24th Annual Public Health Report for Stockport 2017/18

SECTION C: The major risk factors causing disease, death and disability

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Contents

The report is broken down in to levels and sections.

There are six sections:

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

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

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

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

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

- **Section F** contains recommendations

This report presents section C 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 C: The major risk factors causing disease, death and disability

LEVEL 1

Tweets

LEVEL 1 (TWEETS) SECTION C: THE MAJOR RISK FACTORS CAUSING DISEASE, DEATH AND DISABILITY

C1.1 HYPERTENSION

- High blood pressure has no obvious symptoms. Untreated causes strokes & heart disease. Caught early can be treated overview

C1.2 SMOKING

- #Tobacco, the only lawful product to kill half its users, is addictive. About a fifth of #Stockport people smoke overview
- #Stockport. #Tobacco is the only lawful product that is addictive in most cases of normal use overview
- #Stockport. The 1st difference between #smoking & Russian roulette is the time u spend waiting to see if you've lost overview
- #Stockport. The 2nd difference between #smoking & Russian roulette : the odds are worse for smoking overview
- #Stockport. 3rd difference between #smoking & Russian roulette: there isn't a campaign for legalising Russian roulette overview

C1.3 DIET

- Eat real foods, as unprocessed as possible, & help prevent heart disease, stroke, diabetes, obesity & cancer overview
- #Stockport. Eat less sugar, salt and saturated fat overview

C1.4 PHYSICAL ACTIVITY

- #Stockport. Benefit of physical activity on health is huge. Drug with same effect would be called a #miracle cure overview
- Physical activity tackles heart disease, obesity, osteoporosis, diabetes, mental health & probably dementia overview
- A small ↑in activity will improve health hugely in #Stockport. On short journeys leave car at home & #walk briskly overview
- Children & young people who are fit hve better Eng, Maths & Sci exam results. Protect the right to play in #Stockport overview
- ½ of women & 1/3 of men damage their health due to inactivity. In #Stockport walk briskly as if late for an appointment overview
- Do more #walking and #cycling every day in #Stockport. Free and easier to keep up than going to the gym overview

C1.5   ALCOHOL

- Larger and stronger drinks and consumption of cheap #alcohol cause 8,000 #Stockport hospital admissions each year [overview](#)
- #Stockport: The 1st drink of the day may be beneficial. The 2nd eliminates the benefit. The 3d is bad for you [overview](#)
- #Stockport. After drinking allow 1 hour for each unit you have drunk before doing anything dangerous or needing skill [overview](#)

C1.6   WELLBEING

- Stockport. Stress, poor levels of #wellbeing, #loneliness and #isolation are probably the biggest cause of ill health [overview](#)

C1.7   SAFETY AND HEALTH PROTECTION.

- Various agencies protect us from #hazards and risk of injury or infection. Read a report on their work in #Stockport [overview](#)

C1.8   SMOKING IN PREGNANCY

- Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy.
- Stopping smoking is one of the best things a woman and her partner can do to protect the health of their baby through pregnancy and beyond.
- Mothers who smoke have children who smoke – let's support our women to access stop smoking services [overview](#)

C1.9   TYPE 2 DIABETES

- Stop diabetes! Move more & snack less**.** Together we can diffuse the time bomb. https://www.healthystockport.co.uk
- Consequences of diabetes are very severe and include kidney disease, foot disease, heart disease, depression and blindness
- Diabetes costs Stockport £40 million a year and over 25000 people in Stockport are at risk and don't know it. Are you? http://riskscore.diabetes.org.uk/start?_ga=1.205835029.722794865.1476350383

  [Overview](#)

C1.10   ANTIMICROBIAL RESISTANCE

- Remember – not all bugs need drugs! Save our antibiotics for when they're really needed. Become an antibiotic Guardian http://antibioticguardian.com/
- Antibiotics should be taken as prescribed, never saved for later or shared with others.

- It is important that we use antibiotics in the right way - appropriate use of antibiotics will slow down the development of antibiotic resistance

- Community pharmacists are well placed to help provide advice on over the counter medicines to treat symptoms and help with self-care.

[Overview](#)

C1.11 AIR QUALITY – WHAT'S THE PROBLEM IN STOCKPORT

- Motor vehicles are the greatest preventable threat to air quality.
- Harmful emissions from motor vehicles contribute to breathing and lung problems.
- It is important to inform the population of the impact of air pollution and target those particularly susceptible.
- I recommend the need to improve air quality through linking to other issues such as obesity.
- I recommend reducing the use of the car and promoting a healthier transport system.
- I recommend wider use of green walls and green security to mitigate effects of air pollution.

[Overview](#)

C1.12 GREEN INFRASTRUCTURE

- Green infrastructure improves air quality by absorbing greenhouse gases.
- People are more likely to walk and cycle if the route is attractive with green infrastructure
- Exercise taken in green surroundings may have more health benefit than exercise in drab city surroundings
- Greenery reduces the urban heat island effect and reduces flood risk.
- Greenery raises the human spirit, and sight of greenery reduces stress. We need tranquil areas.
- Greenery contributes to biodiversity, much of which is vital for health.
- Green infrastructure can contribute to nutrition (eg allotments, fruit trees).
- Urban drainage is improved and flood risk diminished by green roofs, ponds and wetlands.
- Drives and car parks can be surfaced with lattices to support the vehicles whilst allowing grass to grow through.
- Roof gardens and earth-sheltered buildings allow pressure for development land to be met with much less loss of open space.
- Linear green passages or tree-lined routes can form good walking routes
- Floral displays and water features particularly raise the human spirit.
- Thorny hedges, or thorny plants on walls are an effective means of security.
- Most people should see greenery most of the time
- There should be a network of green walking and cycling routes throughout the borough
- All of the Borough should be within a short walk of a green corridor into the countryside

- All of the Borough should be within a short walk of recreational greenspace
- District centres and the town centre should have a green feel to them. Overview

C1.13 HOUSING

- Cold housing contributes to cardio-vascular, respiratory, rheumatoid diseases, hypothermia and poor mental health.
- Cold is not just winter - death rates rise when the temperature falls below that of a spring day.
- Structural defects (eg poor lighting, or lack of stair handrails) increase risk of accidents and falls.
- Damp and mould are bad for health.
- Overcrowded housing has adverse impacts on mental health, accidents and spread of infection.
- 41 per cent of homeless people have long term physical health problem (cf 28% in the general population).
- 45 per cent of homeless people have diagnosed mental health problem (cf 25% in general population)
- Frequently moving tenancy provides insecurity, stress and disruption to education and relationships.
- Ratio between house prices and earnings is still increasing (hard for young people).
- Quality of new homes fails to meet expectations far more often than it should.
- Gypsies and Travellers have life expectancies 10-12 years shorter than the general population.
- 9% of private rented stock in Stockport has some form of disrepair.
- Stockport Council's comprehensive fuel poverty strategy halved fuel poverty 2011- 2016.
- 10 people are actually sleeping on streets in Stockport but would be about 40 if it weren't for The Wellspring.
- About 100 people in Stockport are sofa surfing.
- Lack of provision for people of nomadic lifestyle pausing to stay amongst us leads to unsuitable encampments
- Around 1,000 new houses a year are needed in Stockport. We need a proper mix not just numbers.
- There is a growing number of single person households.
- An increasing elderly population which would benefit from extra care housing.
- Affordable housing is a major need.
- Unmet market niches include car free housing, flats close to stations, and purpose built cooperative communities.
- We need to view housing need not just as one total figure, but as the sum of a number of specific needs.

Overview

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

SECTION C: The major risk factors causing disease, death and disability

LEVEL 2

Overview

LEVEL 2 (OVERVIEW) SECTION C: THE MAJOR RISK FACTORS CAUSING DISEASE, DEATH AND DISABILITY

C2.1 HYPERTENSION

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

Go to key messages or go to full analysis

C2.2   SMOKING

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

Go to key messages or go to full analysis

C2.3   DIET

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

Go to key messages or go to full analysis

C2.4   PHYSICAL ACTIVITY

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

Go to key messages or go to full analysis

C2.5   ALCOHOL

Alcohol related diseases have been the major cause of our failure further to close the gap in life expectancy during the last decade, despite continuing with the progress in addressing cardiovascular diseases. Over 7,000 hospital admissions of Stockport residents in 2012/13 were attributable to alcohol, double the number seen in 2003/4. Key factors include larger and stronger drinks and the consumption of cheap alcohol from supermarkets, often as pre-loading before a night out to make it cheaper to get drunk. It is regrettable that Government has reneged on its commitment to introduce a minimum unit price.

Go to key messages or go to full analysis

C2.6   WELLBEING

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

Go to key messages or go to full analysis

C2.7   SAFETY AND HEALTH PROTECTION

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

Go to key messages or go to full analysis

C2.8   SMOKING IN PREGNANCY

The case for supporting women who are pregnant to give up smoking is very strong; smoking is the single most modifiable risk factor for adverse outcomes in pregnancy and our ambition should always be to support all women to have a smoke free pregnancy. Reducing rates of smoking in pregnancy is a key priority for the Public Health Department of Stockport Council, Stockport Family, and Stockport Foundation Trust and Primary Care services. There are a wide range of programmes that are in place that are contributing to this reduction with some excellent good practice amongst our midwives and community staff.

However young women living in the most disadvantaged areas of Stockport are far more likely to smoke during pregnancy than older women and all women who live in more affluent areas. For instance, during 2013/14 37.9% of mothers in Brinnington were smoking at time of delivery compared to 5.4% in Bramhall. We need serious consideration about different ways to engage with young women and ensure that all Stockport babies have the very best start in life.

Go to key messages or go to full analysis

C2.9   TYPE 2 DIABETES

Type 2 diabetes develops when the body doesn't produce enough insulin or when the insulin it does produce doesn't work properly. Glucose levels rise in the blood and the consequences are very severe and include kidney disease, foot disease, heart disease, depression and blindness. Treating diabetes and its complications costs Stockport around £40 million. Just under 15,000 people in Stockport are known to have diabetes but an estimated 25,000 people are at risk of diabetes and don't know it. Are you?
http://riskscore.diabetes.org.uk/start?_ga=1.205835029.722794865.1476350383

The good news is that we can all make small changes in our lives to reduce our risk of diabetes. By eating well and moving more, we could reduce the numbers of type 2 diabetes by over half. Visit https://www.healthystockport.co.uk for advice. And identification of people at risk, better care for patients with diabetes and integration of services will improve outcomes in patients with diabetes. **Move more**. **Snack less.**

Go to key messages or go to full analysis

C2.10   ANTIMICROBIAL RESISTANCE

Antimicrobial resistance is a major public health concern. Unless we tackle the issue now, the consequences could be severe.

Antibiotics are essential medicines for treating bacterial infections in both humans and animals but, antibiotics are losing their effectiveness at an increasing rate.

The key to tackling the problem is to use antibiotics less and particularly to avoid using them when they are not needed. Many antibiotics are prescribed and used for mild infections when they don't need to be. All colds and most coughs, sinusitis, otitis media (earache) and sore throats get better without antibiotics.

Individuals (the public, healthcare professionals, educators and leaders) can take action by choosing a pledge and becoming an Antibiotic Guardian http://antibioticguardian.com/

Go to Key messages or go to full analysis

C2.11 AIR QUALITY – WHAT'S THE PROBLEM IN STOCKPORT

Pollution from the increasing number of motor vehicles provides the greatest threat to air quality in Stockport and across the UK. Harmful vehicle emissions contribute to breathing and lung problems and contribute to greenhouse gases, which cause climate change. Motor vehicle use is the largest preventable issue related to air quality. There are still locations that continue to be above the annual mean air quality objective in Greater Manchester, but there is an overall trend of declining concentrations.

The key priorities from the Greater Manchester Air Quality Action Plan include: changing travel behaviour, reducing emissions from Heavy Goods Vehicles and buses on key corridors. It outlines the need to implement planned infrastructure improvements for sustainable transport and stimulate the uptake of Ultra Low Emission Vehicles, whilst continuing to encourage the uptake of smarter travel choices.

I recommend that it is important to inform the local population of the impact of air pollution and target those members of the public particularly susceptible to air pollution. I recommend raising awareness of the need to improve air quality through linking to other public health issues, such as obesity. I recommend reducing the use of the car and promoting a healthier transport system including use of traffic measures. I recommend a much wider use of green walls and green security measures to mitigate the effects of air pollution near roads.

Go to Key messages or Full Analysis

C2.12 GREEN INFRASTRUCTURE

Green infrastructure provides exercise opportunities, reduces stress and promotes well being, addresses the urban heat effect and can help reduce flood risk. Therefore most people should see greenery most of the time, there should be a network of green walking and cycling routes throughout the borough, all of the Borough should be within a short walk of a green corridor into the countryside, all of the Borough should be within a short walk of recreational greenspace, and district centres and the town centre should have a green feel to them. Greenspace should not be lost to development – greenspace-compatible development technologies, such as green roofs, roof gardens and earth-sheltered buildings should be used to avoid this. Some forms of green infrastructure are very cheap such as street trees, green walls, and green security (such as thick thorny hedges instead of fences).

Go to Key Messages or Full Analysis

C2.13 HOUSING

Cold housing, dangerous structural defects (such as poor lighting or lack of handrails), damp, mould and overcrowding are significant health hazards associated with housing. 41 per cent of homeless people reported a long term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population. The ratio between house prices and earnings is increasing, hindering young people entering the housing market. There are quality concerns about rented property (9% of private rented stock in Stockport has some form of disrepair) but also about new homes. Gypsies and travellers are amongst the ethnic groups with the poorest health and lowest life expectancies (10-12 years shorter than the general population). Approximately 10 people at any time are actually sleeping on streets in Stockport but there would be more (about 40) if it were not for the availability of The Wellspring and about 100 are sofa surfing. Frequently moving from tenancy to tenancy provides insecurity and stress and disrupts life. Around 1,000 new houses a year are needed in Stockport but we need to view housing need as the sum of a number of specific needs, ensuring the proper mix of housing is built, not just count overall numbers.

Go to Key Messages and Full Analysis

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SECTION C: The major risk factors causing disease, death and disability

LEVEL 3

Key messages

C3.1   HYPERTENSION

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

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

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

Go to <u>overview</u> or go to <u>full analysis</u>

C3.2   SMOKING

One in 2 smokers will die of a smoking related disease so the only differences between smoking and playing Russian roulette are the delayed effect and the fact the odds are worse for smoking.. Tackling smoking is the single most effective thing we can do to improve health and tackle health inequalities. Deaths from smoking accounts for around 500 deaths a year in Stockport

Tobacco is the only lawful product which kills half of those who use it in the way the supplier intended and is the only drug of addiction that can lawfully be purchased without a prescription. Most smokers are introduced to tobacco in their youth and become addicted before they fully realise the risk. Californian experience is that young people need to be addressed as prospective adults, not as young people, to prevent this. Otherwise it becomes a rite of passage to adulthood.

Smoking in Stockport

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

In 2014/15 around 11.7% of new mothers smoked at the time they gave birth. Furthermore, exposure to passive smoke will still impact until local people make their homes and cars smoke free.

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

How to tackle smoking

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

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

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

Tackling smoking needs legislation. I am pleased the Government intends to introduce standardised plain packaging. Since October 1st 2015 it has been illegal to smoke in a vehicle containing children.

Go to overview or go to full analysis

C3.3   DIET

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

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

It is important to eat food which is nutrient dense rather than simply energy dense. A trend towards energy-rich food, along with declining physical activity, has caused the obesity epidemic.

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

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

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

Go to overview or go to full analysis

C3.4   PHYSICAL ACTIVITY

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

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

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

Health benefits of regular physical activity

Regular physical activity will help to:

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

UK recommended minimum levels of physical activity

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

Pre-exercise screening

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

Helping people take physical activity

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

Go to or go to

C3.5 ALCOHOL

In the 20 years from 1986/7 to 2006/7 the real cost of alcohol fell by more than a third, and consumption increased by a fifth, according to ONS data. Despite some reductions since 2005, consumption remains significantly higher than in the 1990s. Alcohol sales in on-licensed premises fell by more than a third (34%) between 2001 and 2011, while off-sales increased. Two thirds (67%) of alcohol sales are now for consumption at home.

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

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

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

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

Alcohol harm in Stockport

It is estimated that around 7,000 hospital admissions of Stockport residents in 2013/14 were attributable to alcohol, double the number seen in 2005/6. 2,554 admissions involved alcohol-specific diagnoses such as intoxication, dependency or alcoholic liver disease.

If current trends were to continue, we should anticipate an increasing financial and human cost affecting all our communities and all sectors of the economy. Alcohol related ill-health and deaths disproportionately affect the more deprived communities, and are key factors in maintaining health inequalities in the borough. Stockport Lifestyle Survey (2012) found:
- 3% of the respondents reported drinking at high risk levels in the previous week, (men more than 50 units and women more than 35 units in a week), with a further 17% drinking at increasing risk levels.
- 19% of the survey respondents reporting drinking twice the daily guidelines ('binge drinking') at least once in the last week.
- Young adults and people in their 40s are most likely to 'binge' drink, while middle aged adults aged 45-64 are the most likely to drink at increasing risk levels and people aged 45-49 are the most likely to drink high risk amounts.

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

Go to overview or go to full analysis

C3.6   WELLBEING

Various aspects of well-being have been shown to be associated with physical health.

Evidence is particularly strong for the following:

- A positive impact on mortality from strong social support networks
- A harmful impact, especially on heart disease, of working under pressure to deadlines
- Lower mortality in those who have considerable autonomy in their work
- Lower mortality in those of higher social status
- Increased sickness and mortality during processes of change affecting fundamental areas of life identity. This lasts from the time that change first starts to be anticipated until the individual is settled back into a secure new role. It applies to both positive and negative life changes but the impact of negative life changes is greater.

There is also evidence for:

- A beneficial effect on health of aesthetically attractive surroundings and greenspace
- An adverse effect from inequality (i.e. doing less well than others) quite independently of the actual level of deprivation
- An adverse effect of threats hanging over people
- A beneficial effect of striving for a challenging and meaningful goal
- A beneficial effect of a strong personal identity

The biologically plausible explanation for this relationship is the stress reaction

The stress reaction is the mechanism whereby an organism faced with a threat gears itself up to deal with the threat – the "flight or fight" response. It increases strength and agility and speeds up mental processing. However the bodily changes involved in the stress reaction also lead to a depressed immune system, changed gut function, high blood pressure and high blood cholesterol. This may not matter too much in the normal situation where the reaction is short-lived but if it becomes inappropriately long-lasting these bodily changes will lead to cancer, heart disease, gastrointestinal disease and increased susceptibility to infection. These are exactly the effects that have been seen in the above studies (although not all of them in all studies).

The psychological literature contains some detailed theoretical analyses of well being

These include Maslow's hierarchy of needs, Cooper's matrix of occupational stress, the recent "flourishing/languishing" classification, the salutogenesis theory and a range of others. They often place emphasis on social support and strong personal resilience.

It is plausible that the psychological literature and the epidemiological literature are describing the same phenomenon but this scientific link has never been clearly shown.

If this gap were to be bridged we would be able to have much more confidence in the use, as important public health measures, of well-being indicators that have been developed from the psychological literature, such as the WEMWEBBS indicator which is increasingly being used.

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

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

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

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

It is good for mental wellbeing to eat well, get out into natural green spaces and have fulfilling work.

Protective factors that policies and organisations can help create include

- *Control*: the feeling that we can manage our own lives and make our own decisions
- *Participation*: our belief that what we do matters, that we can make a difference
- *Inclusion*: our feeling that we belong, that there are people who care about us
- *Resilience*: our ability to cope with what life throws at us and bounce back
- *Assets*: personal, social and environmental resources we draw on for help and support

Promoting social integration, which has been shown to be weaker in deprived areas, tackles health inequalities in addition to being beneficial to individual's physical and mental health
A starting point for developing social integration is encouraging the development and participation of local groups.
Social cohesion is led by communities coming together in their own interests .Community development programmes have a crucial role in facilitating this , particularly in more disadvantaged areas or amongst more disadvantaged individuals.
As well as substantial benefits to people's health and some wider social benefits, there is increasing evidence that impact of Community Development can be measured financially.
Within a broad approach that values communities coming together, however, measures still need to be taken to address the priority that individuals, and communities attach to healthy living.
The strategy for tackling the challenge of creating opportunities for individuals and communities to live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development- primary community development and purposive community development.

C3.7 SAFETY AND HEALTH PROTECTION

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

Preventing injuries and crashes

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

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

The difference between safe and risk adverse systems

In a safe society people who climb mountains use the proper equipment, train properly, check the weather, inform others of their route and support a mountain rescue service. In a risk-averse society people do not climb mountains.

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

Go to Overview or go to Full Analysis

C3.8   SMOKING IN PREGNANCY

Tobacco smoke brings over 4,000 chemicals into the body, including 200 known poisons and 69 carcinogens. Every cigarette smoked during pregnancy introduces carbon monoxide into the maternal bloodstream and disrupts the foetal oxygen supply for around 15 seconds and in turn reduces the oxygen flow to the foetus for a period of around 15 minutes.

Smoking, and maternal exposure to tobacco smoke, during pregnancy increases the risk of: - ectopic pregnancy, miscarriage, placental abnormalities and premature rupture of the foetal membranes, still-birth, preterm delivery, low birth weight (under 2,500 grams), perinatal mortality and sudden infant death syndrome. It is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of premature birth and a 26.3% increased risk of intra-uterine growth restriction which is associated with both immediate and longer term health consequences.

Significant progress has been made over the years in reducing smoking in pregnancy but young women living in the most disadvantaged areas of Stockport are far more likely to smoke during pregnancy than older women and women who live in more affluent areas. For instance, during 2013/14 37.9% of mothers in Brinnington were smoking at time of delivery compared to 5.4% in Bramhall.

The total annual cost to the NHS of smoking during pregnancy is estimated to range between £8.1 and £64 million for treating the resulting problems for mothers and between £12 million and £23.5 million for treating infants (aged 0–12 months). In the North West this is about £1-7 million per year with the wider societal costs of smoking in pregnancy estimated to be £15- £24 million. Using international evidence it is estimated that the potential savings from interventions to reduce smoking in pregnancy could result in a saving £4 for every £1 invested, mainly due to a reduction in the additional costs to healthcare system from complicated birth and care requirements.

Recent behavioural insights works has stressed that further work needs to be done to be cognisant and address the complexity and significant pressures that these women face in the context of their daily lives, with stress and anxiety being a key barrier to not giving up smoking.

Electronic cigarettes reduce the harm from smoking by 95% but the harms occasioned by nicotine still remain. Nonetheless we do recommend nicotine replacement therapy as part of programmes to stop smoking, including during pregnancy and electronic cigarettes could play the same role if individual women find that they help.

In Stockport we have found evidence that demonstrate that financial incentives offer a solution to supporting vulnerable women to quit and stay quit during pregnancy.

C3.9   TYPE 2 DIABETES – TIME TO DEFUSE THE TIME BOMB

Type 2 diabetes develops when the body doesn't produce enough insulin or when the insulin it does produce doesn't work properly. Glucose levels rise in the blood and the consequences are very severe and include kidney disease, foot disease, heart disease, depression and blindness.

Treating diabetes and its complications costs Stockport around £40 million.

Just under 15,000 people in Stockport are known to have diabetes but an estimated 25,000 people are at risk of diabetes and don't know it. Are you?
http://riskscore.diabetes.org.uk/start?_ga=1.205835029.722794865.1476350383

What increases risk?

- being overweight
- having a large waist (more than 80cm/31.5 inches in women, 94 cm/37 inches in men or 90cm/35 inches in South Asian men).
- being from an African-Caribbean, Black African, Chinese or South Asian background and over 25.
- being from another ethnic background and over 40.
- having a parent, brother or sister with diabetes.
- having ever had high blood pressure, a heart attack or a stroke.
- having had a history of polycystic ovaries, gestational diabetes or having given birth to a baby over 10 pounds/4.5kg.
  suffering from schizophrenia, bipolar illness or depression, or taking anti-psychotic medication.

The good news is that we can all make small changes in our lives to reduce our risk of diabetes. By eating well and moving more, we could reduce the numbers of type 2 diabetes by over half. Visit https://www.healthystockport.co.uk for advice.

How can we reduce the complications from diabetes?

As well as looking after themselves, there are 15 vital checks and services that patients with diabetes should expect from their healthcare team. One of these is a diabetes education course. People who have been on a course feel much more confident about looking after their condition and are less likely to suffer with complications from their diabetes.

And identification of people at risk, better care for patients with diabetes and integration of services will improve outcomes in patients with diabetes.

Go to or go to

C3.10   ANTIMICROBIAL RESISTANCE

Antibiotics (antimicrobials) are essential medicines for treating bacterial infections in both humans and animals but, antibiotics are losing their effectiveness at an increasing rate.

Antimicrobial resistance is the biggest (inter)national public health concern facing us at the current time. It is second on the government list of risks behind terrorism. Inappropriate and prolonged use of antimicrobials is the main driver increasing the rate of antimicrobial resistance. In the last 40 years antimicrobial resistance has increased at an alarming rate and with the very limited number of novel agents currently in development infections are becoming harder and more expensive to treat. UK hospitals are the 2nd highest user of antibiotics per head of population in Europe.

Bacteria can adapt and find ways to survive the effects of an antibiotic and they become 'antibiotic resistant', so that the antibiotic no longer works. The more an antibiotic is used, the more bacteria become resistant to it There are very few new antibiotics in the development pipeline, which is why it is important that we use our existing antibiotics wisely and make sure these life-saving medicines continue to stay effective for us, our children and our grandchildren

Without antibiotics we would face again large numbers of deaths from infections that we have regarded as conquered, we would face again a situation where every injury was potentially fatal through secondary infection and much modern surgery would become impossible.

Unless we tackle the issue now, the consequences could be severe:

- an estimated 10 million deaths globally by 2050
- a cost of £66trillion to the global economy.

The key to tackling the problem is to use antibiotics less and particularly to avoid using them when they are not needed.

Stockport is performing well (below the national average) for prescribing the broad spectrum high risk antibiotics co-amoxiclav, cephalosporins and quinolones. However we continue to prescribe larger than average volumes of antibiotics (in particular Amoxicillin 500mg capsules) compared to 'similar' national and local CCGs most of whom are now showing a percentage decrease.

We must continue to monitor progress and ensure that good practice is promoted and work with the public to increase awareness of using antibiotics wisely.

Go to Overview or go to Full Analysis

C3.11 AIR QUALITY – WHAT'S STOCKPORT'S PROBLEM

Pollution from the increasing number of motor vehicles using our roads provides the greatest threat to air quality in Stockport and across the UK. Harmful vehicle emissions contribute to breathing and lung problems in susceptible people, and contribute to greenhouse gases which cause climate change. It the largest preventable issue related to air quality. There are health inequalities in the impact of air quality as Children, the elderly and those with pre-existing respiratory and cardiovascular disease, are known to be more susceptible to the health impacts from air pollution.

Measurements from the Greater Manchester's diffusion tube network confirms there are locations that continue to be above the annual mean NO2 air quality objective, but there is an overall trend of declining concentrations. Stockport has contributed and signed up to the Greater Manchester Air Quality Action Plan (AQAP) for Greater Manchester. The AQAP has involved a review of the strategies, policies and plans which tackle or are in some way related to air quality, to develop a set of actions which will deliver changes in terms of air quality.

The key priorities therefore include: changing travel behaviour, reducing emissions from Heavy Goods Vehicles (HGVs) and passenger vehicles, implementing planned infrastructure improvements for sustainable transport including rail electrification, and stimulating the uptake of Ultra Low Emission Vehicles (ULEVs) particularly private car users. To reduce emissions from buses on key local corridors, and continued encouragement in the uptake of smarter travel choices is important.

Stockport's local plan will work in line with the South East Manchester Multi Modal Strategy (SEMMMS) Refresh Strategy which has identified that packages of measures will be required to meet future transportation. Town Centre Access Plan (TCAP) which improves access to and around the Town Centre by all modes, to improve public transport. Measures have already been undertaken by a review of the Stockport Travel plan.

I recommend that it is important to inform the local population of the impact of air pollution on health and to tailor messages to target those members of the public particularly susceptible to air pollution. It is important to work with others to promote initiatives to facilitate active travel (for example healthy schools programmes, school travel plans and cycle to work schemes. I recommend raising awareness of the need to improve air quality through linking to other public health issues such as obesity and through working with Health and Wellbeing Boards to include air quality in Joint Strategic Needs Assessments and Health and Wellbeing Strategies. I recommend reducing the use of the car and promoting a healthier transport system including traffic measures such as optimising variable speed limits on Greater Manchester motorways and public debate about a 20mph speed limit throughout the Borough. I recommend much wider use of green walls and green security measures to mitigate the effects of air pollution near roads.

Go to <u>Overview</u> or go to <u>Full Analysis</u>

C3.12   GREEN INFRASTRUCTURE

Green infrastructure is of considerable health and ecological importance.

- It improves air quality by absorbing greenhouse gases.

- People are more likely to walk and cycle if the route is attractive

- Sight of greenery reduces stress.

- Exercise taken in green surroundings may have more health benefit than exercise in drab city surroundings

- Greenery reduces the urban heat island effect.

- Greenery reduces flood risk

- Greenery raises the human spirit, and reduces stress

- Greenery contributes to biodiversity, much of which is vital for health.

- Air quality is improved in various ways.

- Some forms of green infrastructure can provide tranquillity, opportunities for physical activity, and various forms of improvements to nutrition.

- Urban drainage is improved and flood risk diminished by green roofs, ponds and wetlands, and surfacing of drives and car parks with lattices to support the vehicles whilst allowing grass to grow through.

- Roof gardens and earth-sheltered buildings allow pressure for development land to be met with much less loss of open space.

- Linear green passages or tree-lined routes can form good walking routes

- Floral displays and water features provide powerful aesthetic contributions which particularly raise the human spirit.

- Parks can provide walking and cycling routes, recreational use, biodiversity, aesthetic displays and tranquil opportunities for relaxation.

- Green walking routes into the countryside encourage recreational walking.
- Tree screens can reduce noise.

- Thorny hedges, or thorny plants on green walls, or planted under windows can be an effective means of security.

- There are various contributions to energy efficiency.

To see green infrastructure as a priority I suggest we set the following goals;

- Most people should see greenery most of the time
- There should be a network of green walking and cycling routes throughout the borough

- All of the Borough should be within a short walk of a green corridor into the countryside
- All of the Borough should be within a short walk of recreational greenspace
- District centres and the town centre should have a green feel to them.
- Greenspace should not be lost to development – greenspace-compatible development technologies should be used to avoid this

Go to or go to

C3.13   HOUSING

Cold housing contributes to the 40,000 non-flu excess winter deaths that occur nationally each year. Cold is linked to increased risk of cardio-vascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health and cold houses obviously contribute, although they are not the only cause. The effect of cold on mortality is felt not only in conditions of extremely cold weather – death rates start to rise when the temperature below that of a spring day.

Housing also contributes to the risk of accidents and falls. Structural defects (such as poor lighting, or lack of stair handrails) increase the risk of an accident. The average cost of a single hip fracture estimated at £30,000. This is five times the average cost of a major housing adaptation (£6,000) and 100 times the cost of fitting hand and grab rails to prevent falls.

Damp and mould are also significant health hazards associated with housing.

Overcrowded housing has adverse impacts on mental health, accidents and spread of infection.

A recent audit found that 41 per cent of homeless people reported a long term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population.

Frequently moving from tenancy to tenancy provides insecurity and stress and disrupts life especially education and relationships leading to stress, isolation and under attainment.

The affordability ratio, the ratio between house prices and earnings, is high and is still increasing, making it more difficult for young people to enter the housing market and increasing the number of concealed households.

At the other end of the age range, there is a shortage of extra care housing, which is an innovative form of housing with care on site enabling people to maintain their independence for as long as possible. This offers older people an attractive alternative to forms of residential and nursing care.

For those who manage to avoid being caught up in the housing shortage, there is concern nationally about housing quality, including concerns about rented property but also a perception that the quality of new homes fails to meet expectations far more often than it should.

For those who choose a nomadic lifestyle rather than fixed housing, gypsies and Travellers are amongst the ethnic groups with the poorest health and lowest life expectancies (10-12 years shorter than the general population). They have the highest levels of perinatal mortality and frequent mental distress. In addition to poor accommodation, discrimination, bereavement, low literacy, poor access to health information and care are recognized contributory factors. So is the stress of being repeatedly moved on.

9% of private rented stock in Stockport has some form of disrepair. When all tenures are included almost 12000 properties in Stockport (about 1 in 10) had Cat 1 hazards and over 10,000 falls hazards.

Stockport Council's comprehensive fuel poverty strategy led to the number of households in fuel poverty falling by half from 16.5% (20,502 properties) in 2011 to 9.2% (11442 properties) in 2016.

The numbers who are actually sleeping on streets in Stockport is relatively small approximately 10 at any time, although this figure would be higher (about 40) if it were not for the availability of The Wellspring and there are larger numbers (about 100) who are sofa surfing.

Stockport does not have adequate provision for people of nomadic lifestyle pausing to stay amongst us for a time. This lack of provision is the direct cause of encampments being established in unsuitable locations with consequent concerns in the host community.

