pack standardised labelling will be compulsory for all pre-packaged foods throughout the European Union by 2016. A voluntary agreement on alcohol labelling currently exists in the UK with information provided on unit content, drinking in pregnancy, and the daily benchmarks.

Excessive consumption of pre-packaged foods and alcohol is contributing to the rising health burden from non-communicable diseases such as diabetes, cancer and cardiovascular disease. The use of different measurements across food labels and technical information can make information difficult to understand and inconsistent food labelling is associated with the consumption of too much sugar, fat and salt. Accurate tracking of alcohol intake requires knowledge of the alcohol content of different drink servings and evidence suggests that, on the whole, people who drink lack such an understanding³.

Through simplifying and standardising labelling on all pre-packaged food, consumers will be better placed to make comparisons between products and make decisions based on accurate nutritional knowledge. Standardised front of pack labelling is therefore viewed as an important policy tool to help improve dietary choices among the population. Evidence suggests text-based alcohol labelling has little impact on drinking behaviour and public health advocates have therefore called for clear and factual health warning labels on alcohol products, similar to the mandated warnings found on tobacco products

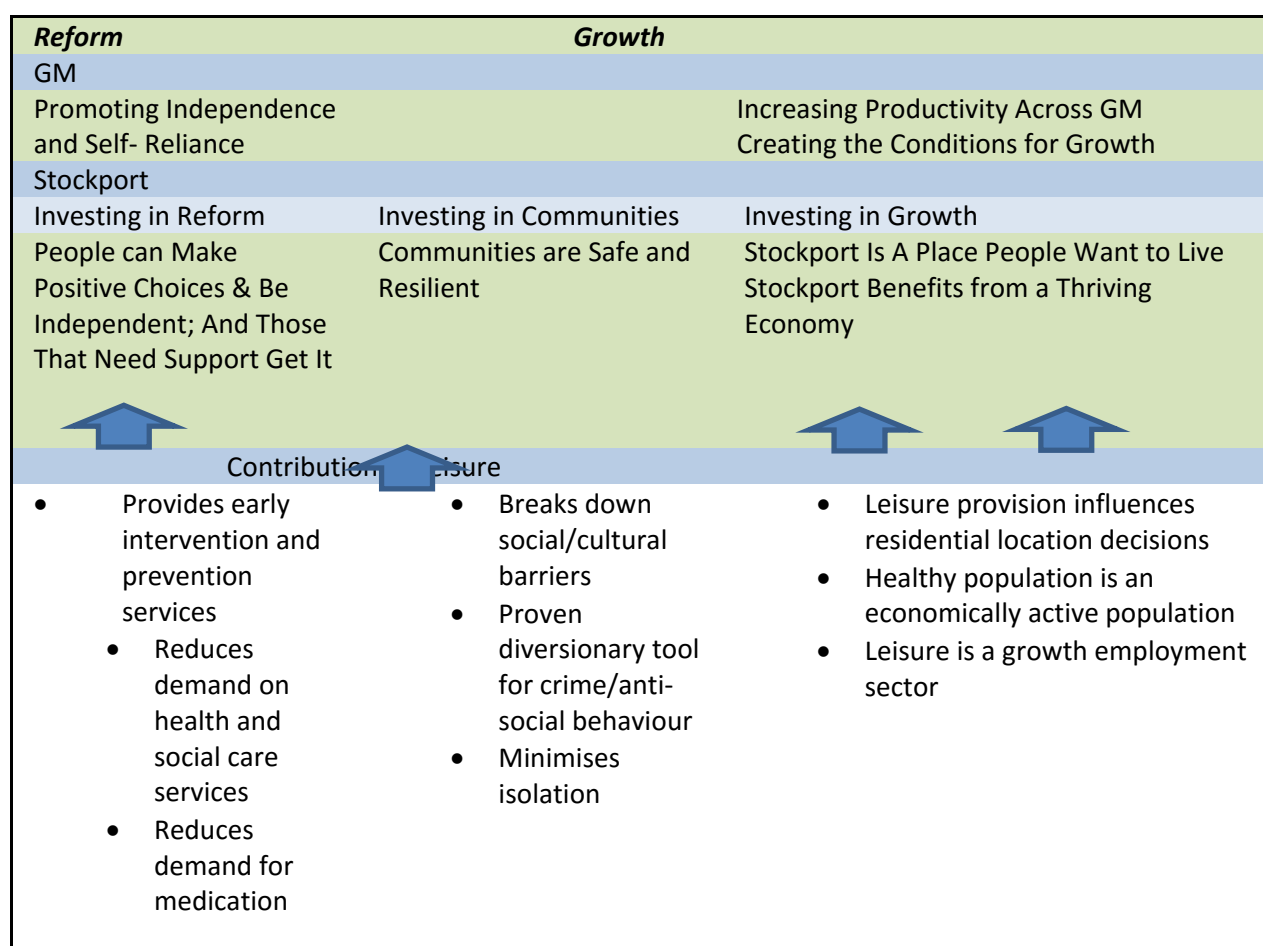
My comment It is very important that people have proper information and find it easy to identify the healthy choice.

4.11 PREVENTION – A STRATEGY FOR HEALTHY LEISURE

The Compact Oxford English Dictionary defines “leisure” as “engagement in, or time free for, enjoyment or relaxation”.

However, if a local government portfolio contains responsibility for leisure, it has, certainly in the past, almost always been regarded as a responsibility for a set of facilities consisting of gyms, swimming pools and indoor sports facilities.

It is important that we consider leisure more widely than that.



Leisure fulfils a number of useful health functions:

- It can be a source of social interaction. The strength of social networks is a major determinant of health, to such a degree that loneliness and isolation can be as strong a health hazard as poverty. Forms of leisure which bring people together and lead to social networks are therefore very valuable for health.
- It can be an opportunity for physical activity. Physical activity has physical health benefits (reduced risk of coronary heart disease, hypertension, type 2 diabetes, chronic kidney disease, some cancers, stroke, peripheral vascular disease, cardiovascular disease, osteoarthritis, osteoporosis), reduces obesity and increases fitness, has mental health benefits (such as reducing levels of depression, stress and anxiety) and makes people feel better by releasing endorphins which stimulate the same receptors as opiates. Inadequate levels of physical activity are the main reason for the current epidemics of obesity, diabetes

and depression and the major risk factor for heart disease and osteoporosis. Physical activity in older people reduces frailty. In England, physical inactivity causes around 37,000 preventable premature deaths amongst people aged 40-79 per year.

If a drug were invented which made people feel better, helped prevent heart disease, obesity, depression, diabetes and osteoporosis and also reduced the effects of ageing then any attempt to withhold that drug from the population would lead to mass protests and possibly to riots. Irrationally, however, physical activity is not quite so popular. Active leisure is an important part of a strategy of addressing the diseases of inadequate physical activity.

- Games can provide mental stimulation and enhance skills.
- Being in green natural settings itself benefits health and some forms of leisure involve the use of such settings.
- Relaxation is important in addressing stress.
- Cultural forms of leisure, such as reading, theatre and film can contribute to the spread of information.

A leisure strategy must aim to achieve all of these benefits.

Leisure as a Source of Physical Activity

The promotion of physical activity is an essential element of a public health strategy. It includes active travel (walking and cycling), physical activity during sport, play and leisure and encouragement to people to be more physically active during work and everyday life (for example using stairs instead of lifts, working at standing desks instead of sitting, taking a walk whilst having one to one work conversations instead of sitting down in an office).

The Stockport Physical Activity Strategy 2015-2018 aims to ‘Create opportunities in Stockport that encourage, inspire and support more people to be more active, more often within a sustainable environment, with the ambition for everybody to be active every day’.

Active travel and everyday physical activity are very important parts of a physical activity strategy as they can be built into everyday life very easily whilst active leisure requires time and effort.

For the purposes of this chapter we are concerned with physical activity in the course of sport, play and leisure but it is important to remember that these are only part of the overall physical activity strategy.

Physical activity takes place in competitive sport and in play, and these are part of the contribution leisure makes to physical activity but the term “active leisure” is usually used for activities that are pursued for enjoyment, more purposeful and planned than play, but less organised than competitive sport. The distinction is not a firm one - highly competitive sports can be pursued for pure enjoyment where the main motivation is taking part rather than to compete. From a health point of view play, competitive sport and active leisure all make a contribution – the health benefit derives from the amount of physical activity, the degree of social interaction and whether it takes place in green settings.

Many of these activities require the movement of large muscle groups and can include both aerobic and anaerobic exercise. Active leisure can count towards the Chief Medical Officer’s

recommended amount of daily physical activity, if performed with at least moderate intensity. Although active leisure performed at low intensity does not count towards the minimum physical activity recommendations, it plays a significant role in reducing sedentary time> Something is better than nothing and moving sedentary people into even low levels of physical activity can achieve significant health benefits. Active leisure is often a good way for inactive people to start to increase their physical activity levels as well as being an effective conduit to promote social interaction.

Swimming is a good form of recreational physical activity if pursued actively, for example by swimming lengths at reasonable speed but it is important to remember that it is the physical activity not the mere contact with water which constitutes active leisure.

Active leisure can be promoted not only by providing gyms and swimming pools but also by:

- ensuring opportunities for recreational exercise; for example through the provision of well-maintained recreational footpaths, playing fields and open space and the promotion of walking, swimming, cycling and running.
- 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 and areas for natural play 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.

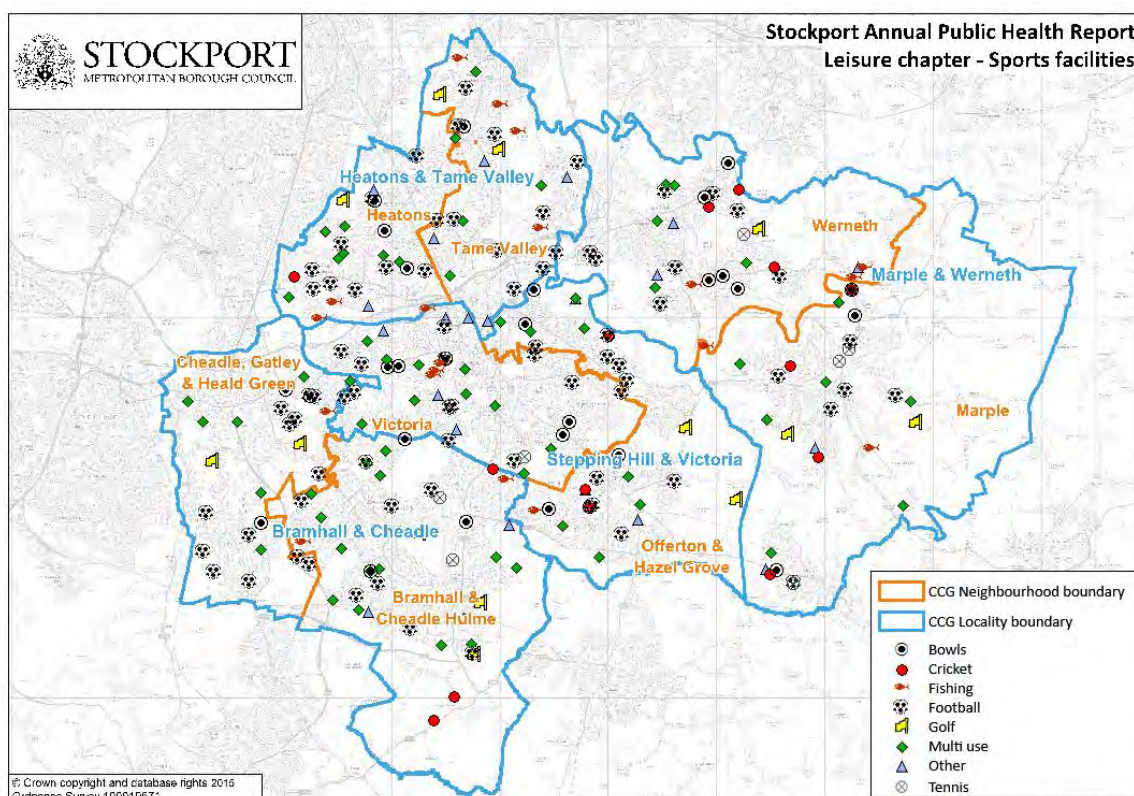
Sport

Across the Borough we are fortunate to have a high number of sustainable sports clubs offering access to sport and physical activity in a variety of activities. All of these clubs can only function due to the countless hours of support offered by volunteers in roles such as coaching, organising and fund raising. Sport Stockport is a voluntary organisation whose main purpose is to provide a voice for voluntary sector sports clubs in the Borough and through an online portal, have over 200 clubs and teams listed. Of these 200 clubs, Stockport has 81 who hold the Clubmark accreditation which demonstrates good practice and ensure a safe environment, particularly for children.

The map below shows some major sports facilities in Stockport. It is not necessarily complete.

The benefits of taking part in sport and physical activity will allow an adult to live a healthier life. Competing in organised activity at one of our many sports club provide the benefits of physical activity described above. In addition sports clubs provide structured activity improving an individual's social skills; participants will meet a variety of people which can lead to improved confidence in all areas of life. Taking part in organised sport, even as an official or a committee member will give participants the opportunity to develop new skills.

Of the six potential benefits that I listed at the start of this chapter for leisure sport therefore provides all of the first three (physical activity, social interaction and new skills). Through the development of physically active habits, increased fitness and enhanced social skills individuals are likely to show improved performance in other areas such as work.



A club's environment is important when they are looking to engage with new participants. In Stockport, many of the clubs have access to some great facilities; examples of these include Stockport Harriers at Woodbank Park, Reddish North End FC at the Mike Doyle Centre or any of the 22 local cricket clubs. In each example, the clubs have opportunities for all members of the community to access provision.

The following table from the 2016 Leisure Needs Analysis (discussed later) shows the most popular sports and other fitness sessions in Stockport

Top Sports in the Stockport Area	Number of person- occasions
Swimming	247,000
Gym Session	246,000
Athletics	204,000
Cycling	149,000
Fitness Class	142,000

Other Structured Events

Competitive sport is only one form of structured activity- others such as the 5 weekly park runs utilise the many green spaces we have across the Borough; over 1000 people per week take part in such activities.

As well as the park runs other structured events taking place in greenspace include

149 Fundays/Carnival/Festivals

8 Football Coaching events

19 General sports events – free at the point of use

15 Orienteering

27 Cross country / fun runs

3 BMX track days

Multicentre research in which Life Leisure in Stockport participated has shown that structured activity (including sport and structured events but also individual structured programmes) is the best form of physical activity for maintaining fitness in people who are already fit. However for people who are unfit less structured activity associated with counselling was more effective. Sport and structured events also provide social interaction.

Walking and Cycling

NICE recognises a number of benefits from walking and cycling as a means of increasing overall physical activity levels. The three main benefits identified in the NICE guidance Physical Activity: walking and cycling 2012 are:

- Reduced risk of coronary heart disease, stroke, cancer, obesity and type two diabetes.
- Keeping the musculoskeletal system healthy – helping older people to maintain independent lives
- Promoting mental wellbeing
-

Walking is as an important form of physical activity because most people can undertake this form of exercise even for older people with movement difficulties. Cycling is also accessible to a large percentage of the population with 85% of adults in the UK in 2011 saying they can ride a bike.

