STOCKPORT
METROPOLITAN BOROUGH COUNCIL

23rd Annual Public Health Report for Stockport 2016/17

SECTION D: The Life Cycle

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

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

SECTION D: the Life Cycle

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 Section D 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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LEVEL 1

Tweets

LEVEL 1 (TWEETS) SECTION D: THE LIFE CYCLE

D1.1 HEALTH OF CHILDREN AND YOUNG PEOPLE

- #Stockport. The foundations of good health are laid in early years overview
- #Stockport. Establishing good habits in childhood is key as many adult health values and behaviours start here overview

D1.2 HEALTH AND WORK

- #Stockport. Poor quality work and #unemployment both damage health overview
- #Stockport. Everyone should have good quality work including #disabled people overview
- #Stockport. #Disabled people should be employed for their abilities not rejected for their disabilities overview

D1.3 HEALTHY AGEING

- Healthy active ageing must be our goal overview
- Physical activity in old age is the best treatment for frailty. People must not be encouraged to give up overview
- When old age does affect people they must be helped to remain independent overview

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LEVEL 2

Overview

LEVEL 2 (OVERVIEW) SECTION D: THE LIFE CYCLE

D2.1 HEALTH OF CHILDREN AND YOUNG PEOPLE

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

Go to key messages or go to full analysis

D2.2 HEALTH AND WORK

Poor quality work and unemployment both damage health and affect the same group – those most marginal to the labour market suffering unemployment or poor quality work dependent on the economy. All people in Stockport should enjoy good quality work:

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

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

Go to key messages or go to full analysis

D2.3 HEALTHY AGEING

The ratio normally used for measuring the proportion of people who are dependent due to old age is calculated by taking the number of people over age 65 and dividing it by the number of people of working age. This is at an all-time high. An alternative measure however would take the number of people within 15 years of life expectancy and divide it by the number of people actually in

employment. This is at an all-time low. The difference between the two measures is the dual effect that life expectancy has on the numerator and the impact on the denominator of participation in the workforce by women and by older people. A healthy ageing strategy must encourage people to remain active into old age, to maintain friendships and a purpose to life, and to continue with healthy lifestyles, such as healthy diets. It must ensure that people are not encouraged to accept that they suffer from old age when in fact they suffer from treatable illness. We must make it easier for old people to remain active and involved, and support people in staying independent when old age does begin to affect them. Physical activity in old age is especially important – it has been shown to ward off frailty.

Go to key messages or go to full analysis

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SECTION D: the Life Cycle

LEVEL 3

Key messages

LEVEL 3 (KEY MESSAGES) SECTION D: THE LIFE CYCLE

D3.1 HEALTH OF CHILDREN AND YOUNG PEOPLE

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

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

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

To improve the health and wellbeing of our children and young people, Stockport's Joint Health & Wellbeing Strategy identified 5 'We Wills'**:**

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

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

Go to overview or go to full analysis

D3.2 HEALTH AND WORK

Worklessness

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

Healthy work

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

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

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

A Healthy Economy

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

Go to overview or go to full analysis

D3.3 HEALTHY AGEING

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

Older people use more health and social care than younger people. Does an ageing population therefore mean the cost of health and social care will rise? This was certainly true when the main factor ageing the population was demography. But if rising life expectancy is also a factor? Do older people use more health and social care resources because they are older or because they are closer to death? If the former, then an ageing population will use more resources. If the latter they might not. Indeed a lengthening life expectancy might reduce the burden because a smaller proportion of the population will be in their last few years of life. In fact, certain analysis raises the rather startling prospect that the financial burden of an elderly population is actually greatest in those areas where people do not live as long; and that increasing life expectancy reduces the cost of care for the elderly, rather than increasing it, provided that healthy life expectancy rises at least as fast.

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

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

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

A healthy ageing strategy must encourage people to remain active into old age, to maintain friendships and a purpose to life, and to continue with healthy lifestyles, such as healthy diets. They must not be encouraged to accept that they suffer from old age when in fact they suffer from treatable illness. It must be easier for old people to remain active and involved, and be supported staying independent when old age does begin to affect them.

Evidence is emerging that that physical activity diminishes frailty, and that moderate levels of physical activity diminish it more than lighter levels. Maintaining physical activity into old age (and especially not reducing to light activities only) could be vital to prolonging health and delaying disability and death.

Go to overview or go to full analysis

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LEVEL 4

Full Analyses

LEVEL 4 (FULL ANALYSIS) SECTION D: THE LIFE CYCLE

D4.1 HEALTH OF CHILDREN AND YOUNG PEOPLE

Indicators of the Health of Children and Young People

There are a number of measures of how healthy our children and young people are. The following table compares Stockport's performance on key indicators with the England average. This is based on the comparison of 2013 / 2014 data.

Indicators where Stockport performs better than the England average	Indicators where Stockport is similar to the England average	Indicators where Stockpot performs worse than the England average
• Child immunisations • Children in care immunisations • Low birthweight • Obese children (age 4 – 5) • Obese children (age 10 – 11) • A & E attendances (age 0 – 4)	• Infant mortality • Child mortality (age 1 – 17) • Teenage conceptions • Child tooth decay • Maternal smoking • Breastfeeding initiation	• Admissions due to alcohol • Admissions due to injury • Admissions due to asthma • Admissions for self-harm • Admissions due to substance use • Admissions for mental health

Table D1 – Performance on key children and young indicators in Stockport compared with the England average.

Stockport's performance on the above indicators against the England average is mixed. The performance is better than or similar to the England average in all indicators except these relating to hospital admissions. Performance on breastfeeding maintenance is relatively strong and improved further in 2014 / 2015 but cannot be benchmarked nationally due to data validation issues. The comparative performance of the following indicators improved in 2013 / 2014 compared with the previous year:

- Maternal smoking
- Low birthweight
- Child mortality (age 1 – 17)
- Breastfeeding initiation
- Obese children (age 10 – 11)

There is some evidence that the performance on child immunisations has deteriorated over the last year which may affect Stockport's comparative performance in this area.

Stockport performs worse than the England average on all the indicators relating to hospital admissions. This is a pattern which is repeated in adult admissions. There is also evidence that hospital admission rates are higher than average in the North West as a whole. Whilst this is concerning, it is important to note that higher hospital admission rates do not necessarily mean that prevalence of these conditions is higher. Other contextual and system factors are likely to be

important. Both the reasons for the high admission rates and solutions to this problem need further scoping. The Stockport Together partnership has identified this as one of its priorities to address.