Around 1,000 new houses a year are needed in Stockport. It is important however that we do not assume that all of these will be conventional family homes. There is a growing number of single person households, and an increasing elderly population which would benefit from extra care housing. Affordable housing is a major need. There are also market niches which are underprovided for, such as car free housing, flats close to railway stations, and purpose built cooperative communities. We need to view housing need not just as one total figure, but as the sum of a number of specific needs. We need to ensure that the proper mix of housing provision is built, not just count overall numbers.

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

SECTION C: The major risk factors causing disease, death and disability

LEVEL 4

Full Analyses

LEVEL 4 (FULL ANALYSIS) SECTION C: THE MAJOR RISK FACTORS FOR DISEASE, DEATH AND DISABILITY

C4.1 HYPERTENSION

Hypertension is a persistently raised blood pressure.

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

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

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

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

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

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

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

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

Hypertension is common in the UK population.

Prevalence is influenced by age and lifestyle factors.

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

50% of those over 60 years have hypertension.

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

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

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

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

How big is the problem?

CVD accounts for 19% of Stockport deaths under 75 years and 31% over 75 years. These have fallen from 37% and 49% in 1995.

Overall, the prevalence of hypertension in the UK is estimated as 31% in men and 26% in women over 35 years increasing from 33% aged 45/54 to 64% aged 75+ in men from 22% to 67% in women.[2] Indeed some American studies suggest that the figure in old age might be even higher

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

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

The higher the BP, the greater is the chance of heart attack, heart failure, stroke, and kidney disease.

For individuals 40–70 years of age, each increment of 20 mmHg in systolic BP (SBP) or 10 mmHg in diastolic BP (DBP) doubles the risk of CVD across the entire BP range from 115/75 to 185/115 mmHg

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

How cost effective is treatment?

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

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

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

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

1 death for every 11 patients treated.

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

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

What can people do to help themselves?

Table C1: lifestyle Modifications
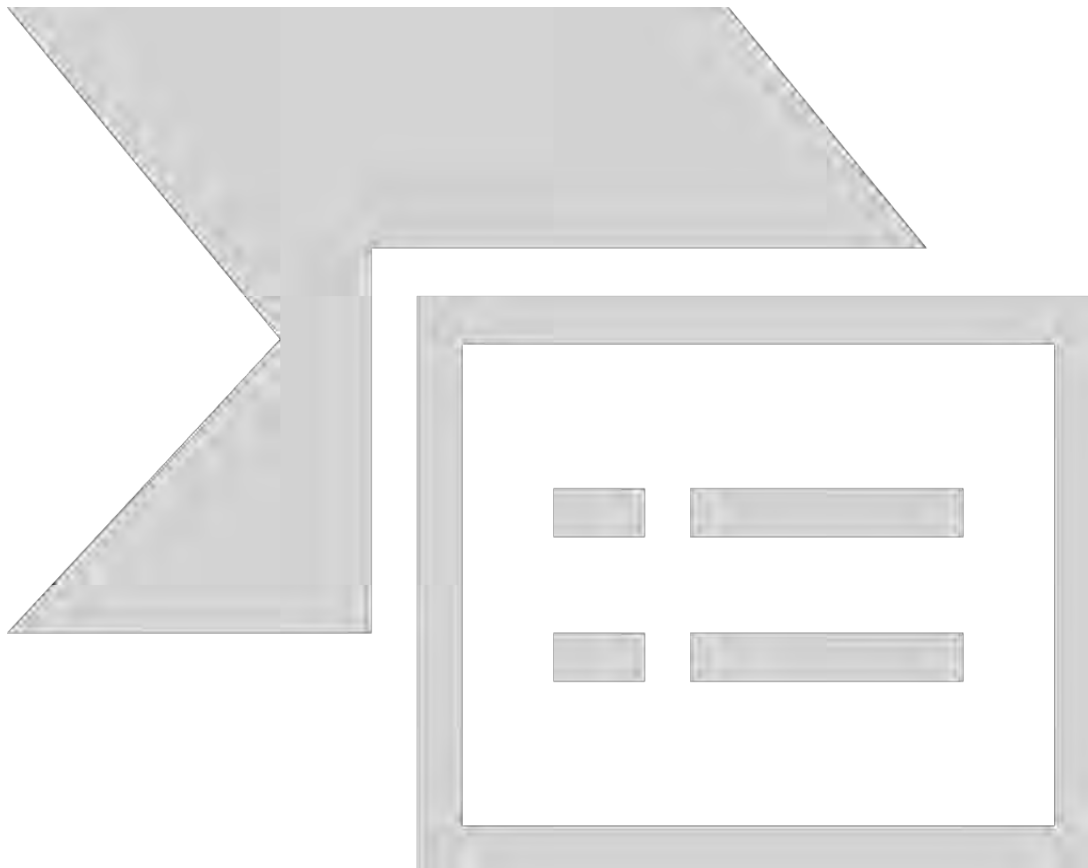
What can Government do?

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

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

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

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

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

What can health professionals do?

Promote healthy food and alcohol consumption and physical activity

Consistent messages - working with public health and communities

Systematically identify and effectively treat people with hypertension

The CG recently ran a campaign to encourage the 11884 Stockport patients over 45 years who don't have a blood pressure recorded, to check their blood pressure: 'I know my numbers, do you?'. This ran alongside a number of initiatives aimed at getting people more active.

C4.2   SMOKING

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

Tobacco is the only lawful drug of addiction. The majority of smokers want to stop smoking but find this difficult. Typically people become addicted to tobacco whilst they are still at school and whilst they are under legal age for purchase, which is now 18, and then face a lifelong addiction. In California, which has been most successful in reducing smoking rates, this problem has been addressed not by campaigns focused on young people but by ensuring that campaigns aimed at adults reach young people. The reason for this is the fear that if smoking is seen as an "adult" thing to do, it may become a rite of passage. Certainly schools are aware that resistance to tobacco which is high at the end of primary school often fades during adolescence.

Were it not for the large number of addicts spread throughout all sectors of society there is little doubt that tobacco would be banned along with heroin and cocaine. Certainly it is every bit as addictive.

Tobacco is the only lawful product that kills people who use it in the way it is intended to be used. The only differences between smoking and playing Russian roulette are the delayed effect and the worse odds. Previous international estimates have suggested that smoking causes 50% of deaths of smokers and that is the figure I quoted in the tweet, the overview and the key messages. However a recent comprehensive Australian study suggests that it could be even more, with smoking directly linked to 2/3 of deaths in current smokers and cutting 10 years of life off the average smoker [1.]

The cost of smoking to Stockport as a borough is considerable. Action for Smoking on Health estimate that the total cost is £78.9 million, the costs to the NHS alone being £15.5 million. It is estimated that Stockport residents spend £84.5 million on tobacco products, a cost that falls disproportionately on the most disadvantaged households. A very low income smoker earning £10,000 and smoking one pack of 20 cigarettes a day will spend up to 27% of their net income on tobacco.

Smoking prevalence data

Various data sources suggest that the prevalence of smoking in the borough is around 17-18%. Data sources which enable trend analysis suggest that the smoking prevalence rate in Stockport is falling – however in more recent years there is no evidence that it is falling in our most deprived areas.

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

Table C2 Smoking and Deprivation			
2007 National IMD Quintile	2012 Current smokers	2009 Current smokers*	2006 Current smokers
1 –most deprived	30.9%	29.5%	26.7%
2	21.3%	22.7%	18.9%
3	16.3%	17.0%	14.1%
4	12.2%	12.3%	14.0%
5 – least deprived	8.1%	8.3%	9.5%

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

Data from Stockpot Health Record (SHR): This is a local system of querying GP practice held records for all but one Stockport GP practice; trend analysis suggests that smoking prevalence is going down very slowly.

Table C3 Smoking prevalence Age 15+ at Stockport GP Practices				
	July 2012	July 2013	July 2014	July 2015
Quintile of Deprivation	Current smoker	Current smoker	Current smoker	Current smoker
Most deprived 0-20%	34.9%	34.2%	34.3%	34.4%
Second most deprived 20-40%	24.9%	25.0%	24.2%	23.3%
Mid deprived 40-60%	18.6%	18.6%	18.1%	17.3%
Second least deprived 60-80%	13.7%	13.2%	12.7%	12.2%
Least deprived 80-100%	10.2%	9.8%	9.4%	8.7%
Total	18.1%	17.8%	17.2%	17.1%
Total Stockport residents	18.2%	17.8%	17.2%	17.1%

Smoking Demographic

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

Smoking prevalence is higher in certain groups:

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

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

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

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

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

Nationally some 2/3 of current smokers say they want to quit smoking with ¾ reporting they have attempted to quit smoking. In the Australian study that I have referred to, on average smokers who die from a smoking-related illness lose around 16 years of life, with about 2/3 of smokers experiencing this, resulting in an overall average loss of life expectancy of 10 years.

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

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

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

The Economic Downturn and Quitting Smoking

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

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

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

Tobacco control

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

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

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

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

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

The strategy has 3 main ambitions

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

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

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

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

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

The Stoptober campaign was first run in 2012 and was reportedly very successful resulting in 160,000 people attempting to quit smoking for Stoptober. The campaign was repeated in Autumn 2013 with around a ¼ million attempting to quit. In Stockport around 1200 residents attempted to quit for Stoptober 2013, this was 2nd highest participation rate in Greater Manchester

What is the Evidence for what works?

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

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

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

Public Health GuidanceNo.10: Smoking Cessation Services

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

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

Public Health Guidance No 23 School based Interventions to prevent smoking

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

Public Health Guidance No 39 Smokeless Tobacco Cessation

Public Health Guidance No 45 Tobacco Harm Reduction

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

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

Smoking Cessation and Harm reduction

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

Of most recent significance for the commissioning of stop smoking services is the NICE guidance on tobacco harm reduction. Although existing evidence is not clear about the health benefits of

smoking reduction, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products.

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

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

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

Anecdotal evidence suggests that recently the numbers of people seeking smoking cessation support it has fallen. One theory being put forward is that this is due to the rise of the E Cigarette which is being marketed heavily. E Cigarettes act as Nicotine delivery devices. It has been reported that in the UK, 25% of all quit attempts are now made using e-cigarettes, making it the most popular quitting aid [7]. Action for Smoking on Health estimates that there are currently 1.3 million E-Cig Users in the UK.[8] At present E Cig s are not regulated, except for the law that came into effect on 1st October 2015 prohibiting their sale to people under 18 and prohibiting proxy sales.. The Medicine and HealthCare Products Regulatory Agency (MHRA) has determined that they should be licenced as a medicine from 2016. There is a considerable debate amongst the medical profession on the merits of e cigarettes. Used as a smoking cessation aid they could undoubtedly have a significant harm reduction effect but the risk is that that they may sustain peoples smoking habit as they become dual users of the e cigarette and tobacco, they may become a gateway product to nicotine addiction, or they may be taken up as a habit by people who would never have smoked. Work by ASH has shown that under a third of e cigarette users are using them exclusively. Out of about 1.2 million e cigarette users only 400,000 were using them as a total replacement for cigarettes and 55,000 were new users who had never previously used cigarettes.

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

E cigarettes do carry a risk of lipoid pneumonia.

Young people

The highest rates of smoking are among young adults. Around 23% of people in England aged 16-24 smoked in 2013. This is reflected locally, data from the Stockport Adult Lifestyle Survey (2012) indicated that 22.9% of 18-24yr olds were smokers.

Rates of smoking among children overall have continued to reduce (3% of secondary age Pupils 11-15 were categorised as regular smokers in 2014 compared to 13% in 1996.[9]This is also reflected locally, according to data from the Trading Standards NW survey, in 2013 11% of Stockport's young people aged 14-17 claimed to be smokers compared to 19% in 2009.

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

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

Prevention of uptake of smoking in Children and Young People

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

- Develop national, regional or local mass media campaigns to prevent the uptake of smoking among young people under 18
- Use a range of strategies as part of any campaign to reduce the attractiveness of tobacco and contribute to changing society's attitude towards tobacco use, so that smoking is not considered the norm by any group
- Ensure retailers comply with legislation prohibiting under-age tobacco sales
- Make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products

NICE guidance on **school based interventions was published in 2010**. It recommends

- Whole-school or organizational wide smoke free policy
- Adult led interventions- integrate information about the health effects of tobacco into the curriculum, deliver interventions to prevent the uptakes as part of PSHE and activities related to Healthy Schools status etc.
- Consider offering evidence based peer led interventions
- Provide training for staff

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

I have already mentioned the Californian view that the priority should be to address children and young people as prospective adults, not as children or young people.

Smoking in Pregnancy

Smoking in pregnancy is a priority area for Stockport; although (at 11.7% in 2014/15;) smoking rates are lower in this group than in the population in general, the Greater Manchester average (13.8%), and, this year, similar to the national average (11.4%); the data still show a variable state rather than an improving trend. However, looking at the data in isolation since 2009/10 would appear to show a more encouraging trend. Smoking in pregnancy is a priority area for action and a more detailed commentary is available.

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

Strategy

We have had our tobacco control strategy reviewed by CLEAR.

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

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

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

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

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

The Council has adopted the Local Government Declaration on Tobacco Control

I would call upon Stockport MPs and political parties to encourage the Government to invest more heavily in comprehensive tobacco control as they have done in California which has shown dramatic drops in prevalence and youth uptake

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

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

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

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

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

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

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

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

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

C4.3   DIET

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

A low fat, low sugar, low salt, high fibre diet contributes to the prevention of heart disease, stroke, diabetes, obesity and cancer. The low fat, low sugar, low salt, high fibre message is a constant and scientifically well-established message and must not be confused with transient scares. Eating at least 5 portions of fruit and vegetables a day is important and some studies suggest that the target should be higher than this.

It is important to eat food which is nutrient dense rather than simply energy dense but over the last few decades the tendency has been towards energy-rich food, including an increasing number of energy-rich snacks and meals from processed energy-rich salt-rich food. Together with declining physical activity, this has caused the obesity epidemic.

The recent Scientific Advisory Committee on Nutrition report to the Government (July 2015) that investigated the effects of carbohydrate on health recommend that the government considers changes to the Dietary Reference Values for free (added) sugars – cutting them down by half (from 10% to 5% of total calories). To achieve this in today's culture of processed food would reverting to the original more prescriptive message of not more than one small portion in a day & cutting everyday high sugar snacks down to a once or twice a week luxury. There would also be no place for sugary drinks in our diets. This may result in changes to the Eatwell plate which is the Government's model of healthy eating and may lead to changes in the key messages from Change4Life www.nhs.uk/change4life – the government's public health social marketing campaign programme for families

The focus should be on healthy dietary patterns. A healthy pattern includes heaps of fresh fruits and vegetables, whole grains, nuts, legumes, lean meat, poultry, and fish. An unhealthy but all-too-frequent pattern includes: piles of processed meat, mounds of french fries, lots of white bread and potatoes and processed breakfast cereals, giant sugary drinks, and packaged cupcakes for dessert

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

- **Eat more fruit and vegetables**. Aim for **at least** 5 portions a day.
- **Eat a balanced diet** in line with the Eatwell plate http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx
- **Eat regular meals.** Try to eat 3 meals a day plus 2 healthy snacks. Don't skip breakfast, it's a really important meal which makes maintaining weight easier and helps you concentrate better.
- **Look out for red, amber and green on food labels** making it easier to choose food that is lower in total fat, saturated fat, sugar and salt. Choose more greens and ambers and fewer reds.
- **Eat less salt.** About three-quarters of the salt we eat comes from processed foods we buy.

- **Eat less saturated fat**. It tends to come from animal sources e.g. butter, ghee and lard. Switch to unsaturated fats e.g. vegetable oils, oily fish and avocados. Remove fat from meats. Avoid trans fats (which are often found in fried fast food).
- **Eat less sugar** – sugar has no nutritional benefit and too many sugary foods can lead to excess weight gain. Excess sugar can cause tooth decay especially if eaten between meals. Cut down on cakes, biscuits, sweets, chocolate and fizzy drinks.
- **Be aware of the calories contained in alcoholic drinks**, and note that alcohol also makes us more hungry so it may lead to over-eating during or after drinking

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

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

The food industry is powerful and the government have been reluctant to challenge them. They have had a significant influence on policy, on the direction of the "responsibility deal", on agriculture and on campaigns like Change4Health.

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

This leads to **difficulty obtaining healthy processed foods**, especially low salt processed foods. Processed food is important under the time pressures of modern life. Families are buying processed ready meals without realising they aren't as nutritious or filling as home cooked foods. Trans fats are a major health problem but have not been banned. The healthy food lobby can't compete with the huge marketing budgets of supermarkets and processed food companies.

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

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

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

Eating patterns are different. Regular meal times are being eroded. 1 in 4 households no longer have a table that everyone can eat round together. We graze constantly, expanding waistlines. We cook less and eat out far more than we used to. It is also more socially acceptable to eat and drink whilst out walking in the street / in public either between meals or consuming a main meal on the go. It is also more socially acceptable to eat and drink whilst out walking in the street / in public either between meals or consuming a main meal on the go.

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

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

Healthy food is more expensive to obtain easily. It is certainly possible to construct cheap healthy diets but the easy way to change from a traditional English diet to a healthier diet is to substitute healthier (low sugar, low salt, low fat, higher fibre) versions of traditional food, add elements of a Mediterranean diet, especially garlic (and leisurely meals) and add at least five portions a day of fruit, vegetable and salad. This simple way to change diet costs more money and preparation time. Such food is less likely to be sold at all in corner shops and the cheaper supermarkets whilst turnover and shelf time lead to a higher price. The price differential between healthy and unhealthy food is least in out of town hypermarkets readily accessible only by car. Driving to the hypermarket, and buying bulk freezer purchases, spreading the cost on your credit card, may not be an option if on a low income

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

There is a demand for these things under the Sustainable Food Cities (SFC) partnership and much innovative work is now taking place in Stockport led by Feeding Stockport (who are part of the SFC network)

The Feeding Stockport programme is diverse and works on many different fronts, with the aim of improving the food system in and around Stockport for the benefit of our population. They are supporting public, private and voluntary organisations and community groups to make a difference.

Collaboration, education, awareness raising, procurement and economic development are

some of the things they are striving to improve. The benefits of a more sustainable food system are far reaching: improving livelihoods, the environment, health and wellbeing, and ultimately making Stockport a fantastic place to live. http://feedingstockport.org.uk/

Coming together under Feeding Stockport, examples of this innovative work by a range of agencies includes:

- GROW COOK EAT project based on the work of the Central Food Enquiry which explored barriers against local residents eating healthily.
- Woodbank Arable Farm and Community growing projects – bringing together community food growing with small scale commercial growing and a farm incubator scheme.
- Improving food access and tackling food poverty through a cross-sector working group. Creating a tiered system of interventions – life after food banks, pantries, bulk buying schemes and economic development of community businesses
- Stockport Homes projects: Green and Edible spaces and the Stockport Pantries
- Mossbank homes and the Bredbury hub and Hawk green Allotment projects.
- Food Enterprise Centre bringing together sustainable food business development across Stockport through a network of enterprise support services, established business mentors, CVS, Local Authority and Housing Partners.
- **Local fruit and vegetable schemes** operate at a variety of venues within the deprived areas of the district
- **Eat Better Live Longer** courses for carers
- **Weaning sessions** for families run in Children's Centres
- **Healthy Snacks and Drinks Policy** in Early Help and Prevention children's centres
- **Sustainable Food Strategy**

C4.4 PHYSICAL ACTIVITY

Benefits of Physical Activity

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

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

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

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

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

- major non-communicable disease, including coronary heart disease (CHD), hypertension, type 2 diabetes, chronic kidney disease and some cancers (colon, breast [post-menopause] and endometrium);
- stroke, peripheral vascular disease and cardiovascular disease (CVD) risk factors such as high blood pressure;
- musculoskeletal health conditions, including osteoporosis, back pain and osteoarthritis;
- depression, stress and anxiety;
- overweight and obesity.

In the UK, it is estimated that physical inactivity causes:

- 10.5% of coronary heart disease cases
- 18.7% of colon cancer cases
- 17.9% of breast cancer cases
- 13.0% of type 2 diabetes cases
- 16.9% of premature all-cause mortality

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

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

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

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

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

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

UK Physical Activity Guidelines

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

EARLY YEARS (under 5s)

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

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

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

CHILDREN AND YOUNG PEOPLE (5-18 years)

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

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

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

ADULTS (19-64 years)

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

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

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

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

OLDER ADULTS (65+ years)

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

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

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

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

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

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

Integrating Physical Activity into Daily Life

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

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

Physical activity in and around the home

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

Physical activity at work and on the go

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

Physical activity with friends or family

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

Physical activity while watching TV

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

<u>Recreational Physical Activity</u>

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

Many recreational activities require the movement of large muscle groups and can be aerobic, which improves cardiovascular health e.g. hiking, cycling, swimming, gardening and dancing.

Physically active pastimes such as these are most beneficial if they are done routinely, and as well as promoting physical health, also play an important role in enhancing mental health and well-being by providing a buffer for stress and facilitating social interaction.

Recreational physical activity can be promoted by:

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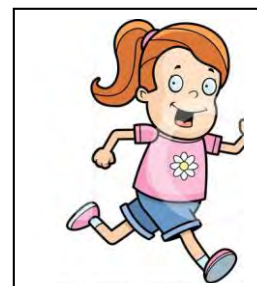
Currently, 71% of women (16+), 61% of men (16+), 76% of girls (2-15) and 68% of boys (2-15) in England do not meet the age relevant minimum physical activity recommendations. Opportunities to engage in high quality recreational physical activity can play an important role in increasing current levels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

Physical Activity in Schools

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

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

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

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

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

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

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

Extra-curricular active recreation - by offering alternative activities for pupils who are not 'sporty', schools can not only increase participation in physical activity but help address the drop-off in young people's participation levels in the 14-18 year old age range.

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

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

Active Travel

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

Active transport is mainly walking, cycling, (although it could include other forms of activity such as skating, skateboarding, or rowing) and includes any incidental activity associated with the use of public transport. Public transport users are more active than car users.

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

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

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

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

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

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

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

The benefits of active transport include:

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

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

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

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

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

Reduction in local congestion;

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

Stockport Walking Strategy

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

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

Draft Cycling Strategy

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

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

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

Personal ability to cycle and fitness

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

Social acceptability, including perceptions linked to attire and travel mode.

Knowledge of routes and facilities available including the time the journey is likely to take.

These and other transport issues must be addressed in order to encourage cycling as a viable mode of transport. During 2012 and 2013, the public profile of cycling has been boosted through British successes at the Olympics and Tours de France. The August 2013 announcement of £77m of Cycle City Ambition Grant funding, including £20m for Greater Manchester, made reference to this and comes on the back of Local Sustainable Transport, Cycle Safety and Links to Communities funding packages. There is an increasing sense that the time has come for the beginnings of a cycling revival, with people having already got back on their bikes, or being closer to making a decision to do so.

C4.5 ALCOHOL

As noted previously the steady improvement of the health of Stockport, and especially its most deprived areas, faster than that of the country as a whole, faltered around the turn of the century and through the first decade of the century improved only in line with the rest of the country. Analysis showed that we were still achieving improvements in cardiovascular disease, which our 1990s strategy had been directed to, but that progress was undermined by emerging problems in cancer, digestive diseases and liver disease. These problems derived from a serious alcohol epidemic. Such an epidemic affected the whole country but it affected Stockport to an above average extent. At first it affected deprived areas most but later became more widespread across the Borough as a whole, paradoxically leading to reductions in inequalities.

Four major factors in this epidemic were

- The drinking of stronger alcohol in larger measures. This led to many people underestimating what they drink. The idea that a glass of wine is 1 unit is based on a 125ml glass of 8%abv. A 175ml glass of wine at 13% is 2¼ units. A pint of 5% beer is 2.8 units not 2 units.
- The emergence amongst young people in generations born from around the 1970s onwards of a culture which saw getting drunk on a night out as an essential part of the experience. In previous generations born post war it had been seen as an acceptable but unintended consequence of a night out and in generations born pre-war it was as an unacceptable consequence to be tolerated only on a few occasions due to inexperience.
- Accompanying this cultural change was the emergence of the practice of pre-loading, drinking cheap alcohol bought at the supermarket at home before going out so that less more highly priced alcohol needed to be bought on the night out itself in order to become drunk.
- Cheaper and more widely available alcohol, especially on off sales for home consumption.

The alcohol epidemic has somewhat abated from its height (mainly due to young people now drinking less) but not yet to such a degree as to regard it as a problem solved or indeed to be certain that the decline will continue.

A major element of the response to the epidemic needs to be policy measures intended to address the dysfunctional drinking culture. Stricter licensing laws are needed and licensing committees need to have more power but the root of the preloading culture is cheap sales by supermarkets and this needs to be tackled by a minimum unit price. It is deeply regrettable that Government has recently decided against this.

More information about the problem of stronger alcohol and larger glasses is another important issue, but awareness of this has probably increased over the last few years and may account for the abatement of the epidemic.

Local strategies cannot wholly pick up the slack of national neglect but nonetheless local action has an important contribution to make. Both our local Stockport Drugs and Alcohol Strategy (2014-17) and the Greater Manchester Alcohol Strategy, focus on addressing complex dependency issues through early intervention and prevention activity including working with front-line services and

communities, while improving access to support treatment and recovery, and for individuals and families affected by harmful and dependent use of alcohol.

The key indicator of impact of the strategy is alcohol-related hospital admissions.

Table C4 Alcohol related hospital admissions

Indicator	Baseline 2010-11	2011-12	2012-13	2013-14	% change since 2010-11
BROAD DEFINITION					
Total alcohol attributable hospital admissions	6,106	6,373	6,526	7,027	15.1%
Admissions (as above) from priority neighbourhoods	851	870	847	not known	-0.5%
Alcohol specific hospital admissions	2,296	2,375	2,392	2,554	11.2%
NARROW DEFINITION					
Total alcohol attributable hospital admissions	1,863	1,859	1,812	1,997	7.2%
Admissions (as above) from priority neighbourhoods	273	291	247	not known	-9.5%
Alcohol specific hospital admissions	756	726	661	786	4.0%

Broad definition

The hospital figures indicate a slight slowing of the upward trend in admissions seen over the last ten years. The definition of alcohol-attributable admissions includes a range of health conditions that risky drinking contributes to, including high blood pressure, cardiac arrhythmias and epilepsy. It is difficult to measure whether the role of alcohol in such conditions is increasing or not, but the figure still provides the best estimate of the scale of admissions in which alcohol is a factor.

The alcohol-specific indicator is a more robust measure of the direct health impacts of alcohol, such as acute intoxication, dependency and withdrawal, but excludes many alcohol related admissions, such as those due to alcohol-related accidents or assaults. This increased less than the alcohol-attributable figure last year.

The proportion of admissions from priority neighbourhood has fallen from 14.8% in 2009-10 to 13.2% in 2012-13. However, the rate of admissions of residents in the most deprived quintile remains almost three times that of residents in the least deprived quintile.

Public Health England benchmarking data indicates that Stockport is significantly worse than national rates in terms of alcohol-related admissions; though lower than the North-west average. Notably, Stockport's ranking, for alcohol-specific hospital admissions, is worse for women (141/152) than for men (126/152).

Narrow definition

The new supplementary indicator, by only looking at primary diagnosis, provides a narrower measure of alcohol harm that is less sensitive to the changes that have occurred in coding over the years and therefore enables fairer comparison between levels of harm in different areas and over time. It is also more responsive to change resulting from local action on alcohol. However, the original indicator is a better measure of the total burden that alcohol has on community and health services.

Hospital admissions are more stable and show less of an upward trend in both attributable and specific indicators. However specific alcohol admissions rose by almost a fifth in the last reporting year making it the largest increase of any of the indicators mentioned.

The proportion of admissions from priority neighbourhood has fallen from 17.4% in 2009-10 to 13.9% in 2012-13. However, the rate of admissions of residents in the most deprived quintile remains almost three times that of residents in the least deprived quintile.

Public Health England benchmarking data indicates that Stockport is significantly worse than national rates in terms of alcohol-related admissions; though lower than the North-west average.

Harmful drinking

The 2012 Stockport Lifestyle survey found 19% of respondents reported binge drinking at least once in the last week (6 + units for woman, 8+ units for men), while 3% drank at a high risk level (over 35 units for women or 50 unit for a men) over the week and a further 17% at increasing risk levels (more than 14(f) or 21(m) units). The number reporting high risk drinking has reduced, from 4% in 2009, while the other figures are not significantly different. Men are significantly more likely than women to either binge drink or exceed weekly guidelines.

The profile by age shows two peaks in binge drinking, first among 18-24 year olds and again among 40-44 year olds. Increasing risk drinking is most common in 45-54 year olds, and high risk drinking peaks in the 45-49 age range.

It should be noted that self-reported levels of consumption of alcohol only account for around half of the alcohol that is sold in the UK, according to Inland Revenue figures, indicating that such surveys tend to under-estimate true consumption levels across the population. This may be due to inaccurate responses as a result of poor recollection as well as heavier drinkers perhaps being less inclined to complete such surveys.

Three key priorities have been identified for 2013-14:

Review of treatment system

The transfer of Public Health into the Local Authority brought about significant changes in the framework in which the alcohol strategy is delivered, including integration of substance misuse commissioning. During 2014-15 we undertook a fundamental review of the treatment system in relation to changing needs, priorities and policies, in order to plan for the future. This will result in a new model for adult community based alcohol provision being implemented in October 2015, which has an emphasis on early intervention, structured treatment and recovery support.

Health & Well-being Capacity Development

Experience has shown that alcohol misuse may be most effectively addressed as part of a broader 'prevention' agenda, which considers alcohol misuse in relation to its underlying drivers and promotes resilience and well-being as part of a broader public health oriented programme. Health promotion work needs to move beyond the 'topic silos' to embrace more holistic and asset-based approaches ("Assets are any resource, skill or knowledge which enhances the ability of individuals, families and neighbourhoods to sustain their health and wellbeing." Jane Foot 2012 *What Makes us Healthy?)* Such approaches develop the capacity of public services in relation to health improvement and empower individuals and communities to maintain and improve their own health and well-being, particularly focusing on deprived communities. The cultures of local communities have important impacts on health choices and influencing those cultures through working with the communities is an important part of the strategy.

Domestic abuse and alcohol

The links complex links between domestic abuse, alcohol misuse and mental health issues are widely recognised, and will be addressed within a holistic, wellbeing focused approach described in the Stockport Domestic Abuse Strategy, including through the recommissioning of voluntary sector support in the Alliance for Positive Relationships, which will commence service delivery in late 2015. This Strategy reviewed how we address domestic abuse, making the links in policy and practice, providing an opportunity to deliver system-wide improvements, especially in relation to prevention, early identification and intervention; alcohol misuse prevention work plays a key part in this.

(d) The Contribution of Local Cultures

The cultures of local communities have important impacts on health choices and influencing those cultures through working with the communities is an important part of the strategy.

C4.6   WELL BEING
The Science - Key Messages

Various aspects of well-being have been shown to be associated with physical health.

Evidence is particularly strong for the following:

- A positive impact on mortality from strong social support networks
- A harmful impact, especially on heart disease, of working under pressure to deadlines
- Lower mortality in those who have considerable autonomy in their work
- Lower mortality in those of higher social status
- Increased sickness and mortality during processes of change affecting fundamental areas of life identity. This lasts from the time that change first starts to be anticipated until the individual is settled back into a secure new role. It applies to both positive and negative life changes but the impact of negative life changes is greater.

There is also evidence for:

- A beneficial effect on health of aesthetically attractive surroundings and greenspace
- An adverse effect from inequality (i.e. doing less well than others) quite independently of the actual level of deprivation
- An adverse effect of threats hanging over people
- A beneficial effect of striving for a challenging and meaningful goal
- A beneficial effect of a strong personal identity

The biologically plausible explanation for this relationship is the stress reaction

The stress reaction is the mechanism whereby an organism faced with a threat gears itself up to deal with the threat – the "flight or fight" response. It increases strength and agility and speeds up mental processing. However the bodily changes involved in the stress reaction also lead to a depressed immune system, changed gut function, high blood pressure and high blood cholesterol. This may not matter too much in the normal situation where the reaction is short-lived but if it becomes inappropriately long-lasting these bodily changes will lead to cancer, heart disease, gastrointestinal disease and increased susceptibility to infection. These are exactly the effects that have been seen in the above studies (although not all of them in all studies)

Stress may also impact on cancer via gene transcription factors

One of the most controversial aspects of the debate about stress has been its role in cancer. It would be predicted from the immune system being affected by the stress reaction that stress would cause cancer via its impact on the immune system. However the evidence has been mixed. The public have generally believed that cancer can be caused by stress but the predominant scientific view has been hostile to that view and indeed respectable public health figures have described it as a fallacy to be countered.

Recent research at the University of Ohio has documented an impact of stress on the progress of breast cancer mediated by its effect on a gene transcription factor. This is quite new and it has a potential to change dramatically the debate about the relationship between stress and cancer.

The psychological literature contains some detailed theoretical analyses of well being

These include Maslow's hierarchy of needs, Cooper's matrix of occupational stress, the recent "flourishing/languishing" classification, the salutogenesis theory and a range of others. They often place emphasis on social support and strong personal resilience.

It is plausible that the psychological literature and the epidemiological literature are describing the same phenomenon but this scientific link has never been clearly shown.

If this gap were to be bridged we would be able to have much more confidence in the use, as important public health measures, of well-being indicators that have been developed from the psychological literature, such as the WEMWEBBS indicator which is increasingly being used.