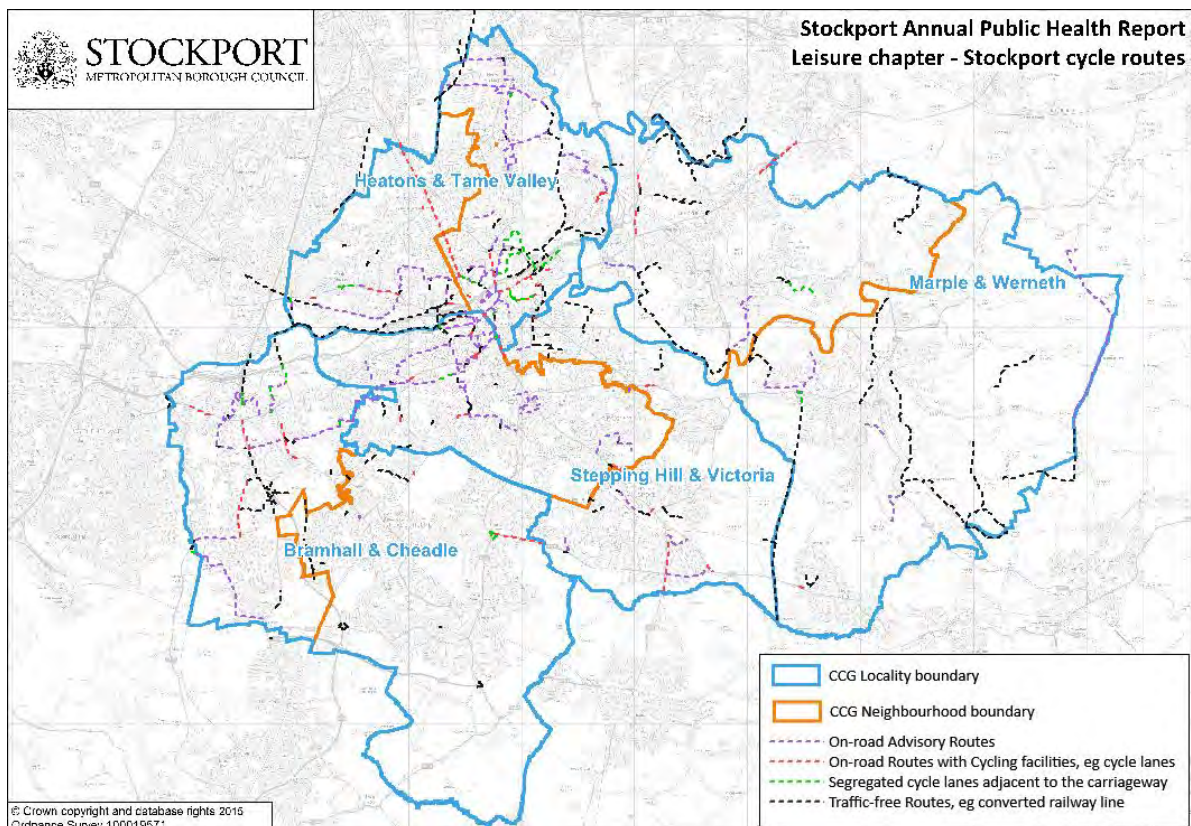
To encourage the participation of Stockport residents in walking and cycling both as forms of recreational activity and as transport modes, the Council seeks to improve both education and the physical assets we have in Stockport.

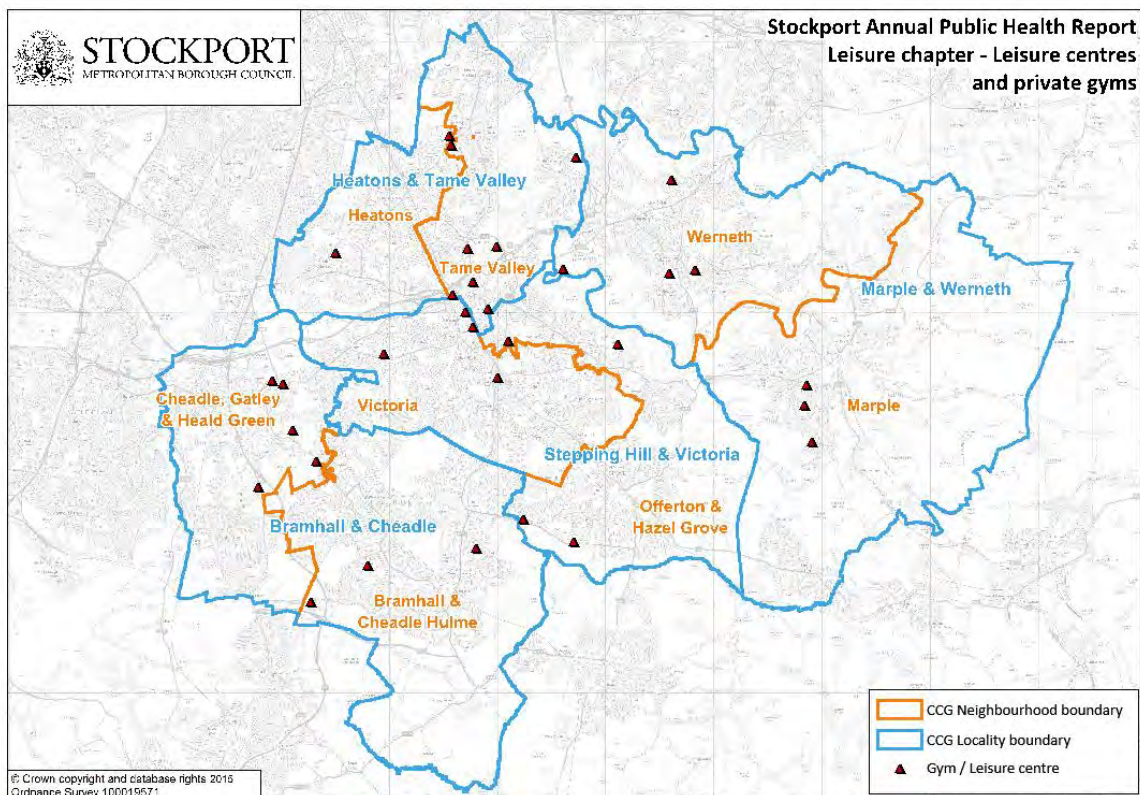
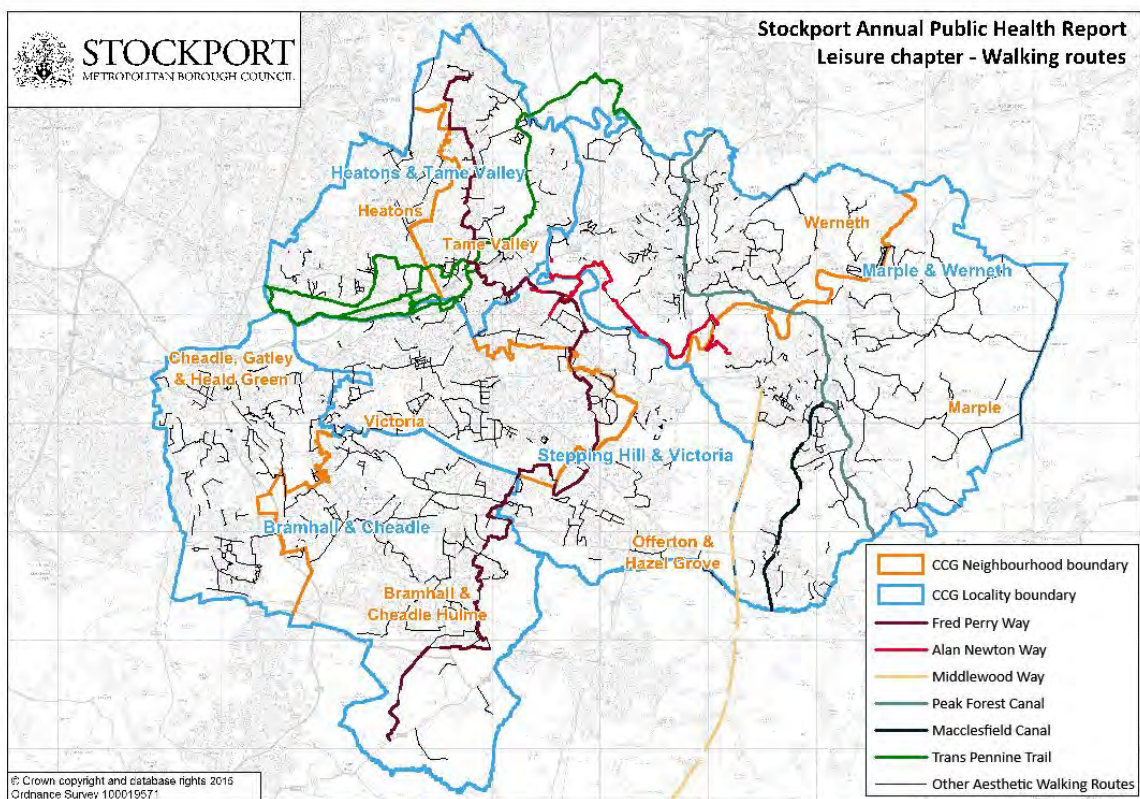
With regards to education, the opportunity to have a road safety officer attend and give training is offered to all primary schools. Approximately 2000 pupils are given cycle training annually and almost 500 pupils the majority being year 2 children are given walking based road safety training. This is a key part of instilling good habits for life. The Council also encourages businesses and residents to take advantage of the Greater Manchester provision of adult cycle training.

As to physical assets the Council:

- Implements as appropriate '20mph zone/ limit' schemes to improve the walking and cycling environment in the borough. The Town Centre Access Plan includes large areas of '20mph zone/ limit' in the centre of Stockport and the Edgeley area. I have long argued that such schemes should be more extensively, courageously and adventurously offered

- Home zones are a form of 20mph zone which also frees up street space for community use, thus contributing not only to the walking and cycling agenda but also to other aspects of the leisure agenda. I have long argued that the Council should be more active in developing home zones, insisting on them in new developments and allowing residents to develop them in streets where the residents would wish to see this form of streetscape.
- Implements the Rights of Way Improvement Plan and footpath/cycle route improvement programme with a range of maintenance and improvement programmes occurring annually to improve or expand the network which currently comprises of 110km of public footpath, 24km of bridleway and 2km of byway open to all traffic as well as the 984km of highway. The Town Centre Access Plan includes a range of walking and cycling improvements most significantly the proposed new bridge across the Goyt to increase access to the Town Centre from the East of the borough.
- Utilises its planning powers to ensure new developments consider walking and cycling as part of the planning application process and secure improvements via legal agreements.
- Bidding for funding to improve the network such as the CCAG funded the Manchester Road scheme in Cheadle which links with the Trans Pennine Trail and leads on to the Wilmslow Rd/Oxford Rd cycleway giving a protected route from Stockport Town Centre to Manchester City Centre, and CCAG2 is planned to create additional links from the south and west of the borough.
- The Council has also benefited from the provision of cycle hubs in the Town Centre and in Stations around the borough through TfGM funding and Northern Rail funding.





Leisure Centres

Traditionally Councils have tasked their leisure operators with increasing usage at leisure centres and making them more commercially viable in terms of reducing the levels of grant required.

It would fit better with the health concept of outcome-oriented commissioning and with the Council's role as an enabling authority if leisure operators were tasked to increase physical activity especially amongst those who currently do not meet physical activity levels.

Evidence is now emerging that physical activity in green settings provides more benefit to health than physical activity in indoor settings. It may well be therefore that the emphasis of our leisure offer should shift from indoor facilities to outdoor ones in the parks and river valleys.

The traditional gym, swimming pool and sports court offer is most useful for structured activity, either structured events or individual structured programmes. This is important for many people and I would not wish in any way to discourage it, but for those who are less fit the evidence suggests more effectiveness from a less structured approach coupled with counselling. Those who do not currently use gyms, swimming pools and sports facilities may well be those who most need to increase their physical activity levels.

The Indoor Leisure Needs Analysis

In September 2016, the Council commissioned the Comprehensive Indoor Needs Analysis to understand in traditional terms the future physical activity needs of the borough and assess current facility provision in this context. The scope of the study was pools, sports halls and fitness suites.

All existing provision has now been mapped and assessed against quality, quantity, accessibility and availability criteria. A series of consultations have also been held with key stakeholders within the authority as well as external partners and National Governing Bodies of Sport to gain qualitative feedback on the user experience. This insight has been complemented by the interrogation of relevant data sources such as Sports England's Active People Survey, Market Segmentation and National Facilities Database, as well as a review of the most recent Census data for the borough.

Initial findings suggest that the quantity of provision is broadly in balance with current demand but that age of the stock and current condition issues mean that quality is the emerging priority for investment. Addressing condition issues may also provide the opportunity to investigate the scope for re-provision in the context of improving health and wellbeing within localities. Further more detailed options will be forthcoming soon. There will also be an opportunity to model longer term options taking into account potential future population growth in the Borough and likely future changes to cross boundary provision.

In terms of publicly available sports halls Stockport has 3.6 badminton-court-sized areas per 10,000 population. This is the second lowest when compared with all the comparators. Tameside has the lowest at 3.3 such areas per 10,000 population and Cheshire East the highest at 4.3 such areas per 10,000 population.

In 2016 when looking at simply comparing the Stockport demand with the Stockport supply, the resident population is estimated to generate a demand for a minimum of 78 such areas (scaled to take account of the number of hours which are hours available for community use). This compares to a current available supply of 78 such areas available for community use in the weekly peak period. So, supply and demand are in balance for sports halls. 27% of the satisfied demand is by facilities outside the Borough.

In terms of publicly available swimming pools across Stockport there is 13.3 sq. metres of water per 1,000 population. Of the neighbouring authorities Cheshire East has the highest provision at 15.6 sq. metres of water and High Peak the lowest at 9.4 sq. metres of water per 1,000 population. The average for NW Region and England wide is 12.7 and 12.4 sq. metres of water per 1,000 population respectively. So Stockport is above the regional and national average.

In 2016 when looking at simply comparing the Stockport demand with the Stockport supply, the resident population is estimated to generate a demand for a minimum of 3,064 sq. metres of water space. This compares to a current available supply for all types of swimming activity of: learn to swim; public recreational swimming; lane and fitness swimming and swimming development through clubs of 3,126 sq. m of water space. This means there is a borough wide positive supply/demand balance of 62 sq. m of water. About 33% of the satisfied demand is by facilities outside the Borough. This includes Arcadia in Levenshulme which is the most local swimming facility for sizeable parts of the Heaton and Reddish. At first sight there is a shortfall of swimming facilities in the North of the borough but this gap disappears when account is taken of the contribution of Arcadia.

The following table shows Life Leisure membership numbers. In this table multi-site membership has been attributed to the centre where the main membership is held

Club	0-14	14-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Blank	Total
Avondale	73	131	332	395	357	233	89	31	2		1643
Cheadle	28	281	325	419	353	246	173	76	19		1920
Grand Central Pools	5	184	710	532	341	276	96	37	5	1	2187
Hazel Grove	10	433	523	609	658	628	361	135	18	4	3379
Houldsworth Vill	37	360	686	713	508	326	107	26	3	1	2767
Marple	1	50	86	101	121	116	90	28	4		597
Priestnall		51	45	48	48	30	15	1			238
Romiley	7	195	359	368	375	299	235	94	17	71	2020
Stockport Sports Vil	40	198	598	567	488	289	96	25	4	34	2339
Total	201	1883	3664	3752	3249	2443	1262	453	72	111	17090

In terms of availability of fitness stations there are some data issues which need to be addressed before a definitive conclusion can be drawn but it does appear that there may be a need for additional fitness stations.

Leisure data from the Stockport Adult Lifestyle Survey 2015

The Stockport Adult Lifestyle Survey 2015 asked two questions, aimed originally at assessing physical activity and social connectedness, which can be used to shed some light on leisure.

The first question "How do you get most of your physical activity" offered five options. 36.7% of the respondents chose "Leisure/sports (gym, swimming, walking, football, etc.)". The second question "Do you join in the activities of any of the following organizations, on a regular basis? Please tick as many as apply" offered the following selections:

Organization	Percentage participating
Sports club	18.9%
Education, arts or music group / evening class	10.8%
Religious group or church organisation	9.0%

Social club / working men's club	5.4%
Group for elderly people (Lunch clubs, etc)	4.1%
Parents' / School Association	3.9%
Women's Group	2.6%
Youth group (Scouts, Guides, Youth Clubs, etc)	2.3%
Political parties	1.9%
Tenants' / Residents' group or Neighbourhood Watch	1.9%
Trade Unions (including student unions)	1.6%
Environmental group	1.3%
Women's Institute / Townsman's Guild	0.8%
Other	5.3%

The question was designed to analyse social connections, but it can be assumed that participating in these organization is part of respondents' leisure activity. Overall, 45.0% of respondents indicated they regularly participated in at least one of these organizations.

Neither question showed a statistical difference by gender.

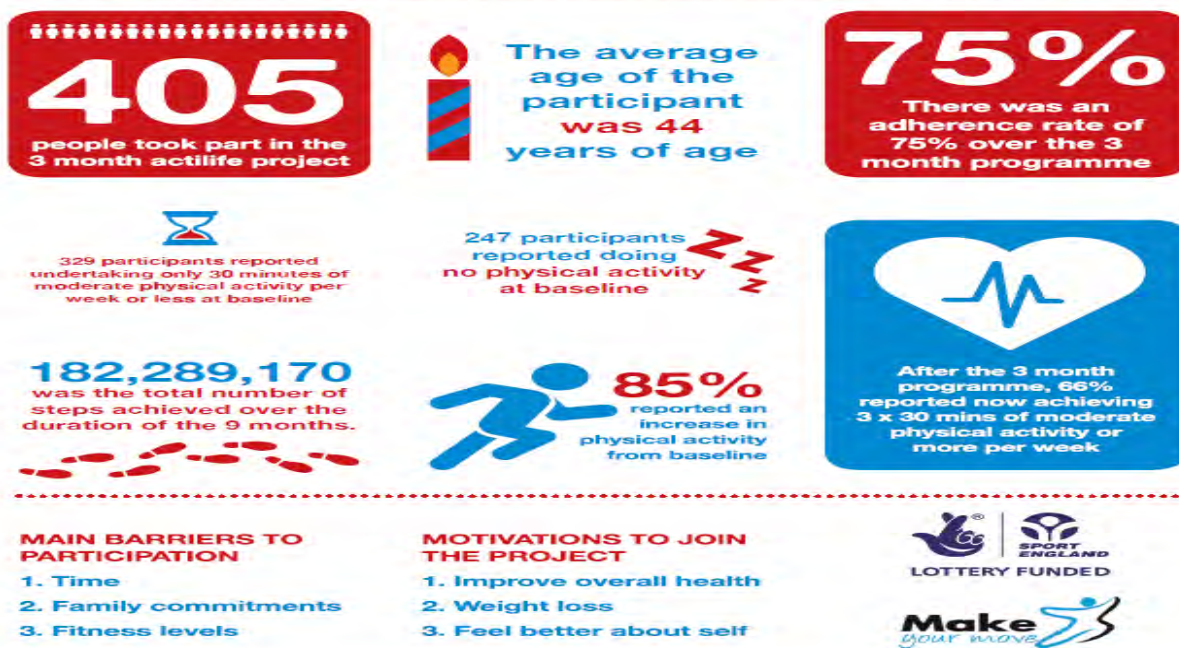
The two questions showed different age profiles. Younger people were more likely to choose leisure/sport as their main source of physical activity, particularly those aged 25 to 34; older people were more likely to participate in organisations, particularly those aged 70 to 80.