Indicator	Most recent value	Trend
Breastfeeding initiation	73.7%	Flat line long term trend
Breastfeeding at 6 weeks	50.3%	Tentative upward trend
Maternal smoking	11.7%	Tentative downward trend
Hospital admissions for unintentional and deliberate injury 0 – 17s	13.8 per 1000	Downward trend but recent increase in rates
Hospital admissions for unintentional and deliberate injury 0 – 5s	17.4 per 1000	Upward trend
Emergency department visits as a result of injury 0 – 17s (Stepping Hill only)	149.4 per 1000	No evidence of a trend
Alcohol related hospital admissions 16 – 19 (broad definition)	7.6 per 1000	No evidence of a trend
Alcohol related hospital admissions 16 – 19 (narrow definition)	5.0 per 1000	No evidence of a trend
Children overweight or obese at reception class	18.5%	Tentative downward trend
Children overweight or obese at year 6	29.8%	No evidence of a trend

Table D2 – Stockport's performance on selected children and young people's indicators with identification of direction of trend.

The rates for some of these indicators vary according to levels of deprivation. Despite concentrated effort in priority areas, significant inequalities remain and there is no clear evidence that they are being narrowed. For example, breastfeeding maintenance in 2014-15 was 45.3% in the deprived areas and 62.6% in the non-deprived areas. It was highest in the Heatons at 77.4% and lowest in Brinnington at 19.4%.

Smoking in pregnancy in 2014-15 was 22.6% in the deprived areas (quintiles 1 and 2) and 5.7% in the non-deprived areas (quintiles 3-5). It was highest in Brinnington at 35.8% and lowest in Cheadle Hulme at 1.1%. This is Stepping Hill Hospital data only so there are the usual caveats around residents in the north and west of the borough attending other maternity units.

Improving the Health of Children and Young People in Stockport

Stockport's Joint Health & Wellbeing Strategy identified 5 'We Wills'. This section of the report will review progress on these.

We will ensure children get the best, healthy start in life from conception to five years by enabling parents to access effective child care and advice, family support and quality early education and childcare provision

Health visiting services are being strengthened over the past few years through the Health Visitor Implementation Plan (2011 – 2015) in order to allow full delivery of the Healthy Child Programme (conception to five years). The Family Nurse Partnership (FNP: a programme targeting first time parents from conception until the child is two) commenced delivery in August 2014 and there are around 70 active clients on the programme at the time of writing. Stockport Council, acting as part of the health service, took on responsibility for commissioning these services from October 2015.

The Council, in partnership with Stockport NHS Foundation Trust, has developed an Integrated Children's Service. This service has brought together key children's health services, such as health visiting, FNP and school nursing, with the Local Authority's early help services. The service has joint management structures and is overseen by senior staff from the Council and Stockport NHS Foundation Trust. Locally we are also developing the Stockport Family model which builds on the Integrated Children's Service through further integration with children's social care.

The Integrated Children's Service is leading on the required increase in free high quality early learning places for two year olds. Since September 2013, 20% of two year old children from disadvantaged families have been eligible for free early years' education. In September 2014 the eligibility criteria were extended to include more low income families and up to 40% are now eligible. Stockport has been successful in securing over 80% take up of eligible places when the national average is 63%. This means that over 1000 two year old children in Stockport are receiving up to 570 hours a year of funded early education. The Integrated Children's Service is also leading on improving the accessibility and quality of information available via the Council website in relation to early learning and childcare places for parents.

Progress in relation to breastfeeding rates is encouraging. There is tentative evidence of an upward trend in relation to breastfeeding maintenance with 50.3% of women still breastfeeding at 6 – 8 weeks after birth. This is one of the highest rates in Greater Manchester and is also above the England average. There is also some tentative evidence that breastfeeding initiation has increased in the last two years. There are very stark inequalities in relation to breastfeeding in Stockport. Stepping Hill Hospital has achieved the re- accreditation in relation to the UNICEF Baby Friendly award. A community infant feeding co-ordinator is now established in post and work towards achievement of the community Baby Friendly award has commenced with achievement of stage one of the award. There is a well-developed breastfeeding peer support programme in Stockport.

11.7% of pregnant women are smoking at time of delivery in Stockport but there is tentative evidence of a downward trend. Very significant inequalities remain however. In order to have an impact on the inequalities that exist in some key deprived areas a maternal smoking incentive scheme has been implemented in Stockport. This evidence-based scheme rewards women for

stopping smoking and staying stopped with shopping vouchers. The final report on the scheme will be available in January 2016. In addition the babyClear programme is also getting underway. babyClear takes the most effective elements from the evidence of what works best to support women to stop smoking and systematically implements those initiatives across maternity settings.

Three year trend data analysis for reception-aged children between 2005 – 2014 indicates that obesity rates for this age group are starting to plateau. However, obesity and overweight combined rates continue to climb steadily (due to the steady climb in the percentage of children who are overweight). Stockport's rates for both overweight and obesity remain below both the national and North West averages. Promoting healthy weight in the early years continues to be a priority for stakeholders with ongoing investment in, and support for, the HENRY programme (Health, Exercise and Nutrition for the Really Young)

Work continues to improve oral health in Stockport. Following the publication of NICE guidance in 2014, a Greater Manchester strategy for oral health is being developed, alongside a local action plan for Stockport.

Public Health and Bridgewater NHS Trust are working together to provide targeted interventions for children living in Brinnington, the area in Stockport with the highest rates of dental decay.

Stockport has relatively low levels of early childhood caries amongst three to five year olds (a type of decay caused by extended bottle use) but higher levels of general decay. This suggests that most parents in Stockport adopt healthy habits for their babies, but that unhealthy habits develop as children reach toddler age and beyond. Our focus for preventative work, therefore, will be on reducing sugar intake and promoting healthy habits in early childhood.

We will keep children safe from harm and reduce childhood injury

The Care Quality Commission conducted a review of health services for Looked After Children and Safeguarding in Stockport in late 2014. A number of actions were identified and a process for addressing these is in place. Overall, the review found that there had been significant improvements in the performance of services since the previous review in 2012. It was felt that Looked After Children and Safeguarding were prioritised by health services in Stockport. The most recent Ofsted inspection of arrangements for safeguarding children and young people took place in February 2012. The overall effectiveness was judged to be adequate which does not match the aspiration of partners. A further inspection of services for children in need of help and protection, Looked After Children and Care Leavers and the functioning of the Local Safeguarding Children's Board, is expected in the near future.

There is an extensive training programme to support partner organisations to effectively safeguard children.

A designated nurse post for Looked After Children was established following the CQC Inspection in 2012. Stockport health professionals are now achieving quality standards in relation to health assessments for children placed by Stockport Local Authority. Stockport's Looked After Children continue to receive good quality health care. Immunisation rates for this group remain high. As part of the Stockport Family processes, the Specialist Nursing Team for Looked After Children now have a link member of staff from Social Care working with them to improve the timeliness of health

assessments and the quality of information available to the health professionals carrying out these assessments. The recent Care Quality Commission report for Stockport highlighted a need to improve the information available to health professionals about the mental wellbeing of Looked After Children. Work is now being undertaken to ensure that information about a young person's mental wellbeing is collated and reported on by CAMHS in advance of every health assessment, to ensure that young people's health assessments are high quality and that their care plans are holistic. Stockport's average SDQ score remains higher (worse) than the national average and work continues to try to improve the mental and emotional wellbeing of all Looked After Children.