Key Messages for People and Organisations

People can build 5 *Ways to Wellbeing* into everyday patterns of life

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

It is good for mental wellbeing to eat well, get out into natural green spaces and have fulfilling work.

Protective factors that policies and organisations can help create include

- *Control*: the feeling that we can manage our own lives and make our own decisions
- *Participation*: our belief that what we do matters, that we can make a difference
- *Inclusion*: our feeling that we belong, that there are people who care about us
- *Resilience*: our ability to cope with what life throws at us and bounce back
- *Assets*: personal, social and environmental resources we draw on for help and support

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

Commissioning effective services National evidence reviews in 2012/2013 support the following

Starting Well – early years with parents and young children:

- Universal and targeted parenting support
- Focus on 'school-readiness' via the home-learning environment and pre-school programmes
- Whole-school approach to mental wellbeing support
- Enhancing the physical environment (green-space/nature; access routes/mobility)

Working Well – working age adults:

- Specific support for unemployed people with mental health problems

- Specific support for return to work of those with mental health problems
- General promotion of mental health in the workplace
- Early identification and screening for mental health problems in the workplace
- Support for volunteering in the workplace
- Action to reduce stigma and discrimination

Ageing Well – older adults:

- Specific physical activity programmes, including community-based walking groups
- Increasing social contact and reducing social isolation/loneliness
- Support for volunteering, including time-banking
- Psycho-social interventions, including CBT (cognitive behavioural therapy) initiatives
- Maintaining activities of daily living (occupational therapy; hearing aids; support for carers)
- Provision of/access to meaningful activities (informal learning/arts-based activities)

Neighbourhoods and Communities.

- Reducing financial difficulties (debt advice)
- Supporting independent living (including issues like fuel poverty and energy efficiency)
- Community capacity building (time-banks, skill-share, 'navigators' to help access services, social prescribing)
- Improved access to the natural environment
- Reducing stigma and discrimination
- Promoting active travel opportunities

Key Messages – Cultural determinants

Promoting social integration, which has been shown to be weaker in deprived areas, tackles health inequalities in addition to being beneficial to individual's physical and mental health

A starting point for developing social integration is encouraging the development and participation of local groups.

Social cohesion is led by communities coming together in their own interests .Community development programmes have a crucial role in facilitating this , particularly in more disadvantaged areas or amongst more disadvantaged individuals.

As well as substantial benefits to people's health and some wider social benefits, there is increasing evidence that impact of Community Development can be measured financially.

Within a broad approach that values communities coming together, however, measures still need to be taken to address the priority that individuals, and communities attach to healthy living.

The strategy for tackling the challenge of creating opportunities for individuals and communities to live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development- primary community development and purposive community development.

C4.5. THE SCIENCE

The Scientific Evidence

In the 1950s the first evidence linking well-being and physical illness showed more heart disease in US accountants busy preparing accounts for the Internal Revenue Service. Work ensued on "type A", a behaviour pattern with increased coronary risk evoked working under pressure to deadlines.

Kasl, Cobb and Gore extensively studied self-reported health, physiological and biochemical parameters during losing a job, divorce, imprisonment, bereavement, entering a care home, moving house, promotion, and getting married. Life changes affecting identity damage health when they begin to be anticipated until full adjustment to the change. This negative effect applies both to beneficial and negative life changes but beneficial changes have less impact and are adjusted to more rapidly.

A study in US Army wives showed social support networks influencing complications of pregnancy In the Granville Train Disaster in Australia weak levels of social support strongly predicted serious mental illness in survivors of this horrific crash where a train left the tracks and collided with the supports of a bridge bringing it crashing down on the train. In the Alameda County Study strength of social support associated with a fourfold difference in all causes mortality. This difference, comparable to the effect of poverty, was so great the researchers refused to believe it attributing it to reverse causality (illness causing deteriorating social networks) predicting it would decline as the cohort was followed for longer periods. It didn't. It strengthened as would a directly causal relationship. Ultimately researchers were convinced. It is now clear that strength of social support is a major contributor to good health. This creates concern at economic policies of labour flexibility with frequent job change and at the finding by Appleyard & Lintell in San Francisco, and Hart in Bristol, that traffic levels weaken residents' social support networks by diminishing neighbour interaction.

Various studies of occupational mortality, including Marmot's study of civil servants show social status a positive factor in maintaining health as is autonomous control of one's own work. Various studies of stress at work show responsibility as good for health if linked to the training, ability and resources to discharge it, but without training, ability and resources it is bad for health. There are also adverse effect of threats hanging over people, a beneficial effect of striving for a challenging and meaningful goal and a beneficial effect of a strong personal identity. So, science clearly shows aspects of well-being affecting susceptibility to disease and influencing death rates. Most of this was known 30 years ago but has only recently come to prominence in practical policies.

Much newer is the recognition that aesthetically attractive settings benefit health. The pioneering study demonstrated patients recovered quicker from a surgical operation if they could see trees from their window. Other studies confirm this including one suggesting greenspace diminishes inequalities.

More controversial is Wilkinson's work suggesting perceived inequality may be important and people may suffer health consequences if they feel they don't share the lifestyle opportunities of others.

The Stress Reaction

The stress reaction occurs in organisms faced with a threat. It prepares for fight or flight. Mental processing speeds up so time seems to slow. Blood flow and energy is directed to muscles making the individual faster and stronger – the person just chased by a bull has no idea how he vaulted that hedge. In this process metabolic and cardiovascular changes occur – e.g. blood pressure, heart rate and blood cholesterol increase. Systems not immediately essential are shut down- the immune system is depressed and gastrointestinal blood flow diminishes.

Used up in fight or flight the stress reaction is an essential mechanism and perfectly healthy. However if it becomes inappropriately persistent it is harmful. Persistent elevation of heart rate, blood pressure and cholesterol causes heart disease and stroke. Depression of the immune system causes cancer and infection. Reduced gastrointestinal function leads to gastrointestinal illness. Cancer, heart disease, gastrointestinal disorders and infection are the diseases most associated with the lack of psychological wellbeing described above. This is the biologically plausible link for the epidemiological observations. A threat hanging over people (a conventional threat, a life change, a deadline, entrapment in an unsatisfactory situation like low status, or a feeling that you can't discharge a responsibility) triggers the stress reaction. It cannot be used up in immediate action, becomes persistent and damages health. This plausibly explains well established epidemiological findings but is not proved. If it is correct social support and tranquil green settings may moderate the impact of stress or operate directly raising the human spirit so their absence creates unease.

The Psychological Perspective

There are a number of psychological approaches to well-being which are helpful to understanding it.

Maslow approached well-being through needs, describing five levels of need – physiological (air, water, food), safety, belongingness (love and friendship), ego-status (position, identity and standing), and self-actualisation (to "be oneself" and "have a task that you must do"). He presented a hierarchy, human beings motivated by the lowest level of needs to be under threat; a drowning man is motivated solely by finding air but later air no longer plays any part in his calculations. Maslow acknowledged that ego status and belongingness needs were sometimes met in the reverse order and some see them as part of the same need – for acceptance - with self-actualisation addressing security of acceptance as safety does to physiological needs. Maslow later added aesthetic and spiritual needs and divided self-actualisers by into transcenders (motivated by spiritual needs) and non-transcenders. He also recognised that needs could be met by deciding, in a greater cause, to accept their absence.

The four level hierarchy with ego status and belongingness as one tier fits Galbraith's four modes of motivation – compulsion (dig the ditch or be shot), compensation (dig the ditch and we'll pay you), identification (the ditch needs to be dug) and adaptation (diggers decide where the ditch goes). Maslow's additional tiers suggest additions to Galbraith's theory – sensualisation (digging ditches is great fun) or spiritualisation (gain one-ness with the earth/build character through hard labour/ counter pride from high status occupation/ make an opportunity for meditation).

Some say Maslow was wrong to see a hierarchy in his needs and they are just a taxonomy of equally important needs. A national advisory group suggested the following fundamental psychological needs

Secure stable ATTACHMENT & TRUST to somebody we can depend on who knows us well

EMPATHIC COMMUNICATION RELATIONSHIP - someone wants to understand our meaning

IDENTITY & BELONGING with identity and position in a family or care-giving social group

CONTAINMENT, SECURITY & DISCIPLINE, living within secure social boundaries and rules

ESTEEM, BELIEF & PURPOSE hope, belief, meaning, value and purposeful occupation

SELF-DETERMINATION understanding and influence over ourselves and our environment

RESILIENCE & HAPPINESS capacity to tolerate frustration and fully experience pleasure

RESPECT & RESPONSIBILITY reciprocal respect, regard and responsibility towards others

Others look at psychological environments in which people function. Cooper produced a matrix of factors to identify occupational stress. An Occupational Stress Indicator is constructed using a biographical questionnaire and six questionnaires on different dimensions of stress. These focus on sources of stress, individual characteristics, coping strategies and effects on the individual and organisation. Organisations use this in a stress audit then reduce or eliminate sources of stress.

Other approaches emphasise personal factors that create resilience. Keyes distinguishes flourishing individuals (with 'enthusiasm for life, actively and productively engaged) and languishing individuals with neither wellbeing nor mental illness. Data from the USA found 50% of the general population moderately mentally healthy, 17% were flourishing, 10% languishing and 23% meeting criteria for mental disorder. There is no comparable UK data. Flourishing individuals have less psychosocial impairment, better physical health, higher productivity, fewer limitations in daily living, lower risk of chronic physical disease with age, fewer missed days of work, less helplessness, clear goals, higher resilience), less cardiovascular disease, and less use of health care. Flourishing, therefore, fits with a healthy ageing strategy.

Salutogenesis is a social theory epidemiologically associated with mortality. Antonovsky coined the phrase interviewing Israeli women with experiences from concentration camps who remained healthy. He sought "the origin of health" rather than the causes of disease, identifying sense of coherence, a pervasive sense in individuals, groups, populations or systems that was the overall mechanism of the process. He claimed sense of coherence (SOC) explains why people stay well and improve their health. A strong SOC is ability to assess your situation (comprehensibility), resources to cope (manageability) and finding meaning to move in a beneficial direction (meaningfulness). Longitudinal studies find SOC associates with perceived good health and reduced mortality regardless of age, sex, ethnicity, nationality and study design.

The Measurement of Well Being

If the stress reaction's biochemical and physiological features were associated with states postulated in psychological literature this would confirm the reaction as the causal link and validate well-being indicators so associated. This experiment has not been done. So how can we measure well-being?

Indicators discussed include emotional intelligence, spirituality, learning and development, measures of resilience including sense of coherence , a single "life satisfaction" survey question, questionnaires addressing dimensions of disability, functioning and/or wellbeing, composite indicators, participation, social networks, social support, trust, violence, physical environment, working life, stigma / discrimination, debt / financial security, social inclusion, equality, safety. EQ5D (5 questions measuring disability and functioning) % people who feel they belong to their neighbourhood, local civic participation, regular volunteering, sickness absence. The JSNA used self-reported well-being. The WEMWEBBS composite indicator is widely used.

The Role of Empowerment

The WHO has produced evidence that empowerment benefits health. This could be because it adds to the sense of status.

- People feel more in control of matters which might otherwise seem like an external threat
- Control of one's own work benefits health, and the same may apply in other settings
- If people often make decisions and risk-judgments they will seem less stressful when they occur.
- Making decisions together is socially supportive
- Involvement diminishes the fear of the unknown
- Involvement in decision making about a life change speeds the process of adjustment

People need to be involved in decisions about their lives and in change processes, to express their opinions and dissent and work with others to bring change for their communities. This challenges politicians and leaders of representative organisations who see themselves as spokespeople for their constituents, leaders of enterprises and public agencies whose duty it is to chart their organisation's future and professionals who may be affronted if their advice is not accepted. An ancient Chinese proverb says "The leader the people love is the second best kind of leader. With the best kind of leader when the job is done the people say "We did it ourselves".

C4.6.   THE IMPLICATIONS FOR PEOPLE AND ORGANISATIONS

FIVE WAYS TO WELL BEING

A number of different elements have been described that enable people to maintain positive mental wellbeing. The 5 Ways to Wellbeing are simple actions that can be built into everyday patterns of life and are known to help people feel more positive about themselves and their place in the world.

Connect, be active, keep learning, take notice and give summarise the findings that to promote mental well-being you need to develop your social and friendship networks, spend time with other people, find physical activities that boost your heart-rate and you enjoy, be curious about your world, explore new opportunities or ways of doing things, think about the patterns and cycles in your life, the way you react to what happens around you, focus on 'now' and take pleasure in the

moment and give your time, your energy, your attention to those around you in small ways or big ones

In addition to these five items, research shows that it is good for mental wellbeing to eat well, get out into natural green spaces and have work that is fulfilling. A recent report by the Children's Society (The Good Childhood Report, 2013) found that for those aged between 10 and 17 years creative imaginative play may be more relevant than giving to their mental wellbeing. For this group the balance of family conflict or harmony, the level of support (emotional and practical) within the family and the level of autonomy granted to children by their parents are vital to mental wellbeing. Autonomy and achievement are cross-cutting themes in the analysis of factors affecting mental wellbeing at this age (Children's Society, 2013).

How Organisations Can Help

In the Key Messages at the start of this chapter I listed some key factors that organisations can promote. These emerged from Mental Well Being Impact Assessment. I also listed services we should aim to commission according to an evidence review. There are clear implications for local authority functions-

Lifestyle Leisure	Libraries, arts, licensing
Community	Community development, youth and senior citizen groups, social cohesion
Local economy	Economic development, local government jobs, business grants
Activities	Benefits advice, play provision, schools programmes, adult learning
Built environment limits	Accessible cycle/walking routes, housing, street lighting, play spaces, speed
Natural environment	Green, open spaces, parks, air quality, sustainable development, allotments
Global ecosystem:	Home insulation, planning and development control

Strategic Principles

Mental wellbeing is the term used to describe how people **think, feel, function, make sense of and experience their lives**:

- how people **feel** about their lives (subjective wellbeing, happiness)
- how people **evaluate** their lives (life satisfaction, meaning)
- how people **function** (relationships, achievement of one's potential)
- **external factors** that can influence all the above (e.g. income, housing, social networks, crime, education, employment).

There is good quality evidence that improving wellbeing, including mental wellbeing, has a wide range of health, social and economic benefits. These include:

- reduced risk of mental illness and suicide
- improved physical health and life expectancy

- better educational achievement
- reduced health risk behaviours such as smoking, alcohol and drug use
- improved employment rates and productivity
- reduced antisocial behaviour and criminality, and
- higher levels of social interaction and participation.

Improvements in outcomes in all the areas influenced by mental health and wellbeing are associated with reduced costs and considerable savings across a wide range of public services, including health, social care, education, employment and criminal justice.

In 2012 the government published a new policy on mental health and wellbeing. *No Health Without Mental Health* (DH, 2012) sets out clear national ambitions and principles:

- Equal importance is given to mental and physical health
- Emphasis is placed on supporting the mental wellbeing of the whole population not just those with mental ill-health
- Application of a life-course approach (starting well, developing well, working well, living well and ageing well)
- Emphasis on early intervention (childhood/ teenage years) to support mental wellbeing and prevent mental ill-health
- Mental health and wellbeing are understood to be key to addressing inequalities in health
- Mental health and wellbeing are seen as a cross-departmental responsibility
- Consistent with the approach outlined in other main health policies:
- No decision about me without me
- Focus on outcomes
- Local decision making
- Personalisation
- Development of a national measure of wellbeing

Local action focused on mental wellbeing in Stockport

Stockport Health and Wellbeing Strategy states that mental wellbeing is a key priority. It is a central theme running throughout the document as well as the focus for an individual chapter. The strategy sets out clear objectives for local activity, as shown in the extract below.

"In order to improve the mental health and wellbeing of people in Stockport and keep people well, we will strengthen support for and the awareness of the effects of poor mental wellbeing in all services and activities, recognising this as the foundation for the health and wellbeing of individuals and communities.

We will do this through:

Establishing a clearly authorised forum through which this policy is implemented, including capacity to direct/affect resource allocation, for example by strengthening the terms of reference and adjusting membership of the Mental Wellbeing Strategic Planning Group (MWSPG);

Incorporating the Mental Wellbeing Impact Assessment process into legally required impact assessment processes for review of programmes and services and identifying responsibility for subsequent implementation by relevant stakeholders;

Promoting the "5 Ways to Wellbeing" as a simple mechanism to engage staff and public in addressing mental wellbeing and embedding this into working practices (part of MWSPG terms of reference + within staff development/training remit);

Providing specific training to strengthen the capacity of all staff and partners to address mental wellbeing issues with confidence and skill (part of MWSPG terms of reference + within staff development/training remit);

Applying the 'wellness service standards' as a quality benchmark for public health services: to the integrated lifestyle service (2012) and cultural determinants service (2013-2014) and for other services in the future.

We will take action to highlight these particular risks and opportunities to mental wellbeing;

Debt as an important risk factor points to the promotion of national and local debt advice resources and services,

Working through and with the CCG to promote early identification of poor mental wellbeing and alternatives to prescribing

Working with early years settings given the importance of maternal and early life mental wellbeing and BME groups in particular

Working with communities to develop local ideas for promoting good mental wellbeing

Working with the new carers centre to strengthen support for mental wellbeing.

In order to improve outcomes for people with mental health problems in Stockport through high quality services that are equally accessible to all we will;

Work in partnership to undertake the Stockport Mental Health Pathways Project"

A wide range of activities have been undertaken in the borough to ensure delivery against these objectives. These include:

Staff capacity building with a network of partners offering dedicated training programmes

Expansion of CBT support through community courses, computerised access and self-help booklets

Production of a handbook showcasing local opportunities to access the 5 Ways to Wellbeing

Social prescribing programmes such as Arts on Prescription, Mums In Art, Physical Activity on Referral in Stockport (PARiS) and bibliotherapy (self-health@your library - books on prescription)

Application of the Mental Wellbeing Impact Assessment Toolkit to a variety of policies and projects

The main focus of these activities is to expand access to wellbeing opportunities across the population. By providing a range of effective support options the intention is to address the extensive low-level needs relating to mental wellbeing and so reduce demand for more expensive, high-level interventions.

THE CULTURAL DETERMINANTS OF WELL-BEING

Promoting social integration, which has been shown to be weaker in deprived areas, tackles health inequalities in addition to being beneficial to individual's physical and mental health. A starting point for developing social integration is encouraging the development and participation of local groups

Social cohesion is led by communities coming together in their own interests. Community development programmes have a crucial role in facilitating this, particularly in more disadvantaged areas or amongst more disadvantaged individuals.

As well as substantial benefits to people's health and some wider social benefits, there is increasing evidence that impact of Community Development can be measured financially.

A social return analysis with imputed financial value was undertaken to track the activity of Community Development professionals in four local authorities It found that an investment of £233,655 would have a return of approximately £3.5 million: every hour spent by community members running groups and activities had 1:6 return on investment. Other examples were recorded evidence exists include Time banks and community based falls prevention for older people

Within a broad approach that values communities coming together, however, measures still need to be taken to address the priority that individuals and communities attach to healthy living.

People living in our deprived neighbourhoods have the greatest need to change lifestyle behaviours, as evidenced by the lifestyle survey, but they are the least likely to access lifestyle support services or make successful changes. Similarly our most vulnerable populations, homeless, refugees, asylum seekers, people with mental health problems may struggle to prioritise good health amongst the challenges they face.

The strategy for tackling the challenge of creating opportunities for individuals and communities to live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development - primary community development and purposive community development.

Primary community development aims to develop the general strength of a community. It is important for two reasons firstly as a direct health promoting intervention in its own right because of the impact of social networks, empowerment and civil society as health determinants. Secondly it is a prerequisite for purposive community development. A metaphor used locally is that you cannot run the bus service before you have built the road.

Purposive means using CD methodology to address health related issues. It uses a unique approach to health improvement which encourages communities to identify their own health agenda and then assists them in developing strategies to create positive ways of addressing health issues. By encouraging genuine participation in the communities' agenda local people become more

empowered. As people become a part of the decision making process they then become more willing to consider change because the impetus for change has come from within their own community.

Using these approaches a range of community based initiatives, that impact on the social and cultural determinants of health, need to be in place. The existence of a range of activities, support groups, self-help groups and the like can all help create a culture that values health and that encourages change.

In both primary and purposive community development an asset based approach is required which focuses on the strengths that exist within the local community and builds on them rather than working from an assumption that the community has deficiencies that need to be tackled.

In communicating this strategy we need to find a framework for talking about the social determinants and cultural determinants of health to a non-professional public health audience. This is not just for people working in the field, but for policy-makers. We need to talk about the topic in a way that people can understand, that is meaningful, and that doesn't align the topic with any existing political perspective or agenda.

A good beginning is "Health starts where we live, learn, work and play"

Local action focused on cultural determinants in Stockport

A lifestyle strategy has three components. One component, the Healthy Stockport Service provides individual support to achieve behaviour change, another component aims to change the environment so that healthier choices are easier to make and a third component – the cultural determinants component – aims to change social norms of behaviour within particular cultures so that healthy behaviour seems more natural. For example our Healthy Stockport service can provide individuals with tailored individual weight loss programmes. The enabling conditions that facilitate change, such as the development of cycling and walking facilities and availability of healthy food can make it easier for people to make changes which will improve their weight but the food and health team provide the community cookery skills training to help individuals and their neighbours cook healthier meals for themselves and their families.

Public health delivers programmes that increase the capacity of people and communities to live healthy lives Programmes include Food, nutrition & health skills, Walking for health, Community development, and the Community stop smoking programme. Each of these programmes are small but together comprises a team of workers dedicated to addressing the social and cultural determinants.

The programmes provide a person centred, holistic approach to health. They work in partnership with individuals, families, carers, groups and other professionals in statutory, independent and voluntary sectors, utilising a range of tools and methods to assist people to maximise their quality of life, promote independence and interdependence, enhance the social networks and organised civil society in their communities and improve their health.

Social and cultural determinant work is largely carried out within the geographical areas of most disadvantage in Stockport. The areas currently worked in are Brinnington, South Reddish, Lancashire Hill, Hillgate, Town Centre, Cheadle Heath, Adswood and Bridgehall and Offerton.

Community Development workers work alongside people in communities, build relationships with key people and organisations to facilitate the identification of common concerns, and help build autonomous groups. They create opportunities for non-formal learning, which will help to increase the capacity of communities. By enabling people to act together, Community development workers help to foster social inclusion and equality.

Communities of interest that are supported include older peoples groups, Health Walkers and a local children and families group, Marbury Minis. People from a particular ethnic/cultural background are also supported for example Asian Heritage Group. A number of gender, sexuality and age related groups are supported for example People Like Us Stockport, PLUS Exercise group. Older people and community generally are brought together via Community cafés - in Lancashire Hill SK community café, in Hillgate Millbrook community café, in Reddish the Welcome café and Marbury House Group and in Heaton Norris Pavilion.

Stockport wide and local groups where mental health issues are the common factor include Start the Week Drop In, Midweek Drop In, Start the Walk, Lancashire Hill (Penny Lane) Photography Group, Stockport Progress and Recovery Centre, Stockport User Friendly Forum, Service User Network Stockport, Hart Art Group, Inspire.

Purposive programmes provide targeted activities to increase the capacity of individuals and communities at high risk of health related harm to eat more healthily through becoming physically active and creating smoke free homes and communities.

Outreach to some of the most disadvantaged populations in Stockport is also provided which includes homeless people, asylum seekers and refuges and travellers.

To enable CD workers to empower their target population the workers follow the public health advocacy policy set out at the start of this report which recognises that the prime responsibility of the worker is to the community that they serve and that the maintenance of the trust of that community must be a priority.

We aim to further develop our cultural determinants programme to constructively challenge local culture and enable people to shift within that challenge. The ultimate aim is to develop further shared activities across different elements of service delivery to deliver our priorities. This would be particularly beneficial in training and capacity building for example increasing capacity to deliver more Health Defenders and Essential Public Health courses. There would still be some differentiation between different elements of service provision however as there are specialist functions that we would want to continue to be delivered. The Stockport Health Inequalities (HI) Programme is a new programme designed to reduce the difference in life expectancy between the most affluent and disadvantaged localities through additional investment in the 4 Neighbourhood Management Areas (NMA) that cover the Priority 1 communities and in seven Priority 2 neighbourhoods.

The programme has three key aims delivered through purposive community development. Firstly raising communities' expectations about health and increasing rates of screening and early diagnosis, secondly empowering communities and supporting the development of increased community resilience through a purposive community development programme and thirdly improving mental wellbeing through implementing best practice in community engagement and empowerment and developing programmes that improve wellbeing.

The focus in each NM locality varies dependant on local health intelligence, community priorities and practical considerations such as the breast screening van schedule A strong partnership has developed between public health and the NM Teams and Boards to deliver the programme which went live on 1st August 2014 when 4 Health and Wellbeing Officers (HWBOs) came into post as members of local NM teams providing capacity to deliver 4 local programmes

Each area has now held a number of health focused engagement and events. These range from an intensive Kill the Chilli fortnight in Offerton to A Big Festival –food event in Adswood and Bridgehall. Programmes have also promoted health messages using different media, including a calendar to every household (A+B), social media via Facebook, you tube videos (Brinnington). Breast cancer screening awareness raising activity and bowel cancer awareness raising initiatives have been timed to coincide with screening van visits and national publicity. Blood Pressure and Health checks have been opportunistically provided by cohort of the public health workforce, including HWBO's.

Some of the work is not branded as "health" related. There is a need to weave health into other priorities and initiatives. For example Adswood and Bridgehall promoted testicular cancer awareness and alcohol reduction at a football competition.

Community Health Champions have been recruited. Champions are not formal volunteers, but people interested in informally promoting healthier living. Champions are offered a range of training but they may choose to focus on whatever issues that they are most interested in. The basic training is informal but more formal training will be available those who want to volunteer regularly and would like an accredited qualification. The Health and Well Being Officers maintain a link and offer ongoing support to these and future champions.

Local programmes also stimulate increased health related activity within existing community groups and have demonstrated that residents can participate in decision making and see changes in health related activity. For example Central's Grow, Cook Eat project was recommended though a Citizen's Enquiry process and is designed to increase people cooking and growing healthier food. It has seen over 200 local people take part so far.

Preparing for the second year of the programme there are many opportunities emerging and a number of challenges to address. Most work to date is in the first domain of increasing expectations about health and increasing rates of screening and early diagnosis. The work programme for year 2 comprises

- Aligning with Investing in Stockport and Stockport Together developments

- Obtaining more real time information about characteristics of people who don't attend screening to enable us to target them more effectively.

- Identifying mental wellbeing priorities and developing an offer.

- Developing effective community based interventions to address alcohol misuse.

- Building on initial GP engagement and developing further partnership initiatives.

- Connecting with our target groups - "never screened " and "yet to reach" "men", and ensuring engage people not already active in existing local groups or activities

- Maximising opportunities for the community to develop its own priorities; initiatives work best when they come from them, not 'well-intended' ideas from services.

- Increased use of social media which will sign up more people for ongoing contact.

- Recruiting and supporting more local champions for health.

- Community coaching and small funds to stimulate interest and responsibility

- Stimulating programmes that more naturally bring the community together such as pop up gardens and food activity rather than discrete health activity.

The development of local plans for P2 areas is taking longer as there is not a local infrastructure similar to that already in place in NM areas. Funded work programmes started in April 2015 in Reddish and Bredbury Green areas.

In North Reddish joint work is taking place between public health and the Re:dish (sic) community partnership. Re:dish are delivering a "community champion" programme utilising the HI programme funding for North Reddish and Marbury Road.

In Bredbury Green a programme to increase healthy eating, community growing spaces and physical activity amongst residents is centred in the newly developed community hub at the Highgate Centre. Led by Mossbank Housing, with tenants, Startpoint, Children's Services, Schools, Stockport Homes and Public Health as partners.

C4.7   SAFETY AND HEALTH PROTECTION

<u>Control of Infection</u>

The protection of the public from infectious diseases continues to be a major element of the public health process.

Infections may be spread by water, by air, by food, by close contact, by animals, or by infectious material coming into contact with bodily fluids (through sexual contacts, through unhygienic injections, or through wounds in accidents or in the course of healthcare).

Water-borne diseases such as typhoid and cholera once ravaged this country but have for many years now been virtually eradicated by the creation of safe water supplies. Legionnaire's disease occasionally develops in water stored in systems like cooling towers or air conditioning systems if the precautions to avoid this are neglected and then spreads by droplet. There have been a few outbreaks in the UK recently.

Air-borne diseases are largely addressed by two measures – respiratory hygiene and immunisation both to protect the individual and to halt the spread of the disease person to person.

Respiratory hygiene is important. Always cough or sneeze into a handkerchief or sleeve. Coughing or sneezing to the open atmosphere spreads disease and coughing onto your hand is not ideal either unless you wash it immediately afterwards. The recommendation is to cough into your sleeve at the inside of the elbow but many people find this embarrassing and the next best is a handkerchief.

Vaccination is the other main strategy for this group of diseases. Smallpox has been eradicated worldwide. Diphtheria has been almost eliminated in this country by immunisation. Polio is now unknown in this country and on the verge of worldwide eradication, although opposition to vaccination is preserving some islands of the disease in parts of Asia and Africa. Unfortunately personal decisions about vaccination can be complicated especially by scare stories. In this country measles, mumps and rubella were a problem which we thought we had contained until the MMR scare affected the uptake rates for vaccination, a problem we are only just recovering from. It is just as understandable that the populations of Pakistan, Sudan and Northern Nigeria have been scared by some equally misleading information about polio vaccine from some religious fanatics and this has delayed the world wide eradication of polio.

 The common cold is the commonest air-borne disease but in terms of diseases causing serious harm flu is far and away the biggest threat amongst diseases in this category of spread.

Food-borne diseases remain a significant problem. Much food poisoning consists only of a short digestive upset, distressing and disruptive but not dangerous. However more serious forms of food poisoning kill. Meticulous food hygiene remains the defence.

Diseases spread only by close contact do not by their very nature break out as epidemics. Some forms of meningitis can spread within families.

Tetanus from the entry of dirt into accidental wounds has been reduced considerably by vaccination.

This country is free of the major insect-spread diseases such as malaria. However the numbers of notifications of Lyme disease continue to increase year on year with 1,040 individuals respectively notified in 2012 in England and Wales. Lyme disease is an infection caused by the bacterium *Borrelia burgdorferi* with humans becoming infected after being bitten by hard-bodied ticks (Ixodes *species*) that are infected with *B. burgdorferi*. Ticks become infected when they feed on birds or mammals that carry the bacterium in their blood. Lyme disease is one of the most important insect transmitted infections in the UK.

There are still cases of zoonoses, diseases spread by animals.

Food Hygiene and Standards.

Every producer and supplier of food has a responsibility to ensure the food they supply is safe and its composition is described accurately. Both Environmental Health and Trading Standards have key roles in enabling and supporting over 2500 premises in the food industry in Stockport to meet their legal responsibilities. This is mainly achieved through proactive targeted projects, unannounced inspections of premises, responding to complaints and by sampling programmes. Work is also carried out in preventing the supply of unsafe food such as illicit alcohol through identification, seizure and destruction. . For the small number of businesses that continually put public health at risk, robust enforcement action is taken in accordance with Council's enforcement policies and the Food Standards Agency's expectations.

The teams work closely with Public Health England – Greater Manchester Health Protection Team following notification of food borne illnesses or food poisoning outbreaks and with the Infection Control Team following liaison with schools, nurseries and residential care home if an outbreak is suspected to implement the appropriate controls.

 Some examples of recent work include:

Food Hygiene prosecution 1 – a local café/takeaway was convicted of 8 food hygiene offences at Manchester Crown Court (Minshull St) following a long history of poor food hygiene standards.

Food Hygiene prosecution 2 - a takeaway rated 0-(Urgent Improvement Necessary) on the national Food Hygiene Ratings Scheme was recently convicted of 12 food hygiene offences.

Food Standards prosecution – a local public house has been fined for selling denatured alcohol (ethanol and propan-2-ol) that was unfit for human consumption and posed a serious risk of danger to public health

Food Standards simple caution – a local retailer has been issued with a simple caution after being caught by the team selling beef as lamb as lamb is currently more expensive

E. Coli 0157 Butchers Project – officers have visited a number of butchers that are deemed high risk and audited against the Food Standards Agency guidance on the control of E.Coli 0157 cross contamination. This work has proved highly successful and we are confident that the risk in these premises has been minimised.

Infection Control Study Day @ Stepping Hill Hospital – a member of the team participated in this event.

Food Allergen Business Training Day– the team trained over 120 businesses (restaurants & takeaways) in the allergen declaration requirements of the new Food Information Regulations at a 1-day drop-in session. The training was extremely well received by businesses and more dates are planned.

Successful FSA-Funded FHRS Display Work – *the food team successfully applied for funding to deliver an FSA project aimed at increasing the levels of food hygiene rating display in businesses rated 3, 4 and 5.*

Healthy Catering Award - developed through the GM Food Liaison Group. The award recognises those catering businesses that have demonstrated a commitment to reducing the level of saturated fat, sugar and salt in the food and drinks they sell.