Age group	leisure/sport	participates
18-49	45.2%	44.1%
50-64	33.8%	41.3%
65+	22.4%	52.7%

Actilife

1.9 In responding to the research findings that structured activity might not always be the first step to encourage physical activity in less fit people, Life Leisure has developed an innovative online programme to combine lifestyle counselling with wearable technology and an interactive platform. This has represented a significant innovation which has attracted interest and been purchased by other boroughs.

The following graphic illustrates the success of one of these initiatives which addressed inactivity in the workplace over a 9 month period.



The Avondale Health Hub

1.10 The Health Hub at Avondale is an example of a new approach to organising a leisure centre in which it is seen not just as a facility to be made available, marketed and promoted, but as a centre for the promotion of physical activity which can serve as a base for organising events in the community and as a source of advice and promotion for other forms of physical activity such as active travel.

The Health Hub's initial aims focused on aligning the facility to work in parallel with Stockport's Healthy Weight Strategy; however, it was soon decided that its' remit should be much broader. It evolved to become a facility for the "non-gym goer" whether that is the result of a health condition, lack of motivation or pre-conceived ideas about entering a leisure facility. Its objective became getting more local people more active more often. Its purpose therefore is to provide a gym for people who don't go to the gym; an environment where inactive people are inspired to start their physical activity journey and a hub where groups grow organically through participation in sport, exercise and health improvement. Indeed it was the only non-clinical facility in the country to have gained accreditation as a national exercise rehabilitation centre in 2013.

Why has The Health Hub been such a success? Firstly, people who weren't in the facilities were asked about their fears, barriers and motivators which was then used to shape and create a facility which defies modern health and fitness business models; secondly, it focused on making their main consumers people who wouldn't normally access a gym.

By taking this approach, the facility had successfully reduced its £175k annual deficit within the first 12 months of operating, increased its membership base from 400 people to over 1500 and significantly contributes to improving the health and wellbeing of those with chronic health conditions or long term limiting illnesses through the programs developed.

This health and wellbeing initiative is made up of many components, all which complement each other to engage the most disadvantaged and under-represented populations in the borough.

The physical “nuts and bolts” of the facility are purposely intended to reduce fears of self-consciousness by providing a no mirror policy in the main gym; aesthetics is thrown out of the window in favor of practicality and a partition is available for those who want to exercise in a secluded area; programs have been designed to support those with limited mobility and the facility has become a “Hub” for a series of partner organisation such as Health Trainers, Physiotherapists and NHS weight management services.

This concept has demonstrated a successful balance between economic sustainability and positive health and wellbeing outcomes for the community it serves.

The Health Hub has been designed to cater for the traditional non-exerciser in order to compliment the strategic aims of improving health and social care within Stockport. It encourages and supports those who are inactive, have long term chronic health conditions or find that their disability can be a limiting factor in participation. There are many different strands to the Health Hub, all of which complement each other to ensure full synergy within the facility; one isn't more prominent than the next but it's the combination of all of them which has led to its success. No formal referral is necessary except for those who come through specialist services such as weight management or GP Exercise Referral. Access to the Health Hub is usually through word of mouth referral or localised marketing campaigns.

Firstly, The Health Hub delivers a menu of programmes, created through an experienced team of health and exercise professionals, to cater for diverse needs. Free of charge, chair based exercise classes were implemented to improve the mobility and preserve independent living whilst the lower back exercise rehabilitation programmes contribute to improving the management of chronic back pain and reducing the likelihood of long term absenteeism from work.

Weight management programmes delivered in partnership with Stockport NHS Foundation Trust and by Life Leisure encourage a stronger relationship between healthy eating and an active lifestyle by removing perceived barriers of a traditional leisure facility.

The Health Hub also welcomes those who want to be active but would rather not use a facility to achieve this. The innovative ‘actiLIFE’ programme has been created which combines cutting edge accelerometer technology, an interactive web based programme and an online personal coach to motivate those whose preferred method of physical activity is daily active living and walking. Users upload their data wirelessly via a mobile or by entering the Health Hub facility and it is then used to further support and motivate the participant by informing the online Coach.

The Health Hub even extends its’ barrier reducing strategy to the subject of cost. Its policy of free usage for Carers and those who are eligible for the local authority Leisure Key subsidy means no one has to feel that cost is a barrier to becoming more active.

The initial aims focused on aligning the facility to work in parallel with Stockport’s Healthy Weight Strategy however, it was soon decided that the Health Hub remit should be much broader. It evolved to become a facility for the “non-gym goer” whether that is the result of a health condition, lack of motivation or pre-conceived ideas about entering a leisure facility. Its objective became getting more local people more active more often.

Even though the aspirations and the vision for the facility were ambitious, the biggest challenge was convincing partners that this was going to be so much more than a refurbished leisure facility. However, through demonstrating results in terms of improved health outcomes and participation, word quickly spread and the facility now houses a number of different partners ranging from health trainers, to Physics to a Stroke information charity. The aspiration is to continue to broaden this further.

The improvements achieved include providing almost 1,000 free leisure access accounts for those receiving benefits, but still balancing business with social returns.

By December 2012, 11 months after the investment, the Health Hub had grown its membership base from 400 to 1200. It has cleared the annual £170k deficit and currently produces a surplus

which, despite providing almost 1,000 free leisure access accounts for those receiving benefits, demonstrates its ability to balance business with social returns.

This surplus has been re-invested for the benefit of the individual and the partners who use the Health Hub too. Part of this reinvestment includes the purchase of a £45k 'Alter G' anti-gravity treadmill which is normally only available in exclusive private health hospitals, rehabilitation units or to elite athletes and certainly not to those living in an area of deprivation. For patients on the pathway for Bariatric surgery or referred to the GP Exercise Referral Scheme, they receive free access for up to 6 months and for those who aren't, the price is reduced by 75% to that of the other providers. Through this subsidy, those with neurological conditions, morbid obesity or limiting joint pain are able to exercise without pain and enjoy the health and social benefits that being active brings.

By creating a sustainable business model and raising the bar for leisure innovation, The Health Hub has gained publicity at a national level both in the industry press and the Daily Telegraph. In July 2013, this once failing facility was not only a finalist at the prestigious UKactive FLAME Awards but by December 2013, was crowned Best National Exercise Rehabilitation Centre of the Year at the National Fitness Awards.

To the customer, this value is seen in many different ways both financial and overall wellbeing. 15% of all Health Hub members live within the top 20% most deprived wards of Stockport. 47% of all members live within the top 40% most deprived wards. Other key outcomes achieved include:

- 55 out of 66 people who accessed the back rehab course recorded improvements in perception of back pain management (measured via clinically valid Roland Morris and Fear Avoidance questionnaires) and improvements in their ability to undertake employment.
- Median weight loss of participants on Weight Management programmes was 7lbs and a waist circumference reduction of 2 inches (110 people).
- Currently over 1000 users who access the Health Hub, are accessing via Leisure Key.
- actiLIFE – over 1000 participants have accessed the actiLIFE programme since 2013 with an average increase in physical activity by 20%.
- In a recently funded Sport England project focusing on those with a BMI>30, 15% of participants lost over 5% or more of their bodyweight during the 6 month engagements.
- The development of community / social networking clubs to provide ongoing peer support – Heart Club for those who have had a myocardial infarction, Stroke Information Charity, BME specific classes. Support is also available from the facility management to apply for funding so they can establish new services to meet their needs.
- Chair based exercise programmes regularly supports 20 or more people per week who would be regarded as frail or have a long term limiting condition.
- The concept of the Health Hub supports the Council's move towards integrating services more closely, particularly those of Health and Social Care.
- Participation to the facility has increased from 400 to 1,650 members and generating a surplus of over £20k per year to be reinvested into the service.
- Used by a wide range of services including neurological physiotherapy unit (STAR team), NHS weight management service, Health Trainers, Occupational Therapists and Care Support Workers.

The success seen by the Health Hub has reinforced Life Leisure's ambition to expand this concept further and replicate this model locally and nationally. By using this model as a blueprint for future leisure facility design, it provides Local Authorities with assurance and with the resource required to achieve joint health and wellbeing outcomes, whilst also replicating the same business success as demonstrated by Life Leisure. This could be achieved through a franchise model or commissioning to other NHS Trusts or Local Authorities.

The scheme was fully evaluated by RSM, a social impact research consultancy, and the following estimates of the financial value of the social benefit were derived

Key

- Avondale = The Health Hub
- PARiS = local authority commissioned GP Exercise referral Service

Impacts resulting from promoting improved health outcomes

Service	Activity model	Impact
PARiS	Avoided societal cost of COPD	£ 214,912
PARiS	Decrease in future heart attacks	£ 874,698
PARiS	Avoided societal cost of future strokes	£ 630,000
PARiS	Benefits of maintaining carer relationships	£ 81,070
PARiS	Benefits of improved back pain management	£ 13,126
PARiS	Benefits of avoiding residential care	£ 1,208,712
PARiS	Benefits of improved mental wellbeing	£ 1,260,444
Avondale	Benefits in a reduction of mental health problems in BME users	£ 73,853
Avondale	Decrease in future heart attacks	£ 74,641
Avondale	Benefits of improved productivity	£ 1,195,080
Avondale	Reduction in the risk of diabetes amongst BME users	£ 14,546
Weightlifting	Benefits of improving mental wellbeing for able-bodied and disabled users	£ 109,444
Weightlifting	Benefits of reduced injuries due to professional weightlifting training	£ 89,549
Total financially evaluated impacts		£ 5,840,076

Impacts resulting from promoting improved fitness outcomes

Service	Activity model	Impact
PARiS	Long term reduction in injurious falls	£ 1,932,185
PARiS	Avoided societal costs of inactivity in adults	£ 153,272
PARiS	Benefits of improved productivity	£ 750,509
Swimming	Avoided societal costs of inactivity in adults	£ 821,934
Swimming	Avoided societal costs of inactivity in young people	£ 2,135,845
Swimming	Benefits of employment	£ 120,273
Swimming	Benefits of improved productivity	£ 1,436,974
Community Sport	Benefits of increasing physical activity in children	£ 18,586
Community Sport	Avoided societal costs of inactivity in adults	£ 119,293
Avondale	Avoided societal costs of inactivity in adults	£ 245,867
Avondale	Economic benefit of a reduction in mental health problems	£ 454,860
Weightlifting	Benefits of employment	£ 14,255
Weightlifting	Benefits of improved productivity	£ 70,167
Weightlifting	Avoided societal costs of inactivity in adults	£ 2,227
Total financially evaluated impacts		£ 8,276,247

Non-financially evaluated impacts

Service	Activity model	Impact
Swimming	Improved educational attainment at GCSE (expected grades improved)	707
Community Sport	Number of additional clubs supported in the local area	47
Weightlifting	Improved educational attainment at GCSE (expected grades improved)	3

It is important that these benefits are borne in mind as we come to a point where investment will be needed in much of the leisure estate and it is important that it is properly focused on our future needs.

As has been recognised elsewhere in the country there is great value if the leisure estate and health estate are considered together and reformulated as healthy living centres.

The importance of physical activity and sport is acknowledged in the Greater Manchester health and social care devolution programme through the Greater Manchester Moving workstream.

Greenspace and its Contribution

Greenspace contributes to health by:

- Encouraging people to take physical activity – there is evidence that people will walk further through greenspace than along less attractive routes. It is plausible, although not evidenced, that other forms of aesthetic attraction, such as attractive architecture or street art, have a similar impact.
- Providing a higher quality of physical activity – research has shown that physical activity taken in greenspace has more health benefits than similar levels of physical activity indoors or in urban streetscapes
- Contributing inherently to the reduction of stress and the promotion of wellbeing. For this reason I have long recommended that people should have sight of greenery for as much of their waking time as possible and that to the end we should aim to ensure the presence of greenery in as much of Stockport's streetscape, workplace space and public space as possible.

Formal Local Authority Greenspace

The greenspaces managed by the local authority are major contributors to health. Our parks are enjoyed by a large proportion of our residents and visitors.

The parenting website Mumsnet has voted three of Stockport's parks among the best places to visit in Cheshire. This is encouraging because it is considered particularly important to encourage physical activity among children and young people.

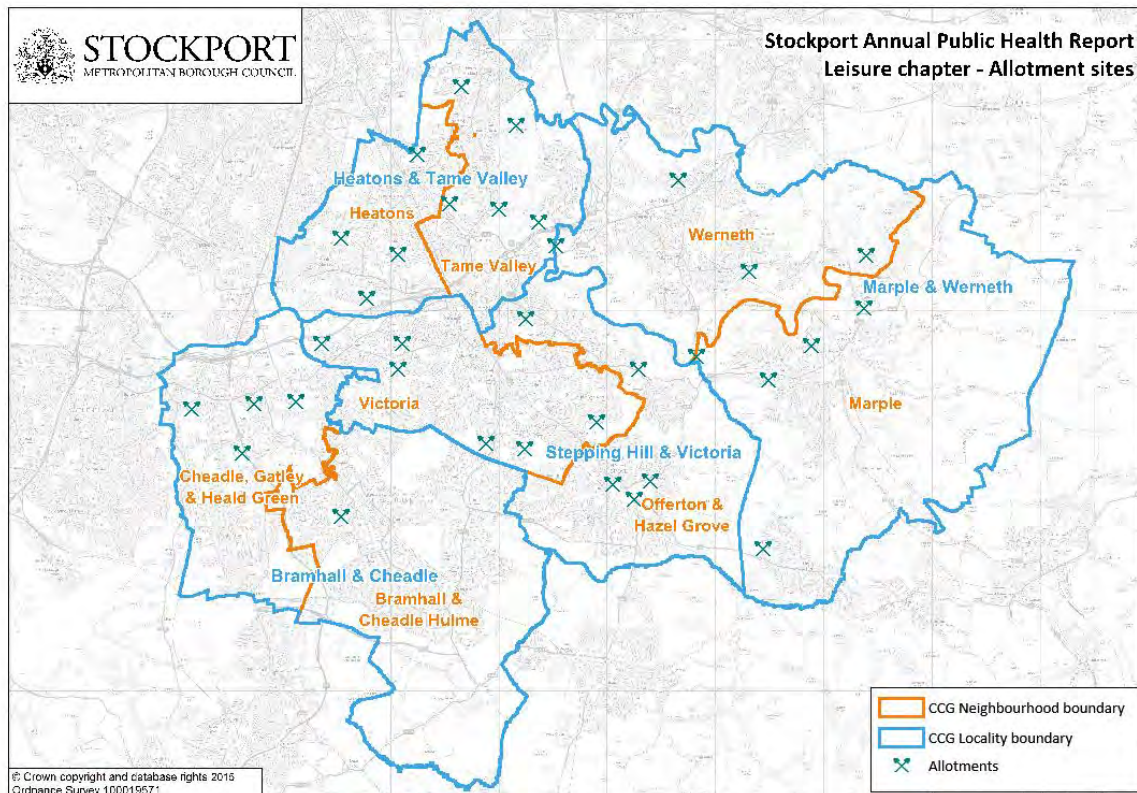
Stockport has some 1200 hectares of publically owned greenspace encompassing:

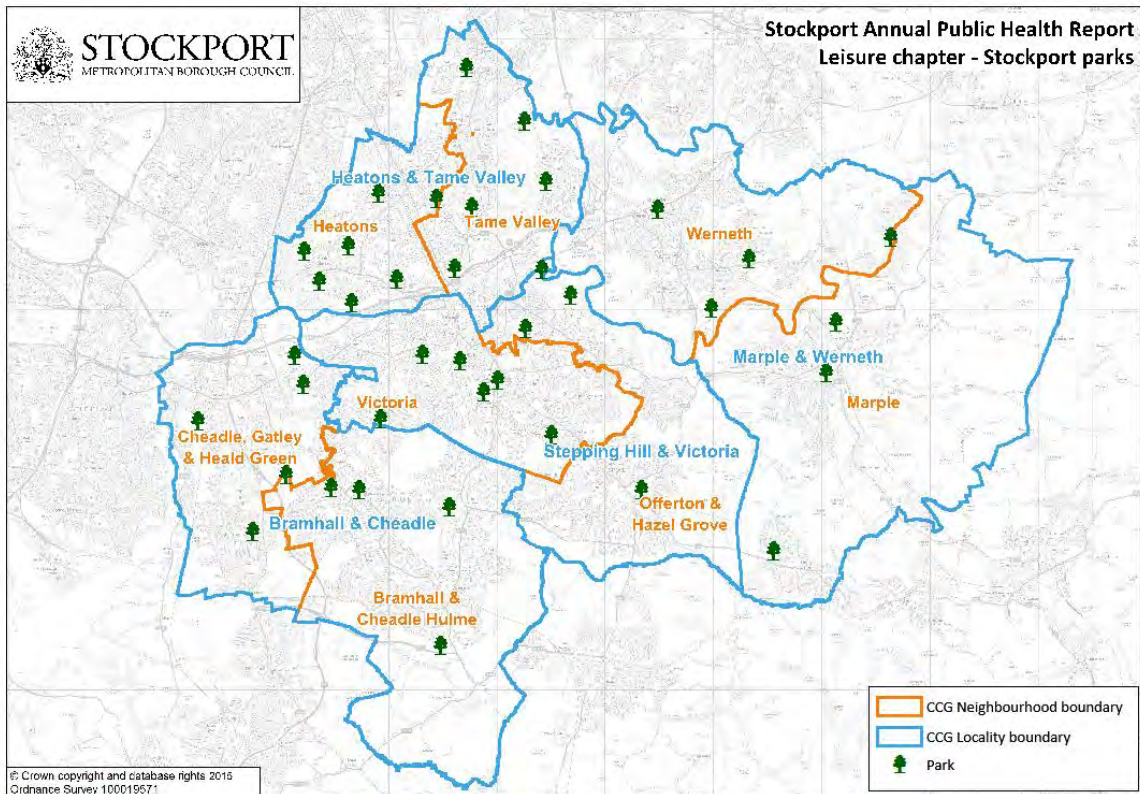
urban and country parks, woodlands, 1726 allotment plots, local nature reserves, 135 play areas, 93 outdoor sports pitches with 191 formal football teams, 18 tennis courts and 23 bowling greens with 998 permit holding crown green bowlers, , cricket, lacrosse and boules teams and 5 approved Park Runs.

In addition there are 136 children's play areas, 7 skate parks, a high quality BMX track, 30 multi-use courts, all of which are free at the point of use and together providing a good and varied leisure offer to young people.

There is also a quality athletics facility with a resident running group that has members from the very youngest to the long since retired. This is important given rising levels of obesity among both adult and child populations in the UK and indicates that parks are being utilised as free and accessible areas in which to engage in exercise.

Parks are also frequently used to access natural environments and this reduces stress and mental fatigue. Stockport has 40+ countryside style sites including some 340 hectares of woodland, 14 Local Nature Reserves and several meadows including a Coronation Meadow, one of only 60 in the country.

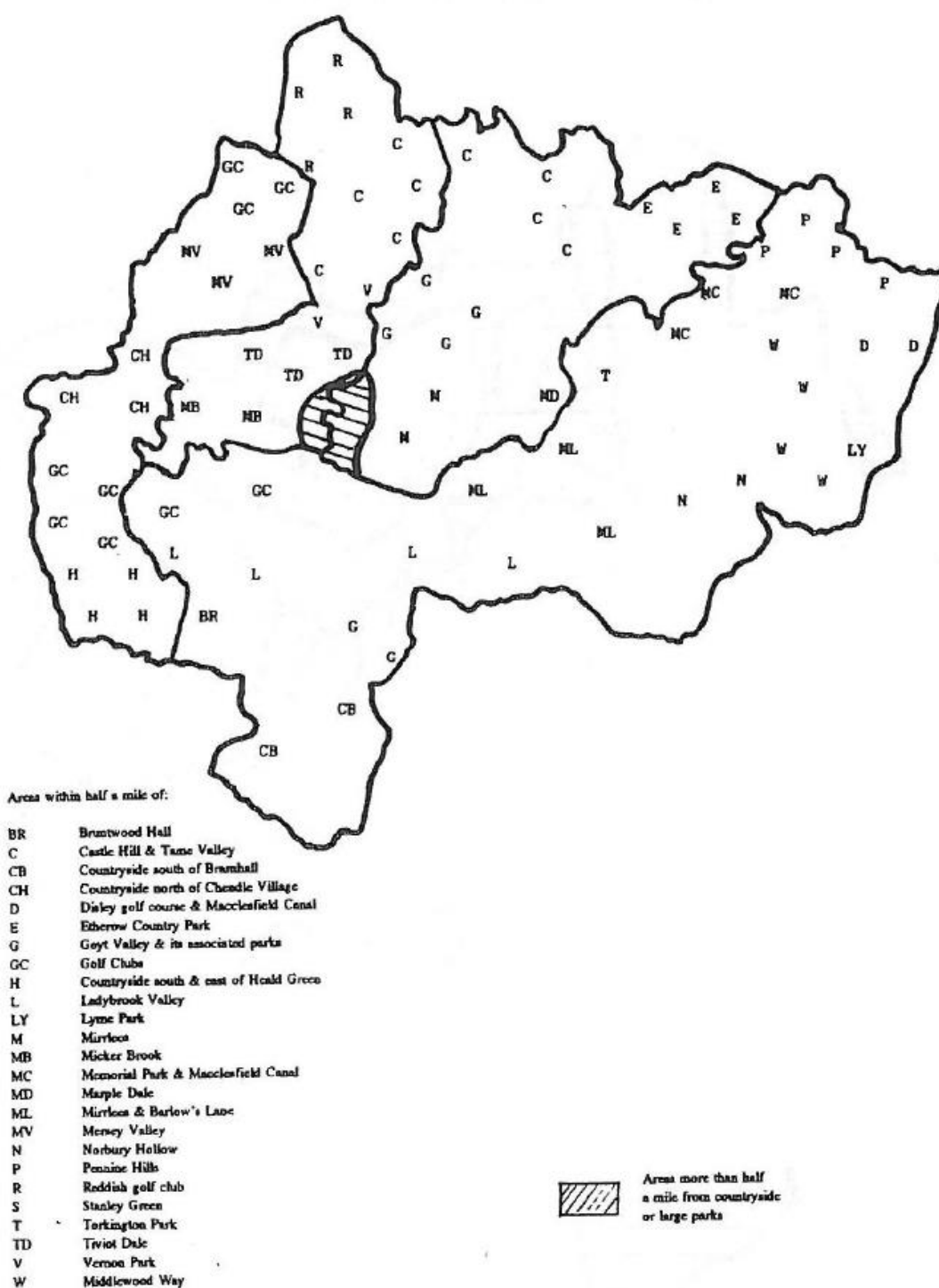




The country parks in Stockport are among the most visited sites in the borough and attract people from across Greater Manchester. This suggests a high level of mental health and social benefits are being derived from park use. Attendees at events held on Stockport's greenspace sites number in excess of 100,000 per annum. The events range from carnivals to duck races with activities that appeal to all age ranges.

Most of Stockport is within a short walking distance of an opportunity to take a long walk in greenspace. This is extremely important given the evidence that physical activity in greenspace provides greater health benefits than other forms of physical activity and the following map shows the facilities which maintain that opportunity.

SOURCES OF COUNTRY WALK OPPORTUNITIES IN STOCKPORT



Events and Groups

I have mentioned events organised in parks earlier in the structured activity section of the section on physical activity and have suggested that they may well be an area of the leisure offer that needs to be expanded as we move towards the Health Hub Model.

Groups associated with recovery from particular conditions such as stroke victims and those prescribed exercise by their general practitioners make use of parks and greenspace and there are volunteers who meet in our parks on a regular basis for social reasons.

In each of these examples the greenspace enhances the benefits of the physical activity and social interaction that is taking place.

Volunteers

Friends Groups are actively engaged in maintaining their local greenspace. With some 60 friends of the park groups and an over-arching umbrella group, the Stockport Greenspace Forum, our relationship with and commitment to them has proved to be equally beneficial. The Council also has productive relationships with third sector and commercial operators. These include organisations that provide opportunities with adults with specific learning requirements, support groups such as recovering alcoholics, co-operative food producers and bee keepers.

There is usually at least one volunteer Task Day occurring each week throughout the year.

Other Green Infrastructure

- 1.15 A variety of different forms of green infrastructure including open plan private gardens, highway verges, street trees, green walls, and small patches of informal greenery contribute to two of the three health benefits of greenspace – the benefits that derive from the sight of greenspace and the creation of aesthetically attractive routes to promote walking and invest walking with the benefits of exercise in green settings. In “Country City” I have recommended that there should be steps taken to ensure that people have sight of greenery for a greater proportion of their waking time and that to facilitate that greenery should be widely introduced into streetscape, public realm and workplaces.

Inactive Leisure

- 1.16 Although ‘inactive’ leisure such as reading, watching television, going to the cinema, playing bingo and playing board games do not contribute to physical activity they can have other health benefits as set out at the start of this chapter including relaxation, social interaction, mental stimulation and acquisition of new skills.

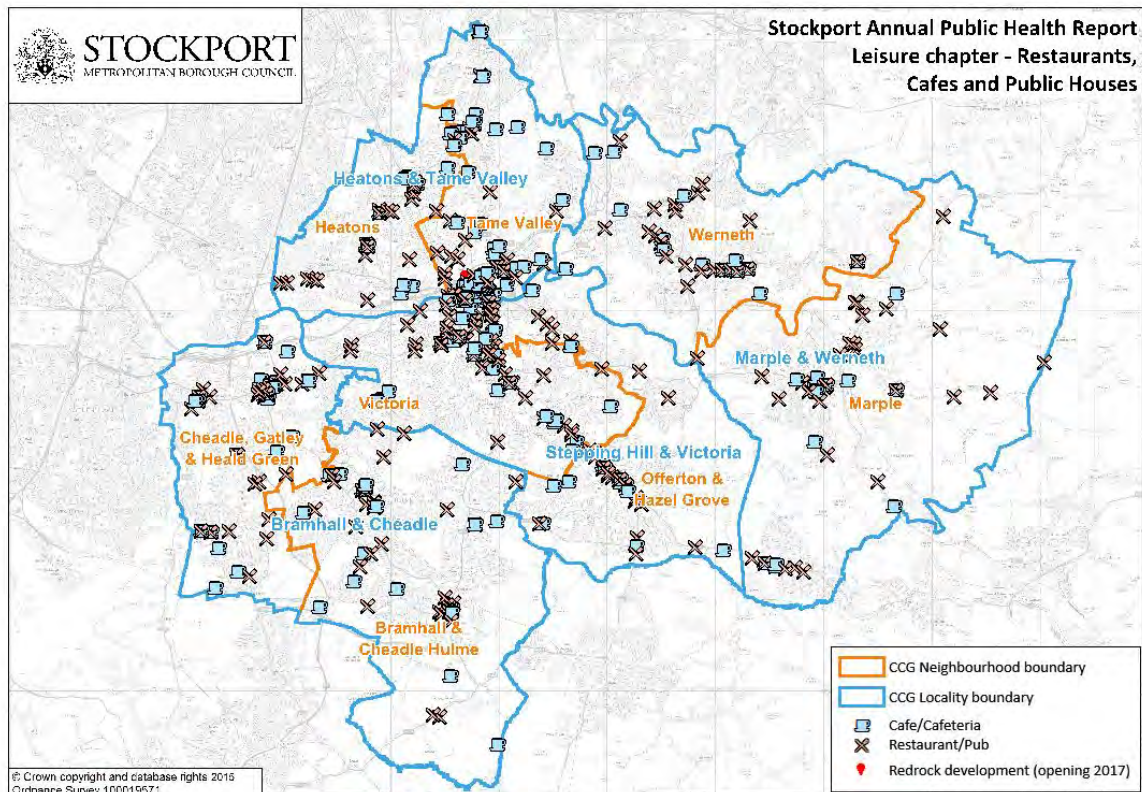
Inactive leisure as a group can play a significant role in reducing social isolation—for example for older people.

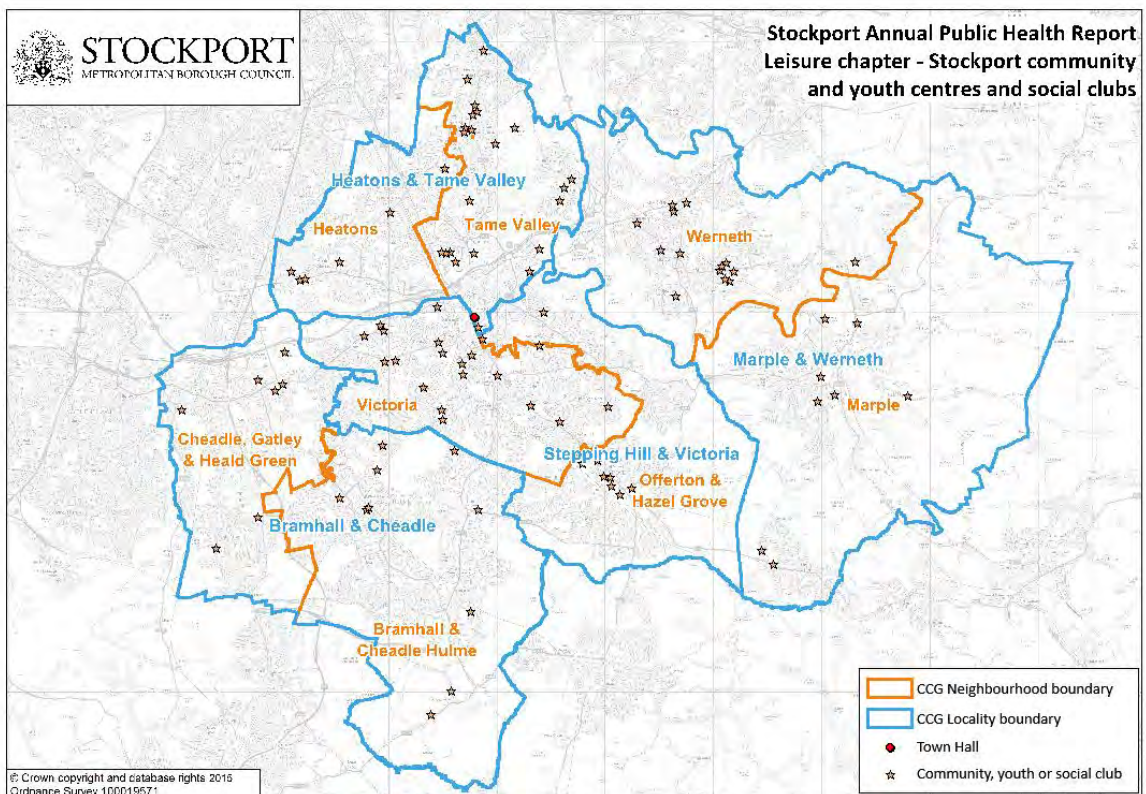
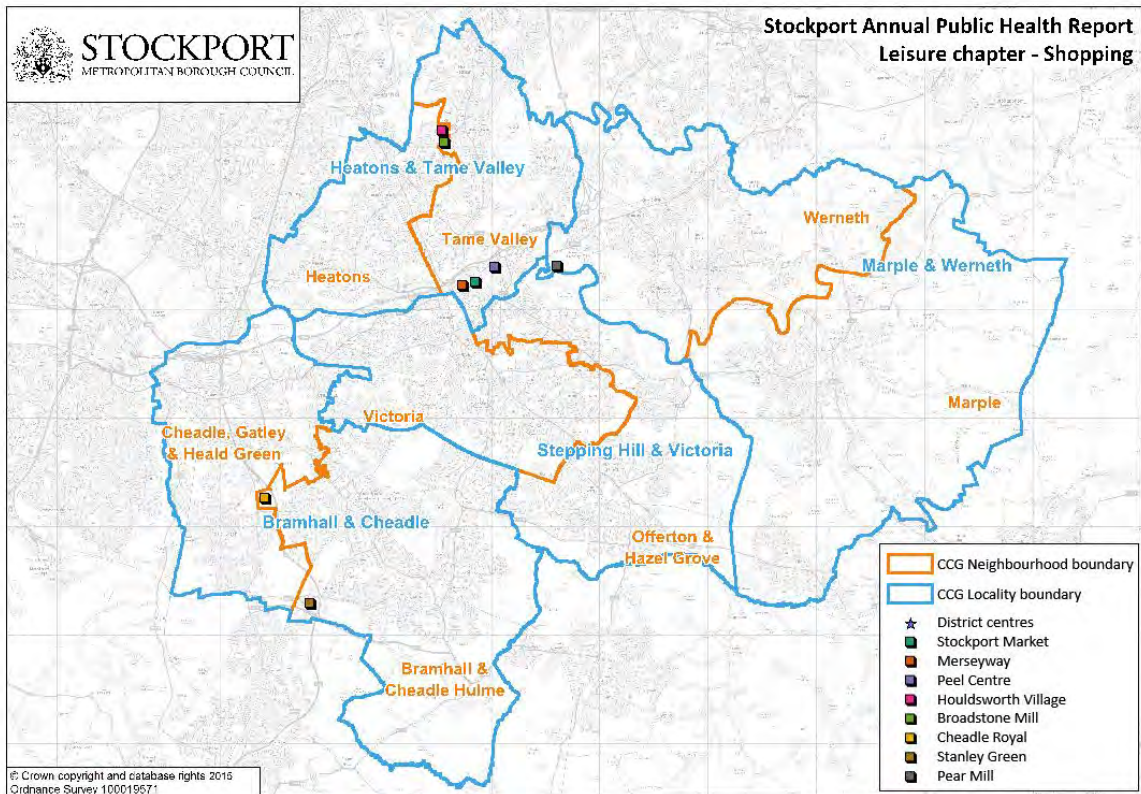
Games can enhance skills, such as the pattern awareness of Chess or Go, the negotiating skills acquired by playing Diplomacy, or the 3D spatial awareness acquired from games like Jenga or Lego. Some computer simulation games allow people to acquire complex design skills, entrepreneurial skills and political skills.