Rates for hospital admissions for unintentional injuries at Stepping Hill are higher than the national average. Rates continue to be highest in the under-5s and 15 to 17 year olds. The children's accident prevention coordinator has been developing networks with a range of agencies across the public and independent sector to raise the profile of children's unintentional injuries and to explore ways in which many accidents can be prevented.

Further Home Safety Equipment Schemes, targeted at vulnerable families with a child under two, have been developed in partnership with other agencies, although the sustainability of these schemes is a concern due to resource limitations and reductions. A number of colleagues (28) from across a range of agencies have been trained by the Child Accident Prevention Trust (CAPT) in injury prevention, thereby creating a network of Child Injury Prevention Champions (CIPCs). The CIPCs have committed to rolling out accident prevention briefings to colleagues from within their own organisations and to parents throughout 2015.

The child injury prevention coordinator has established communication systems to ensure safety alerts are communicated widely and safety campaigns such as Child Safety Week, National Burns Day, and Road Safety Week are highlighted and supported by a range of stakeholders. The coordinator has joined a number of networks where unintentional injury is a concern and developed links with a number of national organisations such as, RoSPA, CAPT, Children's Burns Trust , BRAKE (road safety charity), Injury Minimization Programme for Schools, (I.M.P.S), St John's Ambulance Service and Greater Manchester Fire & Rescue Service (GMFRS).

A number of consultation focus groups held with parents have been useful in obtaining their views on what interventions to prevent unintentional injuries they would be interested in, what safety equipment they would use and recommend to other parents and where they would go for guidance and support if their child had suffered an injury.

As the majority of injuries to children under the age of four take place within a home environment, the child injury prevention coordinator, in partnership with colleagues from the Integrated Children's Services, aims to develop an intervention for parents which links home safety with child development.

Domestic abuse is a factor in the majority of child safeguarding cases, and is also sometimes associated with mental health and substance misuse issues, which interact in a complex way to undermine resilience and the capacity to escape abuse relationships and reinforcing social exclusion. A review of domestic abuse in Stockport led to the development of a new 2 year prevention strategy and action plan 2014-16. The new approach focusses resources on prevention and early help for both victims and perpetrators of domestic abuse.

We will support and promote healthy lifestyles for 5 – 19s through schools and other community settings

The majority of Stockport schools are well engaged with the health agenda with good links with Stockport Council facilitated by the schools' health and well-being co-ordinator. Public health colleagues are working with the co-ordinator to explore how they can work together to develop a coherent health offer.

Stockport Local Authority is the commissioner for the school nursing service. The Local Authority and Stockport NHS Foundation trust have agreed a development plan for the service. The key elements of the plan are as follows:

- Expanding provision of drop-in clinics in secondary schools - these support young people around a range of issues including relationships, sexual health and emotional health
- Expanding school nurses' involvement in delivery of relationships and sex education input in secondary schools
- Provision of feedback to parents from the National Childhood Measurement Programme where children have their weight and height measured in reception class and year six
- Developing partnerships with independent schools.

Healthy weight remains a priority for the partnership. Stockport performs comparatively well in terms of obesity rates when compared to both national and North West averages, with three year data analysis between 2005 – 2014 indicating that obesity rates for this age group are starting to plateau. Analysis over the same period for obese and overweight combined rates show a slight, but steady, decrease since 2011/12. A new physical activity strategy for Stockport will be launched this autumn and the School Sports Partnership works with 87% of Stockport schools to promote pupil participation in physical activity. New national guidance on food standards in schools has recently been published and schools will be offered support in meeting these guidelines. For the first time since the start of the National Child Measurement Programme, all parents in Stockport are to be provided with specific feedback on their child's results to both help inform and raise awareness of support available in Stockport. The All Together Active (A2A) weight management programme for 5 – 13 year olds continues to report positive results for participants. Weight management services for 14 – 16 year olds remains a gap and solutions to this are being explored.

The overall rate of alcohol related hospital admissions for 16-19 year olds in Stockport for 2014/15 (8.2 per thousand population) has increased compared to 2013/14 (7.3), but since the overall numbers involved are quite low, such fluctuation may not be statistically significant, so we will continue to monitor the trend. The majority of schools continue to buy into the Mosaic service which is well developed in Stockport and provides one to one advice and support for children using drugs or alcohol or affected by other people's use. The pathway for children and young people who present at the Stepping Hill Emergency Department with substance use issues has increased the numbers of young people provided with support, and this has recently been revised to further increase the numbers successfully contacted. We will continue to work with schools and parents to support delivery of substance misuse awareness and education.

We will promote positive emotional health, self-esteem and wellbeing for children, young people, parents and carers

CAMHS and its partners are developing a Local Transformation Plan, which will reform the way the service operates.

The plan has an emphasis on providing community based and low level interventions to meet the needs of the population as a whole. The Connect 5 training programme continues to be offered across the borough, supporting front-line workers to address mental health needs in their work. The 'Living Life to the Full' life-skills course is also being rolled out across Stockport, with courses running in children's centres throughout the borough. Beacon Counselling also offer this course in the schools they work in and the Secondary Jigsaw and Transitions team are planning to run courses for young people currently on their waiting lists.

Gaps identified in previous Public Health reports, such as the lack of service for 0-5s are being addressed. An Early Attachment Service has been set up in response to this need and the Health Visiting service and Parenting team are also providing more resource in this area, via the introduction of the Ages and Stages Questionnaire.

CAMHS have also developed their Transitions team, responding to the needs of 16 and 17 year olds. Pennine Care's new Healthy Minds IAPT service is also providing additional resource for 16-19 year olds with mental health needs. A worker has also been commissioned to provide health services and wellbeing support for Care Leavers.

Pathways have been developed for Stockport on responding to self-harm. Training has been rolled out to schools on using the pathway to decrease the number of young people presenting at ED and increase the confidence of schools and other non-specialist CAMHS services to respond to young people involved in self-harm. A multi-agency policy, approved by Stockport Safeguarding Children Board has recently been signed off for use across the borough.

As part of the CAMHS transformation work, Pennine Care, Stockport CCG and Public Health are working together to improve the data we have on Stockport CAMHS service in order to improve our service mapping and needs analysis and to improve outcome monitoring. The reporting systems being developed will enable us to show how effective we are at meeting the needs of Stockport's young people both in terms of service provision and in producing a positive outcome for the young people accessing those services.