School Breakfast Clubs, Mid-Morning Snacks & After School Clubs – The team have developed food hygiene guidelines for these clubs which are often run by separate groups to the main lunch caterer

Food Hygiene Rating Scheme National Consistency Exercise – the food team have recently taken part in a Food Standards Agency national consistency exercise and are awaiting the feedback report in November 2015.

Food Hygiene Rating Scheme Greater Manchester Inter-Authority Pilot Audit – the team participated in this funded exercise and one member led on the piece of work along with colleagues in Trafford and Rochdale Councils. The work identified that there is a good level of consistency in the operation of the scheme amongst the Greater Manchester Authorities and a high level of consistency when rating food premises.

Healthcare Associated Infections

The overuse of antibiotics has created multiply resistant organisms which are difficult to treat, especially (but not exclusively) in hospitals. This requires using antibiotics more sparingly and only when needed combining this with meticulous cleanliness and hygiene in healthcare facilities.

Clostridium difficile – There were a total of 84 cases during 2014/15, down from 113 in 2012/13,

Tab C15.1	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	6	5	3	9	9	6	10	8	6	7	7	8	84

The health economy was set a challenging target of no more than 88 infections for 2014/15 and to be able to achieve less than this a number of actions were put into place, these included:

Performance management of the target on a biweekly basis

Incentive for GP's to examine their antibiotic prescribing habits for high risk antibiotics

Incentive for GP's to review and stop where possible patients on proton pump inhibitors

Development of a joint database with Stockport Foundation Trust for Root Cause Analysis findings

Antibiotic stewardship ward rounds for patients in acute care

Review of both community and acute antibiotic policies

The target for 2015/16 is less than 86 cases. Whilst this is a slight increase on the 14/15 target the numbers allocated to Stockport NHS FT have reduced significantly whilst the number allocated to community have increased. New guidance has been issued to health economies regarding lapses in care which requires implementation in 15/16. A small task and finish group is to be established to determine the effects of this guidance for Stockport.

MRSA Bacteraemia – There were a total of 5 cases during 2014/15, down from 7 in 2012/13

Tab C5	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	0	0	1	0	0	0	0	0	2	0	0	0	5

There was a Zero Tolerance MRSA Bacteraemia target set for every health economy during 14/15. All of these cases were apportioned to acute medical care; however only one was identified in an acute trust outside of Stockport Health Economy. 3 cases have been assigned to Stockport NHS Foundation Trust, and the remaining case assigned to a third party. The root cause analysis of these cases did not identify any significant issues for the wider health economy.

MSSA Bacteraemia

Tab C6	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	5	5	5	7	13	3	7	7	6	5	2	6	71

This has increased from 59 in 2012/13

EColi Bacteraemia

Tab C7	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Stockport	14	12	14	19	23	20	20	16	12	17	9	15	191

This is similar to the figure of 188 in 2012/13

There are no national trajectories set for both MSSA and EColi Bacteraemia, however there is an expectation that acute trusts are actively working to reduce the incidence of these infections in these settings.

Infection Prevention and Control Assessments in General Practice

Since 2004, the Health Protection and Control of Infection Unit have undertaken assessments of infection prevention and control practices and procedures in all General Practices throughout Stockport. For the first time during 2011/12, for those Practices housed in former PCT premises, the assessment was divided in those aspects which are the responsibility of the Practice, and domestic & estates issues which were the responsibility of the PCT. The existing assessment tool is based upon one originally devised in 2003 by the Royal College of General Practitioners and the former Infection Control Nurses Association (now the Infection Prevention Society). It sets particularly rigorous standards which reflects the commitment of local general practitioners to ensuring high standards in this area but also implies the necessity not to panic when it produces a list of shortfalls from perfection.

In 2004/05 67% of Practices assessed achieved the required pass mark & 33% did not and it is a mark of the considerable effort at achieving high standards that by 2011/12, 95% achieved the required pass mark & 5% did not. Practices which failed were reviewed individually to see whether urgent action is needed to address patient safety. No practices required this in 2011/12.

As Practices have been registered with the Care Quality Commission from April 2013, they have had to demonstrate steps taken to monitor & maintain their own infection control standards.

During 14/15 the infection prevention and control assessment has been extensively changed to reflect mandatory requirements, guidance and best practice. This tool has been trialled and will be rolled out during the remainder of 14/15 moving forward into 15/16.

Infection Control and Inspection in Care Homes

During 2010/11 the Health Protection and Control of Infection Unit secured funding to create a temporary post (12 months) to undertake a specific project assessing infection prevention and control standards in nursing and care homes in readiness for CQC registration of these environments. This funding was withdrawn and the project came to an end.

This funding has since been renewed in conjunction with NHS Stockport Clinical Commissioning Group and a new project commenced from September 2013. The aims of this project were to improve infection prevention and control standards within Nursing and Care Homes, with the ultimate aim of ensuring consistent standards across the health economy and to reduce the risk to vulnerable individuals of health and social care infections.

The current pre placement contract for placing individuals has been by the Local Authority. Infection Prevention and Control has not previously been included in this contract. Therefore the Health Protection and Control of Infection Unit are working closely with Adult Social Care to ensure consistent standards are included in all pre placement contracts with nursing and care homes, ensuring consistency across the health economy for Stockport residents.

During 14/15 the majority of the boroughs nursing and care homes have been assessed and some have also undergone the reassessment process. Improvements have been made in all areas assessed, however there are still improvements that could be made to ensure the safety of this vulnerable client group.

Infection Control in Stepping Hill Hospital

Stockport NHS Foundation Trust continues on its journey to zero avoidable Healthcare Acquired Infections (HCAI's), with its achievements in 2014-15.

The key areas of improvement in 2014-15 were MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia and further reductions in CDI (Clostridium difficile toxin associated disease).

- Three MRSA Bacteraemia cases in 2014-15.

- There was a continued reduction in the number of CDI cases year on year since 2012-13. Numbers have fallen to 44 cases in 14/15.

Table C8

2012/2013	81 cases
2013/2014	47 cases
2014/2015	44 cases

Zoonoses

Zoonoses are diseases and infections which are transmitted naturally between vertebrate animals and man.

Transmission may occur by a number of routes, from indirect contact through food or drink to direct contact through occupational exposure on farms, from pets or through leisure pursuits.

Twenty seven such diseases and infections are recognised as occurring in the UK and data on their frequency are obtained from national surveillance programmes.

The most commonly occurring zoonosis in England and Wales is Campylobacteriosis consumption of contaminated chicken would appear to be associated with the majority of campylobacter outbreaks. Non typhoidal salmonellosis is the second most frequent, closely followed by Cryptosporidiosis. VTEC 0157 remains noteworthy because of its potential for causing Haemolytic Uraemic Syndrome.

The numbers of notifications of Hepatitis E continue to increase year on: there is increasing evidence that Hepatitis E is a food borne zoonosis derived from inadequately cooked pork sausages.

Table C9	National available figures	Stockport figures 2014/15
Campylobacteriosis	65,032 (2012)	352
Salmonellosis	7,585 (2013)	34
Cryptosporidiosis	5722 (2012)	47
Hepatitis E	579 (2012)	6
VTEC 0157	795 (2012)	4

The occurrence of zoonoses, including those briefly mentioned above, emphasise the need for continued surveillance and collaboration between human and veterinary health practitioners.

Immunisation report 2014/5

Tab C10 Annual cover data 1/4/14-31/3/15

24 month cohort

Dtap/IVP/Hib	MMR	Men C	PCV
96.9%	92.6%	82%	95.3%

5 year cohort

Pre-school booster	MMR1	MMR2	Men C	PCV
97.6%	96.2%	92.1%	95.1%	93.5%

The WHO recommends vaccine rates to be over 95%.. Although the figure for MMR 2 is not over 95% it remains higher than most areas, due to the hard work of the Immunisation and School Nursing Team catching the young people when they have their School Leavers Booster.

HPV
Human papilloma virus is the major cause of cervical cancer hence the reason for this immunisation programme. Provisional annual data for routine cohort vaccine coverage for 14/15 was unavailable at time of writing this report. Overall the HPV coverage for 13/14 was 91.9%, remains high and amongst the highest in the North West.

Season Influenza uptake 2014/15

Table C11	Over 65yrs	Clinical Risk Groups	Pregnant Women	2yrs	3yrs	4yrs
Stockport	80.1	63.3	72.0	52.6	57.2	43.8
GM	75.1	54.4	49.5	39.6	43.1	33.4
England	72.8	50.3	44.1	38.5	41.3	32.9

The targets for 2014/15 were 75% for clinical at risk group and pregnant women and 75% of over 65 years. Although Stockport did not reach the target for clinical risk groups it is worth noting that Stockport had the highest uptake of seasonal influenza vaccine in all categories across Greater Manchester, apart from the 4year olds. This is an excellent achievement.

From the 1st April 2013, immunisation became the responsibility of Public Health England. We will continue to work closely with them to ensure that Stockport continues to improve on the already good immunisation uptake.

The Flu Strategy Group brings together stakeholders across the Health Economy to co-ordinate a seamless annual influenza vaccination campaign. Typically, the group meets three times during the year to plan and prepare for the forthcoming flu season. From mid-November through to the end of February the group 'meets' via telephone conference on a weekly/bi-weekly basis (dependent on influenza activity) to monitor levels of flu circulating in the community. The benefit of meeting so frequently over the flu season facilitates timely decisions/actions to be implemented in response to influenza levels.

Measles and Mumps

Measles is a disease which virtually everybody will catch unless they are immunised or fail to encounter it due to the immunisation of the population to a coverage level sufficient to stop spread. Bearing in mind the fact that a small number of people cannot be successfully immunised for various reasons there is very little scope for any significant number of people to free ride on the immunisations of others. It is for this reason that the cohort of children who were not vaccinated during the MMR scare are at significant risk.

The idea that measles is a minor disease is certainly true for many but by no means for all. It can cause death, disability or blindness and it is also the cause of a delayed neurological syndrome many years later causing disability and death.

There have been serious measles outbreaks in Greater Manchester which led to some cases in Stockport but these did not spread within the borough. We had formed the view from statistics of uptake levels that the Stockport population, although not immunised to a level of complete safety would probably not experience major outbreaks and these incidents bear that out. This situation has been achieved largely through catch-up campaigns and it is important that people who have not been immunised arrange to have an immunisation so as to protect themselves and strengthen further the protection of the Stockport population.

Mumps is an acute viral illness transmitted by direct contact with saliva or droplets from the saliva of an infected person. Humans are the only known host of the mumps virus. Mumps remains a notifiable disease (like Measles), which means that the Doctor who sees a patient whom they suspect has mumps is required by law to report it.

Table C12	Notification for Stockport MBC 01-Apr-2014 till 31-Mar-2015	
	Confirmed	Total Notifications
Measles	0	Unknown
Mumps	4	45

Mass Immunisation Plan:

The Mass Immunisation Plan exists to ensure that we could carry out mass vaccination should that be necessary in connection with any epidemic. It has been reviewed to ensure it remains fit for purpose following NHS Reforms. The review involves re-visiting venues previously identified for mass immunisation to ensure they continue to be suitable for this purpose & re-establishing links to access the necessary resources to facilitate such sessions (e.g. staff, equipment etc.). The Health Protection Team is working (in collaboration with Civil Resilience colleagues) to identify 'new' venues for Mass Immunisation to provide greater geographical spread across the borough.

Mass Vaccination Exercises take place annually to test the plan and the revised plan will be tested later this year.

Sexually Transmitted Diseases

As well as the conventional infectious diseases, the major (although not only) cause of cervical cancer is sexually transmitted human papilloma virus.

Sexually transmitted diseases can be addressed by:

- Avoiding casual sex with a large number of partners
- Using barrier methods of contraception
- HPV immunisation
- Rapid attention to symptoms of sexually transmitted diseases at a sexual health clinic

Sexual Health - Nationally

The issue of sexual health embraces both avoidance of sexually transmitted diseases and avoidance of unwanted pregnancy.

Up to 50% of pregnancies are unplanned; these have a major impact on individuals, families and wider society.

In England during 2011, one person was diagnosed with HIV every 90 minutes.

Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment.

Rates of infectious syphilis are at their highest since the 1950s.

Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics.

In 2011, 36% of women overall, rising to 49% in black and black British women, having an abortion had had one before.

In 2011, just over half of women having an abortion had previously had a live or stillbirth, indicating that better support is needed to access contraception following childbirth.

Stockport Context re Sexually Transmitted Infections

• In 2013, Stockport is ranked 169 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new sexually transmitted infections (STIs). 1790 new STIs were diagnosed in residents of Stockport, a rate of 630.5 per 100,000 residents (compared to 810.9 per 100,000 in England).

• 55% of diagnoses of new STIs in Stockport were in young people aged 15-24 years (compared to 55% in England).

• In 2013, for cases in men where sexual orientation was known, 17.5% of new STIs in Stockport were among MSM.

• In 2013, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Stockport was 2046.8 (compared to 2015.6 per 100,000 in England).

• In 2013, Stockport is ranked 112 (out of 326 local authorities in England) for the rate of gonorrhea, which is a marker of high levels of risky sexual activity. The rate of gonorrhea diagnoses per 100,000 in this local authority was 33.5 (compared to 52.9 per 100,000 in England).

• In 2013, among genitourinary medicine (GUM) clinic patients from Stockport who were eligible to be tested for HIV, 69.9% were tested (compared to 71.0% in England).

• In 2013, there were 11 new HIV diagnoses in Stockport and the diagnosed HIV prevalence was 1.1 per 1,000 population aged 15-59 years (compared to 2.1 per 1,000 in England).

• In Stockport, between 2011 and 2013, 47% (95% CI 31-64) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% (95% CI 44-46) in England.

• In 2013, in Stockport, the total abortion rate was 17.7 per 1,000 female population aged 15-44 years, compared to 16.6 in England. Of those women under 25 years who had an abortion in that

year, the proportion of those who had had a previous abortion was 21.7%, while in England the proportion was 26.9%.

• In 2012, the under 18 conception rate per 1,000 female aged 15 to 17 years in Stockport was 26.8, in England the rate was 27.7.

• In 2013, the rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care in Stockport was 51.8, compared to 52.7 per 1,000 women in England.

Meningitis

Invasive meningococcal disease presents usually as septicaemia, meningitis or more usually as a combination of both septicaemia and meningitis. It is a medical emergency and carries a mortality of approximately 10%.

There are 13 subgroups of Neisseria meningitidis classified on the basis of the capsular polysaccharide with type B being the most common in the UK.

During 2014/ 2015 there were 53 confirmed cases of invasive meningococcal disease in Greater Manchester In Stockport during 2014/ 2015 there were three confirmed cases with one resulting from type B disease, and two from W135.

The majority of meningococcal disease occurs in infants less than five years of age, with a peak incidence in those under 1 year of age. There is a smaller, secondary peak in incidence in young adults aged between 15 - 19 years of age.

Meningococcal disease shows marked seasonal variation with a peak in winter and a low level in summer. The winter season coincides with that of influenza.

Since 1998 when the meningococcal C vaccine was introduced there has been a substantial reduction in numbers of individuals with confirmed disease.

The public health action (carried out by Public Health England) required after an individual is identified with confirmed/ probable invasive disease involves identification of close contacts and offering chemo prophylaxis with ciprofloxacin and vaccination with either a meningococcal C vaccine or a meningococcal A C W Y vaccine as dictated by the serotyping results. There is ameningococcal B vaccine, however this is not currently included in the national schedule. The JCVI are discussing the effectiveness of the vaccine with a possible roll out in 15/16.

Some Significant Risks

<u>Infection and Travel</u>

The natural tendency of evolution is for parasites to become less harmful as natural selection favours the les virulent organisms (which do not suffer the disaster of their host dying) and the more resistant hosts (who survive the infection). One major example of this is scarlet fever which was once a killer disease but has now evolved into something much less significant. Evolution of the organism is more important to this process as millions of generations of evolution of the microorganism can occur in a single human generation but the two processes do converge.

Often contact with a disease early in life can produce a less severe disease than later in life so diseases which are widespread and to which people become immune from a mild attack in childhood may not b major problems.

When Europeans first visited yellow fever areas they found a disease which, for a combination of the above reasons was relatively mild in local people but was deadly to those arriving from a non-immune population. The opposite effect occurred when Europeans spread measles to the Pacific.

The mingling of previous separated ecosystems can therefore lead to outbreaks of disease. In isolated Arctic and Antarctic settlements an outbreak of the common cold commonly follows the arrival of the first supply ship after the winter – this phenomenon is called "the Spitsbergen cold" after the first community to describe it.

What therefore should we think of increasing international traffic? Some see in it more opportunities for these effects to occur. Certainly new viruses can now spread round the world more rapidly and it is essential that travellers pay attention to the vaccinations they need and to issues like malaria prophylaxis.

However the contrary effect is that as the world becomes more of a single ecosystem there are fewer totally separated populations to develop such situations.

The Risks of a Flu Pandemic

The flu virus changes its genetic make-up by mutation and this results in the creation of viruses to which people have reduced immunity. This explains why there is a flu outbreak each year and why we need to keep on being revaccinated. A flu pandemic occurs when a wholly new virus to which nobody is immune arises and spreads round the world before we have been able to develop a vaccine. The last such pandemic in 2009 and it was very mild, so much so that all the precautions taken seemed to have been an overreaction. The fear is of a pandemic which has a high fatality rate and kills millions, like that which occurred in 1918. With a very high fatality rate the disease cannot spread and often new viruses are not very transmissible anyway but the risk of a disease which is sufficiently virulent to kill large numbers of people, transmissible enough to spread and not virulent enough for the spread to peter out.

It is generally believed that someday the 1918 type of pandemic will happen again although I personally subscribe to a minority contrary point of view that the 1918 pandemic resulted from the closed ecosystems of the First World War armies and the mingling that occurred on demobilisation so is unlikely to occur again unless there is a major disruption of international travel.

Sophisticated surveillance systems are in place around the world to detect a pandemic and in the recent pandemic they worked well, apart from overvaluing the virulence of the illness initially because of a failure to realise that the fatal cases seen in Mexican hospitals were the tip of an iceberg with most mild cases being dealt with outside the health care system.

The Risks of Losing Antibiotics

The Chief Medical Officer has recently warned of the fact that new antibiotics are not being discovered and so there is a danger that increasing resistance to existing antibiotics might leave us

with no reliable antibiotics in which case people might again die from infections of minor wounds and some forms of surgery might become too dangerous to contemplate.

The misuse of antibiotics is fundamentally irresponsible.

Chemical Hazards

Hazardous Substances

The control of hazardous substances emitted to the outside environment is addressed at a multi-agency level whether through routine inspection of industrial premises or in response to an incident.

Response to a major incident is usually instigated by the fire service in the first instance, and where appropriate they will request the assistance of other agencies.

If the incident involved the pollution of a water course, then the responsible agency for this would be the environment agency. The environmental health department are generally responsible for emissions to air or land.

Where a spill or emission arises on private land and it is prejudicial to health, then Environmental Health can serve a notice on that person under the provisions of the Environmental Protection Act 1990 requiring them to carry out the necessary steps to remove the health risk. In most cases these works are carried out by the Council's contractors and the owner or occupier of the premises is recharged for the costs incurred.

A relatively common incident that is dealt with in this way is asbestos fires. The fire service attends the site to extinguish the fire and remove the immediate risk. If fallout from the asbestos fire is likely to affect the nearby population they will request our assistance in the service of a notice on the organisation of a clean-up. This can happen any time day or night.

Land Contamination

Land contamination is dealt with under the planning regime and also under the provisions of Part 2A of the Environmental Protection Act 1990.

Under the planning regime, a developer is required to assess land for potential contaminants and to make sure that the final development is suitable for the end user.

Under Part 2A the Council is required to have a contaminated land strategy and to prioritise any potentially contaminated sites for investigation. Where land is found to be statutorily contaminated it is included on the Council's Contaminated Land Register. The legal test to determine land as contaminated is that it must be shown that there is 'significant possibility of significant harm'.

Air Quality

Pollution from the increasing number of motor vehicles using our roads provides the greatest threat to air quality in Stockport and across the UK. Harmful vehicle emissions contribute to breathing and lung problems in susceptible people, and contribute to greenhouse gases which cause climate change.
Other Industrial sources, such as manufacturing industry, boilers or large stationary engines, have been recognised as contributing to total pollutant concentrations. However, these sources are regulated through the Environmental Permitting Regulations (EPR) regime and the Industrial

Emissions Directive by the local authority and the Environment Agency, depending on the size and type of the process.

Planning applications for all types of developments are screened and assessed for potential impacts on air quality and necessary comments/restrictions imposed on developments.

Local air quality monitoring is carried out by Environmental Health which forms part of the Greater Manchester air quality network. The main pollutants that are analysed are particulates and nitrogen oxides. In Stockport along main road transport routes where monitoring and modelling of air quality has shown that exceedances are likely, the Council has declared Air Quality Management Areas.

Stockport has contributed and signed up to the Greater Manchester Air Quality Action Plan (AQAP) for Greater Manchester. The AQAP has involved a review of the strategies, policies and plans which tackle or are in some way related to air quality, to develop a clear, robust and meaningful set of actions which will deliver real changes in terms of air quality. These actions focus on road transport as it is the major contributor to poor air quality in the region.
The key objectives of this Plan are that:

It is predicted that Air quality across Greater Manchester will gradually improve and it is anticipated that low emission behaviours will have become embedded into the culture of our organizations and lifestyles by 2025. We will support the UK Government in meeting and maintaining all EU thresholds for key air pollutants at the earliest date to reduce ill-health in Greater Manchester

Where there are major incidents that may affect air quality, DEFRA recommend that a multi-agency 'Air Quality Cell' (AQC) should be convened. This is co-ordinated by the Environment Agency in consultation with Public Health England. Other agencies such as the Met Office, Food Standards Agency and local authority representative can join the AQC. The Council were recently involved in an AQC following a large fire at a waste recycling plant in the Bredbury area. The Council took over the air quality monitoring after the agency stepped down and continued to assess the situation over several days until we were satisfied that conditions on the ground were stabilised and were not going to worsen. Throughout the incident we liaised with Public Health England to ensure the correct messages were given to the local community.

Noise and Nuisance
The impact on health and wellbeing as a result of noise or other nuisance in the neighbourhoods of Stockport is potentially significant. Environmental Health dealt with 2300 complaints about noise or other nuisance in annual year 2012/13. Such issues not only have the potential to affect physical health but also impact in most cases on mental health and wellbeing. Noise and other issues e.g. smoke, fumes, premises, animals, odour, accumulations, deemed to be prejudicial to health or a nuisance are addressed utilising The Environmental Protection Act 1990.

Health and Safety

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

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

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

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

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

Unsafe products

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

- giving detailed business advice to ensure compliance with relevant safety requirements in a number of areas, including cosmetic products, toys, electrical equipment and electronic cigarettes.
- undertaking routine inspections of businesses selling high risk products
- investigating complaints about unsafe products
- taking samples for testing
- participating in local, regional and national initiatives
- taking enforcement action against those who put the public at risk

Some examples of recent work include;

Second Hand Electrical items project – the team successfully bid for £3.5k from the Dept. for Business, Innovation & Skills to fund the market surveillance of second hand electrical items in Stockport. Officers visit ed a number of 2nd hand shops with an expert from a local independent testing laboratory. Only minor issues were identified and the businesses have been reminded of their legal obligations.

Legal Highs – working closely with the police the team have visited a number of premises selling lethal highs including nitrous oxide and advised about the retailers legal responsibilities. At one premises over 3000 products were seized and submitted for analysis. The intense activity has thus far resulted in a number of premises agreeing to no longer stock and sell such products and a decline in the number of associated complaints.

Dangerous Satellite Receivers – following a referral from another Local Authority officers sampled a number of satellite receivers from a local business, nearly half of which failed safety tests. The company received a written warning and have taken corrective action.

Oxylite weight loss tablets – following a warning from the Food Standards Agency that these pills had been linked to cases of Hepatitis, the team mailshot a warning letter to gyms, beauty salons, health shops etc. and published a warning on the Council's website.

Operation Treacle **(fireworks)**– the team continue to commit to investigating complaints about the sale of unsafe fireworks as part of the Safer Stockport Partnership's annual Operation Treacle campaign.

Electrical Fires Protocol **–** the team continue to operate the joint protocol with Greater Manchester Fire & Rescue Service whereby the fire service report details of any products thought to have caused electrical fires through to us for intelligence sharing, investigation and actioning.

Targeted enforcement activity including prosecutions has been undertaken in Stockport for over 10 years to prevent the sales of age restricted products such as alcohol, tobacco, fireworks, "legal highs", knives and sunbed use. Future test purchasing will also include sales of e-cigarette, which are now illegal to persons under the age of 18. The annual survey of young people carried out by Trading Standards North West has shown a steady decline in the number of young people claiming to purchase alcohol and also indicated that in Stockport fewer of them now believe that shops in Stockport will sell to those underage.

There is a multiagency prevention and response service in Stockport to provide information within communities about rogue trader activities and to respond in cases where rogue traders may actually be targeting vulnerable people. The Safer Stockport Partnership has now established a total of 11 "No Cold Calling Zones" in Stockport on the basis of data relating to doorstep crime and rogue trader activity. Officers undertake intelligence led periodic "Rogue Trader Days" targeting suspected fraudsters and also regularly educate legitimate traders regarding their legal responsibilities (e.g. issuing cancellation rights).

Health and Safety at Work

The Health and Safety Executive (HSE) and Local Authorities (Las) are the principal Enforcing Authorities (EAs) for Health and Safety at Work etc. Act 1974 (HSWA) in Great Britain. The primary purpose of the HSWA is to control risks from work activities. The role of the EAs is to ensure that duty holders manage and control these risks and thus prevent harm to employees and to the public. Regulation activity is split between the two authorities dependent upon work premises type.

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

The Section has responsibility for administering the annual Safety Certificate at Edgeley Park Football Stadium. This involves an annual ground inspection, match day inspections, chairing the Safety Advisory Group meetings, ensuring compliance with the safety certificate and giving advice to the club. It has also entered into a Primary Authority (PA) partnership with National Tyres and Viking International. As part of this partnership the team provides PA advice to the company and responds to health and safety referrals from other LAs.

The section continues to work with Greater Manchester Police Crime Reduction Advisors in order visit premises that have suffered robberies.

"Smoke Free" legislation is also enforced by both Environmental Health and Trading Standards.

Recent activity:
- **h&s Prosecution 1** - a local care home were fined for breaching h&s legislation following the death of a vulnerable adult in respite care.
- **h&s Prosecution 2** - a national department store in Stockport was convicted for failing to make a suitable and sufficient assessment of the risks following a near-fatal fall from height of an employee.
- **h&s Prosecution 3** - a local pub owner was fined for breaching a h&s notice requiring that he ensure the safety of underground metal pipework and therefore posing and explosion risk.

Housing Standards

Housing should provide an environment that is as safe and healthy as possible. Poor housing conditions can be a major cause of accidents and ill health. The quality of the home has a substantial impact on health; a warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors that help to improve well-being include the neighbourhood, security of tenure and modifications for those with disabilities. Research has shown that poor housing costs the NHS a substantial amount each year.

Various sources of housing and health data suggests that poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. Housing-related hazards that increase the risk of illness include damp, mould, excess cold and some structural defects that increase the risk of an accident, such as poor lighting, or lack of stair handrails.

Tackling problems of poor housing to protect the health, safety and welfare of the occupants is a key environmental health priority. The introduction of the Housing Act 2004 enables the Environmental Health profession to ensure that everyone has a decent home to live in. The Act allows Local Authorities to focus on helping tenants living in private sector housing, by requiring landlords to carry out necessary repair or improvement works.

Powers are also available under The Environmental Protection Act 1990 and the Public Health Act 1936 to ensure housing provision is of a satisfactory standard. The Environmental Protection Act concentrates on ensuring premises are not in such a state as to be prejudicial to health or a nuisance whereas the Public Health Act allows the LA to take action where a premise are in such a filthy and unwholesome condition as to be prejudicial to health or, are verminous.

The Housing Standards Team deal with a range of housing related duties. The team investigate requests for service relating to:
- Conditions in privately rented homes

- Filthy and verminous premises
- Poorly maintained privately owned dwellings
- Harassment and illegal eviction of private tenants
- Licensing of Houses in Multiple Occupation
- Empty Domestic Properties
- Immigration inspections

All of the above are statutory functions with the exception of bringing empty properties back to use. The team deal with empty properties in the borough by implementing the Council's Empty Property Strategy.

Emergency Planning

Emergency plans are maintained, reviewed and tested under the auspices of the Health Economy Resilience Group for the health service and the Local Resilience Forum for multi-agency work. The HERG operates at local level. The LRF operates at Greater Manchester level but has a local group. A core group of key individuals serve on both groups and provide a reference group giving assurance to the Health & Well Being Board.

Preventing Injuries and Crashes – What we Can All Do to Help

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

C4.8 ADRESSING THE CHALLENGES OF SMOKING IN PREGNANCY

The case for supporting women who are pregnant to give up smoking is very strong; smoking is the single most modifiable risk factor for adverse outcomes in pregnancy and our ambition should always be to support all women to have a smoke free pregnancy.

Reducing rates of smoking in pregnancy is a key priority for the Public Health Department of Stockport Council, Stockport Family, and Stockport Foundation Trust and Primary Care services. Key stakeholders throughout Stockport are committed to reducing the local inequalities that exist and ensuring that all Stockport babies have the very best start in life.

Health effects of smoking in pregnancy

Smoking during pregnancy contributes to a wide range of health problems for expectant mothers, their unborn babies and their families. Tobacco smoke brings over 4,000 chemicals into the body, including 200 known poisons and 69 carcinogens. Every cigarette smoked during pregnancy introduces carbon monoxide into the maternal bloodstream and disrupts the foetal oxygen supply for around 15 seconds and in turn reduces the oxygen flow to the foetus for a period of around 15 minutes.

Smoking, and maternal exposure to tobacco smoke, during pregnancy increases the risk of: - ectopic pregnancy, miscarriage, placental abnormalities and premature rupture of the foetal membranes, still-birth, preterm delivery, low birth weight (under 2,500 grams), perinatal mortality and sudden infant death syndrome. It is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of premature birth and a 26.3% increased risk of intra-uterine growth restriction which is associated with both immediate and longer term health consequences. Research studies have confirmed the correlation between maternal smoking and lower birth weight. Babies born to women who smoke during their pregnancy are an average 175-200g lighter than those born to non-smoking mothers. In the UK Each year it causes up to 5,000 miscarriages, 2,200 premature births 300 perinatal deaths. (Royal College of Physicians, 2010).

Antenatal exposure to maternal smoking risks not only the viability of the pregnancy but the immediate and future health and the physical and intellectual development of the child increasing risk of:- congenital abnormalities (such as cranial, eye and facial defects including cleft lip and palate), impaired lung function and cardio-vascular damage, acute respiratory conditions such as asthma, and problems of the ear, nose and throat. Exposure to smoke in the womb is also associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour. In addition, it has been suggested that smoking during pregnancy may have a detrimental effect on the child's educational performance.

Babies born to mothers who smoke are further disadvantaged as those mothers are less likely to breastfeed than non-smoking mothers and those who do, produce a smaller amount of milk and breastfeed for a shorter time. There is a strong link between cigarette smoking and socio-economic group. In 2014, 30% of adults in routine and manual occupations smoked compared to 13% in managerial and professional occupations.

Children who live with parents or siblings who smoke are up to 3 times more likely to become smokers themselves than children of non-smoking households. It is estimated that, each year, at least 23,000 young people in England and Wales start smoking by the age of 15 as a result of exposure to smoking in the home.

Smoking in pregnancy data in Stockport.

Significant progress has been made over the years in reducing smoking in pregnancy with Stockport rates of smoking at time of delivery close to the England average and significantly lower than the North West average. However there are still clear inequalities. Young women living in the most disadvantaged areas of Stockport are far more likely to smoke during pregnancy than older women and women who live in more affluent areas. For instance, during 2013/14 37.9% of mothers in Brinnington were smoking at time of delivery compared to 5.4% in Bramhall.

Mothers from the most deprived areas of Stockport are consistently twice as likely to be smoking at delivery as the overall Stockport resident average. Data from Stepping Hill Hospital shows that on average, since 2007-08, roughly one in three mothers from the most deprived quintile of Stockport were smoking at delivery. This is in contrast to rates overall of 15% and in the least deprived quintile of 4%. Since the start of 2012-13 the rates in the most deprived quintile have ceased to decline and have in fact risen slightly whereas all other areas have shown at least some moderate decrease in the same period. The net result of this has been the gap in the rates between the most deprived areas of Stockport and the rest getting wider.

The cost of smoking in pregnancy

The total annual cost to the NHS of smoking during pregnancy is estimated to range between £8.1 and £64 million for treating the resulting problems for mothers and between £12 million and £23.5 million for treating infants (aged 0–12 months). In the North West this is about £1-7 million per year with the wider societal costs of smoking in pregnancy estimated to be £15- £24 million.

Using international evidence it is estimated that the potential savings from interventions to reduce smoking in pregnancy could result in a saving £4 for every £1 invested, mainly due to a reduction in the additional costs to healthcare system from complicated birth and care requirements.