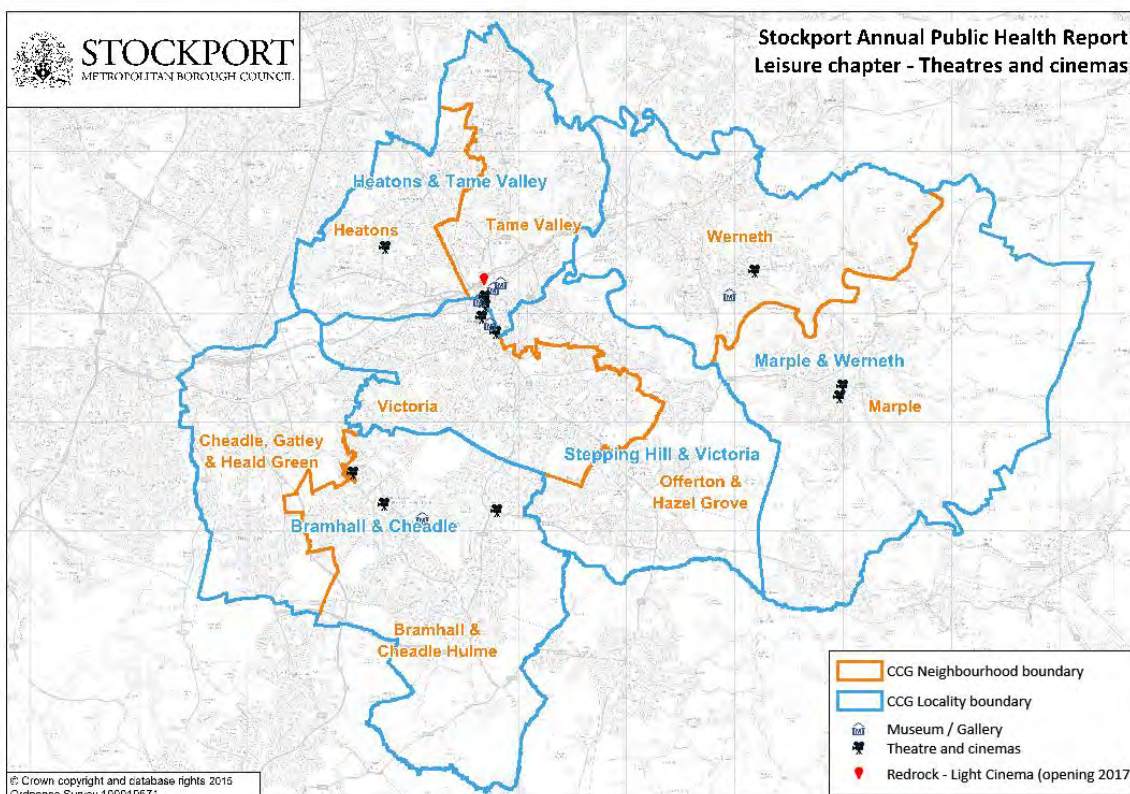
Much of the research around sedentary or inactive pursuits has focussed on ‘screen time’, most notably watching television, using a computer or playing video games (excluding ‘active’ gaming) and emerging evidence for both adults and children suggests that isolated sedentary behaviour has a negative effect on depression and mental wellbeing.

However not all screen time is pursued in isolation. Social media help maintain social networks and video games can be played collectively.

It is possible to engage in 'inactive' leisure whilst still reducing sedentary time. Simple examples of this include gently stretching while watching television, standing up during the commercial breaks or standing up and moving around whilst making a phone call. The more determined could watch television whilst walking on a treadmill. Shopping is an important leisure activity for many people and has great health significance in terms of its impact on lifestyle.



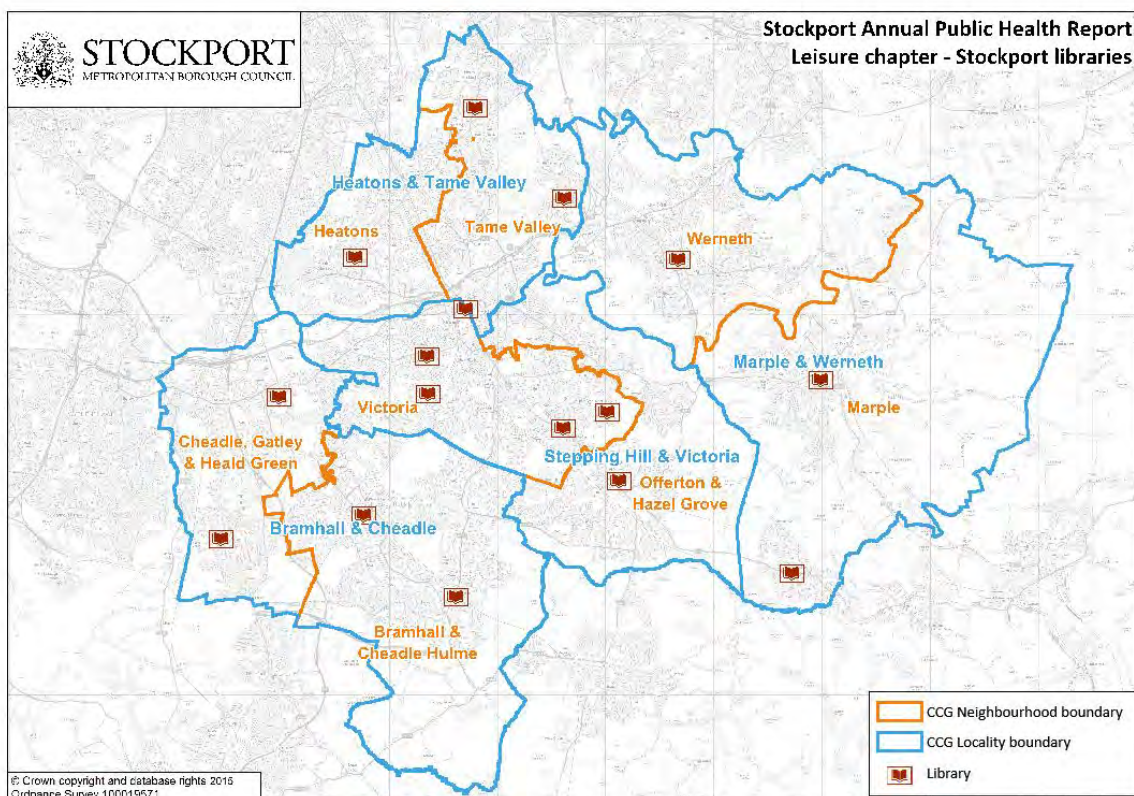




Libraries

Stockport library service offers an extensive range of services which have direct benefit on citizen's health and well-being, specifically on their mental health. There are Self-Health collections in all libraries which were developed in partnership with health professionals and are promoted widely in health settings including by GPs. The collections are part of the national Reading Well: Books on Prescription scheme endorsed by health professionals and aimed at supporting an individual's health needs. Books can be recommended by GPs or other health professionals from the relevant reading list or citizens can self-refer to the scheme and use it without a professional recommendation. The books have been recommended by experts, and have been tried and tested and found to be useful.

Self-Health collections have materials which cover all areas of self-help including diet, fitness and common mental health conditions such as anxiety, depression and phobias. There are a number of book lists aimed at specific conditions such as mood boosting, dementia, young people's mental health and next year a dealing with long term conditions list is due to be launched. There is evidence from the National Institute of Clinical Excellence (NICE) that self-help reading can help people with common mental health conditions, such as anxiety and depression.



Recent research shows that people see their library as a safe, trusted and non-stigmatised place to go for help with, and information about, health problems. There is also evidence that reading for pleasure has a positive effect on people's health and wellbeing².

- Reading is a proven stress buster, reducing stress by as much as 67%³
- Reading helps prevent the onset of dementia by 35%⁴
- Social activities available in libraries help combat feelings of isolation and loneliness.
- Library staff are trained to help customers find medical information that is reliable and relevant - a much safer way of seeking health information than simply searching the internet.
- 12.8% of adults in Stockport have never been online and research has shown that older people, people with low incomes and people with poor health are less likely to be online. Libraries are well placed to support communities to gain digital skills for health, supporting people to get online and take more control over their own health.
- Mental health and wellbeing self-help groups use libraries as safe neutral meeting venues.
- Therapeutic reminiscence boxes for dementia with outreach sessions delivered in community settings and training sessions delivered with local groups and health and care workers.
- Libraries are recruiting points for Dementia Friends scheme.
- Provision of computer-based packages and online resources for managing depression (e.g. Beating the Blues, Living Life to the Full, MoodGym).
- Bibliotherapy Ready Group at Marple Library, which promotes the health benefits of reading and discussing books in a social group.

²The Reading Agency Literature Review: The impact of reading for pleasure and empowerment
June 2015

³Mindlab Research commissioned by Galaxy, 2009 reported in www.telegraph.co.uk/health/healthnews/5070874/Reading-can-help-reduce-stress, March 2009

⁴ Leisure Activities and the Risk of Dementia in the Elderly, New England Journal of Medicine 2003, 348:2508-2516

- Health Trainers meeting with clients in libraries as they are seen as neutral and welcoming places

Services are delivered via a network of 16 libraries in partnership with Life leisure, Public Health, the NHS and community and voluntary organisations. The service has Team Librarians who deliver outreach activities in a variety of community settings including but not limited to local libraries.

Museums and Cultural Activity

Stockport's museum provision consists of the following assets:

Air Raid Shelters
Bramall Hall
Chadkirk Chapel
Hatworks
Stockport Museum/Staircase House
War Memorial Art Gallery

These facilities provide accessible and engaging opportunities for local residents to improve their wellbeing through learning and social interaction.

The Council is seeking to maximise participation in museums and broader cultural activity by developing a framework which acts to improve the quality of cultural provision and celebrates Stockport's unique heritage. It is anticipated that this framework will provide the stimulus for events and other participation opportunities which give local people an accessible means to improve their wellbeing.

Community Groups

...health grows and spreads, not by treatment of sickness, not by prevention of disease, not primarily through any form of correction, whether of physical or social ills, but through cultivation of the social soil.' (Pearse & Crocker 1943)

People experiencing poorer health and wellbeing, or social isolation and loneliness tend to be older or more deprived. People who are struggling to manage due to low income and other disadvantage often have fewer other resources to draw upon, including social support networks, education and work contacts or experience. Some of this translates into more demand health and social care services.

The 2016 NICE guidance *Community engagement: improving health and wellbeing and reducing health inequalities*, notes the significant increase in recent years in published evidence on community engagement, providing good evidence that community engagement improves not only improves health and behaviours, but "...also improve people's social support, wellbeing, knowledge and self-belief."

We want to make it easier for people to look after themselves and each other and build resilience within their families and communities; that is the ability to adapt and cope with negative life experiences such as loss and difficult or traumatic experiences. We aim to help people to recognise and make use of their own strengths and the potential sources of support in their community, and to strengthen the networks and promote the kind of give and take that binds communities together.

This vision for people in Stockport can be described as” *People in Stockport will be able to fulfil their purpose and will we will have connected, kinder, engaged, healthier communities*”.

There are a large number of community led groups and activities in Stockport operating independently or with a relatively small amount of support from public or private sector. In order to support local people and communities to become even further engaged Stockport is developing a family of approaches as advocated by Public Health England focused on “...mobilising assets within communities, promoting equity and increasing people’s control over their health and lives.”, This includes, initiatives to support strong communities, volunteer and peer roles, collaborations and partnerships and increased access to community resources. In 2015-6 some notable developments are in progress including work to create an online database which maps communities assets in Stockport to enable this information to be widely available for all to use. In addition a community "hubs" network has been established to share practice and offer support to any community groups and organisations that identify themselves as offering something to their own community. Within the council there has also been further investment in community facing roles to enable communities to maximise their potential, to do more for their neighbourhoods and to build and strengthen community networks.

^[1] NICE, 2016 *Community engagement: improving health and wellbeing and reducing health inequalities*. www.nice.org.uk/guidance/ng44

Town Centre Regeneration Projects

Stockport Council is currently engaged in ambitious plans for the development of the Town Centre *‘To realise Stockport’s potential as the pre-eminent town centre in south Greater Manchester – the location of choice for business, living, leisure and retail.’*

The Council has a proactive strategy for achieving this vision involving selective interventions; leading on development where market failure is evident and ensuring Stockport’s key assets such as the shopping centre, the market and the train station etc. work to optimal effect.

This strategy has implications for a number of aspects of the issues dealt with in this chapter, including green infrastructure, walking and cycling and leisure facilities.

The redevelopment of Grand Central Leisure complex to provide a new commercial office quarter, Stockport Exchange improves walking routes from the Town Centre to the station and on to Edgeley, provides new public realm, and improves the setting in which the Grand Central leisure facility is situated.

The Redrock development will provide a new cinema and leisure complex on the site of the former Great Egerton St car park.

The acquisition of the Merseyway Shopping Centre in April 2016 is part of a process of improving the shopping offer. The same is true of improvements in the historic Marketplace and Underbanks is an important part of the town, rich in local heritage. In September 2014 a £7 million Council-led investment programme was launched for the Marketplace and Underbanks. By attracting new businesses, events and visitors into the area the Council is working to bring currently unoccupied buildings back into use, drawing visitors back into the area. Realising this vision requires collaborative working between the Council, businesses, landlords, agents, local stakeholders and potential investors. The work is already beginning to deliver results, with businesses once again choosing to invest in this area and bring life back to previously unoccupied buildings.

The Stockport Town Centre Access Plan is an ambitious vision and development plan seeking to improve access to and around Stockport town centre. The plan considers access by all methods of travel and specifically aims to ease congestion for buses and general road traffic and encourage walking and cycling. Phase One of the plan is underway with the whole plan scheduled for completion in 2020.

In partnership with TfGM, the Council are developing a new transport interchange on the site of the current bus station. The new interchange will provide a modern, attractive concourse and offer greater access for all passengers. It will also have better facilities, modern waiting areas, improved security and easier access to travel information and tickets. This will help promote healthier travel strategies. The site of the bus station has important opportunities for improving green infrastructure and some of the development ideas under consideration in the process include exciting opportunities. For example, a green roof to the building, starting level with the A6 on the road viaduct, could provide a large town centre green space. There are also opportunities to open up access to the riverside.

Stockport is the place where the Trans Pennine Trail crosses the urban envelope of Greater Manchester. It is an incredible indication of our success in preserving river valleys that it does this in less than a mile. We should be proud of this and show it off, but I am not sure that we are as aware as we should be of this fact, its significance or the important message it conveys about our town.

Inequalities Relating to Leisure

This section will consider some of barriers to participating in leisure activities. Some of these barriers might be characterised as relating to age, gender, religion, socio-economic and ability. It will also cover some of the initiatives set up to overcome these barriers.

The Stockport JSNA 2015 arranges vulnerable groups in the borough in the following categories; 6,500 people in Stockport are suffering from mental health problems, 11,600 have some sort of physical or sensory impairment, there are 100 asylum seeker households, 2,700 people are looking for work, 5,000 people have a learning disability, 2,500 people have been diagnosed with Autism and there were 500 homeless applications. These categories are by no means mutually exclusive and residents listed here can appear in more than one category.