We will work closely with families to provide early interventions and preventative programmes to reduce the development or impact of health or wellbeing problems

It is felt that progress in relation to this is covered in the narrative in the previous section

Some Priority Issues

Below is a summary of some of the areas where it is felt that further developmental work is needed:

- Whilst the performance on many children indicators is positive compared with the England average there are significant health inequalities on some key indicators (e.g. breastfeeding, maternal smoking).

- Hospital admissions for specific conditions in children and young people tend to be higher than the national average (e.g. Asthma, unintentional injury, alcohol).

- There is positive progress in relation to integration of children and young people's services with development of the Integrated Children's Service and the Stockport Family approach. We need to maintain momentum and further embed these.

- Integration is a key priority for both children and adults services but work in relation to this has tended to develop separately. It is suggested that more work is needed to promote integrated working between children and adults services.

- The Local Authority is now the lead commissioner for some children's public health services (health visiting, Family Nurse Partnership, school nursing). We need to develop an approach to commissioning of these services which has the greatest benefit to children and families in Stockport and supports the integration agenda.

- There are significant financial pressures on the public sector including services for children, young people and families. It is vital that we maintain a strong focus on prevention in order to reduce demand for services further down the line.

- We need to maintain a strong focus on mental wellbeing in relation to promoting mental wellbeing, preventing mental health problems and ensuring appropriate pathways for these needing support and treatment. There is a CAMHS transformation plan and an ongoing work being progressed by CAMHS and the Integrated Children's Service. This work needs to be maintained and further developed.

- Domestic abuse is a factor in the majority of child safeguarding cases, and is also sometimes associated with mental health and substance misuse issues, which interact in a complex way to undermine resilience and the capacity to escape abusive relationships and reinforcing social exclusion. In order to address this it was been agreed that we should:
    - Promote awareness of domestic abuse and support available including encouraging GPs and their staff to undertake the online domestic abuse training module.
    - Identify domestic abuse lead roles within new integrated Stockport Together neighbourhood teams, to support GPs and practice staff in identification and referral, and act as contacts for liaison between the APR and primary care services. Domestic abuse training should be incorporated into the induction for new integrated teams.

D4.2 HEALTH AND WORK

WORKLESSNESS

One way of asking about the effect of work and health is to look at the opposite side of the coin and ask what the effect on health is of being without work.

There are over a thousand studies from the 1930s and 1980s about the effect of worklessness on health and more are being generated during the current recession. Yet only a handful of those are useful because certain common analytical errors continue to be made.
Unemployment correlates with poor health by time (when unemployment rises health deteriorates), by geographical area (health is worst in areas where unemployment is highest) and in individuals (unemployed people suffer worse health than employed people). People's health deteriorates when they lose their job.

But unemployment rate rises and falls with recession so the time relationship could be with recession not with worklessness. Unemployment rates are highest in areas of multiple deprivation so the geographical correlations could be documenting multiple deprivation not just worklessness. The fact that unemployed people are sicker than employed people could show only that sick people are more likely to be without work. If people's health deteriorates when they lose their job this is what we would expect from what we know of the health effects of life changes.

Another common analytical error is to say that most spells of unemployment are short. This is true but it only shows that there is an underlying rate of people changing jobs. What matters are the longer spells. The following diagram (fig 17.1) shows 12 people who change jobs in a year, one each month, being out of work for a month and 1 person who is unemployed for the whole year.

_ _ _ _ _ _ _ _ _ _ _ _ 12 people unemployed for a month

_____ 1 person unemployed for a year.

Over 90% of the people shown in this diagram were unemployed for only a month. But at any given time 50% of those who were unemployed were unemployed for the whole year.

This diagram is, of course, only a theoretical example and reality is much more complex. But it does show how a study of spells of unemployed may be dominated by short spells of gaps between jobs when a large proportion of those without work at any given time are experiencing much longer unemployment.

For all these analytical problems we do indeed know that worklessness is bad for health. We know it from :

- Longitudinal studies following people over prolonged periods of time
- Studies which meticulously correct for the factors described in the above account
- A study which shows that people's health improves when they retire from worklessness.

THE IMPACT OF UNEMPLOYMENT ON HEALTH

From work done by Brenner during the 1980s recession we know that each 1% increase in unemployment sustained for five years produces in the 5th year:

- a 1.9% increase in total mortality,
- a 4.3% increase in male mental hospital admissions,
- a 2.3% increase in female mental hospital admissions,
- a 4% increase in prison admissions,
- a 4.1% increase in suicide and
- a 5.7% increase in homicide.

This is greater than the effect shown by longitudinal studies which show that for every 100 men unemployed for five years there will be 2 extra deaths a year amongst those men and 1 extra death amongst their wives, implying an impact on the health of unemployed people themselves which is no greater than the impact which the above figures project for the whole community. Thus the effect of worklessness on the health of communities is greater than the sum of the effect of worklessness on the health of unemployed individuals and their families. This is because the effects of unemployment spread more widely – to those who fear losing their jobs, those who accept shorter hours or worse conditions, those who are affected by overwork in workforces that have been reduced, and those who lose the benefits of the work the unemployed could have done. These effects not only add to the ill health experienced by unemployed people themselves but they also affect the baseline set by the controls in the longitudinal studies.

MITIGATING WORKLESSNESS

The health damage of unemployment is

- greater the stronger the sense of commitment to the work ethic
- less in those whose work involved responsibility for structuring their own time
- reduced by strong supportive social networks
- affected by the stigma of unemployment. Health improves when unemployment is redefined as retirement.

<u>WORK IS ALSO BAD FOR HEALTH</u>

So if worklessness is bad for health then work must be good for it? Well not necessarily

In the 19th century recessions improved health

There have been some studies which show health improving on factory closures

One third of the social class inequality in health is work related according to a study from 1978. Although this study is old and has not been repeated it may well still be valid.

HOW CAN BOTH THESE STATEMENTS BE TRUE?

So how can we say that work is bad for health and worklessness is also bad for health?

The health damage of work and worklessness are not opposites

Some people securely enjoy good quality work

Some people enjoy good quality work when times are good but suffer poor quality work or insecurity when times are bad

Some people suffer poor quality work when the economy is booming and unemployment when it isn't

Some people, especially people with disabilities or other employment problems, rarely experience work and when they do it is of poor quality

Work provides

- Income
- Structure to the day
- Social contacts
- Status
- Sense of identity
- Sense of contributing to society

In good quality work these benefits are considerable and it is good quality work which is good for health.

It is good quality work which is good for health whilst poor quality work is harmful and falls on the same people as the harm of unemployment but at different times in their lives.