Good Practice in Stockport

 As smoking in pregnancy is the main modifiable risk factor in pregnancy and associated with a range of serious problem Stockport local services have always felt this was a very important areas to address. We have taken a system wide approach to addressing this issue. Since 2012:

- Routine Carbon Monoxide (CO) monitoring takes place for all pregnant women at booking, for smokers at every contact, and on admission to hospital, in line with NICE guidance (2010). CO validation is in place at the 36 week routine antenatal contact, as opposed to at birth, to improve reliability of the data. Every midwife in Stockport now has access to a CO monitor in either a GP practice or Children's Centre. Pregnant women who smoke and admitted to hospital are now offered Nicotine Replacement Therapy (NRT). These products have also been introduced in the antenatal clinic, dispensed by the Specialist Midwife under a patient group direction (PGD).

- Staff in midwifery regularly receive training and 30 minute update session on stop smoking services and midwives responsibilities are delivered at the public health mandatory study day for all midwives and assistant practitioners. In addition 'Stop Smoking Champions' have been identified in all of the maternity clinical areas, and the No smoking policy leaflets and posters are displayed in all areas of the maternity unit, signposting Specialist Midwife support. To keep the profile high and give clear succinct messages to staff, patient stories are used on a regular basis in staff publications. A software package for CO monitoring is used which serves as a motivational visual aid to counsel parents with regards the effects on smoking on the foetus.
- CO monitoring has been established in admission areas such as Triage and the Delivery Suite, the Early Pregnancy Unit and Fertility Service.
- The voucher incentive scheme which was introduced in 2013/14.The Family Nurse Partnership working with young women with very complex situations has started to show some real success in reducing smoking during pregnancy. Nationally this is still an area of work that FNP practitioners can improve and new resources will soon be available to support staff.

Why do women continue to smoke during pregnancy?

Despite significant programmes to support women to be smoke free during their pregnancy as outlined above there are still higher rates of women in our more deprived communities who are unable to give up smoking during their pregnancy. Recent behavioural insights works has stressed that further work needs to be done to be cognisant of and address the complexity and significant pressures that these women face in the context of their daily lives, with stress and anxiety being a key barrier to giving up smoking. Insight work completed by Wareing (2016) found a catalogue of huge challenges for women including homelessness, fear, domestic violence, anxiety, depression, losing their job, no partner support, caring responsibilities for siblings etc. Risk and responding to risk was a key part of their lives and impacted on their ability to engage in trusting relationships. Wareing also reported that women were often faced with a huge range of mixed messages from partners, families, health and social care professionals, and that whilst the women knew the consequences of smoking such as low birth weight they knew little about the long term implication such as the child have future severe respiratory conditions. It is clear that further insight work is needed to target local approaches.

E cigarettes and Pregnancy

The question of using e cigarettes continues to be a challenging one. An expert independent evidence review[1] published by Public Health England (PHE) concludes that e-cigarettes are around 95% less harmful than smoking tobacco and have the potential to help smokers quit smoking.

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[1] E-cigarettes: an evidence update A report commissioned by Public Health England (2015)
Authors: McNeill A, Brose LS, Calder R, Hitchman SC .Institute of Psychiatry, Psychology & Neuroscience, National Addiction Centre, King's College London
Hajek P, McRobbie H (Chapters 9 and 10) Wolfson Institute of Preventive Medicine, Barts and The London School of Medicine and Dentistry Queen Mary, University of London

However this report did not include any advice on e-cigarettes and pregnancy. There are however a number of guidelines available for Midwives with the following advice:

- Women who report that they have stopped smoking completely, but are using e-cigarettes should be congratulated and encouraged to stay away from all tobacco use and referred to the local Stop Smoking Service to be supported not to return to smoking and encouraged to consider using nicotine replacement therapy (NRT). There is a strong evidence base that using NRT in combination with behavioural support from a specialist stop smoking service is the most effective way of quitting smoking.

- Women who report using e-cigarettes whilst continuing to smoke should be advised to stop smoking, referred to the Stop Smoking Service and encouraged to consider using NRT in combination with behavioural support.

The Smoking in Pregnancy Challenge Group has produced a short briefing to assist health professionals in responding to some of the most frequently asked questions.

Key messages include:

- Although not completely risk free, electronic cigarettes carry a fraction of the risk of smoking for users, with no known risks to bystanders.
- Electronic cigarettes do not contain carbon monoxide (CO) or many of the other harmful chemicals found in cigarettes.
- Nicotine is one of the harmful components of tobacco smoke and using electronic cigarettes, or indeed nicotine replacement therapy, will not remove this risk but it will remove many other risks which is why we do recommend licensed nicotine replacement products to support people stop smoking, including in pregnancy. The same logic applies to e-cigarettes. However e cigarettes maintain the behaviour patterns that operated whilst smoking which may increase their immediate effectiveness but may also make it harder subsequently to give up e cigarettes than it would have been for NRT
- If a pregnant woman chooses to use an electronic cigarette and this helps her to stay smoke free, she should not be discouraged from doing so.

Incentives

In Stockport we have found evidence that demonstrate that financial incentives offer a solution to supporting vulnerable women to quit and stay quit during pregnancy. The Cochrane review (2013) indicated that that the use of 'incentives' with pregnant women and their 'significant other' provide a cost-effective measure to promote smoking cessation within the target group and a substantial return on investment equating to up to £4 saved for every £1 spent on the intervention. A recently published randomised control study undertaken by the universities of Glasgow & Stirling found substantial evidence for the efficacy of incentives for supporting smoking cessation in pregnancy.[2]

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[2]Tapin. D, Bauld. L. Purves, D. et al, (2015) financial incentives for smoking cessation in pregnancy: randomised controlled trial. BMJ 2015;350:h134 doi: 10.1136/bmj.h134

In Stockport women are identified by an appropriate health care professional. The criteria for participation include teenage pregnancy, living in an area of deprivation/ high smoking prevalence, living with a smoker/s and smoked throughout previous pregnancies. The offer focusses on enhanced stop smoking support, shopping vouchers (up to £260) alongside with engagement of a significant other supporter SOS. The early findings indicate from local Stockport data accord with the evidence that incentives work and generated real and cost effective benefits for women and their babies Targeted financial incentives combined with enhanced support are more effective than standard stop smoking support and need to be integrated into service commissioning priorities and the focus on women in 'challenging situations' is supportive of public health priorities to address health inequalities and is a justified ongoing investment for PH/CCGs. Very helpfully the incentive has resulted in a significant increase in smoke free homes, providing extended protection for other family members. The presence of the SOS was supportive of efforts to quit.

Greater Manchester work.

The Greater Manchester Population Plan has identified an intention to develop a sustainable, resilient and consistent GM approach to stopping smoking in pregnancy. This is a positive way forward and Stockport will contribute our own learning and hopefully benefit from the experiences of colleagues elsewhere.

Recommendations Arising from the chapter on smoking in pregnancy

- Stockport NHS FT should be commended on their proactive approach to reducing smoking in pregnancy and achieving excellent outcomes through the Baby Clear programme. I recommend that these high levels of interventions are maintained and all staff are supported in having the knowledge, skills and confidence to address smoking appropriately and consistently.
- I recommend that Stockport NHS FT should ensure that all midwives, health visitors and FNP nurses have access to the latest information on e-cigarettes and pregnancy and know that whilst licensed nicotine replacement products are the recommended option, if a pregnant woman chooses to use an electronic cigarette and if that helps her to stay smoke free, she should not be discouraged from doing so.
- The use of the financial incentive scheme alongside access to stop smoking services appear to be achieving good results and I therefore recommend that this should be maintained.
- The vast difference in smoking in pregnancy rates in certain geographical   wards in Stockport continues to cause me concern. I recommend further local behavioural insights should be used to develop support that will help women remain smoke free during and after their pregnancy.

C4.9 TYPE 2 DIABETES – TIME TO DIFFUSE THE TIMEBOMB

Type 2 diabetes develops when the body doesn't produce enough insulin or when the insulin it does produce doesn't work properly. Glucose levels rise in the blood and the consequences are very severe and include kidney disease, foot disease, heart disease, depression and blindness.

- Diabetes doubles the risk of cardiovascular disease (heart attacks, heart failure, angina, strokes).
- Diabetes is the most common reason for end stage kidney disease and the most common cause of blindness in people of working age.
- In 2015/16 there were 4 major (above or below knee leg) and 29 minor (toe, foot or finger) hospital admissions for amputations for people who have diabetes, and in many cases this is avoidable
- In 2015/16 20 patients died directly from diabetic complications in Stockport and a further 250 deaths occurred in patients with diabetes - around half of these are likely to be related to their diabetes.
- It is estimated that 80% of diabetes costs are incurred in treating potentially avoidable complications.
- Nearly 1 in 5 people with diabetes have clinical depression and for those with anxiety and/or depression health care costs increase by around 50%.

An estimated £14 billion pounds (10% of the NHS budget) is spent a year in England and Wales on treating diabetes and its complications. For Stockport direct diabetes care cost £6.8m, and if complications relating to other conditions are included the total cost of diabetes is more likely to be £40 million.

In Stockport an estimated 20,280 have diabetes (types 1 and 2), this is 8.7% of our population, and only 14,575 of these patients are currently known to their GP. This figure is expected to rise to 22,564 (9.2%) by 2025.

In addition Public Health England estimates that there are 27,148 patients at risk of developing diabetes (11.7% population). These are people with raised levels of glucose in their blood that, if unchecked, is likely to lead to diabetes.

So there are thousands of people in Stockport sitting on their own personal time bomb.

The good news is that we can all make small changes in our lives to reduce our risk of diabetes. By eating well and moving more, we could reduce the numbers of type 2 diabetes by over half. Visit https://www.healthystockport.co.uk for advice.

Stockport string is an easy and fun way to start assessing your risk of diabetes. Read about how Stockport County supported our campaign http://www.countysupporterscoop.co.uk/news-events/council-encourages-residents-to-watch-their-waist/

What increases risk?

- being overweight
- having a large waist (more than 80cm/31.5 inches in women, 94 cm/37

inches in men or 90cm/35 inches in South Asian men).

- being from an African-Caribbean, Black African, Chinese or South Asian background and over 25.
- being from another ethnic background and over 40.
- having a parent, brother or sister with diabetes.
- having ever had high blood pressure, a heart attack or a stroke.
- having had a history of polycystic ovaries, gestational diabetes or having given birth to a baby over 10 pounds/4.5kg.
- suffering from schizophrenia, bipolar illness or depression, or taking anti-psychotic medication.

You can estimate your personal risk here
http://riskscore.diabetes.org.uk/start?_ga=1.205835029.722794865.1476350383

And ensure that you attend for your free NHS healthcheck for advice about how to stay healthy as you get older.

How can we reduce the complications from diabetes?

As well as looking after themselves, there are 15 vital checks and services that patients with diabetes should expect from their healthcare team. One of these is a diabetes education course. People who have been on a course feel much more confident about looking after their condition and are less likely to suffer with complications from their diabetes.

In Stockport, less than 3,500 patients with diabetes have attended a course. There is a Diabetes Xpert 6 week course in Stockport that patients with type 2 diabetes can refer themselves to.

There is a national diabetes audit that is repeated every year, which each GP practice is asked to take part in. Last year around 25% of our practices took part and, in patients from those practices; around half of all patients with diabetes received all the NICE recommended treatments. This was third highest in Greater Manchester but there is considerable room for improvement. This year over 60% practices returned data and we are awaiting further data from the audit.

NICE (the National Institute for Health and Care Excellence) has produced national guidance and quality standards that, if followed, lead to the best outcomes in people with diabetes. There are local (Greater Manchester) pathways around reducing the risk of amputation and joint specialty recommendations for diabetic foot services. Diabetes UK, in conjunction with the Department of Health and many other key agencies, have developed best practice for commissioning diabetes services and a diabetes sample service specification.

Pharmacists, optometrists and dentists can all contribute to an integrated service that wraps around the patient with diabetes.

So all the ingredients for Stockport Together to develop and deliver an integrated model of care, with the patient at its heart, to reduce complications from diabetes and improve health outcomes.

Move more

Snack less

Together we can defuse the time bomb and look forward to healthier lives.

Recommendations Arising from the chapter on Type 2 diabetes

- I recommend that the CCG, Stockport Together, the MCP and general practice prioritise the identification of people at risk of diabetes, developing a register of patients with non-diabetic hyperglycaemia through consolidation of existing codes held in the records; running query searches and increasing uptake of the NHS health checks - and offering people behaviour change support to reduce their risk.
- I recommend that the CCG and Council run a Know your numbers campaign with support from the public of Stockport, Diabetes UK and using Stockport String messages.
- I recommend that the CCG prioritises the commissioning of an integrated service for patients with diabetes from the MCP, using the full support of all primary care contractors.
- I recommend that the CCG and MCP work together with GPs to ensure that diabetes patients receive all the NICE recommended treatment targets
- I recommend that Stockport Together work with the MCP and GPs to deliver structured education to all newly diagnosed diabetics and offer tailored support to patients with a learning disability.
- I recommend that the Council engage public and partners across Stockport to create a culture and environment that reduces obesity.
- I recommend that the professionals working in health and social care set an example to the public of Stockport by taking steps to reduce their risk – walking briskly (or equivalent physical activity) for at least 20 minutes a day and reducing their glucose intake.
- I make a similar recommendation to other people in a leadership role.
- That the CCG and MCP ensure a 100% participation in the national diabetes audit.

C4.10 ANTIMICROBIAL RESISTANCE: ANTIBIOTICS – THE GOOD, THE BAD AND THE UGLY.

What's the problem?

Antibiotics are essential medicines for treating bacterial infections in both humans and animals but, antibiotics are losing their effectiveness at an increasing rate.

Antimicrobial resistance is the biggest (inter)national public health concern facing us at the current time. It is second on the government list of risks behind terrorism. Inappropriate and prolonged use of antimicrobials is the main driver increasing the rate of antimicrobial resistance. In the last 40 years antimicrobial resistance has increased at an alarming rate and with the very limited number of novel agents currently in development infections are becoming harder and more expensive to treat. UK hospitals are the 2nd highest user of antibiotics per head of population in Europe.

Bacteria can adapt and find ways to survive the effects of an antibiotic and they become 'antibiotic resistant', so that the antibiotic no longer works. The more an antibiotic is used, the more bacteria become resistant to it There are very few new antibiotics in the development pipeline, which is why it is important that we use our existing antibiotics wisely and make sure these life-saving medicines continue to stay effective for us, our children and our grandchildren

Unless we tackle the issue now, the consequences could be severe:

- an estimated 10 million deaths globally by 2050
- a cost of £66trillion to the global economy

NHS England has recently written to all Acute Trust Boards outlining the benefits of appropriate day 3 review of empiric IV antibiotics. The benefits of getting this right are significant and include:

- Protection of antibiotics as effective treatments for future generations
- Improved patient outcomes through earlier targeted treatment
- Reduction in Hospital Acquired Infections (HAIs) that are costly to treat and prolong length of stay.
- Bed days saved by adopting a structured approach to IV antibiotic review
- Financial savings by reviewing all patients on IV antibiotics at 48 hours resulting in significant drug budget and nursing time savings by switching from IV to oral antibiotics

How are we doing in Stockport?

The latest data on resistant bacteria is found on the Fingertips tool -
https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/0/gid/1938132908/pat/46/par/E39000037/ati/152/are/E38000174/iid/92377/age/1/sex/4

The CCG are measured on 3 targets.

- A reduction in the number of antibiotics prescribed in primary care.
- A reduction in the proportion of broad spectrum antibiotics prescribed in primary care.
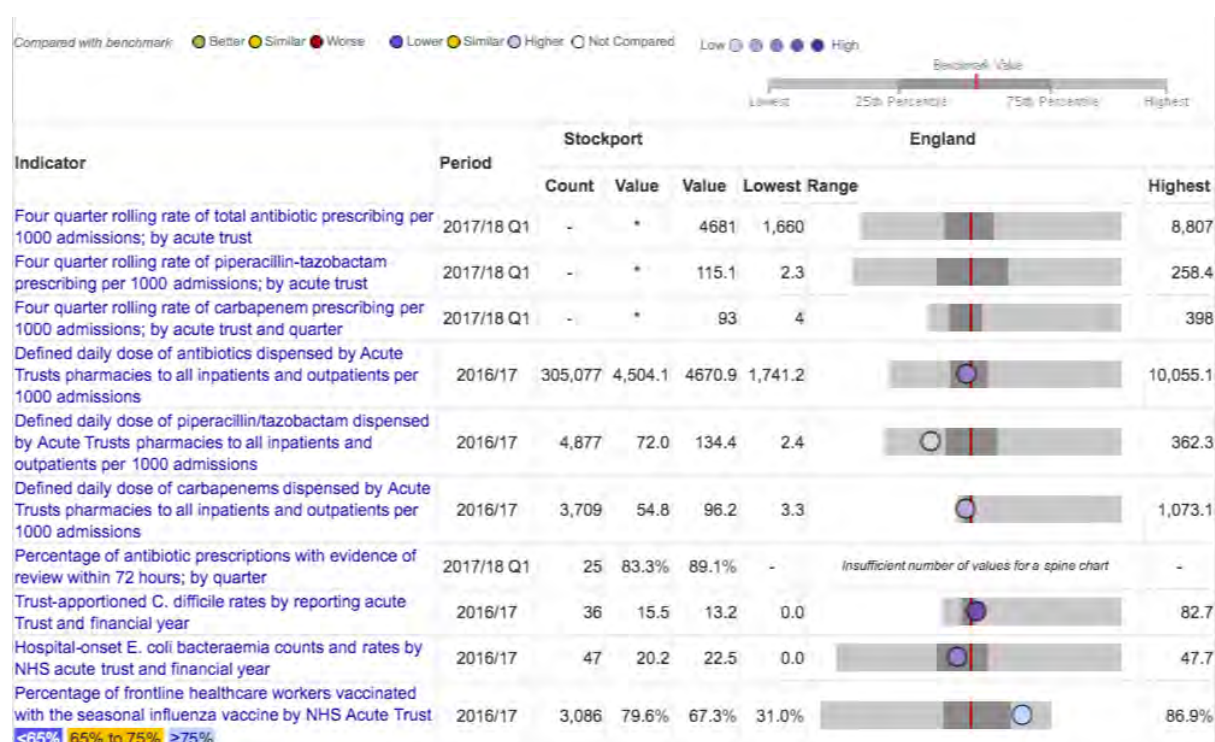- An increase in the % of Nitrofurantoin items issued versus Trimethoprim (new 17/18 measure)

Data shows that Stockport CCG is doing well in the second area. We continue to be below the national average for prescribing the broad spectrum high risk antibiotics co-amoxiclav, cephalosporins and quinolones, and there is room for further improvement in the 3rd area in order to meet national recommended targets.

However, Stockport CCG does not perform as well as other CCGs if you look at the numbers of antibiotics prescribed in primary care. What this means is that overall, we continue to prescribe larger than average volumes of antibiotics (in particular Amoxicillin 500mg capsules) compared to 'similar' national and local CCGs most of whom are now showing a percentage decrease.

Of the 12 Greater Manchester CCGs we are 1 of 2 areas that have not met recommended reduction targets for the volume of antibiotic items we issued to patients in 2016/17.

Data for Stockport NHS Foundation Trust shows that the Trust's performance is around the average for most indicators but is outstanding for the uptake of influenza vaccination amongst staff.

Indicator	Period	Stockport		England				Highest
		Count	Value	Value	Lowest	Range		
Four quarter rolling rate of total antibiotic prescribing per 1000 admissions; by acute trust	2017/18 Q1	-	*	4681	1,660			8,807
Four quarter rolling rate of piperacillin-tazobactam prescribing per 1000 admissions; by acute trust	2017/18 Q1	-	*	115.1	2.3			258.4
Four quarter rolling rate of carbapenem prescribing per 1000 admissions; by acute trust and quarter	2017/18 Q1	-	*	93	4			398
Defined daily dose of antibiotics dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	305,077	4,504.1	4670.9	1,741.2			10,055.1
Defined daily dose of piperacillin/tazobactam dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	4,877	72.0	134.4	2.4			362.3
Defined daily dose of carbapenems dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	3,709	54.8	96.2	3.3			1,073.1
Percentage of antibiotic prescriptions with evidence of review within 72 hours; by quarter	2017/18 Q1	25	83.3%	89.1%	-	Insufficient number of values for a spine chart		-
Trust-apportioned C. difficile rates by reporting acute Trust and financial year	2016/17	36	15.5	13.2	0.0			82.7
Hospital-onset E. coli bacteraemia counts and rates by NHS acute trust and financial year	2016/17	47	20.2	22.5	0.0			47.7
Percentage of frontline healthcare workers vaccinated with the seasonal influenza vaccine by NHS Acute Trust	2016/17	3,086	79.6%	67.3%	31.0%			86.9%

What are Stockport Foundation Trust and Stockport CCG doing about it?

- The CCG monitor inappropriate antibiotic prescribing by general practice using a tool called the 'tartan blanket'. This highlights in red inappropriate antibiotic prescribing
- The CCG has trained the staff medicines co-ordinators on antimicrobial resistance
- A CCG wide audit tool was delivered in some GP practices looking at the volume of antibiotics issued following circulation of their figures last year and a letter and a hints and tips document was shared with the teams
- A urinary tract infection audit tool has been developed which will be launched by the CCG shortly and delivered across all practices showing red on the tartan blanket for certain antibiotics and 3 day prescribing
- The CCG work closely with secondary care to update and promote the local antibiotic guidance
- The CCG have visited Mastercall to look at their prescribing of antibiotics and how they audit their use
- The CCG promote the 'tap on the bugs' app to all health care professionals and use of the PHE leaflet when in consultation
- Lead GPs have done radio slots on Imagine to engage the public
- The CCG are delivering Antimicrobial resistance training to the non-medical prescribers
- The CCG have added an online training course on antibiotic resistance for all staff to complete and recommended this to all practice staff

- The FT continues to encourage appropriate antibiotic prescribing, with guidelines based on local resistance patterns and national recommendations. The 'Tap on the Bugs' app is regularly updated as appropriate.
- The FT support clinicians in ensuring all patients on antibiotics have a senior review by day 3, achieving the required standard for Q2 CQUIN. We are tasked with a 2% reduction in overall antibiotic use which, while challenging, is on track at this point.
- The FT encourage all staff to have their flu vaccine, building on our huge success in this area last year.
- The FT have an ongoing programme of antibiotic and infection education for junior doctors and non-medical prescribers, as well as participating in grand rounds.
- The FT complete regular audits on antibiotic prescribing within the trust and feedback results to encourage improvements in antibiotic prescribing and review.
- Work is ongoing at the FT in the fight against healthcare associated infections by maintaining raised awareness about infection prevention and correct use of antibiotics.

What more can be done about it?

Many antibiotics are prescribed and used for mild infections when they don't need to be. All colds and most coughs, sinusitis, otitis media (earache) and sore throats get better without antibiotics.

Community pharmacists are well placed to help provide advice on over the counter medicines to treat symptoms and help with self-care.

Individuals (the public, healthcare professionals, educators and leaders) can take action by choosing a pledge and becoming an Antibiotic Guardian (www.antibioticguardian.com).

Antibiotics should be taken as prescribed, never saved for later or shared with others; it is important we use antibiotics in the right way, the right drug, at the right dose, at the right time for the right duration. Appropriate use of antibiotics will slow down the development of antibiotic resistance

The Public Health England TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) project includes a leaflet "Treating your infection". This leaflet can be given to patients to take away from the consultation as an aid to understanding and self-care on occasions where there isn't a clear, immediate need for antibiotics.

Managing Your Infection

Version: 2
Published: July 2017
Review date: July 2020

1: How to help make yourself better

You can do the following to help your infection.

Take paracetamol to reduce a fever; always follow the instructions

Ask your pharmacist for advice on reducing your symptoms

Get plenty of rest until you feel better

Drink enough fluids to avoid feeling thirsty

Use tissues when you sneeze to help stop infections spreading

Wash your hands to help stop infections spreading

For more information visit the **NHS Choices** website: www.nhs.uk

Developed with: Public Health England; TARGET www.rcgp.org.uk /TARGETantibiotics; e-Bug www.e-Bug.eu; Kingfisher Treasure Seekers Ltd

2: Check how long your symptoms last

An **earache**: most get better by **8 days**

A **sore throat**: most get better by **7-8 days**

A **cold**: most get better by **14 days**

A **cough**: most get better by **21 days**

If you are not starting to improve a little by the times given above, seek advice from your GP practice. If you are feeling a lot worse, phone **NHS 111**, **NHS Direct Wales** or **NHS 24**.

Endorsed by: GIG NHS; ANTIBIOTIC GUARDIAN; Royal College of Nursing; IPS; RCGP Royal College of General Practitioners; BSAC The British Society for Antimicrobial Chemotherapy; Royal Pharmaceutical Society; BIA British HIV Association

3: Look out for serious symptoms

Severe headache

Very cold skin

Trouble breathing

Feeling confused

Chest pain

Problems swallowing

Coughing blood

Feeling a lot worse

If you have an infection and develop any of the symptoms above, you should be seen urgently by a doctor.

4: Where to get help

NHS England CALL 111 when it's less urgent than 999

NHS Direct Wales 0845 46 47 Galw IECHYD Cymru

NHS Scotland NHS 24 Call us free on 111

N.Ireland Contact your GP practice HSC Public Health Agency

Emergency Call 999 immediately

Recommendations

Remember – not all bugs need drugs!

- The Health and Wellbeing Board champion Antimicrobial Stewardship in Stockport
- The Council, CCG and Foundation Trust participate actively in all national campaigns to raise public awareness of using antibiotics only when needed
- The Council, CCG and Foundation Trust encourage members of the public to become antibiotic guardians, with champions in every neighbourhood.
- The Council, CCG and Foundation Trust identify antibiotic Guardian champions in every general practice, community clinic and ward.
- The CCG and Foundation Trust continue to work together to identify inappropriate prescribing and put controls in place to reduce this.
- The Foundation Trust ensure that hospital in-patients on empirical IV antibiotics receive a comprehensive review within three days and the IV therapy is stopped and patients moved to oral therapy or directed therapy where possible.
- The Council, CCG, Foundation Trust, Viaduct Health and Pennine Care work collaboratively to prevent infections by maximising the uptake of required vaccinations (especially influenza) in at-risk patient groups, care home staff, children and all community and hospital healthcare workers.
- The CCG continues to review and improve variation in prescribing in primary care by:

Level 5

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- Using national recommended diagnostic support FeverPAIN for patients over age 3 years presenting with sore throat, to guide management
- Using no or delayed / back-up antibiotic strategies for respiratory tract infections including sore throat
- Using the TARGET Treating Your Infection patient information leaflet to promote both self-management of respiratory tract infections and safety netting
- Using the TARGET Patient information leaflets for parents of children, particularly 'Caring for children with cough' which can be distributed within childhood vaccination programmes.

The leaflets can be found here:

http://www.rcgp.org.uk/clinical-and-research/toolkits/target-antibiotic-toolkit.aspx

This chapter was written by Dr Vicci Owen-Smith, Gill Damant and Jan Grime contributed material or data and Jan Grime and Sarah Turner made comments.

C4.11 AIR QUALITY – WHAT'S THE PROBLEM FOR STOCKPORT?

Pollution from the increasing number of motor vehicles using our roads provides the greatest threat to air quality in Stockport and across the UK. Harmful vehicle emissions contribute to breathing and lung problems in susceptible people, and contribute to greenhouse gases which cause climate change. It the largest preventable issue related to air quality. There are health inequalities in the impact of air quality as Children, the elderly and those with pre-existing respiratory and cardiovascular disease, are known to be more susceptible to the health impacts from air pollution.

The main pollutants of concern in the UK are particulate matter (PM), oxides of nitrogen (NOx), and ground level ozone. The most health-damaging particles are those with a diameter of 10 microns or less, (≤ PM10), which due to their size are small enough to penetrate and lodge deep inside the lungs. Population exposure, close to roadsides are often much higher than those in background locations.

Long term exposure to air polution increases the mortality from cardiovascular causes. Exposure to high levels (e.g. during short term pollution episodes) can also exacerbate lung and heart conditions, significantly affecting quality of life, and increase deaths and hospital admissions. There are currently 19,550 people registered with a Stockport GP who have a diagnosis of asthma; a rate of 64.9 per 1,000. Rates have been reasonably steady since 2004/05. Around 3,300 of these diagnoses are for children and young people. Around 500 hospital admissions are made each year for asthma, around a half of which are for children and young people, around £5.8 million is spent on prescribing for asthma each year in Stockport.

How is the harm caused?

The main pollutants of concern in the UK are particulate matter (PM), oxides of nitrogen (NOx), and ground level ozone. Road transport accounts for 31% of nitrogen oxides (NOx), 19.5% of smaller PM particles and 18% of large PM particle UK emissions. It frequently accounts for more than 64% of air pollution at urban monitoring sites[3]. It is estimated that over 95% of Greater Manchester's transport emissions come from road vehicles. Defra has been estimated that removing all fine particulate air pollution would have a bigger impact on life expectancy in England and Wales than eliminating passive smoking or road traffic accidents[4]. Defra estimate the overall population burden is estimated to be equivalent to nearly 23,500 deaths in the UK per year.

Particulate matter (PM)

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[3] Air pollution: outdoor air quality and health 2017
https://www.nice.org.uk/guidance/ng70/chapter/Context
[4] Air Quality and Public Health Impacts and local actions 2017
https://laqm.defra.gov.uk/public-health/public-health-impacts.html

The most health-damaging particles are those with a diameter of 10 microns or less, (≤ PM_{10}), which due to their size are small enough to penetrate and lodge deep inside the lungs. Chronic exposure to particles contributes to the risk of developing cardiovascular and respiratory diseases, as well as of lung cancer. The biggest impact of particulate air pollution on public health is understood to be from long-term exposure to PM2.5, which increases the age specific mortality risk, particularly from cardiovascular causes. Exposure to high levels of PM (e.g. during short term pollution episodes) can also exacerbate lung and heart conditions, significantly affecting quality of life, and increase deaths and hospital admissions. Children, the elderly and those with pre-existing respiratory and cardiovascular disease, are known to be more susceptible to the health impacts from air pollution. Levels of PM2.5 at short-term concentrations exceeding 200 μg/m3 cause significant inflammation of the airways. Population exposure, close to roadsides are often much higher than those in background locations. It is usually said that asthma is not caused by traffic emissions but that they condition the airways to react more to the actual causal allergens. However if the effect of this is that people suffer regular attacks when they otherwise would not have done so then the distinction between causing asthma and predisposing to asthma may seem an artificial one.

It has been shown that as particulate matter levels increase, so too does mortality and morbidity, both daily and over time presuming other factors remain the same. An association also has been observed between outdoor air pollution and increase in cancer of the urinary tract/bladder as well as cancer of the lung. Heart and blood vessel diseases like strokes and hardening of the arteries are one of the main effects of air pollution. These can be caused by a few years exposure to even low levels of PM2.5. Therefore, reducing concentrations of particulate matter would lead to fewer deaths and less illness in the population.[5] Public Health England conducted a study of local authority areas and claims that anthropogenic particulate air pollution PM 2.5 (produced by humans) in England was attributable for 25,002 deaths in England and 3,427 for the North West directly. Out of this Stockport's attributable to 151 deaths and 1636 life years lost[6].

Nitrogen Dioxide (N02)

Symptoms of bronchitis in asthmatic children increase in association with long-term exposure to NO2. Reduced lung function growth is also linked to NO2 at concentrations currently measured (or observed) in cities of Europe and North America. Defra suggests that on average around 80% of oxide of nitrogen (NOx) emissions in areas where the UK is exceeding NO2 limit values are due to transport, although urban and regional background, non-transport sources are still considerable. The largest source is emissions from diesel light

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[5] Ambient (outdoor) air quality and health 2016
http://www.who.int/mediacentre/factsheets/fs313/en/
[6] Estimating local mortality burdens associated with particulate air pollution (2014) p10
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf

duty vehicles (cars and vans) and there has been significant growth in these vehicle numbers over the last ten years in the UK.[7]

Other important pollutants are Sulphur dioxide (SO_2), Non-Methane Volatile Organic Compounds (NMVOCs), Ammonia (NH_3), Ozone (O_3).

Other Industrial sources, such as manufacturing industry, boilers or large stationary engines, have been recognised as contributing to total pollutant concentrations. However, these sources are regulated through the Environmental Permitting Regulations (EPR) regime and the Industrial Emissions Directive by the local authority and the Environment Agency, depending on the size and type of the process.

How is this monitored locally?

The national air quality objectives have been set for the UK. These objectives have been put in place to protect people's health and the environment. If a local authority finds any places where the objectives are not likely to be achieved, it must declare an Air Quality Management Area there. Air pollution varies substantially over small distances. It is typically highest near to emission sources and the amounts can decline rapidly as you move further away from the source. For example, pollution levels next to a busy road can vary from the part of the pavement nearest to the traffic to the part of the pavement farthest away.

Air Quality Management areas have been declared on the major roads throughout Stockport; the M60, A34, A6 and the A626. Shaw Heath was decommissioned in 2011.