Age related inequalities

‘Older Women and Participation in Leisure’ Carmichael et al (2006) reports that leisure pursuits decline in frequency and the type of leisure pursuits alter from active to passive as we age. Although there is a positive correlation between retirement and physical activity, barriers to exercise are social isolation and health deterioration. The participation of older women in exercise and recreational physical activity is less than their male counterparts. According to Stockport’s Adult Lifestyle Survey 2015, just under 50% of under 35 year olds participate in sport and leisure activities compared to people in their 70’s which are less than 27%. This decreases to just 12% in the 85 plus category.

Age group	leisure/sport	participates
18-49	45.2%	44.1%
50-64	33.8%	41.3%
65+	22.4%	52.7%

Stockport’s social enterprise Life Leisure currently deliver 6 ‘chair-based’ classes per week called ‘Extend’ which engage approximately 100 older adults each week. They are currently developing a new low impact physical activity concept called ‘Smile’ which aims to engage with older adults and those with mental health conditions and adults with physical or learning disabilities.

Life Leisure have delivered 4 Postural Stability courses in the last 12 months at Stockport Homes sheltered accommodation, to those at risk of a fall. 74% completed the 6 month course and within this group 72% achieved an improvement their functional scores.

Gender related inequalities

Deem concludes in Women, Leisure and inequality (2006) that constraints on women's leisure time are predominantly due to domestic labour, childcare, working hours of male partners, lack of independent income and absence of transport. She found that women participating in the least amount of leisure activity were married, had children under 16 years old, had no transport and left school at the minimum age. In an article in The Economist entitled 'It's a man's world' (2009) statistics showed British men enjoy 35 minutes more leisure time a day than women do.

Life Leisure run a remote coaching program which has proved successful for those who are not able to visit a gym regularly. Participants can do physical activity whenever and wherever it fits into their lifestyle and monitor this via an online platform.

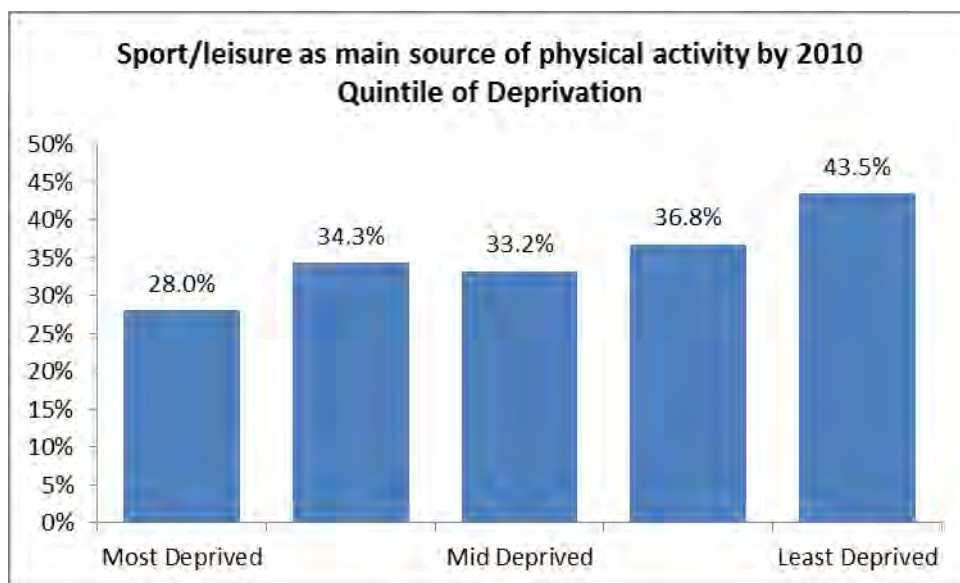
Religion related inequalities

With the changing role of women and the types of leisure activities available, leisure time is on the increase. Ibrahim, in the report 'Leisure and Islam' (2006) writes that in more traditionally religious households women's leisure time would be restricted around the needs of the children. Religions such as Islam have never frowned on leisure activities but the more traditional forms of the religion would often demand the strict segregation of the sexes. Those who categorised themselves as no religion or preferred not to say in the Stockport Adult Lifestyle Survey were more likely to participate in leisure or physical activity with percentages in the 40s compared to those who identified themselves as Muslim which were just 26%. However most British Muslims have a more relaxed approach to their religion than descriptions based on traditional stereotypes would assume.

Life Leisure run women only swim sessions each week at most of their leisure centres throughout the borough.

Socio-economic related inequalities

According to Roberts et al in the Public Health England paper 'Social and Economic in Diet and Physical Activity' (2013) people from lower socio-economic groups tend to have poorer access to environments that support physical activity such as parks, gardens or safe areas for play; are less likely to visit green space, and are more likely to live close to busy roads. These groups are more likely to live in areas that do not support walking and cycling. Fear of traffic can be a strong disincentive to allowing children to play outside and to walking and cycling. In Stockport's Adult Lifestyle Survey 2015, results demonstrated that 28% of people participated in leisure and physical activity from the least affluent areas of Stockport compared with 44% from the more affluent.



The Leisure Key is Stockport Council's discount card for residents who are eligible through circumstances such as age, income or disability. The Leisure Key provides reduced charges for leisure and cultural activities; such as sports, swimming and theatre tickets.

Life Leisure has combined with Stockport Homes to deliver holiday activities and community sessions throughout all of Stockport's priority areas. Police and Crime Commissioner funding has provided opportunities for young people and the summer of 2016 saw 1,143 participants attending sessions. Stockport's Doorstep Sports Clubs have engaged with over 330 young people in the 13 years old plus category.

Life Leisure's 'I wish I'd tried' scheme provides varied, accessible and low cost sports activities for over 25 year olds across Stockport and targeting priority areas. There have been 1023 new participants register for the scheme this year, with 9,649 visits to sessions since the summer of 2016.

Ability related inequalities

Bult (2011) in the review 'What influences participation in leisure activities of children and youth with physical disabilities?' states that gross motor function, manual ability, cognitive ability, communicative skills are the most important variables associated with participating in leisure and social activity.

In the last 12 months Life Leisure's 'I wish I'd tried' scheme has had 185 participants accessing this with a disability. The health professional referral scheme PARIS has had 549 people access the service with a disability. The PARIS scheme provides specialist advice, activity sessions and support for people who have a medical condition and who need to be more physically active to better manage their health.

Recommendations arising from the chapter on leisure

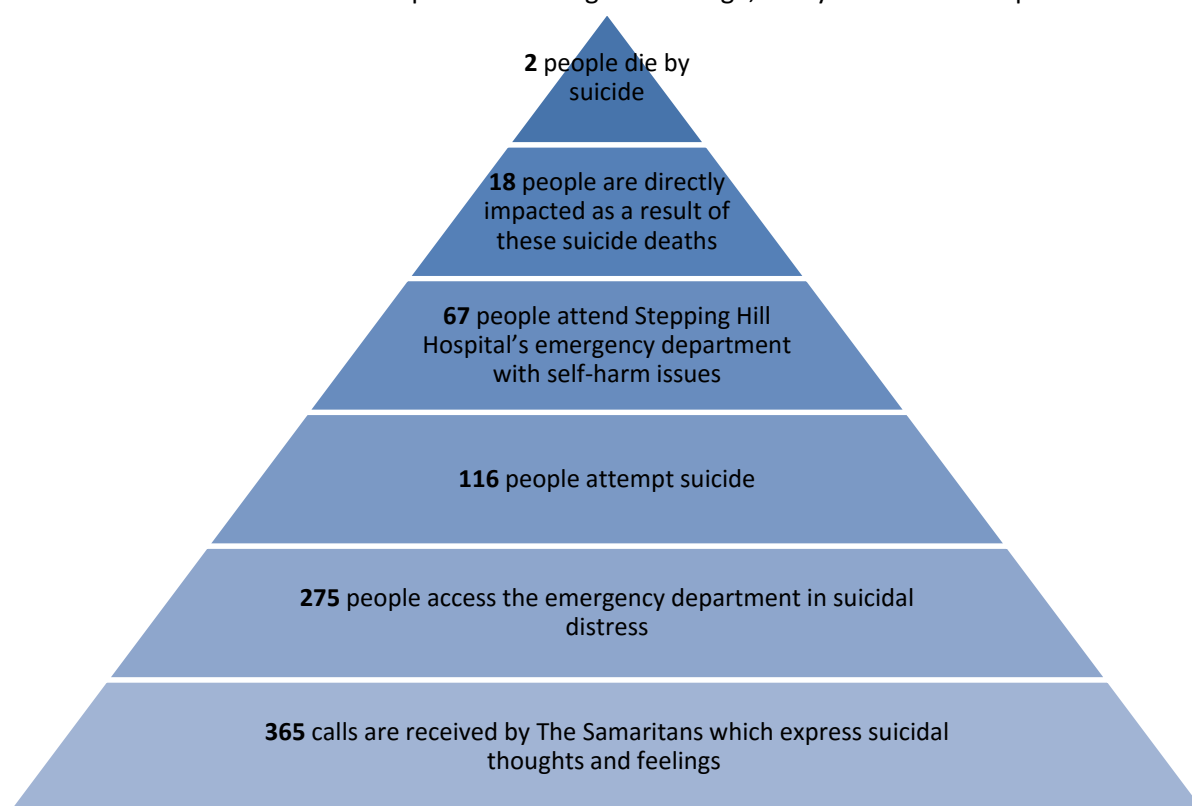
- I commend Life Leisure on the establishment of the Health Hub at Avondale and I recommend that the Council agree with Life Leisure a strategy for establishing over a period of time one such hub in each neighbourhood of the borough with neighbourhoods that contain significant areas which are in the two most deprived national quintiles being the first priority.
- Whilst there are obvious limits to the speed and extent of the reshaping of existing estate I recommend, as a long term strategic objective, that the Council and Stockport Together adopt the principle that health and leisure estate be considered together and that the ideal to aim at eventually is a series of Healthy Living Centres where primary care, health improvement, libraries and cultural facilities, organisation and facilitation of physical activity, gym and swimming facilities and opportunities (including meeting rooms) for community organisation and the development of social networks.
- Pursuant to para 191 of the National Planning Policy Framework, I recommend that, as part of the preparation of the Local Plan for the spatial framework, the map of country walk opportunities and the map of the aesthetically attractive pedestrian network be invested with planning policy significance. To the extent that it is possible for planning officers and councillors, under existing policies and para 191, to have regard to these maps as a material factor I request that they do so.

4.12 PREVENTING SUICIDE: IT'S NOT INEVITABLE

Suicide can be prevented and in Stockport there is plenty of work underway to make Stockport a place in which people never see suicide as their only option. We have local leaders, partnerships, information and assets which can help us achieve this ambition, and there's good reason why preventing suicide should be a priority for Stockport.

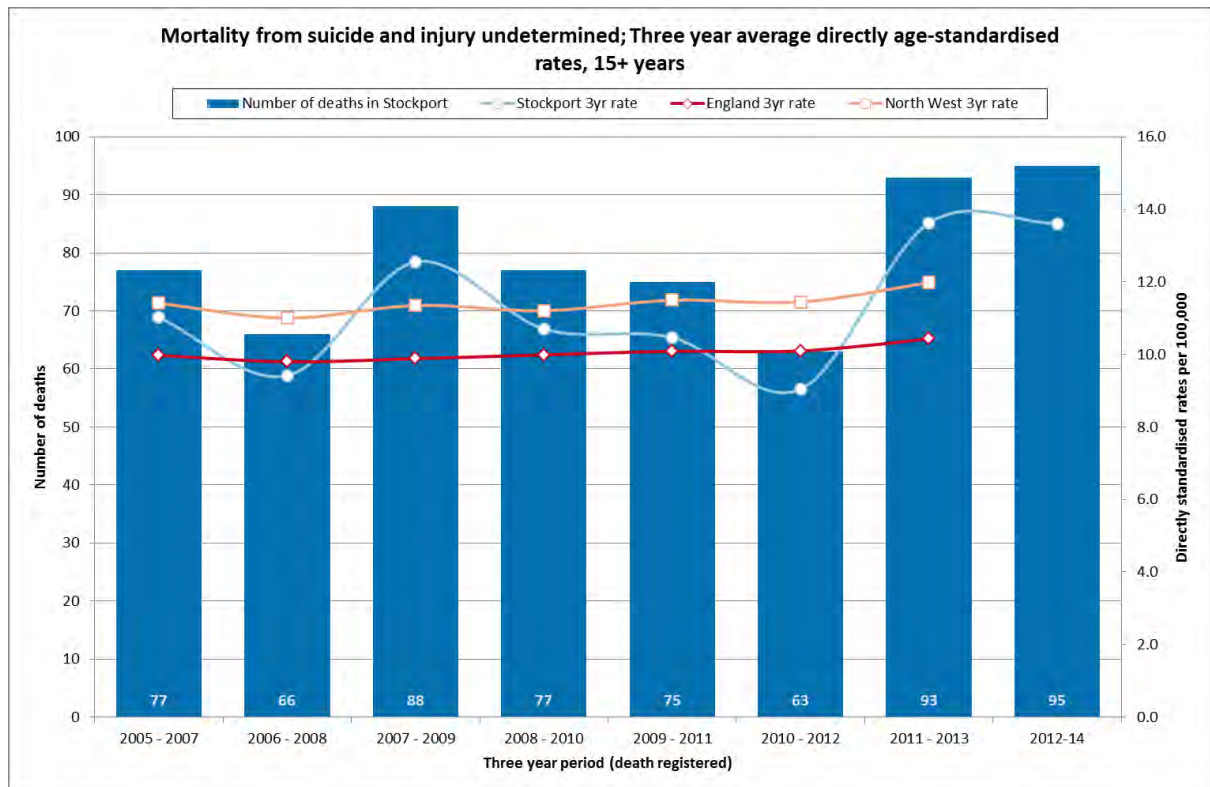
Every two hours in the UK, someone dies as the result of suicide. In Stockport, someone dies every two weeks from suicide, between 20-30 people every year. For every person who dies by suicide, approximately nine people (adults and children) are directly impacted by the tragic event.

But deaths from suicide are the tip of the iceberg. On average, every month in Stockport:



Death lies at one end of a continuum of a common suicidal process. If we are to prevent suicide all aspects of the continuum are important. These include suicide attempts, parasuicides (behaviour that appears to be a suicide attempt but is not intended to succeed), self-harm (which has occurred previously in about half of all suicides) and suicidal ideation and thoughts. Some suicides represent self-harm that went too far, parasuicides that accidentally succeed or impulsive responses to suicidal ideation. It is not necessarily helpful to focus too strongly on intention.

Numbers like this reveal the true extent of suicide harm in Stockport. We use rates of suicide (number per 100,000 people) to enable us to compare with other areas or against the national picture. This is shown in the graph below.



National and regional rates have remained relatively flat whereas the Stockport rate has varied to a greater extent. This is wholly expected given the small numbers involved at a local level.

Suicide has a huge impact on individuals, and society. Estimates on the number of people are affected by each suicide range from six to 60, on average nine adults and children are directly impacted. The economic cost of each death by suicide in England for those of working age is estimated to be £1.67 million (2009 prices)⁵. But suicide is not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

Who is at risk?

- Men are nearly three times more likely to die by suicide than women.
- Deaths from suicide and undetermined intent peak for both men and women in the 35 to 49 age range.
- Around two in three who die by suicide are not known to mental health services.
- 80% of people that take their own life have made previous attempts.
- At least half of people who die by suicide will have engaged in self-harm at some stage in their lives, often shortly before death.
- Suicide is a significant inequality issue as there are marked differences in the suicide rates according to people's social and economic backgrounds. Brinnington and Central ward (our most deprived ward) has the largest number of suicides and deaths of undetermined intent in Stockport.

⁵ McDaid D, Park A, Bonin E-M. Population level suicide awareness training and intervention. In Knapp D, McDaid D, Parsonage M, editors. Mental health promotion and prevention: the economic case. London: Department of Health; 2011. p.26-28.

- Other risk factors include those in criminal justice service, people with drug and alcohol problems (often not in touch with services), physical health conditions, and pain management issues.
- There are also people that take their own life who have none of these risk factors.
- More data on suicide deaths can be found in our JSNA mental wellbeing summary: <http://www.stockportjsna.org.uk/wp-content/uploads/2016/05/2015-JSNA-MH-wellbeing.pdf>
- The fact that suicide rates fell in wartime suggests that resilient communities working together to address adversity may have a reduced rate of suicide (although of course another explanation is that war offers alternative more socially acceptable mechanisms for self-destruction, which may even be socially honoured).

What can be done?

Nationally the Government published the 2012 strategy 'Preventing Suicide in England, a cross government strategy to save lives'⁶. The strategy highlights six priority areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

This being a cross-government strategy highlights the need for strong leadership and partnership working. At a local level it relies on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and criminal justice system, transport and the voluntary sector. The second annual report on this strategy reviews the actions that can be taken by different partners across society and reminds that **"Local actions can, and do, make a difference"**⁷.