GOOD QUALITY WORK is

- Meaningful
- Enjoyable
- Able to be integrated into life
- Pleasant surroundings

And has

- Significant autonomy
- Resources, power and training appropriate to responsibilities
- No unnecessary deadlines
- Good social support
- No bullying

CHALLENGE 1 ALL PEOPLE IN STOCKPORT SHOULD ENJOY GOOD QUALITY WORK

The health service and local government are significant employers and can help create good quality work by

- Addressing worklessness and training through opportunities for disadvantaged groups
  Improved occupational health support for employees

- Operating as best practice leaders and acting as exemplars
- Fostering understanding of the importance of good quality work and ensure this is understood by those working to attract jobs
- Strong political leadership on the need to create good quality work
- Encouraging exemplar businesses to emphasise the benefits in recruitment, retention, morale and productivity

CHALLENGE 2 DISABLED PEOPLE IN STOCKPORT SHOULD BE EMPLOYED FOR THEIR ABILITIES INSTEAD OF BEING REJECTED FOR THEIR DISABILITIES

Disabled people are often rejected when they would make good employees. Employers often have fears about attendance and sickness although in fact the evidence is that these fears are groundless.

Employers say that they need the best person for the job, but the important part of this statement is "for the job". It is not discrimination to reject visually impaired people for the job of cricket umpire. It is however utterly wrong to reject somebody for an office job that she would be perfectly capable of doing just because you don't want to buy a braille keypad (that is the meaning of "reasonable adjustment"). And it is positively foolish to reject a visually impaired person for a job that particularly depends on skills in other senses (a wine taster for example) as visually impaired people are likely to have developed those other senses in a compensatory way.

We must address the problem of exclusion of disabled people from the workforce by

- Moving people from incapacity benefit to work
- Using health and social care resources to create work rather than day care
- Statutory organisations acting as exemplars
- Political and business leadership to emphasise the good work record of disabled workers

Mental health investment is an important opportunity to focus on supporting people with mental health problems in work, rather than trying to replace the factors which work provides through some form of day care.

CHALLENGE 3 WE SHOULD SHAPE THE ECONOMY OF STOCKPORT SO THAT IT CREATES GOOD QUALITY WORK FOR EVERYBODY

A knowledge based economy creates good quality work

A knowledge based company can locate anywhere in the world. Why should it come to Stockport instead of Fiji or the Mull of Kintyre?

In this setting of mobile knowledge-based industries culture and environment are not drags on the economy – they become economic drivers instead.

A healthy economy would:

- Protect open space and create peace and beauty
- Reduce motor vehicle exhaust emissions
- Reduce unemployment
- Grow slowly and steadily rather than fitfully

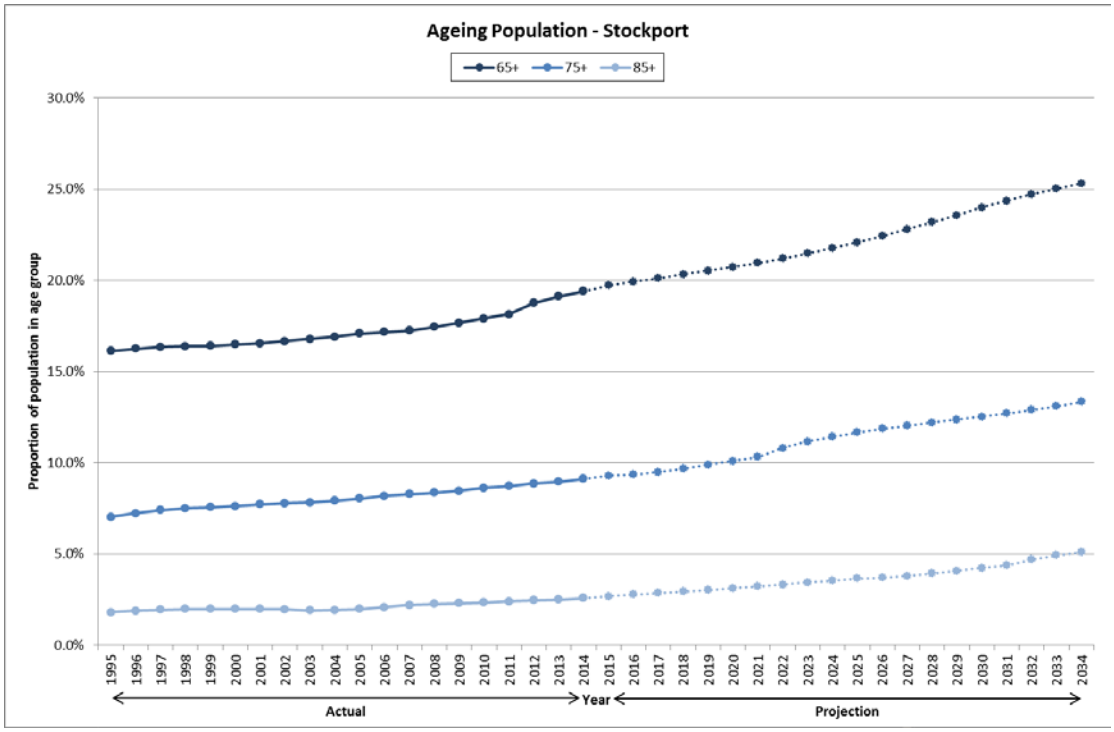
- Provide security, relieve poverty and avoid pressures for geographical mobility
- Avoid chemical and physical hazards and noise and avoid accidents
- Provide pleasant working conditions
- Train people for the responsibilities they carry and avoid giving people responsibilities without resources and power
- Avoid overwork, underwork or working under pressure to deadlines
- Provide work that is meaningful and satisfying, under the control of the worker and flexible enough to accommodate other roles
- Avoid the disruption of communities
- Empower consumers to act to promote health and protect the environment
- Empower people to do not just to demand.

D4.4 HEALTHY AGEING

An Ageing Population

Stockport, like most of the country, has an ageing population. Indeed our population is ageing more than many parts of the country because we do not have the renewing effect of high levels of immigration.

Fig D1



Further details can be found in the JSNA.

A population can age for a number of reasons

- for demographic reasons because a cohort of people, due to say a baby boom, comes into old age
- because fewer people die young
- because the age of death of people who survive to old age increases.

In the 1970s and 1980s the UK experienced an ageing population because a cohort of increasing population had reached old age. In the 19th century people used to have a lot of children so some would survive the high infant mortality. In the 20th century reproductive behaviour adjusted to much lower infant mortality. However there was a gap of about a generation whilst this happened and as a result there was a generation of large families most of whose children survived (although a lot of the men were killed in World War I). This generation grew into old age in the 1970s and 1980s. This was the largest ageing of the population the country had ever experienced so it conditioned our expectations of what an ageing population would bring.