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[7] Air Quality; A Briefing for Public Health Directors (March 2017) p17
https://laqm.defra.gov.uk/assets/63091defraairqualityguide9web.pdf
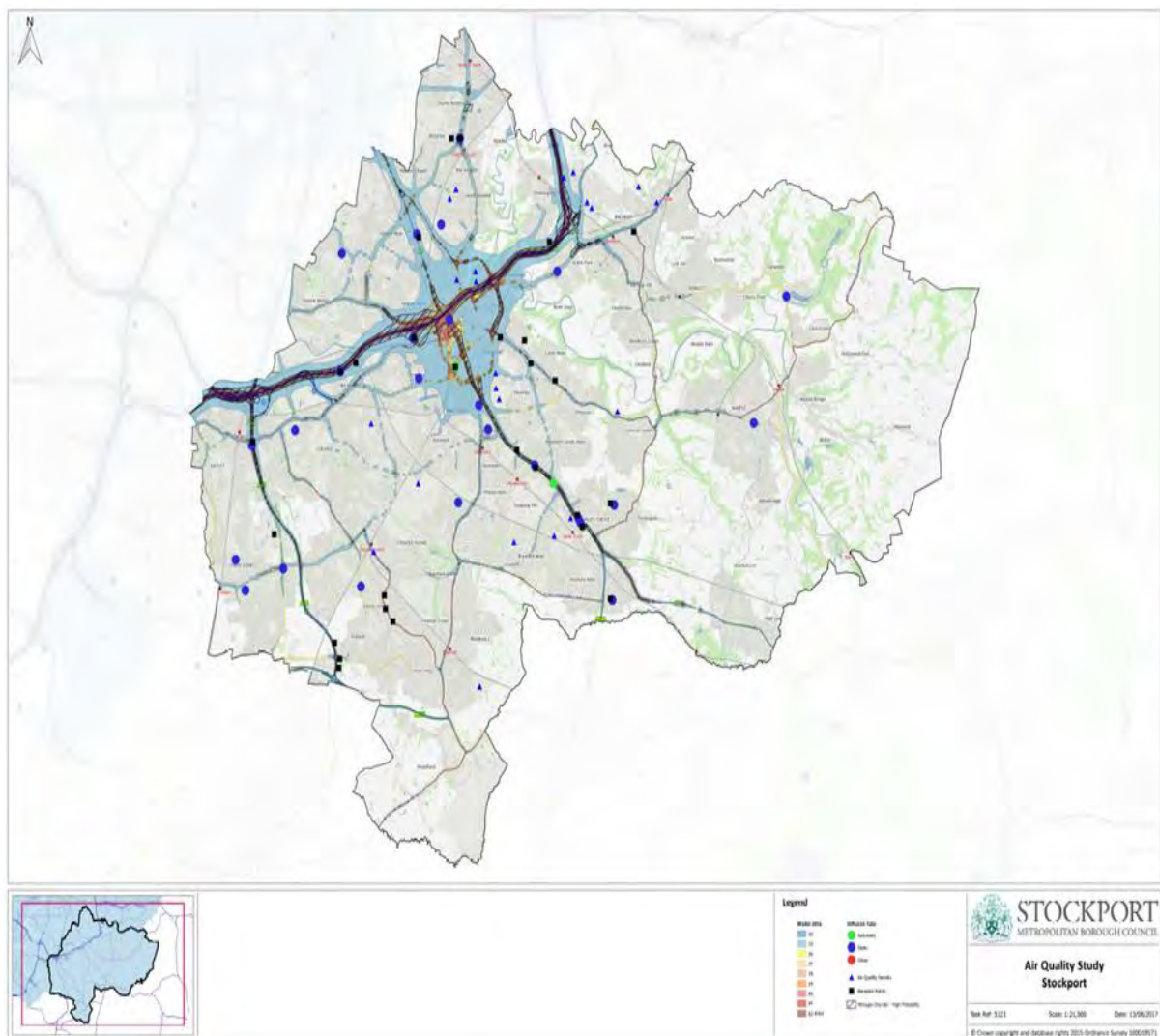
Map of Stockport detailing key AQMAs 2016.

Measurements from the Greater Manchester's diffusion tube network confirms there are locations that continue to be above the annual mean NO2 air quality objective, but there is an overall trend of declining concentrations at different site types as is visible from the graphs.
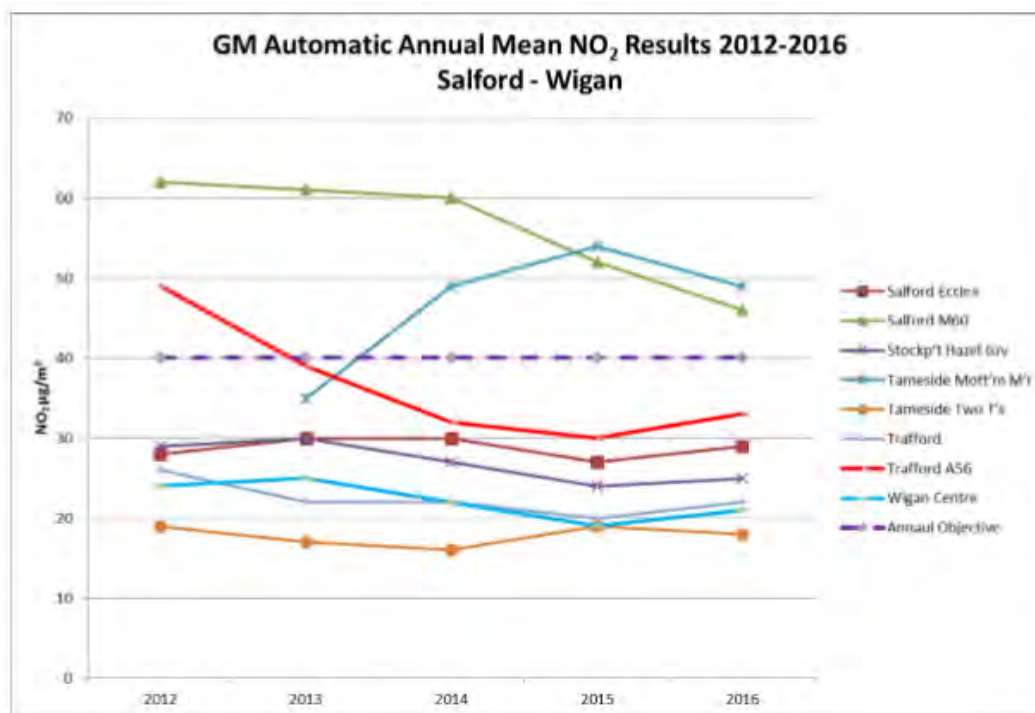
Trends in Annual Mean NO2 Concentrations Measured at Automatic Monitoring Sites Salford - Wigan from 2016 Air Quality Annual Status Report (ASR) for Greater Manchester (July 2017)

Level 5   116
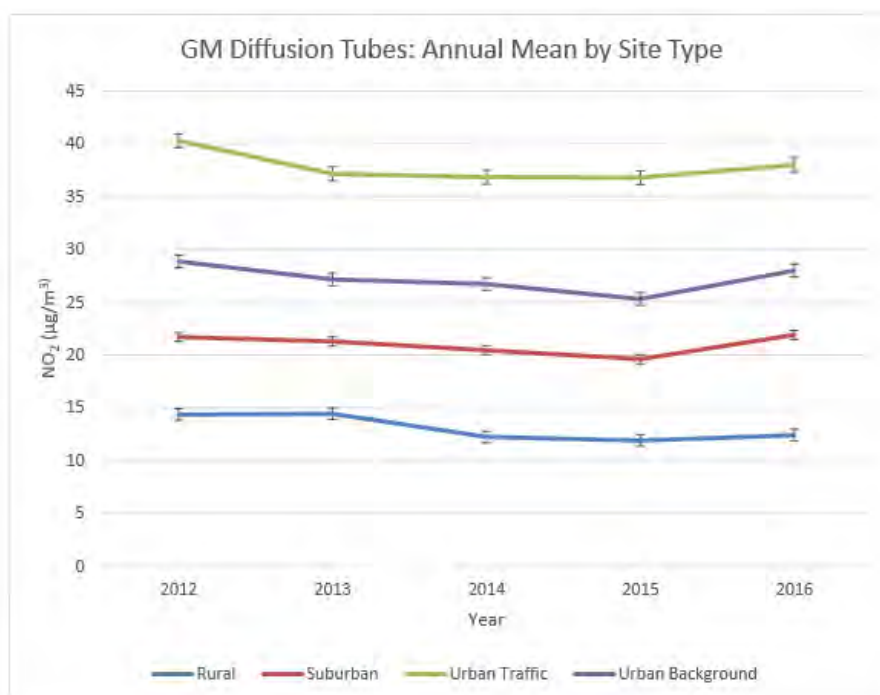
GM Diffusion Tubes: Annual Mean by site type from 2016 Air Quality Annual Status Report (ASR) for Greater Manchester (July 2017)

GM Automatic Annual Mean PM$_{2.5}$
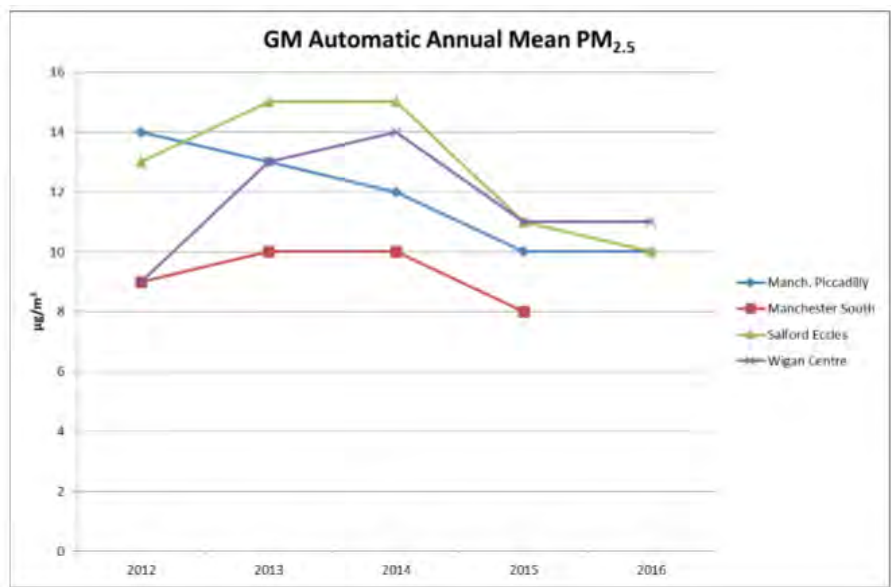
Trends in Annual Mean PM 2.5 Concentrations Measured at Automatic Monitoring Sites from 2016 Air Quality Annual Status Report (ASR) for Greater Manchester (July 2017)

GM Automatic Annual Mean PM$_{10}$ 2012-2016 Salford - Wigan

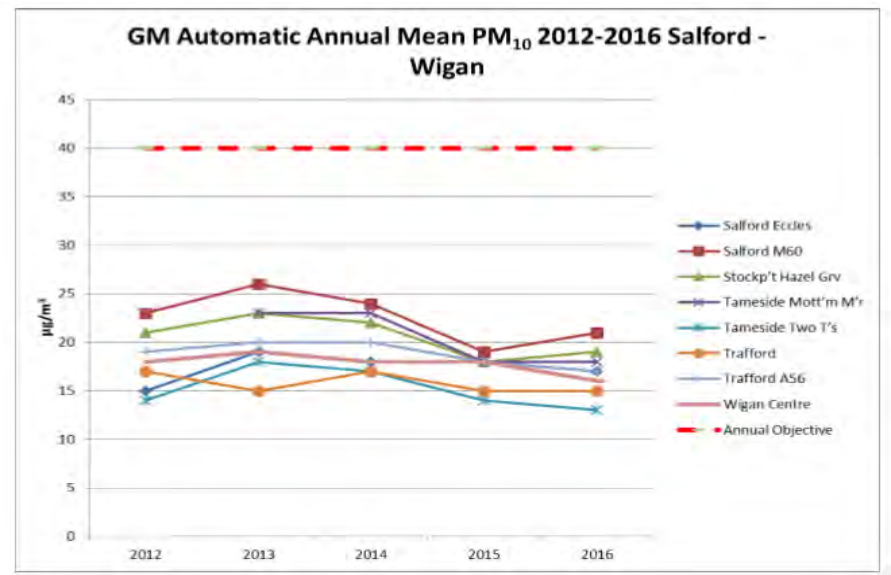Trends in Annual Mean PM10 Concentrations Measured at Automatic Monitoring Sites – Salford - Wigan from 2016 Air Quality Annual Status Report (ASR) for Greater Manchester (July 2017)[8]

What are our plans to improve air quality?

National - NICE Guidance

In June 2017 NICE Guidance was published which sought to inform the public and advise local authorities on the effects of air pollution. The recommendations were to reduce emissions public transport and fleet, focus on planning – continuity of approach, local travel plans, town planning, traffic planning, and active travel – promotion of walking/ cycling and instigating clean air zones, congestion charges.
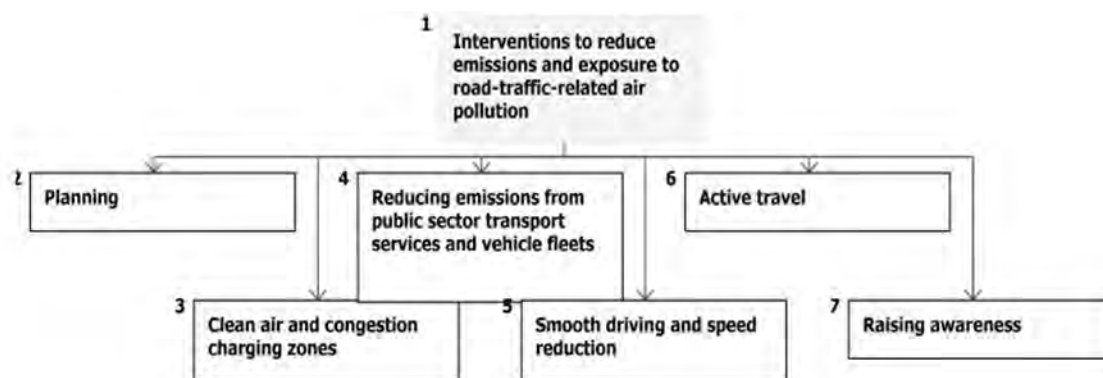
NICE interactive Flowchart on Air pollution: outdoor air quality and health June 2017[9].

Greater Manchester - Strategy and Action Plans

Greater Manchester's Combined Authority (GMCA) is made up of the ten Greater Manchester councils and Mayor, who work with other local services, businesses, communities and other partners to improve the city-region. 7 out of 10 Greater Manchester (GM) authorities have been identified as needing to develop action plans on air quality. DEFRA are keen to see GM boroughs working together as one to address the issues. The Greater Manchester Low Emission and Air Quality Strategy states that the 2020 carbon

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[8] Air Quality Annual Status Report (ASR) for Greater Manchester 2015 p44
https://www.trafford.gov.uk/residents/environment/pollution/air-quality/docs/GMASR2015.pdf

[9] NICE interactive Flowchart on Air pollution: outdoor air quality and health June 2017.
https://pathways.nice.org.uk/pathways/air-pollution

targets will be a core delivery focus and goal of transport strategy and planning will develop, gain funding for and deliver transport interventions which enable (GM) to reduce its emissions, adapt to climate change, improve air quality, raise awareness of the carbon and health impacts of transport choices.[10] The GM Air Quality Action Plan is led and coordinated by Transport for Greater Manchester (TfGM) but implementation of actions is done jointly by TfGM and the local boroughs.

Stockport has contributed and signed up to the Greater Manchester Air Quality Action Plan (AQAP) for Greater Manchester. The AQAP has involved a review of the strategies, policies and plans which tackle or are in some way related to air quality, to develop a set of actions which will deliver changes in terms of air quality. These actions focus on road transport as it is the major contributor to poor air quality in the region.

The key priorities therefore include: changing travel behaviour, reducing emissions from Heavy Goods Vehicles (HGVs) and passenger vehicles, implementing planned infrastructure improvements for sustainable transport including rail electrification, and stimulating the uptake of Ultra Low Emission Vehicles (ULEVs) particularly private car users. To reduce emissions from buses on key local corridors, and continued encouragement in the uptake of smarter travel choices is important. The introduction of ULEVs will help to reduce impacts on both short and long journeys. HGVs and buses make up a relatively small amount of road transport but contribute significant amounts to emissions. Where necessary and viable identifying 'Clean Air Zones'. A Clean Air Zone is an area of the City in which measures will be introduced with the purpose of reducing pollutants produced by traffic. The main measure within a Clean Air Zone will be to charge a fee for the most polluting types of vehicles to enter the zone.

An overview of the ongoing work towards this for GM includes:

- Three new park and ride sites have opened.
- Salford have reviewed licensing rules requiring applicants for new private hire licence to have vehicle less than 4 years old. Salford are waiving license and testing fee for private hire with electric vehicles.
- The 'A6 Quality Bus Partnership' to achieve 100% of the high frequency 192 service on the A6 corridor to be of Euro 5 standard by January 2014. Targets were phased for services operating only part of their routes on the A6. Stagecoach introduced 40 new hybrid vehicles by 2013.
- 'Anti-idling' policies were promoted with freight companies throughout Greater Manchester.
- A TfGM feasibility study regarding 'Clean Air Zones' is underway.
- There has been an increase in the extent of EV charging network.

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[10] The Greater Manchester Low Emission and Air Quality Strategy (2016) p7
https://www.greatermanchester-ca.gov.uk/airquality

- Encouraging the uptake of cycle logistics/ cargo bikes.
- Campaigns have been designed to encourage cycling (e.g. Women on Wheels).
- "Dirty Diesel Campaign" to encourage the public to report smoky or heavily polluting vehicles.

Stockport (SEMMs Refresh and Stockport Local Plan)

Stockport's local plan will work in line with the South East Manchester Multi Modal Strategy (SEMMMS) Refresh Strategy which has identified that packages of measures will be required to meet future transportation needs to cover the period up to 2040. The SEMMMS will deal with transport issues across Stockport, parts of Manchester, Tameside, Cheshire East, and Derbyshire was approved by central Government in 2001. The multi-modal plan includes developing integrated transport corridors and bus priority measures, improvements to rail stations and services, proposals for Metrolink and tram-train lines and services, improvements to town, district and local centres, pedestrian and cycle facilities, new roads, and a 'smarter choices' programme to help people to choose to reduce their car use. These measures may include: Metrolink/tram train routes to Marple, Stockport town centre, the airport and Hazel Grove. Segregated bus routes and bus priority schemes, improved rail services and new/ improved rail stations. New roads built such as the A6 to M60 Relief Road. There have already been a wide range of improvements to routes including, Connect 2 route, TPT improvements, Middlewoodway improvements, and the cycle route to Manchester Airport. The SEMMs refresh will improve walking and cycling routes and facilities on and off the highway. It will also improve public realm in the district and local centres. It aims to create connected neighbourhoods that encourage the use of more sustainable forms of transport. The improvement of the provision of transportation infrastructure will support the introduction of smarter choices to encourage the use of sustainable transport.[11]

Stockport Town Centre is a key focus for a number of proposed transport improvement schemes including the completion of the Town Centre Access Plan (TCAP) which improves access to and around the Town Centre by all modes, a new transport interchange, substantial improvements to Stockport Rail Station, new tram train/metrolink routes and a masterplan to improve the A6 Corridor through the Town Centre. The TCAP work in the Town Centre is focused on the improvement of walking, cycling and public transport usage as well as reducing the congestion of local routes through the centre.

A review of Stockport's sustainable travel plan in 2017 has included an increase in electric charging points the town centre and free parking on street bays for EVs, Metroshuttles buses have been moved to diesel hybrid and there is an ongoing increase in hybrid buses on a number of routes through Stockport. Taxi licencing has encouraged/enforced a move to

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[11] Stockport Local Plan Issues Paper 2017 p43
http://stockport-consult.objective.co.uk/portal/localplan/slpip

lower emission vehicles. A total of 152 drivers in the Council and partner fleets have received SAFED training and have achieved a reduction of 9% in fuel usage. There has been an increased synergy between public health policy and transport policy to encourage active transport. A 20mph speed limit zones have been implemented affecting a number of primary schools within Stockport as part of 'Safer Routes to School'.

As part of the travel plan there are local walking maps, a 'walk a day' scheme, and improvements to way-finding district within the district. Stockport Metropolitan Council run a 'walk to work week' and a bike week, There is a GM cycle map and Stockport have piloted a scheme for this in Hazel Grove. A cycle link bridge between Marple – Stockport has been built, new cycle routes are planned from GM funding, and cycle training in primary schools has been rolled out across Stockport. There are plans to roll out the Mobike scheme across Stockport, currently used in Manchester, in early 2018. This is a low cost bike-sharing scheme. Mobike users can book their bikes via an app and unlock them using a code obtained.

What more could be done?

Long term solutions

I recommend the use of driverless vehicles and the use of hotlanes**.** Driverless vehicles will make driving easier, allow people to be more productive and offer greater mobility to a wider range of people than ever before. They will also help improve road safety, reduce emissions, and ease congestion. As a result they could provide significant economic, environmental and social benefits, including improving social inclusion. Instead of today's car ownership model, consumers would buy a service like ordering a taxi today, but with a wider range of vehicle configurations to suit different types of travel – family outings, long-distance sleeper travel, or shared commutes You don't need to give up a room of your house or a part of your garden or a potential communal area of your street to park it. You pay only for the use you make of it – you don't need to pay the insurance and depreciation whilst it stands idle. What overrides these benefits is the logistical cost of delivering the car to your door when you need it. With driverless vehicles these costs disappear. Car hire, car clubs and driverless taxis merge into a single concept.

I recommend hotlanes (high occupancy toll lanes) which are highway lanes which convey public transport vehicles but sell spare capacity to private vehicles prepared to pay a toll and vary the toll so as to benefit vehicles with multiple passengers. A guided hotlane available only to vehicles fitted with guidance devices and systems for computer control would offer private drivers the option of paying extra (both in modifying their car and by way of a toll) for a significant congestion-avoiding driverless portion of their journey. Such tolls could raise the funding for infrastructure investment to make a significant part of the bus network driverless. On congested city roads this could be seen as an advantage for both public and private transport.

I recommend that the Hyperloop could replace HS2 and HS3. The Hyperloop is a variant on a very old concept, first developed by a British physicist in the 19th century, of a train running in a depressurised tube. Such a train can potentially achieve very high speeds. Could the Hyperloop provide such rapid transport between airports that it was possible to operate the four London airports, Manchester Airport and perhaps some other regional airports as a single hub airport? Bear in mind that the Hyperloop is much cheaper, much more energy efficient (powered by solar panels on the outside of the tube so better for the environment/air quality) and much easier to construct – it can be elevated on poles, built on the ground, buried, submerged, or built above motorways or railways or canals. This would be much less demanding of land and much less intrusive on neighbouring areas and fast enough to allow reasonable journey times via links to hubs. The proposal would be to develop a complete national system via six phases.

Short term solutions

I recommend that it is important to inform the local population of the impact of air pollution on health and to tailor messages to target those members of the public particularly susceptible to air pollution. It is important to work with others to promote initiatives to facilitate active travel (for example healthy schools programmes, school travel plans and cycle to work schemes. I recommend raising awareness of the need to improve air quality through linking to other public health issues such as obesity and through working with Health and Wellbeing Boards to include air quality in Joint Strategic Needs Assessments and Health and Wellbeing Strategies. I recommend reducing the use of the car and promoting a healthier transport system including traffic measures such as optimising variable speed limits on Greater Manchester motorways and public debate about a 20mph speed limit throughout the Borough. I recommend much wider use of green walls and green security measures to mitigate the effects of air pollution near roads.
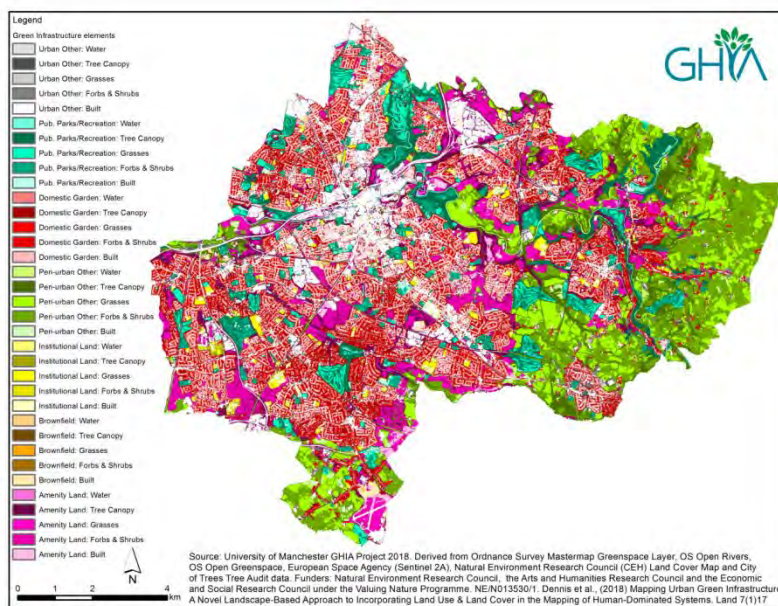
C4.12 GREEN INFRASTUCTURE
The Value of Green Infrastructure

Trees, flowers, greenery and water features are often seen as merely aesthetic features to be readily sacrificed in order to save money or to make way for other "more important" uses of land. This is an incorrect perception. Green infrastructure is actually of considerable health and ecological importance and provides many other multifunctional benefits. Green Infrastructure also contributes to improved land and property values and brings benefit to local economies.

The following map shows the types of green infrastructure within Stockport

The following are some of the benefits that green infrastructure produces.

Most forms of green infrastructure provide the following:-

- It improves air quality by absorbing greenhouse gases.
- People are more likely to walk and cycle if the route is attractive
- Sight of greenery reduces stress. Ulrich has shown that people recover faster after an operation if they can see a tree from their window. Similar effects on stress are likely to occur in other settings.
- Evidence is beginning to emerge that exercise taken in green surroundings has more health benefit than exercise in drab city surroundings
- Greenery reduces the urban heat island effect. This is especially important as we experience warmer summers

- Greenery reduces flood risk by delaying the passage of rain into the drains, making communities better resourced to manage increased levels of rainfall
- Greenery raises the human spirit, and reduces stress, thereby improving both physical and mental health.
- Greenery contributes to biodiversity, much of which is vital for health. For example, flowers that help maintain bee populations encourage pollination, thereby making a key economic contribution whilst keeping healthy food options affordable.
- Air quality is improved by the way green infrastructure encourages walking and cycling, the absorption of greenhouse gases, and the way some forms of green infrastructure diminish travel times and food miles.

Some specific forms of green infrastructure make particular contributions:-

- Small patches of green infrastructure can provide areas of tranquillity.
- Large grass areas open to the public can provide important opportunities for physical activity
- Fruit trees available for the public to pick the fruit can help promote the eating of fruit
- Land that is available for cultivation of vegetables can improve nutrition as well as offering a physical activity opportunity
- Volunteer maintenance of green infrastructure can provide a physical activity "green gym" opportunity and also opportunities for social networking.
- Urban drainage is improved and flood risk diminished by green roofs, ponds and wetlands, and surfacing of drives and car parks with lattices to support the vehicles whilst allowing grass to grow through
- Roof gardens and earth-sheltered buildings allow pressure for development land to be met with much less loss of open space
- Linear green passages or tree-lined routes can provide good walking routes
- Floral displays and water features provide powerful aesthetic contributions which particularly raise the human spirit
- Parks can provide walking and cycling routes, recreational use, biodiversity, aesthetic displays and tranquil opportunities for relaxation
- Agriculture within the urban envelope ("city farms") can diminish food miles as can multi-storey farms
- Green walking routes into the countryside encourage recreational walking and reduce the need to use cars to access the countryside
- Tree screens can reduce noise
- Thorny hedges, or thorny plants on green walls, or planted under windows can be an effective means of security
- Green roofs and green walls can improve energy efficiency although the effect is not a large one

The Prioritisation of Green Infrastructure

All too often green infrastructure is seen as of low priority and an easy win in terms of value engineering on a project. The green roof or roof garden or green wall is the first item to be cut from a scheme. Street trees are regarded as maintenance costs rather than as assets often without full assessment of low maintenance options. Developers assume that policies requiring green infrastructure can be readily ignored by references to viability. There is a lack of imagination – green walls are not thought of, tarmac is automatically selected without thinking of grass blocks, metal fencing is ordered automatically instead of a thorny hedge, choices of roof covering are made between tiles or slates rather than between green roof and solar panels.

This approach needs to change to one where we see green infrastructure as a priority and where people and organisations are familiar with the ways that they can contribute to its development. Green walls, for example, are very cheap. Green   roofs are often perceived as more expensive than ordinary roofs but if considered from the earliest concept stage and factored into the project budget many savings can be made. Such savings include lower maintenance costs (particularly for flat roofs), reduced costs in terms of surface water disposal and some energy efficiency savings from both reduced heating and cooling requirements. Additional benefits include increased property values from reduced insurance costs as insurers recognise the need to tackle climate change impacts on the built environment. Communities can help their own improvement; a terraced street can be transformed by pot plants and hanging baskets.

Housing density will be a key issue in not only delivering the much needed new homes in Stockport but also critical in examining how that housing can incorporate much needed green infrastructure. The Homes & communities Agency has commissioned a Sustainable Suburbia toolkit (http://www.sustainablesuburbia.co.uk/) that highlights the benefits of designing in GI into new housing development whilst achieving maximum densities of housing. These ideas should be applied to urban schemes.

There are economic approaches, such as Natural Capital Accounting, which value the "ecological services" provided by greenspace. Such approaches can produce substantial nominal value for greenspace – a mature street tree, for example, might in some settings be valued at tens of thousands of pounds, and perhaps even £100,000. This can certainly be a way to bring home the importance of green infrastructure. However, like all attempts to monetise social and environmental value, there is fierce debate as to whether this is a sensible way to emphasise value, an artificial attempt to measure the immeasurable, or a philosophically undesirable attempt to monetise everything.

If we are to see green infrastructure as important and essential we should set ourselves some goals. I suggest

- Most people should see greenery most of the time
- There should be a network of green walking and cycling routes throughout the borough
- All of the Borough should be within a short walk of a green corridor into the countryside
- All of the Borough should be within a short walk of recreational greenspace
- District centres and the town centre should have a green feel to them.
- Greenspace should not be lost to development – greenspace-compatible development technologies should be used to avoid this.

Action on Greenspace

Most people should see greenery most of the time.

The following map shows the availability of greenspace by ward
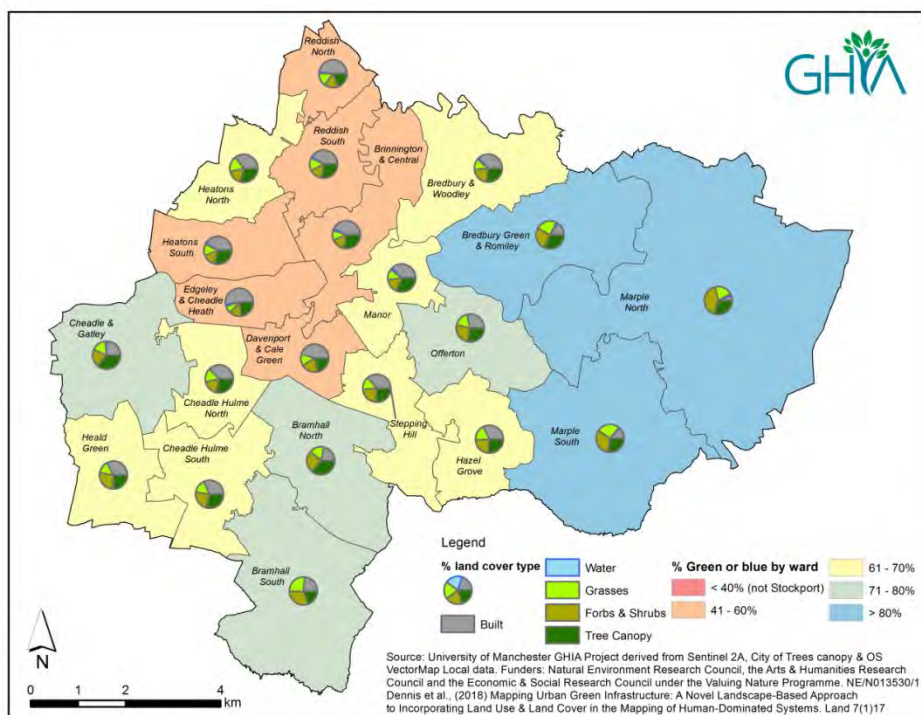
The Council should set itself the objective of ensuring that greenery is visible from most parts of the highway network and public realm. Sites at which this is not the case should be recorded and opportunities to achieve this should be taken whenever a planning application is considered, or work is carried out on public buildings or on highways. It should be a major consideration whenever the removal of greenery is being considered for any purpose. The following map shows the current extent of vegetation cover.

Source: University of Manchester GHIA Project derived from Sentinel 2A, City of Trees canopy & OS VectorMap Local data. Funders: Natural Environment Research Council, the Arts & Humanities Research Council and the Economic & Social Research Council under the Valuing Nature Programme. NE/N013530/1. Dennis et al., (2018) Mapping Urban Green Infrastructure: A Novel Landscape-Based Approach to Incorporating Land Use & Land Cover in the Mapping of Human-Dominated Systems. Land 7(1)17

To eliminate the white spaces on this map requires a little thought and imagination.

An ambitious programme of fruit tree planting should be developed.

Members of the public could be encouraged to adopt small patches of land to grow things on. This could include food following the example of Incredible Edible in Todmorden .