The All-Party Parliamentary Group (APPG) on Suicide and Self-harm Prevention's report⁸ reflects that there are three main elements that are essential to the successful local implementation:

1. Carrying out a "suicide audit".
2. The development of a suicide prevention action plan.
3. The establishment of a multi-agency suicide prevention group.

⁶ Preventing Suicide in England: A cross government strategy to save lives (2012) <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

⁷ Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

⁸ All-Party Parliamentary Group on Suicide and Self-Harm Prevention. Inquiry into Local Suicide Prevention Plans in England (2015). <http://www.samaritans.org/sites/default/files/kcfinder/files/APPG-SUICIDE-REPORT.pdf>

Public Health England have supported this by publishing guidance for on how to develop a local suicide action plan⁹. This sets out how local areas can support the national strategy in the six areas of action. It re-emphasises the need for a partnership approach. Issues around data collection are also highlighted. Collecting and analysing local data on the number of suicides, the context in which they occur, the groups most at risk and how the picture is changing over time is critical for effective suicide prevention work.

Local data and intelligence may be gathered by:

- undertaking a suicide audit to gather data from coroners' reports about individual suicides
- examining demographic, social and service data held by partners across primary care, health services, social care and other partners to help to understand the prevalence of risk factors and other related issues. This includes intelligence from any relevant NHS trust patient safety Serious Untoward Incident reviews and/ or other patient safety incident reviews
- working with partners to introduce real-time suicide surveillance

It also highlights eight priorities for short term action at a local multi-agency level:

- Reducing risk in men
- Preventing and responding to self-harm
- Mental health of children and young people
- Treatment of depression in primary care
- Acute mental health care
- Tackling high frequency locations
- Reducing isolation
- Bereavement support

Local action

In Stockport, we have a multi-agency Stockport Suicide Prevention group. The group developed and designed a web resource which puts all local and national services and resources together in one accessible place to offer support for those in suicidal distress, offers help and support for anyone with suicidal thoughts, people who are concerned about others, and those bereaved by suicide.

<http://www.stockportsuicideprevention.org.uk/>

The group has developed a local suicide prevention strategy with the ambition “to make Stockport a place in which people never see suicide as their only option”. To enable this, the strategy has three main areas of action:

- Reduce the risk of suicide - using the evidence to target high risk groups. This includes actions around targeting training for services which come in to contact with high risk

⁹ Public Health England, Local Suicide Prevention Planning. A Practical Resource (2016)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/562280/PHE_local_suicide_prevention_planning_a_practice_resource.pdf

groups and ensuring they are represented within the strategy; ensuring the website is promoted to the high risk groups.

- Be a catalyst for change - ensure individuals, communities and services are able to recognise and respond to suicidal distress, including the needs of those affected by suicide. This includes the 'Connect 5' training where over 1,000 mental health front line staff have been trained in evidence based interventions to promote mental health and wellbeing (and this is on-going). Front line staff are also provided with complimentary self-help materials.
- Support action to enhance wellbeing and resilience in the population as a whole. This includes involvement in Wellbeing week every year, which is a multi-agency collaboration. Furthermore the '5 ways to wellbeing' handbook is used across health and social care system.

I have made various recommendations in support of this strategy and when we can see how the strategy works out over the next few years I commit to ensuring that suicide prevention is addressed as part of the next JSNA.

Recommendations arising from the chapter on suicide prevention

- I recommend that all relevant agencies introduce the use of the SAFE tool to improve suicide awareness and response in front-line workers
- I recommend that the police, the coroner, the Council, the CCG and the NHSFT introduce a method of collecting real-time suicide data for surveillance and to enable appropriate actions, including harm reduction in high risk locations.
- I recommend that all relevant agencies (including the police and probation service) develop a pathway of care for those accessing services in suicidal distress and ensure that pathways for self-harm meet the NICE guidance (CG16 and CG133), including the needs of those without a diagnosis of mental illness.
- I recommend that all relevant agencies participate in an annual suicide audit.
- I recommend that all relevant agencies ensure that bereavement support is available proactively to people affected by suicide.
- I congratulate the coroner on recent steps to enhance partnership in proactively identifying hazards to health, recommend that it continues, and in the context of suicide prevention I include the coroner in the agencies to which the preceding two recommendations are addressed.
- I recommend Stockport NHS Foundation Trust, Stockport Clinical Commissioning Group, and Pennine Care NHS Trust identify dedicated trainers to increase the capacity for training across Stockport.
- I recommend that Stockport Suicide Prevention Group review the existing Suicide Prevention Strategy action plan against the Public Health England guidance

4.13 STOCKPORT TOGETHER UPDATE

In 2015, I wrote a chapter on Stockport Together. I do not intend to write a further complete chapter but there has been such considerable progress during the year that it is right to include an update in the summary.

Stockport Together is creating a ground-breaking new integrated way of providing health and social care, known as a Multi-speciality Community Provider. This will break down organisational barriers and focus on the needs, strengths and wishes of individual people, rather than the doing things according to needs of separate services.

The aspect of Stockport Together that I am most excited about is the Healthy Communities workstream. This is about working with people and those around them, in their families and communities, empowering people to help themselves and each other, in a way that recognises the expertise and resources that they have available to them to help maintain and improve their health and wellbeing. This is not replacement for medical and clinical approaches, but can help prevent some of the need for medicine and hospital admissions, both of which can have unwanted consequences, including side-effects and the detrimental effects on physical and mental health and wellbeing of a prolonged stay in a hospital bed.

Our new way of working in partnership with people, communities and voluntary organisations builds on the assets or strengths that people can access, enabling people to take more control over their own health and wellbeing, taking care of themselves and each other. We help people to connect with others, to 'co-produce' better health and wellbeing throughout our communities. Not doing things *for* people or *to* people, but working *with* people in a spirit of equality and respect. Even when facing life changing health challenges, people can find they have something to offer others, and in doing so often gain a new sense of purpose and self-worth in doing so. As human beings, we thrive on interdependence and mutual support, and by unleashing this often hidden capacity in our communities we can transform the way in which health and wellbeing are achieved in the modern world.

Public services can learn from working in partnership with voluntary organisations, which are often closer to the communities they serve and already working in empowering ways with people. That's why we are investing in new voluntary sector-led initiatives like the Voluntary Sector Support for Discharge service working with hospital staff, patients and carers, to help people to get home from hospital safely and comfortably, able to address their the practical and social needs and ensure a rapid recovery. The huge contribution of those who care for their loved ones due to illness or disability can be a lonely and difficult experience and that's why we are also supporting a new Carers Connect project, to help develop online resources for connecting with others as well as face to face activities, support and learning, to enable more carers to benefit from peer support.

**24th Annual Public Health Report for
Stockport - 2017/18**

SECTION E: The Strategic Response

LEVEL 5

Additional Analysis

LEVEL 5 (ADDITIONAL ANALYSIS) SECTION E: THE STRATEGIC RESPONSE

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.stockportjsna.org.uk/>).

The JSNA has recently been refreshed and the overall priorities and key objectives can be found here <http://www.stockportjsna.org.uk/2016-2019-priorities/>. If there are any questions arising from the JSNA analysis then please contact the public health intelligence team at JSNA@stockport.gov.uk.

5.1 RESILIENT COMMUNITIES

Analysis undertaken in previous Stockport Annual Public Health Reports remains relevant and is available from the Public Health team on request, for health and work this includes:

- Section 3 of the 14th report – Faith and Health in Stockport
- [JSNA briefing - Neighbourhood Profiles](#)

5.2 EARLIER DIAGNOSIS

- [JSNA briefing - Cancer](#) (See screening pages)

5.3 NHS CHANGES

No additional material

5.4 NHS CHALLENGES

No additional material

5.5 PREVENTION – A CORNERSTONE OF “PUBLIC SECTOR REFORM”

No additional material

5.6 COUNTRY CITY

Analysis undertaken in previous Stockport Annual Public Health Reports remains relevant and is available from the Public Health team on request, for health and work this includes:

- Chapter 6 of the 15th report – western Stockport Cycle Trunk Route
- Chapter 7 of the 15th report – Public Health Advice for GM Local Transport Plan (LTP2)
- Chapter 13 of the 16th report – Climate Change
- Chapter 14 of the 16th report – Spatial Strategy
- Section 4.6 of the 16th report – Protecting Walking Routes : Effect of Pedestrian Impermeable Street Designs
- Chapter 20 of the 17th report – Climate Change
- Chapter 21 of the 17th report – Network Rail

5.7 BEHAVIOUR CHANGE

The following is the full list of cognitive biases from Wikipedia

Name	Description
<u>Ambiguity effect</u>	The tendency to avoid options for which missing information makes the probability seem "unknown." ^[8]
<u>Anchoring</u> or <u>focalism</u>	The tendency to rely too heavily, or "anchor," on one trait or piece of information when making decisions (usually the first piece of information that we acquire on that subject) ^{[9][10]}
<u>Attentional bias</u>	The tendency of our perception to be affected by our recurring thoughts. ^[11]
<u>Availability heuristic</u>	The tendency to overestimate the likelihood of events with greater "availability" in memory, which can be influenced by how recent the memories are or how unusual or emotionally charged they may be. ^[12]
<u>Availability cascade</u>	A self-reinforcing process in which a collective belief gains more and more plausibility through its increasing repetition in public discourse (or "repeat something long enough and it will become true"). ^[13]
<u>Backfire effect</u>	When people react to disconfirming evidence by strengthening their beliefs. ^[14]
<u>Bandwagon effect</u>	The tendency to do (or believe) things because many other people do (or believe) the same. Related to <u>groupthink</u> and <u>herd behavior</u> . ^[15]
<u>Base rate fallacy</u> or <u>base rate neglect</u>	The tendency to ignore base rate information (generic, general information) and focus on specific information (information only pertaining to a certain case). ^[16]
<u>Belief bias</u>	An effect where someone's evaluation of the logical strength of an argument is biased by the believability of the conclusion. ^[17]
<u>Bias blind spot</u>	The tendency to see oneself as less biased than other people, or to be able to identify more cognitive biases in others than in oneself. ^[18]
<u>Cheerleader effect</u>	The tendency for people to appear more attractive in a group than in isolation. ^[19]
<u>Choice-supportive bias</u>	The tendency to remember one's choices as better than they actually were. ^[20]
<u>Clustering illusion</u>	The tendency to overestimate the importance of small runs, streaks, or clusters in large samples of random data (that is, seeing phantom patterns). ^[10]

<u>Confirmation bias</u>	The tendency to search for, interpret, focus on and remember information in a way that confirms one's preconceptions. ^[21]
<u>Congruence bias</u>	The tendency to test hypotheses exclusively through direct testing, instead of testing possible alternative hypotheses. ^[10]
<u>Conjunction fallacy</u>	The tendency to assume that specific conditions are more probable than general ones. ^[22]
Conservatism or regressive bias	A certain state of mind wherein high values and high likelihoods are overestimated while low values and low likelihoods are underestimated. ^{[23][24][25][unreliable source?]}
<u>Conservatism (Bayesian)</u>	The tendency to <u>revise one's belief</u> insufficiently when presented with new evidence. ^{[23][26][27]}
<u>Contrast effect</u>	The enhancement or reduction of a certain perception's stimuli when compared with a recently observed, contrasting object. ^[28]
<u>Curse of knowledge</u>	When better-informed people find it extremely difficult to think about problems from the perspective of lesser-informed people. ^[29]
<u>Decoy effect</u>	Preferences for either option A or B changes in favour of option B when option C is presented, which is similar to option B but in no way better.
<u>Denomination effect</u>	The tendency to spend more money when it is denominated in small amounts (e.g. coins) rather than large amounts (e.g. bills). ^[30]
<u>Distinction bias</u>	The tendency to view two options as more dissimilar when evaluating them simultaneously than when evaluating them separately. ^[31]
<u>Duration neglect</u>	The neglect of the duration of an episode in determining its value
<u>Empathy gap</u>	The tendency to underestimate the influence or strength of feelings, in either oneself or others.
<u>Endowment effect</u>	The fact that people often demand much more to give up an object than they would be willing to pay to acquire it. ^[32]
<u>Essentialism</u>	Categorizing people and things according to their essential nature, in spite of variations. ^{[dubious – discuss][33]}
Exaggerated expectation	Based on the estimates, real-world evidence turns out to be less extreme than our expectations (conditionally inverse of the conservatism bias). ^{[unreliable source?][23][34]}
<u>Experimenter's or</u>	The tendency for experimenters to believe, certify, and publish data that agree with their expectations for the outcome of an experiment, and to disbelieve,

<u>expectation bias</u>	discard, or downgrade the corresponding weightings for data that appear to conflict with those expectations. ^[35]
<u>Focusing effect</u>	The tendency to place too much importance on one aspect of an event. ^[36]
<u>Forer effect</u> or Barnum effect	The observation that individuals will give high accuracy ratings to descriptions of their personality that supposedly are tailored specifically for them, but are in fact vague and general enough to apply to a wide range of people. This effect can provide a partial explanation for the widespread acceptance of some beliefs and practices, such as astrology, fortune telling, graphology, and some types of personality tests.
<u>Framing effect</u>	Drawing different conclusions from the same information, depending on how or by whom that information is presented.
Frequency illusion	The illusion in which a word, a name or other thing that has recently come to one's attention suddenly seems to appear with improbable frequency shortly afterwards (see also <u>recency illusion</u>). ^[37] Colloquially, this illusion is known as the Baader-Meinhof Phenomenon. ^[38]
<u>Functional fixedness</u>	Limits a person to using an object only in the way it is traditionally used.
<u>Gambler's fallacy</u>	The tendency to think that future probabilities are altered by past events, when in reality they are unchanged. Results from an erroneous conceptualization of the <u>law of large numbers</u> . For example, "I've flipped heads with this coin five times consecutively, so the chance of tails coming out on the sixth flip is much greater than heads."
<u>Hard–easy effect</u>	Based on a specific level of task difficulty, the confidence in judgments is too conservative and not extreme enough ^{[23][39][40][41]}
<u>Hindsight bias</u>	Sometimes called the "I-knew-it-all-along" effect, the tendency to see past events as being predictable ^[42] at the time those events happened.
<u>Hostile media effect</u>	The tendency to see a media report as being biased, owing to one's own strong partisan views.
<u>Hot-hand fallacy</u>	The "hot-hand fallacy" (also known as the "hot hand phenomenon" or "hot hand") is the fallacious belief that a person who has experienced success has a greater chance of further success in additional attempts.
<u>Hyperbolic discounting</u>	Discounting is the tendency for people to have a stronger preference for more immediate payoffs relative to later payoffs. Hyperbolic discounting leads to choices that are inconsistent over time – people make choices today that their future selves would prefer not to have made, despite using the same

reasoning.^[43] Also known as current moment bias, present-bias, and related to [Dynamic inconsistency](#).

[Identifiable victim effect](#) The tendency to respond more strongly to a single identified person at risk than to a large group of people at risk.^[44]

[IKEA effect](#) The tendency for people to place a disproportionately high value on objects that they partially assembled themselves, such as furniture from [IKEA](#), regardless of the quality of the end result.

[Illusion of control](#) The tendency to overestimate one's degree of influence over other external events.^[45]

[Illusion of validity](#) Belief that furtherly acquired information generates additional relevant data for predictions, even when it evidently does not.^[46]

[Illusory correlation](#) Inaccurately perceiving a relationship between two unrelated events.^{[47][48]}

[Impact bias](#) The tendency to overestimate the length or the intensity of the impact of future feeling states.^[49]

[Information bias](#) The tendency to seek information even when it cannot affect action.^[50]

[Insensitivity to sample size](#) The tendency to under-expect variation in small samples

[Irrational escalation](#) The phenomenon where people justify increased investment in a decision, based on the cumulative prior investment, despite new evidence suggesting that the decision was probably wrong. Also known as the sunk cost fallacy.

[Less-is-better effect](#) The tendency to prefer a smaller set to a larger set judged separately, but not jointly

[Loss aversion](#) "the disutility of giving up an object is greater than the utility associated with acquiring it".^[51] (see also [Sunk cost effects](#) and endowment effect).

[Mere exposure effect](#) The tendency to express undue liking for things merely because of familiarity with them.^[52]

[Money illusion](#) The tendency to concentrate on the nominal value (face value) of money rather than its value in terms of purchasing power.^[53]

[Moral credential effect](#) The tendency of a track record of non-prejudice to increase subsequent prejudice.

[Negativity effect](#) The tendency of people, when evaluating the causes of the behaviours of a person they dislike, to attribute their positive behaviours to the environment

and their negative behaviours to the person's inherent nature.