Shortly after this the first generation of men to live their entire adult life in peacetime matured into old age. This also modified the gender ratio in old age so it became more common for old people to have a partner. The pressure of ageing then eased off for a few years but in 2016 the post war baby boom starts to reach the age of 70 and from that point on cyclical increases and decreases in numbers of old people will occur similar to those which have in the past affected the child population.

However in parallel to this process life expectancy is increasing.

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

Scenarios for Health and Ageing

Let us assume that at the moment disability (and hence health care costs) occurs as follows:-

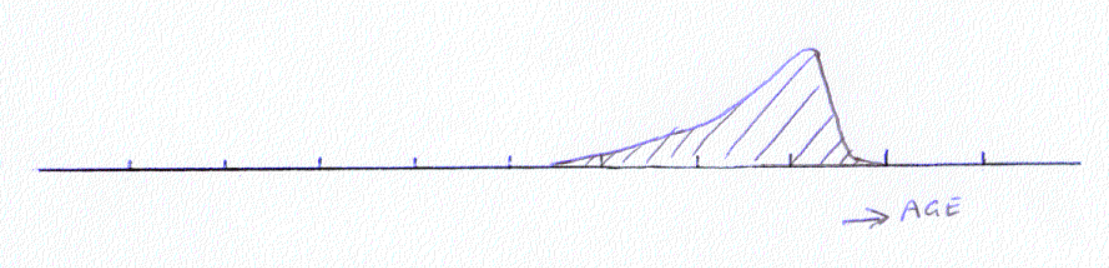


Fig D2

The fear is that increasing life expectancy does not delay the onset of disability, it simply makes it last longer. For every extra year of life there is an extra year of woe. We live longer, but the extra time is spent taking longer to die.

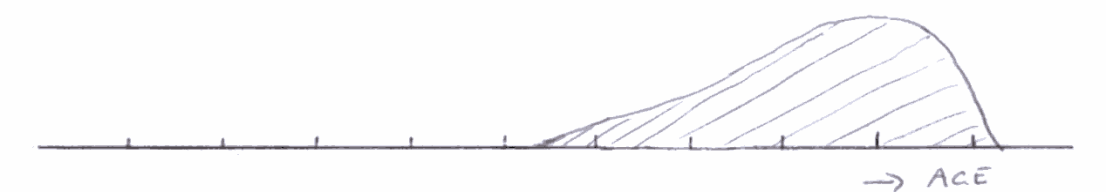


Fig D3

In this case there will be a huge increase in disease burden for the individual (and hence health and social costs for the population) as a result of an increased life expectancy

Another possibility however is that all that happens is that disability and death are both delayed. For every extra year of life woe is delayed by a year but there is no change in the amount of woe. We

live longer and the extra time is spent living – we spend no extra time on dying.

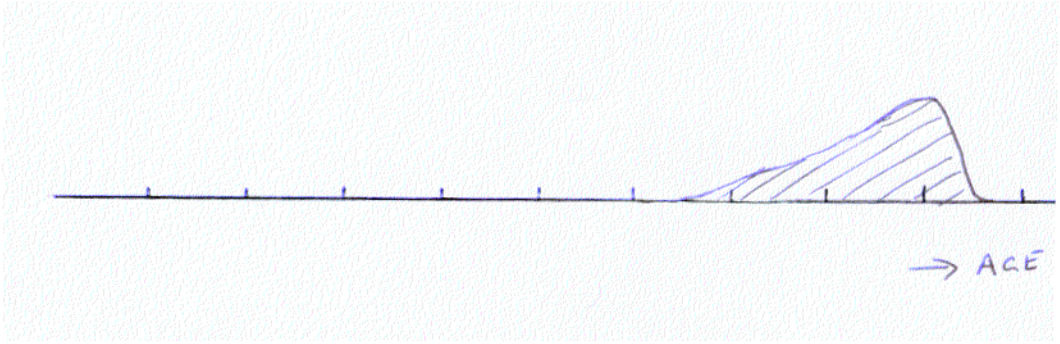


Fig D4

In this case there will be no increase in the disease burden incurred by the individual. At a population level the health and social care costs will be delayed and the proportion of the population incurring them at any one time may therefore be reduced.

An intermediate possibility is that disability may arise at the same time but may develop more slowly. Woe increases with the extra years but not by as much. We live longer and the extra time is partly spent enjoying more life and partly spent taking more time to die.

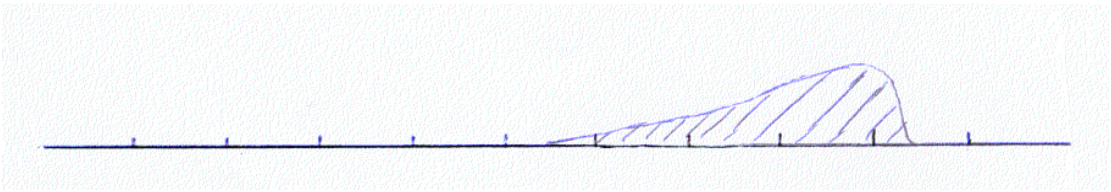


Fig D5

In this case there will be some increase in the disease burden incurred by the individual and some increase in the health and social care costs incurred by the population, but it will not be anything like as great as in the first scenario.

The most optimistic scenario however is that we will live longer and we will spend less of that time ill. For each extra year of life there will be fewer years of woe. We will live longer and die quicker. My preferred mode of death is to be shot by a jealous lover at the age of 104.

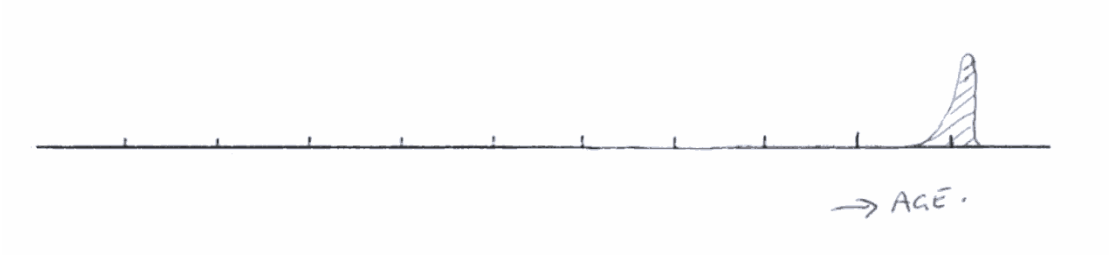


Fig D5

If this scenario is correct then the lifetime disease burden on the individual becomes less as life expectancy increases – we have the double benefit of living longer and suffering less. Health and social care costs for the population are both diminished and delayed – again a double benefit.

The theoretical basis for the nightmare scenario (longer life more disease) is that as people avoid the causes of premature death – infections, accidents, heart disease, violence, famine – they come to live long enough to suffer from chronic diseases and as a result to suffer a greater and longer disease burden.