Friends of Groups have a key role in parks and other major areas of greenspace. They could be encouraged to broaden their remit so as to see how the surrounding areas, or the corridors to the parks, could be greened.

Employers and businesses should seriously consider greening the interior of their buildings with plants and the Council should set a good example by encouraging employees to decorate Council buildings with pot plants.

There should be a network of green walking and cycling routes.

A considerable number of pleasant walking routes already exist in the town.

The river valleys have been meticulously preserved.

Areas of countryside have been preserved close to the major centres of the town and are well served by public footpaths.

A number of council estates have been built on the Radford principle in which pedestrian and vehicular routes are separate and pleasant walking routes therefore exist whilst a

number of private estates have been built on the "linked closes" principle whereby vehicular access consists of a single main road with a plethora of cul de sacs leading off it, but those cul de sacs are linked by pedestrian passages so that it is possible to walk through the estate passing from one pleasant quiet close to another. Both these approaches to design have gone out of fashion for some years now and indeed are sometimes seen as breaching the Secure by Design guidelines, but this is an unimaginative application of those guidelines.

The planning principle that developers who engulf public footpaths must replace them with attractive routes has been applied in the town for many years and has created a number of pleasant passages through the town.

In some parts of the town many roads are heavily tree lined.

Parks and recreation grounds are a surrogate for countryside.

Pedestrianised shopping areas are also pleasant to walk through.

A network should start with these existing routes, of which there are a considerable number, and aim to link them.

Ways to do this were fully discussed in "Country City" (available on the Annual Public Health Report website) which in turn repeated proposals made in my earlier report "Ginnels, Snickets and Leafy Lanes".

Opportunities to complete the network mapped in Country City should be taken as they arise, especially when planning applications or highways work takes place adjacent to the network.

All of the Borough Should be Within a Short walk of a Green Corridor into the Countryside

Country City contained a map showing how almost the entire borough is within half a mile of an opportunity to start a country walk. We should be proud of the fact that long distance footpaths come to the very edge of Stockport Town Centre.

As well as the countryside outside the urban envelope countryside is brought deep into the borough by the Mersey Valley, Reddish Vale, Marple Dale, the Micker Brook, the Goyt Valley and the Ladybrook Valley. Linked parks such as Woodbank Park, Vernon Park and Memorial Park bring these even closer to residential communities.

The countryside north of Cheadle Village and the countryside between Bramhall and Woodford help break up what would otherwise be continuous conurbation, as does the lasagne shape of Bramhall with its layers of housing and open space. Some of the golf clubs also contribute.

Mirrlees Open Space and the riverside walk that links it to the Ladybrook Valley provide another green corridor which actually provides almost a tenth of the borough with its green corridor to countryside.

These are complex interrelationships and they must be understood if the current situation is to be retained since a corridor can be blocked at a single point. .

All of the Borough Should be Within a Short Walk of Recreational Greenspace

The following map shows the catchment areas of parks, gardens and natural and semi-natural space. There is good access to recreational greenspace. It is important this is maintained.
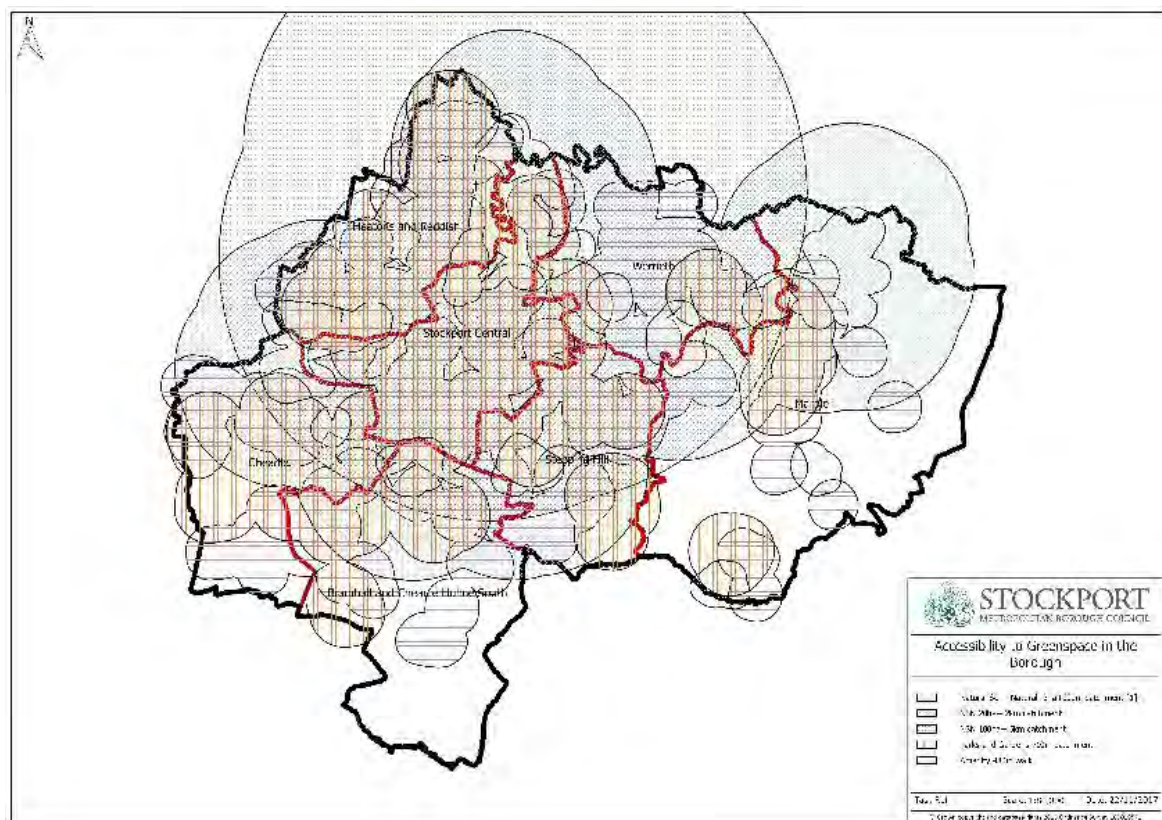
District Centres and the Town Centre Should Have a Green Feel to Them

The project based interventions including those highlighted in the Town Centre Urban Green Infrastructure Enhancement Strategy should be brought to fruition, in particularly;

• Transforming Mersey Square to a more pedestrian friendly hard and soft landscaped space, providing more tree planting to the north of the river
• Engaging with businesses in the town centre and district and local centres to provide more greenery such as green roofs and canopies and tree lined avenues

- Improve the main gateways into the town centre and other centres with additional tree planting ie Wellington road and Portwood Street
- Take opportunities to link centres with nearby parks and gardens, create a pocket park within the Town Centre and create a public green area on the roof of the bus station.
- Take opportunities to ensure the River Mersey in the Town centre is more of an asset e.g. thinning trees to open up views, and completing the riverside path from the west to reach Mersey Square and from the east to reach Tiviot Bridge St. so that it follows all the open parts of the river.
- Encourage raised beds in right places similar to the Stevenson Square planters in the Northern Quarter in Manchester
- Green Infrastructure should play an integral role within public realm and should provide places to rest and enjoy the greenery for example via street planting, new public squares and furniture

Greenspace Compatible Development

It is generally perceived that there is a conflict between development and open space. This conflict is then presented as an obstacle to essential building so that protection of green space becomes a goal to be weighed in the balance against (and usually trumped by) the need, for example, for more housing.

If priority is then given to protecting the Green Belt the implication is that protection of areas of open space within the urban boundary becomes even more difficult. I have always argued that greenery within the urban envelope and land at the fringes of the Green Belt (where development will put the whole conurbation further from countryside) are especially important and that if greenspace is to be lost the ideal is to create new settlements in the countryside, linked to public transport.

However the question must be asked whether it is actually right to see development and greenspace as in conflict at all.

Roof gardens provide the opportunity to maintain public open space and building on the same piece of land. Earth sheltered buildings take this a stage further with several aspects of the building buried behind or beneath earthen mounds – the building may be invisible from all aspects except one (often the south-facing one) where windows and doors are situated. Light tubes carry the potential to bring in daylight even through the windowless aspects.

Greenspace – compatible development aims to identify the ecological role which a particular piece of greenspace fulfils and ensure that those roles are preserved in any development. A green view can be preserved by screening with plantings. An attractive green walk can be preserved by maintaining an attractive green passage. Wildlife corridors can be built in. If recreational open space is required it can be re-provided in roof gardens. If

the land is on the edge of open access countryside or country park then an attractive passage through to the countryside or park would be maintained.

This approach to greenspace no longer thinks of it as just empty space – it asks what uses it fulfils and demands that they be provided in any development. Development changes its character as well becoming not just buildings but also other important functions.

In areas which are short of open space the concept can be extended so that the needs which we would like to see fulfilled by the open space that we would like to see there can also be built into the proposed developments. We should not just be protecting green infrastructure – we should be creating it. The Reddish Vale Country Park was not merely preserved – it was recreated from dumps, disused railway sidings and a rundown industrial estate.

Developers will often argue that the added costs of greenspace-compatible development make it unviable. However this depends on whether the development gain in land value can be captured. The formula $H = B + L + P$ implies that the price of a house (H) is the sum of the building cost (B), the price of the land (L) and the profit (P). H and P can remain constant if any increase in B is matched by a fall in L. L is much higher after the grant of planning permission than before. If strict enforcement of greenspace-compatibility causes L to be less than it would otherwise be this merely reduces a windfall profit; it does not undermine a viable development.

Recommendations

- I recommend that the full range of benefits of green infrastructure are fully appreciated, that Stockport continues to be proud of its past achievements in this area and that it fully reaffirms its commitment to seeing this as a major priority not a luxury

- I recommend we set the following goals:

  (a) Most people should see greenery most of the time

  (b) There should be a network of green walking and cycling routes throughout the borough

  (c) All of the Borough should be within a short walk of a green corridor into the countryside

  (d) All of the Borough should be within a short walk of recreational greenspace

  (e) District centres and the town centre should have a green feel to them.

  (f) Greenspace should not be lost to development – greenspace-compatible development technologies should be used to avoid this.

- I recommend that whenever work is carried out on public realm or on highways or whenever a planning application is considered the opportunity to taken to ensure that

  (a) greenery is visible from any point in the borough

  (b) the network of aesthetically attractive pedestrian routes continues to be protected and to develop

  (c) cycle routes should also be aesthetically attractive

  (d) the highway system should be progressively greened

- I recommend an ambitious programme of fruit tree planting should be developed.

- I recommend members of the public be encouraged to adopt small patches of land to grow things on. This could include food, following the example of Incredible Edible in Todmorden.

- I recommend that all employers and businesses encourage the placing of pot plants or similar in indoor areas and that the Council and the NHS take a lead in this.
- I recommend that the principles of greenspace-compatible development be built into the Local Plan and be rigorously insisted on in any development on open space or in areas of open space deficiency

- I recommend the development of green infrastructure in the Town Centre by

  - Transforming Mersey Square

  - Engaging with businesses to provide more greenery such as green roofs and canopies and tree lined avenues

  - Additional tree planting in Wellington road and Portwood Street

  - Linking centres with nearby parks and gardens,

  - Creating a pocket park within the Town Centre

  - Creating a public green area on the roof of the bus station.

  - Ensuring the River Mersey in the Town centre is more of an asset

  - Encouraging raised beds in right places

  - Providing places to rest and enjoy the greenery for example via street planting, new public squares and furniture

- I recommend the vigorous promotion of green walls and green security

- I recommend protection of the accessibility from all parts of the borough of recreational greenspace and of country corridors

- I reiterate the recommendation from Country City that we consider situating a central building in each park to draw people into and through the park. In the current financial climate it could also help resource the park.

This chapter was written by Stephen Watkins with contributions from Angie Jukes and Sally Maguire.

C4.13 HOUSING

Health Implications of Housing

In 2010, the Building Research Establishment (BRE) calculated that poor housing cost the NHS at least £600 million per year in England, based on data from the English House Condition Survey, with the total cost to society each year estimated to be greater than £1.5 billion. A major factor in this is falls, leading to otherwise avoidable hospital admissions. Using 2011 data BRE suggests that bringing the highest risk housing up to average standards could save the NHS £435m in first year treatment costs (equating to about £2m in Stockport)

Cold housing is a major contributor to up to 40,000 non-flu excess winter deaths (equating to 200 in Stockport). Cold is linked to increased risk of cardio-vascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health and cold houses obviously contribute.
The National Institute for Health and Care Excellence produced guidelines (March 2015) on health risks associated with cold homes. The conclusions from this paper are summarised as:

1. Cold temperatures are a significant cause of illness and death in winter.
2. The risk increases with falling temperatures, but the risk starts to increase at relatively moderate cold outdoor temperatures, before emergency responses.
3. Cold homes play a significant part of the problem; fuel poverty is important but also situational/attitudinal factors.

Accidents are one of the major causes of death and 45% of accidents occur in the home. Structural defects (such as poor lighting, or lack of stair handrails) increase the risk of an accident. The majority of injuries to people aged 75 and older occur at home. Unintentional injury is a leading cause of death among children and young people aged 1–14, with one million visits to accident and emergency departments by children every year (equating to about 5,000 in Stockport) arising from injuries in the home. The annual cost to the UK government from falls in those aged 60+ is £1 billion with the average cost of a single hip fracture estimated at £30,000. This is five times the average cost of a major housing adaptation (£6,000) and 100 times the cost of fitting hand and grab rails to prevent falls.

Damp and mould are also significant health hazards associated with housing.

Overcrowded housing has adverse impacts on mental health, accidents and spread of infection.
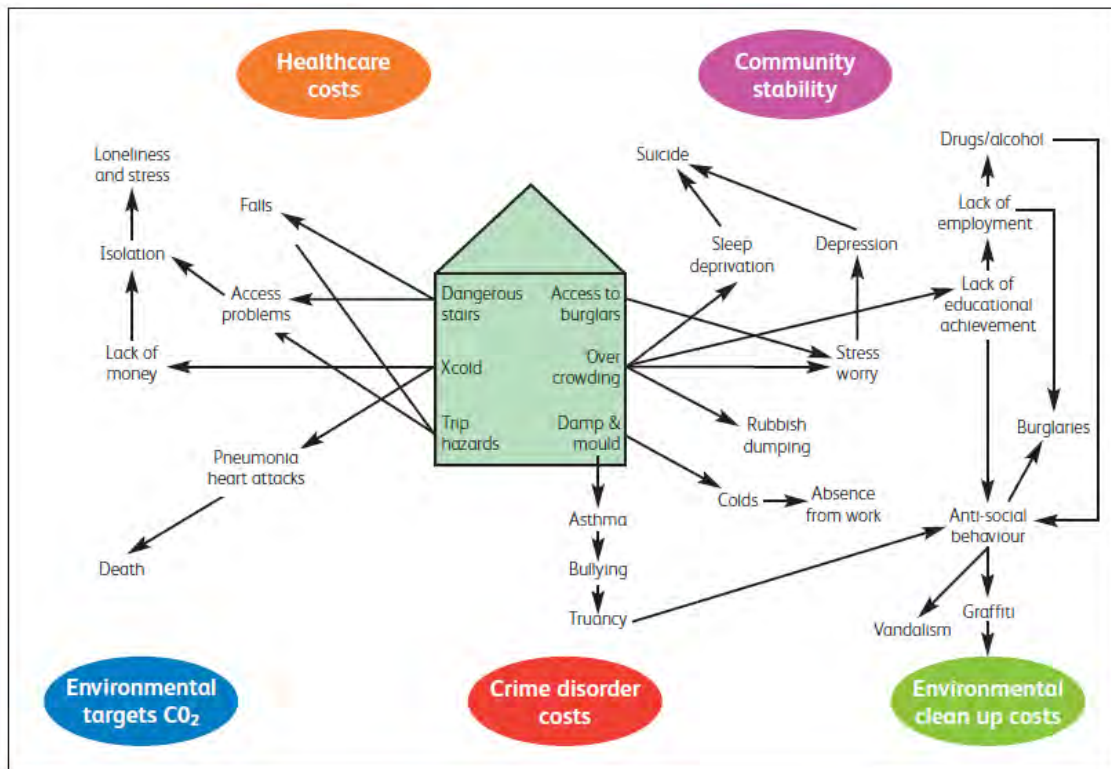
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The environment in which housing is situated has a number of elements with a significant impact on health. Outdoor air pollution impacts on cardio-respiratory mortality and morbidity. Open/green space brings direct benefits to physical and mental health and wellbeing which are more fully described in the chapter on green infrastructure. Transport accessibility from home to employment, education, social networks and services is important to reduce isolation and improve opportunities). Street safety impacts on road traffic accidents and on opportunities for physical activity. Low levels of social integration, and loneliness, significantly increase mortality. In neighbourhoods that are perceived to be less safe and/or where there are no community facilities there are usually fewer opportunities for integration, for example through volunteering. Fear of crime and harassment, and the presence of needles and syringes impact on mental wellbeing. Noise from neighbours also has a negative effect.

Fuel Poverty is a serious problem faced by a significant number of potentially vulnerable people across Stockport. A fuel poor home is a household unable to afford to heat their homes adequately for health and comfort which leads to the effects of cold described above and also to poor wellbeing. Affordable Warmth is the ability to heat the home to an adequate level for household comfort and health without developing a debt as a result. To heat a home adequately in England, it is recommended that the living room (or main room) is heated to a minimum of 21ºc with other rooms heated to 18ºc. Anything less can cause detrimental effects on the health and well-being of the occupants. Fuel poverty is faced by thousands of people across the borough. Stockport has approximately 93,571 privately owned properties 13,559 private rented, 17,986 social housing, a total of 127,116 dwellings. Stockport Council has a comprehensive Fuel Poverty Strategy (2015-17) in place coupled with a proactive action plan to reduce fuel poverty. This had led to the number of

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households in fuel poverty falling by half from 16.5% (20,502 properties) in 2011 to 9.2% (11442 properties) in 2016. The proportion of Fuel Poor households in the North West is 10.9%

Moving house is stressful. It is a life change and like all life changes health is damaged from the point at which the change is anticipated until the individual is securely settled in their new life. For people with insecure housing this life change occurs repeatedly. This is extremely damaging.

Housing Shortages & Housing Need

On 1 April 2017 there were 128,171 dwellings within the Borough.

The 2014 Household projections indicate that the number of households will grow in Stockport by an average of 900 households per year over the next decade. Between 2007 and 2017 the number of households in Stockport is estimated to have grown by 6090. In the same period 3,704 new homes were provided.

Consequently within the boundaries of the Borough there is a mismatch between the number of new households forming and the number of homes being built. There are currently two major factors on housebuilding that point to a future rise in housing provision in the Borough.

The first is the Greater Manchester spatial framework (GMSF) which is a new statutory development plan for greater Manchester, looking ahead to 2035. The Draft GMSF published in October 2016 identified a housing need for Stockport of 1,011pa and a housing requirement of 965 homes pa over a twenty year period. This is more than double the figure of 450 new homes per annum set by the current Core Strategy.

The second is the new National methodology on housing need. This was the subject of consultation by the Government until 9 November 2017. Under the proposed new arrangements localised calculations of need would be replaced by a single national methodology which would become the standard for Councils to employ. Under this system more complex assessments are placed by a simple three step calculation based on household calculations and an affordability ratio. Under this system housing need for Stockport would be set at 1,078 homes pa. This further reinforces the fact that need generated in the Borough is currently running ahead of new home construction.

The Housing need figure set out in the GMSF and the National methodology is reflective of housing need across the community as a whole. One of the critical issues facing the Borough is the extent to which the housing stock is being replenished in a way which matches housing need.

It is important that we do not assume that all of these will be conventional family homes.

There is a growing number of single person households, and this may need to be reflected in provision of flats. Flats in the town centre, or close to railway stations are particularly useful for young single professionals. There may be scope to build flats above low rise retail and industrial developments.

There is an increasing elderly population which would benefit from extra care housing as described in a later section of this chapter. Another section of the chapter describes the need for affordable housing which is probably the most significant issue in the current housing market.

There are also market niches which are underprovided for. With a growing number of young people delaying learning to drive there will be an increased demand for car free housing, where the space between houses can be used for children's play and for community interaction. This is a relatively small market niche but it is underprovided for to such a degree that housing in such developments sells at a premium.

There is also a small growing niche for purpose built cooperative communities in which individual houses are smaller but a number of houses share the facilities that are often underused such as spare rooms and dining rooms, or the facilities that many houses lack such as games rooms and libraries, or facilities that can be better equipped if shared such as offices and utility areas. In one such development in Preston the community even shares a large well-equipped kitchen and the various households take it in turn to cook a communal meal.

We need to view housing need not just as one total figure, but as the sum of a number of specific needs. We need to ensure that the proper mix of housing provision is built, not just count overall numbers.

The latest full year of housing data currently available is for 2015/16. Of the total completions in 2015/16, 16% were flats and 84% were houses. This represents a lower

proportion of flatted development than seen in recent years, where figures a few percentage points around 50% have been recorded. Just over half (53%) of flats had two bedrooms, with 40% being one-bed flats. Only around 11% of the flats in total were affordable units, made up of six 1-bed properties. For houses, the mix was more skewed towards larger properties, with 2-bed units making up around 12% of the houses, 3-bed properties contributing around 34%

Full details of the composition of new homes is set out in the table:

Dwelling Type / Size	Number of Gross Completions	% of Total	Number of Affordable Completions	% of Total	% of Type
Flat - 1 bed	22	6.51	6	10.71	27.27
Flat - 2 bed	29	8.58	0	0.00	0.00
Flat - 3 bed	1	0.30	0	0.00	0.00
Flat - 4 bed	3	0.89	0	0.00	0.00
House - 1 bed	0	0.00	0	0.00	0.00
House - 2 bed	34	10.06	23	41.07	67.65
House - 3 bed	97	28.07	27	48.21	27.84
House - 4+ bed	152	44.97	0	0.00	0.00
Total	338	100	56	16.57	

56 of the 338 completions were affordable dwellings (16.6%) with around 89% of those being houses. Just under half of all the affordable dwellings were 3-bed houses with the remainder being 2 bed properties and 1 bed flats. In contrast 222 out of the 282 market homes were homes of 3 or more bedrooms - some 79% of the total. This illustrates that whilst the housing being built is responding to thriving market sectors it is not necessarily reflective of overall housing needs.

Housing need arises across the Borough – but the extent to which the housing stock is being replenished is far from being evenly distributed across the Borough.

Committee Area	2013/14 Net Completions	% of Total	2014/15 Net Completions	% of Total	2015/16 Net Completions	% of Total
Bramhall	76	20.32	32	6.90	57	17.76
Central	130	34.76	165	35.56	16	4.98
Cheadle	20	5.35	60	12.93	13	4.05
Heatons & Reddish	75	20.05	133	28.66	71	22.12
Marple	51	13.64	33	7.11	9	2.80
Stepping Hill	15	4.01	19	4.09	135	42.06
Werneth	7	1.87	22	4.74	20	6.23
Totals	374	100	464	100	321	100

The rate of building is strongly linked to particular sites coming on stream at any one time. So long as each area has a share of housing over a period of a decade or so, problems need

not arise. However, with development opportunities being limited it is more probable that disparities in provision will arise.

The table of Gross Housing Completions by type' shows that nearly half of all dwellings delivered in this monitoring period were in Stepping Hill. However this Committee Area has seen low delivery in recent years which means that this is redressed somewhat. Heatons & Reddish and Bramhall areas saw the next highest levels of completions. The Central area has seen low levels of development in this monitoring period, however this primarily because the larger existing developments in the town centre have now been completed or have reached a pause in their phasing. A number of schemes either within or adjacent to the town centre area are either under construction or are in the process of being worked up.

More notable are Committee Areas where completions have been relatively low for a number of years – such as Werneth and Marple. This may serve to limit housing choice in those areas.

Quality of Housing

The Housing Health & Safety Rating System (HHSRS) considers the following hazards:-

A PHYSIOLOGICAL REQUIREMENTS
- Hygrothermal Conditions
- Damp and mould growth
- Excess cold
- Excess heat
- Pollutants (non-microbial)
- Asbestos (and MMF)
- Biocides
- Carbon Monoxide and fuel combustion products
- Lead
- Radiation
- Uncombusted fuel gas
- Volatile Organic Compounds

B.PSYCHOLOGICAL REQUIREMENTS
- Space, Security, Light and Noise
- Crowding and space
- Entry by intruders
- Lighting
- Noise

C. PROTECTION AGAINST INFECTION
- Hygiene, Sanitation and Water Supply
- Domestic hygiene, Pests and Refuse
- Food safety
- Personal hygiene, Sanitation and Drainage
- Water supply

D PROTECTION AGAINST ACCIDENTS
- Falls
    - Falls associated with baths etc,
    - Falling on level surfaces etc,
    - Falling on stairs etc
    - Falling between levels
- Electric Shocks, Fires, Burns and Scalds -Electrical hazards
    - Fire
    - Flames, hot surfaces etc
- Collisions,
- Cuts and Strains
- Collision and entrapment
- Explosions
- Position and operability of amenities etc
- Structural collapse and falling elements

The private rented sector makes up 10.6% (13,559 dwellings) of the total housing stock in the borough. The Council are aware that most of the private rented sector in Stockport is made up of landlords who own a small number of properties and a few large scale investors.

BRE were commissioned in 2013 to review the quality of privately owned homes. They produced a series of housing stock models. The last survey highlighted that the stock in Stockport is generally of a good condition. (source: BRE Stock Modelling, 2016 update) but nonetheless estimates that 9% of private rented stock in Stockport has some form of disrepair.

When all tenures are included almost 12000 properties in Stockport (about 1 in 10) had Cat 1 hazards and over 10,000 falls hazards. Cat 1 hazard can be classified as having a serious and immediate risk to a person's health and safety such as damp and mould growth, excess cold, fire risks, faulty boiler, dangerous electrics, excess cold etc. The Council has a range of measures including the enforcement function which has been detailed separately in this report to drive up standards in the borough.

The Council has an Investment and Assistance Policy in place which outlines the types of assistance available from the Council for householders and landlords in the private housing sector and the criteria to qualify for that assistance. All types of assistance are subject to the availability of resources, which since the removal of the Government capital housing allocation, has been limited.

 It would be wrong to believe that housing quality is purely a matter of concern for the private rented sector or for old houses whose owners have been unable to maintain them adequately. Concern has also arisen over the quality of new homes and has been sufficiently serious as to give rise to an investigation by the All Party Parliamentary Group on Excellence in the Built Environment. I gave evidence to the enquiry in which I referred to the health problems of the stress of faults in new housing and the difficulties often experienced in getting them put right and the cost of obtaining redress, to the high tolerance of error in the construction industry, to certain deficiencies in the civil law and to the inadequacy of many

warranties. Although the substantial majority of new homes are satisfactory, it would be shocking if this were not the case. It is not sufficient that 90% of new homes are without serious problems – the figure should be 99.9% or even higher. We would not board an aeroplane on the assurance that it had a 90% chance of not crashing. The APPG recommended the establishment of a New Homes Ombudsman.

Housing Enforcement

The Housing Standards Team consists of 3 Environmental Health Officers and 2 Enforcement Officers dealing with a range of issues across the borough. The team predominantly deal with disrepair in the private rented sector. The team also have powers to deal with owner occupied properties where they are causing a nuisance to others.

The team are responsible for dealing with;
- Disrepair in the private rented sector
- Housing of Multiple Occupation (HMO) licencing
- Filthy and Verminous properties
- Empty Properties
- Immigration Inspections
- Disrepair of owner occupied properties that are effecting others

Legislation is available to enable landlords to gain possession of their property by serving notice on assured shorthold tenants, without needing a justification. Many tenants feel insecure about their tenancy and are unwilling to contact the Council about property conditions as they fear they will be evicted.

Where tenants do make contact there is a range of legislation available for officers to implement.

The Housing Act 2004 is the primary piece of legislation used to improve conditions within private rented properties. The Act introduced the Housing Health and Safety Ratings System which ensures properties are safe to live in. This involves carrying out inspections based on 29 hazards. These hazards include; Excess Cold, Fire Safety, Electrical Safety, Falls, Personal Hygiene etc.

Where a tenant has a problem with their rented property they access advice on line and a standard template letter is provided on the Council webpages for tenants to use to contact their landlord. However, many tenants contact the Service either after unsuccessfully resolving their issues or instead of making contact themselves.

Where a tenant has a problem that they are not able to resolve, a property inspection is carried out. Following the inspection attempts are made to work with the Landlord to resolve any issues informally, unless the inspection reveals conditions that are an emergency.

Where a problem fails to be resolved informally, or negotiation has failed, the Housing Act 2004 offers a range of enforcement options, including:
- Improvement Notice
- Emergency Remedial Action
- Prohibition Order
- Emergency Prohibition Notice
- Hazard Awareness Notice

Other legislation available to assist tenants includes:
- Environmental Protection Act 1990
- Prevention of Damage by Pests Act 1949
- Building Act 1984
- Public Health Act 1961

Officers are working will colleagues across Greater Manchester in order to maximise the costs coming back to the council. Landlords are made aware that non-compliance leads to the Authority claiming back costs and this message needs to be clear so it acts as an incentive for landlords to improve the standard of their properties without the council having to get involved.

The Housing Standards Team use powers available to them in all the above pieces of legislation to help protect tenants and to ensure that landlords who provide rented accommodation in the borough supply a good quality service to their tenants.
Over the past 5 years the information shared with residents of Stockport has improved, the Service has become more accessible and tenants are more aware of their rights. This has led to has led to an increase in the amount of enforcement action taken by the team.

Publicising this enforcement action spreads the message amongst the Landlord Community that Stockport will not tolerate poor standards in rented accommodation.
In addition to prosecuting rogue landlords, charges have recently been introduced in relation to service of notices with Stockport currently charging £300 per notice. Officers are working with colleagues across Greater Manchester in order to maximise costs coming back to the Council. Landlords are made aware that non-compliance leads to the Authority claiming back costs. It is important that landlords understand that Stockport will not tolerate substandard accommodation

Year	Number of Disrepair complaints	Notices served	Prosecutions	Total Fine
12/13	770	10	0	0
13/14	645	48	1	£2,500
14/15	547	33	2	£5,000
15/16	508	118	3	£21,000
16/17	588	163	2	£20,434.95

The Housing & Planning Act 2016 introduced additional powers for Local Authorities to address rogue landlords.

A civil penalty can now be an alternative to prosecution for certain offences under the Housing Act 2004. These include failure to comply with certain notices and offences in relation to licensing of HMO's. The maximum penalty is £30,000. Officers across AGMA have worked in partnership to produce a policy which ensures civil penalty fines are consistent across Greater Manchester. When considering whether to serve a civil penalty rather than prosecute regard is had to the seriousness of the offence, the harm to the tenant and the impact on the wider community.

The Act also provides power to apply for banning of landlords or letting agents for a minimum of 12 months. Banning Orders would be put in place when rogue landlords commit serious offences against tenants. This could include failing to carry out work required by the council to prevent a health and safety risk to tenants, threatening tenants with violence, or illegally evicting them.

If a Landlord or Property Agent is subject to a banning order they could be prevented from letting or managing a property indefinitely. Their name would also be included in a national database of rogue landlords and property agents.

Regulations have yet to be published by the government but are expected imminently.

Responsibility will be given by the Secretary of State to Local Authorities to maintain a Rogue Landlord and Property Agent's database, containing those with Banning Orders, or those committing Banning Order offences. These powers are also expected imminently.

In 2006 the Government introduced a Mandatory Licencing Scheme for Houses in Multiple Occupation that consist of three storeys, with 5 or more tenants, sharing some amenities. This power was introduced to improve conditions and management standards in higher risk residential accommodation. Changes to HMO licensing requirements are expected by the end of the calendar year. The revised legislation will remove the storeys element, so any property housing 5 or more tenants who share amenities will require a licence. This will lead to a huge increase in licensable properties.

A review of the service has been undertaken to identify how a more targeted approach can further increase the positive impact interventions the Council has on the private rented sector.

The revised proposed approach will involve:

a.   _Tenant Self Help_ - Improved information available for tenants to enable them to help themselves in some cases. Improving information and advice available on Council web pages will enable tenants to resolve their own problem in some cases, giving the Housing Standards Team time to focus on key cases and take on more proactive work.

b.   _Informal and Quick Case Management Complaints_ – A system where tenants cases that do not fall into category a, are dealt with quickly and informally. Systems will be put in place to enable officers to deal with the more compliant landlords as soon as made aware of a problem.

c.   _Formal and Charge_ – The most difficult, worst cases where our efforts are required will be subject to formal action, civil penalties, prosecution on a more frequent basis.

Formal systems will be put in place to deal more quickly with Landlords who are not compliant and own properties in poor conditions

In addition the team will use GIS software to identify hotspot areas within localities. This will enable resources to be targeted efficiently in order to carry out co-ordinated enforcement activity to tackle nuisance, environment and housing issues. All this work will aim to further increase standards in the private rented sector and in localities as a whole.