Negativity bias

Psychological phenomenon by which humans have a greater [recall](#) of unpleasant memories compared with positive memories.^[54]

Neglect of probability

The tendency to completely disregard probability when making a decision under uncertainty.^[55]

Normalcy bias

The refusal to plan for, or react to, a disaster which has never happened before.

Not invented here

Aversion to contact with or use of products, research, standards, or knowledge developed outside a group. Related to [IKEA effect](#).

Observation selection bias

The effect of suddenly noticing things that were not noticed previously – and as a result wrongly assuming that the frequency has increased.

Observer-expectancy effect

When a researcher expects a given result and therefore unconsciously manipulates an experiment or misinterprets data in order to find it (see also [subject-expectancy effect](#)).

Omission bias

The tendency to judge harmful actions as worse, or less moral, than equally harmful omissions (inactions).^[56]

Optimism bias

The tendency to be over-optimistic, overestimating favourable and pleasing outcomes (see also [wishful thinking](#), [valence effect](#), [positive outcome bias](#)).^{[57][58]}

Ostrich effect

Ignoring an obvious (negative) situation.

Outcome bias

The tendency to judge a decision by its eventual outcome instead of based on the quality of the decision at the time it was made.

Overconfidence effect

Excessive confidence in one's own answers to questions. For example, for certain types of questions, answers that people rate as "99% certain" turn out to be wrong 40% of the time.^{[23][59][60][61]}

Pareidolia

A vague and random stimulus (often an image or sound) is perceived as significant, e.g., seeing images of animals or faces in clouds, the [man in the moon](#), and hearing non-existent [hidden messages](#) on [records played in reverse](#).

Pessimism bias

The tendency for some people, especially those suffering from [depression](#), to overestimate the likelihood of negative things happening to them.

Planning fallacy

The tendency to underestimate task-completion times.^[49]

Post-purchase rationalization

The tendency to persuade oneself through rational argument that a purchase was a good value.

<u>Pro-innovation bias</u>	The tendency to have an excessive optimism towards an invention or innovation's usefulness throughout society, while often failing to identify its limitations and weaknesses.
<u>Pseudocertainty effect</u>	The tendency to make risk-averse choices if the expected outcome is positive, but make risk-seeking choices to avoid negative outcomes. ^[62]
<u>Reactance</u>	The urge to do the opposite of what someone wants you to do out of a need to resist a perceived attempt to constrain your freedom of choice (see also <u>Reverse psychology</u>).
<u>Reactive devaluation</u>	Devaluing proposals only because they are purportedly originated with an adversary.
<u>Recency illusion</u>	The illusion that a word or language usage is a recent innovation when it is in fact long-established (see also <u>frequency illusion</u>).
<u>Restraint bias</u>	The tendency to overestimate one's ability to show restraint in the face of temptation.
<u>Rhyme as reason effect</u>	Rhyming statements are perceived as more truthful. A famous example being used in the O.J Simpson trial with the defense's use of the phrase "If the gloves don't fit, then you must acquit."
<u>Risk compensation / Peltzman effect</u>	The tendency to take greater risks when perceived safety increases.
<u>Selective perception</u>	The tendency for expectations to affect perception.
<u>Semmelweis reflex</u>	The tendency to reject new evidence that contradicts a paradigm. ^[27]
<u>Social comparison bias</u>	The tendency, when making hiring decisions, to favour potential candidates who don't compete with one's own particular strengths. ^[63]
<u>Social desirability bias</u>	The tendency to over-report socially desirable characteristics or behaviours in one self and under-report socially undesirable characteristics or behaviours. ^[64]
<u>Status quo bias</u>	The tendency to like things to stay relatively the same (see also loss aversion, endowment effect, and system justification). ^{[65][66]}
<u>Stereotyping</u>	Expecting a member of a group to have certain characteristics without having actual information about that individual.
<u>Subadditivity effect</u>	The tendency to judge probability of the whole to be less than the probabilities of the parts. ^[67]

<u>Subjective validation</u>	Perception that something is true if a subject's belief demands it to be true. Also assigns perceived connections between coincidences.
<u>Survivorship bias</u>	Concentrating on the people or things that "survived" some process and inadvertently overlooking those that didn't because of their lack of visibility.
<u>Time-saving bias</u>	Underestimations of the time that could be saved (or lost) when increasing (or decreasing) from a relatively low speed and overestimations of the time that could be saved (or lost) when increasing (or decreasing) from a relatively high speed.
Unit bias	The tendency to want to finish a given unit of a task or an item. Strong effects on the consumption of food in particular. ^[68]
<u>Well travelled road effect</u>	Underestimation of the duration taken to traverse oft-traveled routes and overestimation of the duration taken to traverse less familiar routes.
<u>Zero-risk bias</u>	Preference for reducing a small risk to zero over a greater reduction in a larger risk.
Zero-sum heuristic	Intuitively judging a situation to be zero-sum (i.e., that gains and losses are correlated). Derives from the zero-sum game in <u>game theory</u> , where wins and losses sum to zero. ^{[69][70]} The frequency with which this bias occurs may be related to the <u>social dominance orientation</u> personality factor.

Social biases

Most of these biases are labeled as [attributional biases](#).

Name	Description
<u>Actor–observer bias</u>	The tendency for explanations of other individuals' behaviours to overemphasize the influence of their personality and underemphasize the influence of their situation (see also Fundamental attribution error), and for explanations of one's own behaviours to do the opposite (that is, to overemphasize the influence of our situation and underemphasize the influence of our own personality).
<u>Defensive attribution hypothesis</u>	Attributing more blame to a harm-doer as the outcome becomes more severe or as personal or situational <u>similarity</u> to the victim increases.
<u>Dunning–Kruger effect</u>	An effect in which incompetent people fail to realise they are incompetent because they lack the skill to distinguish between competence and incompetence. Actual competence may weaken self-confidence, as competent individuals may falsely assume that others have an equivalent understanding. ^[71]

<u>Egocentric bias</u>	Occurs when people claim more responsibility for themselves for the results of a joint action than an outside observer would credit them.
<u>Extrinsic incentives bias</u>	An exception to the <i>fundamental attribution error</i> , when people view others as having (situational) extrinsic motivations and (dispositional) intrinsic motivations for oneself
<u>False consensus effect</u>	The tendency for people to overestimate the degree to which others agree with them. ^[72]
<u>Forer effect</u> (aka <u>Barnum effect</u>)	The tendency to give high accuracy ratings to descriptions of their personality that supposedly are tailored specifically for them, but are in fact vague and general enough to apply to a wide range of people. For example, <u>horoscopes</u> .
<u>Fundamental attribution error</u>	The tendency for people to over-emphasize personality-based explanations for behaviours observed in others while under-emphasizing the role and power of situational influences on the same behaviour (see also actor-observer bias, <u>group attribution error</u> , positivity effect, and <u>negativity effect</u>). ^[73]
<u>Group attribution error</u>	The biased belief that the characteristics of an individual group member are reflective of the group as a whole or the tendency to assume that group decision outcomes reflect the preferences of group members, even when information is available that clearly suggests otherwise.
<u>Halo effect</u>	The tendency for a person's positive or negative traits to "spill over" from one personality area to another in others' perceptions of them (see also <u>physical attractiveness stereotype</u>). ^[74]
<u>Illusion of asymmetric insight</u>	People perceive their knowledge of their peers to surpass their peers' knowledge of them. ^[75]
<u>Illusion of external agency</u>	When people view self-generated preferences as instead being caused by insightful, effective and benevolent agents
<u>Illusion of transparency</u>	People overestimate others' ability to know them, and they also overestimate their ability to know others.
<u>Illusory superiority</u>	Overestimating one's desirable qualities, and underestimating undesirable qualities, relative to other people. (Also known as "Lake Wobegon effect," "better-than-average effect," or "superiority bias"). ^[76]
<u>Ingroup bias</u>	The tendency for people to give preferential treatment to others they perceive to be members of their own groups.
<u>Just-world</u>	The tendency for people to want to believe that the world is fundamentally just,

<u>hypothesis</u>	causing them to rationalize an otherwise inexplicable injustice as deserved by the victim(s).
<u>Moral luck</u>	The tendency for people to ascribe greater or lesser moral standing based on the outcome of an event
<u>Naïve cynicism</u>	Expecting more <i>egocentric bias</i> in others than in oneself
<u>Naïve realism</u>	The belief that we see reality as it really is – objectively and without bias; that the facts are plain for all to see; that rational people will agree with us; and that those who don't are either uninformed, lazy, irrational, or biased.
<u>Outgroup homogeneity bias</u>	Individuals see members of their own group as being relatively more varied than members of other groups. ^[77]
<u>Projection bias</u>	The tendency to unconsciously assume that others (or one's future selves) share one's current emotional states, thoughts and values. ^[78]
<u>Self-serving bias</u>	The tendency to claim more responsibility for successes than failures. It may also manifest itself as a tendency for people to evaluate ambiguous information in a way beneficial to their interests (see also <u>group-serving bias</u>). ^[79]
<u>Shared information bias</u>	Known as the tendency for group members to spend more time and energy discussing information that all members are already familiar with (i.e., shared information), and less time and energy discussing information that only some members are aware of (i.e., unshared information). ^[80]
<u>System justification</u>	The tendency to defend and bolster the status quo. Existing social, economic, and political arrangements tend to be preferred, and alternatives disparaged sometimes even at the expense of individual and collective self-interest. (See also status quo bias.)
<u>Trait ascription bias</u>	The tendency for people to view themselves as relatively variable in terms of personality, behaviour, and mood while viewing others as much more predictable.
<u>Ultimate attribution error</u>	Similar to the fundamental attribution error, in this error a person is likely to make an internal attribution to an entire group instead of the individuals within the group.
<u>Worse-than-average effect</u>	A tendency to believe ourselves to be worse than others at tasks which are difficult ^[81]

Memory errors and biases

Main article: [List of memory biases](#)

In [psychology](#) and [cognitive science](#), a **memory bias** is a [cognitive bias](#) that either enhances or impairs the recall of a [memory](#) (either the chances that the memory will be recalled at all, or the amount of time it takes for it to be recalled, or both), or that alters the content of a reported memory. There are many types of memory bias, including:

Name	Description
Bizarreness effect	Bizarre material is better remembered than common material.
Choice-supportive bias	In a self-justifying manner retroactively ascribing one's choices to be more informed than they were when they were made.
Change bias	After an investment of effort in producing change, remembering one's past performance as more difficult than it actually was ^[82] [unreliable source?]
Childhood amnesia	The retention of few memories from before the age of four.
Conservatism or Regressive bias	Tendency to remember high values and high likelihoods/probabilities/frequencies lower than they actually were and low ones higher than they actually were. Based on the evidence, memories are not extreme enough ^[24] [25]
Consistency bias	Incorrectly remembering one's past attitudes and behaviour as resembling present attitudes and behaviour. ^[83]
Context effect	That cognition and memory are dependent on context, such that out-of-context memories are more difficult to retrieve than in-context memories (e.g., recall time and accuracy for a work-related memory will be lower at home, and vice versa)
Cross-race effect	The tendency for people of one race to have difficulty identifying members of a race other than their own.
Cryptomnesia	A form of <i>misattribution</i> where a memory is mistaken for imagination, because there is no subjective experience of it being a memory. ^[82]
Egocentric bias	Recalling the past in a self-serving manner, e.g., remembering one's exam grades as being better than they were, or remembering a caught fish as bigger than it really was.
Fading affect bias	A bias in which the emotion associated with unpleasant memories fades more quickly than the emotion associated with positive events. ^[84]
False memory	A form of <i>misattribution</i> where imagination is mistaken for a memory.
Generation effect (Self-generation)	That self-generated information is remembered best. For instance, people are better able to recall memories of statements that they have generated than

effect)	similar statements generated by others.
<u>Google effect</u>	The tendency to forget information that can be found readily online by using Internet search engines.
<u>Hindsight bias</u>	The inclination to see past events as being more predictable than they actually were; also called the "I-knew-it-all-along" effect.
Humor effect	That humorous items are more easily remembered than non-humorous ones, which might be explained by the distinctiveness of humour, the increased cognitive processing time to understand the humour, or the emotional arousal caused by the humour. ^[citation needed]
<u>Illusion of truth effect</u>	That people are more likely to identify as true statements those they have previously heard (even if they cannot consciously remember having heard them), regardless of the actual validity of the statement. In other words, a person is more likely to believe a familiar statement than an unfamiliar one.
<u>Illusory correlation</u>	Inaccurately remembering a relationship between two events. ^{[23][48]}
Lag effect	See <u>spacing effect</u> .
<u>Leveling and Sharpening</u>	Memory distortions introduced by the loss of details in a recollection over time, often concurrent with sharpening or selective recollection of certain details that take on exaggerated significance in relation to the details or aspects of the experience lost through levelling. Both biases may be reinforced over time, and by repeated recollection or re-telling of a memory. ^[85]
<u>Levels-of-processing effect</u>	That different methods of encoding information into memory have different levels of effectiveness. ^[86]
List-length effect	A smaller percentage of items are remembered in a longer list, but as the length of the list increases, the absolute number of items remembered increases as well. ^{[87][further explanation needed]}
<u>Misinformation effect</u>	Memory becoming less accurate because of interference from <i>post-event information</i> . ^[88]
<u>Modality effect</u>	That memory recall is higher for the last items of a list when the list items were received via speech than when they were received through writing.
<u>Mood-congruent memory bias</u>	The improved recall of information congruent with one's current mood.
Next-in-line effect	That a person in a group has diminished recall for the words of others who spoke immediately before himself, if they take turns speaking. ^[89]

<u>Part-list cueing effect</u>	That being shown some items from a list and later retrieving one item causes it to become harder to retrieve the other items ^[90]
<u>Peak–end rule</u>	That people seem to perceive not the sum of an experience but the average of how it was at its peak (e.g. pleasant or unpleasant) and how it ended.
Persistence	The unwanted recurrence of memories of a traumatic event . ^[citation needed]
<u>Picture superiority effect</u>	The notion that concepts that are learned by viewing pictures are more easily and frequently recalled than are concepts that are learned by viewing their written word form counterparts. ^{[91][92][93][94][95][96]}
<u>Positivity effect</u>	That older adults favour positive over negative information in their memories.
<u>Primacy effect</u>, <u>Recency effect</u> & <u>Serial position effect</u>	That items near the end of a sequence are the easiest to recall, followed by the items at the beginning of a sequence; items in the middle are the least likely to be remembered. ^[97]
Processing difficulty effect	That information that takes longer to read and is thought about more (processed with more difficulty) is more easily remembered. ^[98]
<u>Reminiscence bump</u>	The recalling of more personal events from adolescence and early adulthood than personal events from other lifetime periods ^[99]
<u>Rosy retrospection</u>	The remembering of the past as having been better than it really was.
Self-relevance effect	That memories relating to the self are better recalled than similar information relating to others.
<u>Source confusion</u>	Confusing episodic memories with other information, creating distorted memories. ^[100]
<u>Spacing effect</u>	That information is better recalled if exposure to it is repeated over a long span of time rather than a short one.
<u>Spotlight effect</u>	The tendency to overestimate the amount that other people notice your appearance or behaviour.
Stereotypical bias	Memory distorted towards stereotypes (e.g., racial or gender), e.g., "black-sounding" names being misremembered as names of criminals. ^{[82][unreliable source?]}
Suffix effect	Diminishment of the recency effect because a sound item is appended to the list that the subject is <i>not</i> required to recall. ^{[101][102]}
<u>Suggestibility</u>	A form of misattribution where ideas suggested by a questioner are mistaken for memory.

<u>Telescoping effect</u>	The tendency to displace recent events backward in time and remote events forward in time, so that recent events appear more remote, and remote events, more recent.
<u>Testing effect</u>	The fact that you more easily remember information you have read by rewriting it instead of rereading it. ^[103]
<u>Tip of the tongue phenomenon</u>	When a subject is able to recall parts of an item, or related information, but is frustratingly unable to recall the whole item. This is thought an instance of "blocking" where multiple similar memories are being recalled and interfere with each other. ^[82]
Verbatim effect	That the "gist" of what someone has said is better remembered than the verbatim wording. ^[104] This is because memories are representations, not exact copies.
<u>Von Restorff effect</u>	That an item that sticks out is more likely to be remembered than other items ^[105]
<u>Zeigarnik effect</u>	That uncompleted or interrupted tasks are remembered better than completed ones.

5.7 HEALTH AND WELL BEING STRATEGY

Analysis undertaken in previous Stockport Annual Public Health Reports remains relevant and is available from the Public Health team on request, for health and work this includes:

- Chapter 3 of the 16th report – Public Health Goals

5.8 LOCAL AUTHORITY RESOURCES

Analysis undertaken in previous Stockport Annual Public Health Reports remains relevant and is available from the Public Health team on request, for health and work this includes:

- Chapter 9 of the 16th report – Finance Situation

5.9 PUBLIC HEALTH AND PUBLIC POLICY

No additional material