It is certainly true that people have to die of something and that diseases that are commoner in older people, such as cancer, increase in incidence as diseases that kill a lot of young people decline. But the theoretical basis for the delayed disease scenario (longer life, same amount of disease) is that there is no particular reason to suppose that these diseases will cause a greater burden. Most people make most use of health care in the year before their death. This is true whenever that death is. Therefore if most people die when they are old that is when most health care costs will occur. It has nothing to do with age – it is related to proximity to death.

The optimistic scenario (longer life less disease) was first put forward by Fries and became known as the compression of morbidity scenario. Fries believed that if death from disease were avoided people would eventually die of old age. He believed there was a natural age of death which varied for each individual but was normally distributed around an age that increased by a few months each generation, having been three score and ten in biblical times and now being four score and five. This was genetically programmed, probably in the part of the chromosome known as the telomere. We would not be able to increase this maximum longevity, apart from the few months by which it naturally increased each generation, until we were able to genetically re-engineer the telomere, at which time massive extensions of longevity would occur. Until then all increases in life expectancy would be achieved by increasing the proportion of the population who survive to the maximum longevity. Death from old age is, Fries argued, quick. Hence if more people survive to reach this maximum age the total amount of morbidity would be reduced.

An alternative theoretical perspective, without the concept of a maximum longevity, but still with the perspective of compressed morbidity, views ageing as a harmonious deterioration of organ systems which diminishes resilience and increases the probability of death. Old age brings “frailty” – a term used here with the particular meaning that people are fully healthy and fit but are less likely to recover from factors which disturb that health and fitness. Improving population health delays people experiencing the disease that will kill them. The older they are when they encounter that disease the less resilience they will have and the shorter their death will be. On this basis the compression of morbidity consists of somebody living on, fit and well, into old age until they die suddenly of a disease or injury which a younger person would have recovered from.

This third theoretical perspective is increasingly gaining support and the evidence for it is increasing. Indeed work is being developed on ways of both recognising and treating frailty. Particularly exciting is the discovery that physical activity is a powerful treatment for frailty. This carries the potential for intervening to prevent the pessimistic scenario and promote the optimistic scenario. It turns the frailty perspective from being an optimistic but nonetheless fatalist scenario into a perspective which, both for the population and the individual, carries the potential for action to prolong health and delay death.

The Population Financial Implications of the Scenarios

In a theoretical population with no migration and a fertility rate that maintained a constant population the proportion of the population experiencing the need for health and social care associated with the disability and dependency of old age would be given by the formula:

$$\frac{\text{Life expectancy minus healthy life expectancy}}{\text{Life expectancy}}$$

As life expectancy appears in the denominator of this equation then an increase in life expectancy will in itself reduce the proportion, provided it is matched by an increase in healthy life expectancy so that the numerator doesn't increase.

For example:

Life expectancy	Healthy life expectancy	Proportion needing care
70	65	7.1%
80	75	6.25%
90	85	5.5%

Table D3

The increasing 20 years life expectancy (from 70 to 90) with an unchanged gap between healthy life expectancy and life expectancy (5 years) has reduced the population burden by 1.6 percentage points out of 7.1 percentage points, a reduction of 22.5%

However changing healthy life expectancy affects the figures even more spectacularly:

Life expectancy	Healthy life expectancy	Proportion needing care
75	65	13.3%
75	68	9.3%
75	70	6.7%

Table D4

An extra 5 years of healthy life expectancy with constant life expectancy of 75 reduces the population burden by half.

If compression of morbidity occurs these two effects would operate together reinforcing each other:

Life expectancy	Healthy life expectancy	Proportion needing care
75	65	13.3%
80	75	6.25%
90	87	3.3%

Table D5

Applying this theoretical calculation to the figures for Stockport wards gives the figures in Table 18.4:

Table D6 2001 Ward	1999-2003 Life expectancy	1999-2003 Healthy life expectancy	Theoretical proportion needing care in a population which had these life expectancies, no migration no change in fertility and no cohort effects *
Brinnington	72.3	60.5	16.3%
Cale Green	75.0	65.1	13.3%
North Reddish	77.9	68.8	11.7%
South Reddish	73.8	65.2	11.7%
Edgeley	76.3	67.8	11.1%
Manor	76.1	67.7	11.0%
Great Moor	77.4	68.9	11.0%
Bredbury	78.3	70.0	10.7%
Davenport	75.9	68.1	10.3%
Romiley	79.0	71.0	10.1%
Cheadle Hulme North	77.7	70.5	9.3%
Heald Green	80.5	73.1	9.2%
Heaton Mersey	80.1	72.8	9.1%
Hazel Grove	80.0	72.9	8.9%
Cheadle	81.3	74.3	8.7%
South Marple	82.3	75.6	8.1%
North Marple	79.4	73.0	8.1%
Heaton Moor	78.9	72.7	7.9%
Cheadle Hulme South	81.2	74.9	7.8%
West Bramhall	81.7	75.8	7.2%
East Bramhall	82.3	76.8	6.7%

* the theoretical proportion in this theoretical population does not correspond to the actual proportion in the ward due to the impact of migration, fertility and cohort effects.

Although the theoretical population we are discussing in these calculations is a population isolated from issues of migration and fertility and not therefore an actual population at all, these calculations raise the rather startling prospect that the financial burden of an elderly population is actually greatest in those areas where people do not live as long and that increasing life expectancy reduces the cost of care for the elderly rather than increasing it, provided healthy life expectancy rises at least as fast.

What Can We Learn from Centenarians and Populations Where Ageing Well is Normal?

There are a number of populations in the world where it is much more common for people to live to over 100 and to remain healthy well into old age – Okinawa, Sardinia, some Seventh Day Adventist communities in California, Georgia, and some remote valleys in Ecuador and in Pakistan. These communities have been the subject of study as have centenarians in a number of different countries.

About two thirds of centenarians demonstrate compression of morbidity, remaining fit and active well into their 90s so these groups definitely demonstrate a desirable characteristic. About 30% of the chance of living to be over 100 seems to be genetic but about 70% seems to be environmental. The best documented environmental factors are a healthy diet, exercise (and especially remaining

active into old age), social support networks with a strong marriage and good friendships, a strong sense of personal identity with a goal to life, and some element of continuing challenge.

This is not exactly a surprising list. Indeed it could be said that years of careful scientific study of old people has shown that you are most likely to live to be old if you live a healthy life! The studies do however emphasise the prominent place in a healthy life of exercise and of various key forms of mental well-being.

A Healthy Ageing Strategy

A healthy ageing strategy must

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

<u>The Role of Healthy Lifestyles</u>

The idea that it is too late to worry about good health when you are old is simply wrong. The drive to maintain healthy lifestyles must continue throughout life.

<u>The Role of Expectations and Age Discrimination in the NHS</u>

When I was 58 I began to develop some trouble with my ankle. I found it difficult to walk uphill. I commented to my wife that I felt like an old man when I walked up hill. I was fine when I walked on the flat or swam. However I did have two episodes where the ankle became swollen and painful.

I went to see a physiotherapist. She told me that there was restricted movement in the ankle probably as a result of an old injury in my twenties. She gave me exercises to carry me out. Most importantly she advised me to force the ankle to bend when I was walking uphill.

I carried out the exercises. The ankle got a lot better. It still isn't right. I still have to force it when walking uphill, and I still walk more slowly uphill than I would like. But my life is in no way restricted.

Imagine that I had had the idea that life ends somewhere in your 60s and that by your late 50s you are coming to the end of your life. Many people have that idea, especially in poorer areas. Being 58, I would just have accepted that I couldn't walk uphill. I would have stopped walking uphill. I would therefore have walked a lot less. I would have become less fit. I would fairly soon have stopped walking. A downward spiral would have gathered pace, all of it as a result of one eminently treatable and not very disabling start.

Suppose that the health professional I had gone to see had said "Oh, it's just your age". I would have been a bit distressed that I was wearing out so quickly. I would have felt upset to abandon my ambition to be shot by a jealous lover at 104. But I would undoubtedly have resignedly accepted

reality. Except that it wouldn't actually have been reality. Although it would rapidly have become so as I accepted it as such.

An immense amount of harm and premature ageing is caused by people accepting treatable illnesses as old age and restricting their lives instead of tackling the problem. Often people do this because of a culture that tells them that life ends in your 60s and you are lucky if you reach your three score and ten. We have to fight that attitude and substitute for it a culture which says that you shouldn't even consider being old until you have reached four score and five and even then think twice about it.

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

Experiential training of front line staff can assist with shifting cultural thinking.

The Role of Well Being

Of the five factors which the studies of centenarians and of long lived populations showed to be most strongly associated with a long healthy life, three are elements of well-being - social support networks with a strong marriage and good friendships, a strong sense of personal identity with a goal to life, and some element of continuing challenge. A fourth – exercise – is well known to be a factor which promotes a sense of well-being.

From an ageing well standpoint it is important that old people are encouraged to retain a place in the world and a goal in life. It is also important that old people maintain social networks, friendships and leisure activities.

From a standpoint of preparation for ageing it is important that these aspects of mental well-being play an important part in the Borough's health improvement programmes.

The Role of Physical Activity

Evidence is emerging of the role of physical activity in addressing the issue of frailty. It is coming to seem that physical activity in old age actually reduces frailty. It also appears that moderate intensity activity is more effective than lower levels of activity. Yet all too often older people are discouraged from physical activity, or directed towards relatively lighter forms of activity, because of a perception that this is the correct response to frailty. This could, literally, be a fatal error.

Supporting Older People Staying Independent

A key aspect of healthy ageing is the importance of sustaining functional independence so that older people, if they choose, can live in their own home environment for as long as possible. There are many different facets to independent living, the most immediate of which are being able to wash, dress and meet other basic nutritional and physical needs. But leading a satisfying and independent life also includes being able to regularly leave the home environment to see friends, take part in leisure activities, attend medical and other appointments, do light maintenance tasks around the home and garden, and keep in touch with family and community. The preservation of meaningful

and productive social activity in particular has significant importance for the wellbeing and psychosocial health of older people and may, in itself, play a vital role in motivating and sustaining independent living at the individual level.

The opportunity to experience an independent and rewarding older age is of primary relevance to older people themselves, their families and carers, but it is increasingly important as a means of managing the population impact of simultaneous increases in longevity and the ageing of the baby boom generation, who are now entering early older age.

This dual population effect is expected to create within the next 20 years an unprecedented demand on the UK health and social care system, on long-term care in particular. In demographic terms alone, ONS forecast that the 65+ age group is predicted to rise by 64% between 2007 and 2032, from 8M to 13.2M, with the 85+ population growing most rapidly by an average of 136%. This is coupled with expected ongoing increases in life expectancy but also increasing multiple morbidity and disability.

As already described, there are a number of possible scenarios for the impact of an ageing population on public service provision and society more generally. However, any of these scenarios will be positively influenced by taking action to ensure that years gained in life expectancy are healthy and productive ones, so as to minimise the negative effects of ageing and delay people's need for intensive (and unfortunately sometimes necessarily intrusive) formal health and social care support.

Achieving this will likely involve action across the public sector:

Implementing a financing system for long-term care which takes account of the anticipated rise in the volume and frequency of long-term care needs

Health, social and informal care working effectively and systematically in a community setting to achieve continuity of care for older people

Investing in healthy ageing and support which offers 'protection' against disability and dependence

Wider social recognition of the importance and value of older people within culture and society, including environments and communities which show increasing awareness of the daily challenges experienced by older people

Similarly, to tap into widest possible potential to improve health and wellbeing, the approach should address the risk factors which limit or reduce functional independence in older people and include:

- Environmental conditions
- Social circumstances – loneliness or the effects of living alone in particular
- Lifestyle - physical activity and nutrition in particular
- Psychosocial health
- Physical health
- Existing co-morbidity

In terms of the health and social care system specifically, there is evidence that when implemented systematically and consistently, community-based integrated health and social care can support and improve the quality of life, independence and psychosocial health of even very frail cohorts of older people i.e. those with established disability and chronic care needs.

Keeping people out of hospital is important to maintaining their independence since all too often a hospital admission can be the start of a process of decline.

Even when people finally need to go into residential care independence remains the driving value – the aim is not just to care for people but to enable them to live as fulfilling a life as possible.

However, as already indicated, the key to achieving success at both the individual and population level is to identify and address the multiple and co-existing risk factors which impinge on independence in older age as a key component of all elderly care. This should also form the basis of implementing 'Making Every Contact Count' starting with the younger older people and continuing through to the 85+ population.

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

SECTION D: the Life Cycle

LEVEL 5

Additional Analysis

LEVEL 5 (ADDITIONAL ANALYSIS) SECTION D: THE LIFE CYCLE

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.

D5.1 HEALTH OF CHILDREN AND YOUNG PEOPLE

For more information about the health and wellbeing of children and young people visit http://www.chimat.org.uk/

JSNA briefing - Early years health at a glance

JSNA briefing - School age health at a glance

D5.2 HEALTH AND WORK

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 13 of the 18th report – Health and Work
- JSNA briefing - Young adult health at a glance

D5.3 HEALTHY AGEING

For more information, help and advice about a range of issues relating to the health and wellbeing of older people visit http://www.ageuk.org.uk/stockport/

JSNA briefing - Older people's health at a glance