Housing and Care

Housing can contribute to care by
- extending healthy life expectancy,
- facilitating independent living,
- preventing and reducing hospital admissions, length of stay, delayed discharges and readmission rates[12],
- avoiding loss of mobility and increased disability,
- falls prevention,
- preventing Winter Deaths,
- supporting people with dementia,
- enhancing mental well-being; and
- prevention of hospital admission and the speeding up of discharge through provision of appropriate accommodation

In addition to meeting the demand for housing for older people, there are other groups who require specialist or supported forms of housing, including those with physical, sensory and learning disabilities. There is also demand for housing for those with additional needs transitioning from the family or other housing as well as housing for people who are at risk of homelessness, fleeing domestic violence or suffering from mental health or other potentially complex issues. Finally, there are also a percentage of homes required to be built to wheelchair design standards. It is desirable that as far as possible housing takes account of the principle of universal design, that it should be usable to as great a range of people with frailties and disabilities as possible so as to minimise the need for future adaptations

Older People
The demographic most impacted by housing and care at both a national and Borough level is undoubtedly older people, who are active users of health care. Their state of health and dependency has serious implications for the National Health Service and nationally the older population is increasing. By 2035, projections show[13] the number of people aged over 85 will be almost 2.5 times larger than 2010, reaching 3.5 million and accounting for 5 per cent of UK's population in the same period. Those aged over 65 will account for 23 per cent.

Between 2014 and 2025 the number of people within Stockport aged over 65 is projected to increase 19 percent from 55,600 to 66,500, and of these around 11,000 will be over 85 – a 49 percent increase compared to the 7,400 recorded in 2015[14]. This would mean one in five

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[12] NHS England, 'Quick Guide on Health & Housing'
[13] Older People: UK National Statistics Publication Hub
[14] *Stockport 2016-2019 Strategic Joint Needs Assessment*

people in the Borough would be over 65, with over half of having some form of health problem or disability and with 20 percent managing two or more conditions[15].

The impact upon health and social care authorities of this shift in population profile is considerable, for example with increased hospital admissions and the need for residential care placements. The key is to increase 'healthy life expectancy' as far as possible, something which can be facilitated by appropriate housing combined with the right care, support and other services.

As people grow older their housing needs can change. Older people spend between 70 and 90 per cent of their time in their home, thus a warm, secure environment that meets individual requirements is crucial. Over the next few decades, there will be a marked increase in the number and proportion of residents aged 65 and over which is expected to increase by 43.6% from 56,700 in 2015 to 81,400 in 2037.

Diversifying the housing market can help the needs of older people in the short, medium and longer term. A significant number of older people would like to remain in their existing homes however consultation and research has demonstrated that this is sometimes because no other choices exist. What independent housing provision specifically designed for older people exists is limited in terms of quality and choice. This is both in terms of type, tenure and affordability. Traditional sheltered accommodation (Category 2), the largest "retirement home" living offer in the social sector, was built at a time when grant rates were relatively generous. It is now often dated and difficult to let precisely because it does not always meet people's current aspirations. Accordingly a comprehensive review of a number of sheltered schemes has led to some of them being either demolished and redeveloped or modernised or remodelled.

The private market is also constrained by date, space standards and/or affordability issues.

There are around 1132 units of retirement housing for rent in Stockport, plus 1190 units of sheltered housing. Social housing providers also have 521 units of retirement accommodation for sale, whilst private providers have 662 units for sale.

Extra care housing which offers age friendly alternatives to forms of residential care is also limited in terms of size and availability. Provision needs to be increased.

This is an innovative form of housing which offers older people an attractive alternative to forms of residential and nursing care. Although not restricted to frailer older people, precisely to maintain an active community, it offers a form of housing with care on site enabling people to maintain their independence for as long as possible. A number of Extra Care schemes have been developed and now operate in the borough. Stockport currently has extra care schemes in Edgeley, Reddish, Marple and Heald Green. These are managed by a partnership between Stockport Council, Registered Providers – housing associations and Stockport Homes – and a contracted care provider. All the schemes consist of self-contained apartments and are available to rent, with a small proportion of shared-

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[15] *Ibid*

ownership. They range from remodelled former traditional sheltered housing through to new build provision with bistro, hairdressing and other communal facilities on site. These extremely popular schemes reflect market choices and range in tenure from social rent, market rent and shared ownership through to private market provision.

Disabilities
- There is a wide range of disabilities. Ideally mainstream housing would be designed with mobility-impaired and visually-impaired people in mind. However there is also a need for bespoke forms of supported housing for people with learning and other disabilities built to high specifications and standards. Housing developments such as Heys Court, Cherry Tree or Dawlish Avenue have proved enormously popular with residents and led to significant savings in the social care budget. Going forward however, there remains unmet demand for such accommodation, and work will continue to meet these needs although lack of clarity on funding makes this more difficult.
- Residential care is for people aged over 18 years old who are no longer able to remain living independently at home due to physical disabilities, sight or hearing loss, frailty or illness. There are currently 58 care homes with 2,351 beds for people aged 65 or over available in Stockport. In Stockport residential homes are all independently owned and managed. Although residents are not exclusively elderly, older people predominate in this housing type.

Dementia
An estimated 4,000 people in Stockport have dementia. Due to increased awareness and opportunistic screening more people are being diagnosed and being diagnosed early. Stockport currently has a diagnosis rate of 74% (Feb, 2017) and has the highest total number of people diagnosed across Greater Manchester due to Stockport's high prevalence. There is a significant deprivation profile for dementia in Stockport, with rates in the most deprived areas more than double those in the least deprived[16].
The 2017-2020 Stockport Dementia Strategy builds on Stockport's first dementia strategy (2010) and focusses on identified gaps. In particular there is a focus on improving dementia care in care homes, improving care provided in people's own homes and improving care for people with more advanced dementia living at home.

Social isolation
Social isolation is a major risk factor for almost all forms of poor physical and mental health, including dementia. The effect of loneliness and isolation on mortality is comparable to the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking (Holt-Lunstad, 2010), is associated with an increased risk of developing coronary heart disease and stroke (Valtorta et al, 2016) and increases the risk of high blood pressure (Hawkley et al, 2010). Experimental analysis suggests that 13% of the adult population in Stockport may be isolated, looking at three different factors namely: living alone, not participating in an organisation / group and not participating in volunteering. The analysis

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[16] Stockport Dementia Strategy

showed that those aged 65 and older, not in good health, or living in areas of high deprivation are more likely to have high social isolation scores.

Mental health and substance misuse

There are three short term rehabilitation housing schemes in Stockport for residents with enduring mental health difficulties, plus a dedicated ward at Stepping Hill for emergency admissions. There is also a small scheme run in partnership between Acorn Recovery and Stockport Homes to support ex-substance misusers through communal living and support, plus the H4 hospital discharge project helping reduce presentations at ED by homeless people. The prevalence of substance misuse and the cost to public services of the resulting healthcare, criminal justice and housing implications makes this an area requiring further resources.

Deprived Areas
There is a strong correlation between care needs and deprivation. Poorer people age more quickly and are far more likely to start to suffer ill health at an earlier stage in life – often when in their fifties[17]. People in poorer areas not only die younger but in their shorter lives experience more years of sickness. Hence the highest demand for care is experienced by those living in areas where social housing is the predominant tenure.

Independent Living
Many provisions are already available in the Borough for residents who want to remain in their own home but require some care and/or support to sustain this.

- Telemonitoring services enable older and vulnerable people to live independently through a range of sensor and equipment installed in their home, including GPS tracking for people with dementia, lifting services to avoid hospital admission and daily checks/reassurance visits to reduce social isolation. The largest service in Stockport is Carecall operated by Stockport Homes, which has almost 4,600 customers in 2017.
- Adaptations are provided through Disabled Facilities Grants or self-funded options. A range of equipment is available to help residents remain living safely and independently in their homes. In the financial year 2016/17, 209 adaptations were made within Stockport Homes' properties, with a further 225 for customers in other tenures.
- The Staying Put Scheme, managed by Stockport Homes on behalf of Stockport Council, helps older homeowners, younger homeowners on a low income, and people of any age and tenure living with a disability to live independently. It helps residents to access adaptations or carry out essential repairs and/or improvements. In 2016/17, over 95% of applicants for DFGs or Home Repairs Assistance (HRA) elected to use the SPS
- Stockport Homes' Housing and Care Options for Older People (HOOP) is a free service that provides advice, information and practical help with housing and care issues for people living in Stockport. It helps with advice with a range of issues including housing choices and options, care issues and finance.
- Adults Social Care currently delivers home care to 1510 people, representing around 15,700 hours per week. 1315 people are receiving direct payments (some of these will

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[17] *Providing Care for an Ageing Population* – 2017 GMHP

be personal assistants, community based and home care) and 138 people are receiving day care.

- Stockport Homes Housing Support Team gives short to medium term support to vulnerable people who are struggling to maintain their tenancy, frequently linked to mental health difficulties such as anxiety or depression. Officers primarily work with customers within Stockport Homes' properties, Registered Social Landlords or renting in the private rented sector. Support is provided with setting up home, and settling into the local community as well as to existing residents to successfully maintain their tenancies.
- In Stockport, Older Persons Activities Coordinators linked to The Prevention Alliance amongst other organisations provide regular opportunities for older people to get out of their home and meet others for social events, trips and food.
- A significant strand across the Stockport Together Programme is the total Intermediate Tier offer. This broadly aimed at increasing home based delivery and reducing the needs for intermediate tier bed capacity. A clear priority is a shift from step down to increased step up provision. Two Support at Home services have recently been commissioned, which are flexible re-ablement type services created as a result of piloting step up and step down services during Winter 2016. The service was doubled, with two components: Better at Home (280 hours) providing step up support and the WIRE (280 hours) providing step down support, differentiated to ensure that a proactive as well as reactive service can be provided.

Future Challenges - Hospital discharge and lack of short-term placements for step up/down accommodation, especially for older people.
This is to support timely, targeted use of re-ablement and rehabilitation that is focused on enabling and supporting independence, speedier discharge of people from hospital and in the longer term aims to prevent, reduce and delay the need for residential and nursing home beds. The commissioning of bed based services will need to have due regard for optimising patient flow, such as supporting timely hospital discharge, 7 days admissions, minimising length of stay in the intermediate tier beds and no preventable delays in discharges from the home. The future models of bed based capacity will need to be flexible and innovative solutions to people's needs and circumstances with focus on 'home first'. However, this will need to be balanced with the needs of people presenting with complex needs that can't be met in the person's place of residence. Crucial to achieving a responsive Intermediate Tier service in care home provision is the use of 'trusted assessors' and a culture of trust that supports the external service at times of crisis or concern. Step up accommodation is in shorter supply than step down, and as such more focus could be given to this in future.

Future Challenges - Lack of planning by older people – presenting in crisis, forced to make unsuitable decisions
Older people are frequently unaware of the housing and care options open to them, or do not wish to consider moving from their current accommodation until a move is forced upon them by declining health or a serious incident. A wider range of options is needed, particularly ones which allow the person to remain in their own home living as independently as possible for as long as possible and publicising these options more widely

to both older people and their relatives/carers. The shortage of high quality domicillary care and care homes is a contributory factor to these shortages.

*Future Challenges - Lack of available and affordable land for viable new buil***d**

Stockport has relatively high house prices and a lack of available land for new build. Existing housing stock does not always meet the aspirations of residents needing care, whether this is the unpopularity of bedsits or the lack of specialist schemes for those with particular care needs. Remodelling existing schemes to better meet demand, as well as working creatively with financial models to develop viable new schemes is needed to address these issues.

Housing and the Creation of Communities

In the full version of the 21st Annual Public Health report published in 2012/13 and its on line revisions and updates for the subsequent reports I have discussed the need for community resilience and the importance of social networks. (Ref:21st Annual Public Health Report for Stockport)

The way in which housing is developed will clearly play an important role in facilitating or hindering the development of communities. Streets can be developed in a way that promotes social action, if treated not primarily as a road for benefit of car users but as a space for all people to meet and be active. Tranquil sitting areas and recreational spaces can also help mould a community together. In a large housing development a community hub should be provided.

Interest is increasingly turning to new forms of housing development in which each house has a minimum number of rooms but extensive shared facilities, including spare bedrooms and recreational rooms housed in a communal building. No such settlement currently exists in Stockport but the benefits of this type of housing in developing communities needs to be promoted.

Demand for housing in the UK is still rising. Yet the economic downturn and upheavals in the public sector means the future of many house building programmes is now uncertain. Past experience shows when housing demand and financial pressures are high, the social aspects of communities are often overlooked.

In addition although much is known about what makes homes physically and environmentally sustainable, much less is known about the social aspects of what makes communities thrive.

Agencies and organisations involved in developing new housing need to balance a great many requirements and the specific needs of local residents for many years to come, producing sustainable outcomes for local people in the long term.

New building in Stockport needs to be set in the context of lessons learned from the building programmes of the of the past and the regeneration work that has taken place across the country over the last two decades.

Future communities, a collaboration between home and communities Agency, Local Government Association and the Young foundation stress that successful new communities will be built by a partnership of practitioners working with future and existing residents identify 10 ingredients of success http://www.futurecommunities.net/.

Put Residents in control
• New settlements provide a huge opportunity to govern communities differently - with residents in command of what happens locally

Early engagement of existing and future residents
• The conversation between people who will live in the new settlements and those involved in building them should start well before the first brick is laid.

Facilitate social networks
• Communities where many residents have strong social links with others living nearby and where people are more likely to get involved in community orientated activities tend to be places with higher levels of resident wellbeing

Choose a stewardship approach
• Planning for the long term management or 'stewardship' of an area has been found to contribute significantly to the popularity and success of new communities in the past

Community ownership and management of assets
• Transferring assets, such as community centres or parks to local people can give communities a greater opportunity to shape the way these assets are run to ensure that they provide the maximum benefit to local people

Maintain high quality public space
• The quality of the local environment is a key element in what makes somewhere a good place to live

Promote environmentally friendly behaviours
• Meeting the UK's ambitious targets to reduce CO2 emissions by 80 per cent by 2050 will require some radical changes to the way we live

Achieve good design
• New developments should provide communities with homes that are comfortable and well matched to their needs, and to their future needs as they grow older, and a public realm that is safe and inviting.

Economic development
• Economic sustainability is a key ingredient of the overall sustainability of communities.

Community builders lead this

• Local authorities have a strategic role as place-shapers in their area. This will mean that in most cases they will take a lead role in driving forward the creation of new communities.

There are national examples on future communities website.

Social Housing Providers, the Council and some faith groups have invested in a number of community development programmes to help build and sustain communities in Stockport, particularly in areas of social housing were the population are more adversely affected by the wider determinants of health. Recent examples include Stockport Homes work to develop community initiatives in Edgeley and Mosscare's work to develop a Bredbury community hub.
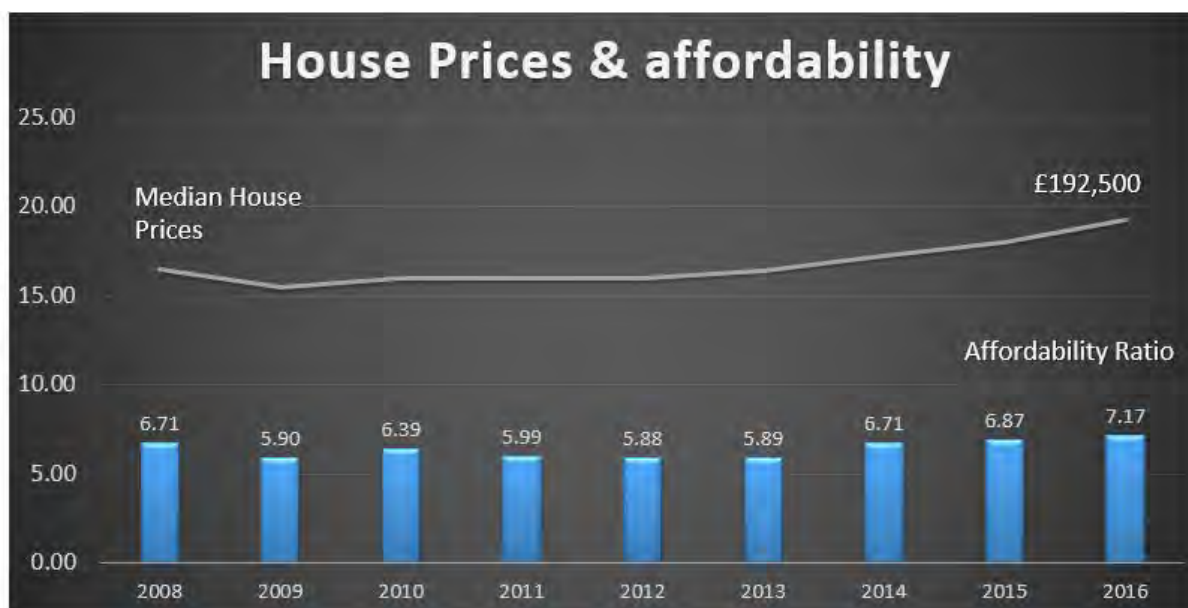
Greenspace Compatible Development

Greener housing is discussed in the chapter on Green Infrastructure.

Affordable housing

Stockport forms part of a much wider housing market area that encompasses most of Greater Manchester. The Strategic Housing Market assessment that accompanies the GMSF indicates that whilst there are distinctions within the area, all of Greater Manchester effectively operates as a broad housing market. This means that housing need generated within one district may legitimately be met by homes within a neighbouring district. As a consequence the correlation between housing need, housing supply and housing affordability is a complex one.

What is apparent is that the ratio between house prices and earnings is significant – and it is widening.

House Prices & affordability

Median House Prices

£192,500

Affordability Ratio

Year	2008	2009	2010	2011	2012	2013	2014	2015	2016
Ratio	6.71	5.90	6.39	5.99	5.88	5.89	6.71	6.87	7.17

The table above shows that by 2014 the affordability ratio had returned to its pre-recession level – due mainly to a steady increase in house prices in recent years. The Government has signalled that where the affordability ratio exceeds a factor of 4, then compensatory measures may need to be taken in terms of housing provision. Some people will clearly be able to obtain housing in the more affordable parts of the Greater Manchester Housing market – but that solution will not be suitable for all. Accordingly for those people who have strong social or economic reasons to live in the Borough, the affordability of housing to purchase is likely to be an ongoing problem.

One of the potential consequences of higher house prices is the creation of 'hidden' households – households that otherwise might naturally form, but are prevented from doing so by economic circumstances. Most commonly this might be a younger couple living in the parental home of one of the partners – when ordinarily the couple would form a household in their own right. (A similar situation may arise in the context of other circumstances and relationships)

Across Greater Manchester the proportion of concealed families has increased significantly between the last two censuses. The likelihood is that this proportion will have further risen in the meantime.

Stockport's position is less prominent than in certain other Boroughs within the conurbation – but some of the difference can be accounted for by differing cultural practices amongst communities in each area.

Change in proportion of concealed families 2001 - 2011
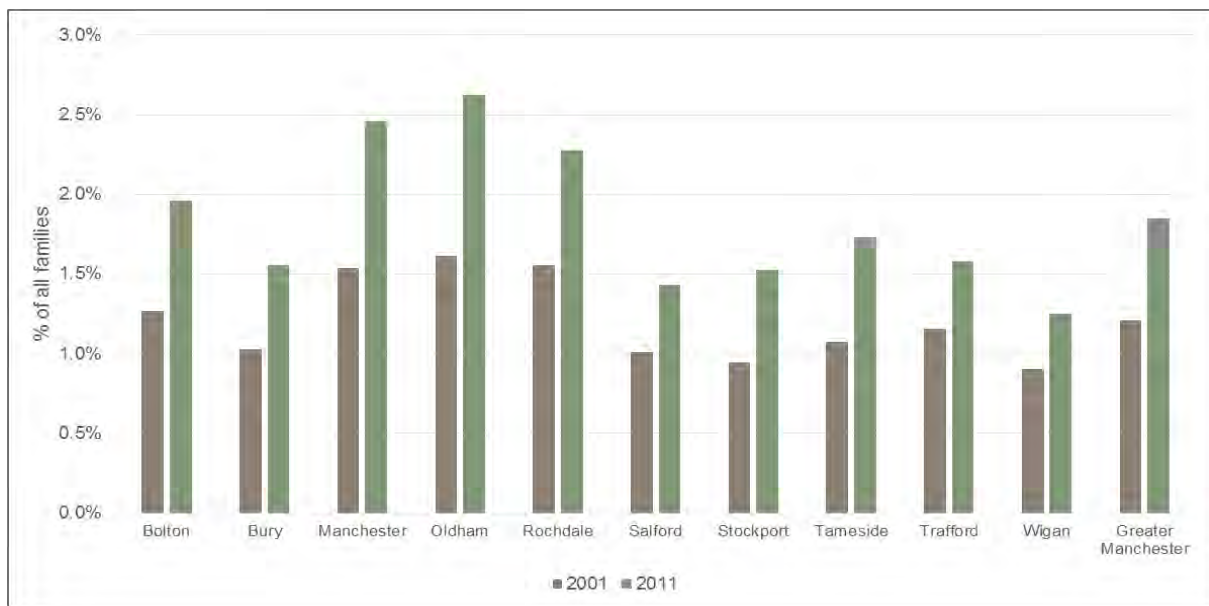
Source: 2011 Census

Homelessness

The health of people experiencing homelessness is significantly worse than that of the general population, and the cost of homelessness experienced by single people to the NHS and social care is considerable. A recent audit found that 41 per cent of homeless people reported a long term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population. Alcohol, drug and mental health problems are both the cause and result of homelessness in many cases.   This means that there is a small but significant group of people who have complex needs and very poor health in Stockport's hospital system, temporary housing schemes, in the prison system and on the streets or sofa surfing. This puts pressure on public sector services.

The Stockport Homeless Health Audit gauged the health needs of this population in 2016 and compared this with a prior survey in 2013. The sample size of 40 is small, but is also a substantial portion of the homeless population in Stockport.

The survey shows that the homeless in Stockport are people with combinations of health problems, which in many cases would intensify the difficulty of dealing with a given health issue. The relationship between their health and housing situation would also be one of compounding difficulties; over half responded they are permanently unable to work due to health issues. As might be expected mental health, physical health and substance use difficulties remain high and secondary care use remains high but more people are **registered with GPs and dentists, (**92.5% and 42.5%) this reflects positive work undertaken by services and the voluntary sector in Stockport that have prioritised getting people registered.

Homelessness is rising nationally and in Stockport. Stockport is committed to preventing homelessness for all groups, reflected in decreasing levels of non-priority homelessness and

rising levels of 'homelessness relief' – rehousing over 500 people since 2012 despite there not being a statutory duty to do so.

In 2016/17 in Stockport there were 238 statutory homelessness acceptances against 491 presentations for homelessness. A significantly larger number (1745) of cases were prevented from becoming homeless as result of intervention and support from Stockport Homes as shown in the following figures

Stockport Homes provide the following statistics in 2016/17

Homelessness prevented	1745
Homeless presentations Of which	491
• considered requiring Full Duty	238
• Intentionally homeless	21
• Not in Priority Need	221
• Not Homeless	3
• Ineligible	8

The main reasons for homelessness from 2009/10 onwards have been consistent each year: domestic abuse and termination of assured shorthold tenancy.

Further information about the homeless needs in Stockport and the homeless prevention strategy can be found here

https://www.stockport.gov.uk/housing-strategies-and-documents/preventing-homelessness-strategy

Based on the numbers of lettings made previously, these two changes alone could see up to 200 young people each year affected by affordability issues.
In 2016/7 there was an average of 61 children in temporary accommodation at any one time. (43 in Stockport Homes Temporary Accommodation and 21 in other community accommodation.)

Homelessness services in Stockport are recognised at a national level as one of the first ten in the country to achieve the Government's Gold Standard. The Gold Standard Challenge is a peer review scheme designed to help local authorities deliver more efficient and cost effective homelessness prevention services. It has been designed to support local authorities to deliver effective and efficient services that prevent and tackle homelessness effectively. By achieving the 10 Local Challenges set out in the Gold Standard, Stockport Homes and the Council have demonstrated that they have comprehensive prevention services in place for all customers, and are dedicated to continually improving these.
The Homelessness Reduction Act 2017 amended the legal framework around homelessness, and will come into effect in April 2018. This will place a requirement upon local authorities

to intervene at an earlier stage to try and prevent people from becoming homeless, and requires more structured and on-going support to find and retain accommodation. The Act also places greater responsibilities on local authorities and partners to help relieve homelessness where it does occur. It seeks a partnership approach with people to focus on positive outcomes, and recognises that each household will need different levels of assistance.

In October 2017, the government confirmed that £3.8m would be allocated for the GM Homelessness Prevention Trailblazer Programme. The aim of the programme is to develop a GM-wide homelessness prevention approach in order to improve homelessness prevention outcomes and develop an effective response to homelessness in advance of the Homelessness Reduction Act implementation. The programme funding is for a period of 2 years and covers a number of themes, including Housing First, social lettings and health and housing. A further Government funding of £1.8m for GM has also been made available for a 'Social Investment Bond', focusing upon the most entrenched rough sleepers, with additional resources being sought following an assessment of likely levels of demand.

There is a widespread perception that the introduction of Universal Credit and the freeze on Local Housing Allowance rates for private renters is increasing the number of people made homeless.

The numbers who are actually sleeping on streets in Stockport is relatively small approximately 10 at any time, according to Stockport Homes; this was the confirmed figure in the most recent annual estimate returned to DCLG, which provides a "snapshot" of rough sleepers on given night . Stockport Homes works continually with people sleeping rough, including visiting all reported sites within 24 hours to identify people and offer accommodation and support. According to the Wellspring this figure would be higher (about 40) if it were not for the availability of their organisation and there are larger numbers (about 100) who are sofa surfing.

There are others frequently moving from tenancy to tenancy which provides insecurity and stress and disrupts life especially education and relationships leading to stress, isolation and under attainment. These numbers are hard to estimate, 1,561 people approached the Housing Options Team for advice on their housing situation in 2016/17. This will have been for a variety of reasons, including moving from place to place and also having accommodation that is at risk, e.g. due to receiving notice from their landlord.

There is a continuing need for people who are skilled in helping people navigate the system.

Stockport, Trafford and Oldham are developing a housing first scheme for people who have experienced domestic abuse. This is a model where people are provided with housing on an unconditional basis and provided with intensive support. More likely to sustain tenancies than under previous system whereby support withdrawn relatively quickly after the tenant moves in. This project will also provide advice and support to people who are fleeing domestic abuse but have no recourse to public funds, a group which are not eligible for assistance under homelessness legislation.

. H4 project picks up   frequent attenders at A+E who are homeless or have drug and alcohol problems and supports them to access accommodation upon discharge, and future long-term housing solutions. Since launching in May 2015 H4 Hospital has:
- Worked with 358 homeless people in total
- Supported 272 people to sign up with a GP, Dentist or other primary care professional as required
- Reduced the use of crisis services for 82% of those identified as "frequent flyers"
- Supported 174 people who were threatened with homelessness to access accommodation upon discharge

MARS (multiagency adults at risk) identify and co-ordinates work with adults at risk.

At Greater Manchester level a Social Investment Bond will target entrenched rough sleepers with multiple complex needs. Other GM strategic work includes:
- Establishing dedicated advice hubs for rough sleepers
- Increasing prevention options available, including Social Lettings
- Housing First
- Ensuring customers get a consistent service across GM

The Wellspring is a*n independent* resource centre for homeless and disadvantaged people. It provides one to one support, referral into housing, free food and drink, educational and health services, computer courses, showers clean clothing, social space and activities such as walking groups. Tt is open 365 days a year from 10 am – 2 pm and Monday to Thursday evenings from 5 pm – 8 pm.

Stockport Council and Stockport CCG commission a health service for the homeless and insecurely housed, a GP and an Advanced Nurse Practitioner (ANP) provide drop in appointments at the Wellspring.   Between October 2016 and Sept 2017 the service treated on average 63 different people and 96 different treatment episodes a month. Each of these episodes might cover several different health needs therefore appointments are generally relatively long,   additional contacts and informal follow up often occurs between recorded appointments.

Asylum seekers are housed through Serco in Northwest whilst waiting for their application to be processed. Numbers in Stockport are small.   If given leave to remain they have 3 weeks to find somewhere to live.   Stockport homes support any that want to live in Stockport to achieve this.

Asylum Seekers who have received 'Leave to Remain' / Refugee Status and presented themselves to Stockport Homes as homeless:

	Full Duty Accepted	Not in Priority Need	TOTAL
2016/17	10	4	14
2015/16	9	3	12
2014/15	8	1	9

Refugees have the same rights and responsibilities as other citizens so can access housing by the same routes. Refugees who come to Stockport via the specific Refugee Protection Programmes (approximately 5 households a year) are provided with housing for the first year and supported by Stockport Homes to find permanent accommodation subsequently.

Nomadic Lifestyles

Poor living environment, insecure accommodation, and the constant prospect of being 'moved on' is a major contributor to poor health[18] of gypsies and travellers.
However health does not always improve for those people when obliged to live in bricks and mortar.
Gypsies and Travellers are amongst the ethnic groups with the poorest health and lowest life expectancies (10-12 years shorter than the general population). They have the highest levels of perinatal mortality and frequent mental distress. In addition to poor accommodation, discrimination, bereavement, low literacy, poor access to health information and care are recognized contributory factors.
The recognised health and wellbeing issues for gypsies and travellers include:

Mental Health	3 times more likely to commit suicide - Twice as likely to feel depressed - Higher levels of domestic abuse (between 60% - 80% of women experience DV). - Bereavement - Impact of discrimination
Maternal Health	- Disproportionately represented in maternal mortality data - Higher neonatal death rate 17% of Gypsy and Traveller mothers have experienced the death of a child compared to less than 1% of the wider population.
Physical Health	- Lower life expectancy (by 10-20yrs) - Low rates of immunisation - Susceptible to Measles outbreaks 3 times more likely to have chronic cough or bronchitis - Approx 38% have long term illness
Lifestyle & culture	- Poorer diet - Smoking prevalence of 47% (c/f 18% in gen population) - Lower levels of physical exercise - Unaccustomed to appointment systems - Distinct gender roles - Lower use of mainstream health services - Poorer uptake of preventative healthcare - Low literacy

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[18] Greenfields M, Brindley M. Impact of insecure accommodation and the living environment on Gypsies and Traveller Health. National Inclusion Health Board / the Traveller Movement. 2016

An estimated 0.6% of a given population is of Gypsy & Traveller ethnicity. Increasing numbers live in houses or permanent sites - approximately 2/3. Stockport has no permanent site for Gypsies, Travellers or Travelling Show People. Neither does it have an identified transit site. Travellers who need or want to encamp in Stockport are therefore obliged to do so on unauthorised sites. This is costly for the Local Authority, contributes to poor community cohesion and exacerbates prejudice and discrimination and hinders the potential for access to better health

The Gypsy and Traveller Accommodation Assessment (GTAA) of 2007[19] estimated a need for 35 pitches in Stockport. Subsequent to the revocation of the Regional Spatial Strategy, for which the GTAA was undertaken, AGMA agreed that the requirements and provision recommended by the inspector should be implemented[20]. For Stockport this meant providing 1 transit site of 5 pitches and 3 or 4 other permanent sites in the subsequent 5 - 15 years. A consultation process was started in October 2011 but no sites were developed before another GTAA was undertaken in 2013.

This GTAA published at end the of 2014 highlighted a shortfall of 34 pitches 2014/15 – 2019/20 across Greater Manchester for Gypsies & Travellers (p.110[21]) and 139 plots for Show People

Specifically in Stockport there is an estimated need for 9 transit pitches plus 5 pitches for Show People

Recommendation – strategic and proactive planning in individual boroughs but also strategically across GM

The number of unauthorised encampment varies from year to year. In 2011, Stockport had one of the highest averages in Greater Manchester[22].

Table 9.8(b) Summary of unauthorised encampments reported in Stockport 1st April 2010 to 31st August 2013	
Total unauthorised encampments	34
Total caravan days (2013 data)	1,039
Number of months (2013 data)	8
Average caravan days each month	130
Average caravan days each year (2013)	1,039

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19 Affordability Research Communities 4. Gypsy and Traveller Accommodation and Service Delivery Needs in Greater Manchester – 2007/8

[20] Broyd I. (Inspector appointed by the Secretary of State for CLG). Report to Stockport Metropolitan Borough Council. Feb 2011

[21] Brand S. Greater Manchester Gypsy and Traveller Accommodation Assessment. Arc4. December 2014

[22] Strategic Statistics Division. Gypsy & Traveller caravan sites provided by Local Authority and registered providers in England. CLG. July 2011

Average no. caravans	12
Average duration (days)	9
Median no. caravans	12
Median duration (days)	9
Range of number of caravans	1 to 18

Based on the above data, GTAA suggests that nine pitches (accommodating 2 vans each) would have been sufficient to accommodate these unauthorised encampments. It also suggests these might be provided as part of a Manchester-wide approach to transit need. Show People have different accommodation requirements from gypsy and travellers and there is an identified need for additional sites for this group. The GTAA recognises a shortfall of 5 plots in Stockport.

The GTAA emphasises the role and responsibility of Local Authorities and provision of sites, "Local authorities have a legal duty to provide emergency accommodation within their own areas if Travellers present themselves in that area. Whilst a Local authority does not have a duty to find an authorised pitch or site they are expected to facilitate the traditional (Traveller) way of life. A number of other requirements[23], in relation to welfare of children, access to essential services and right to private and family life, make it important that local authorities seek to provide sufficient pitches in their own area to reflect current and meet possible future transit needs".
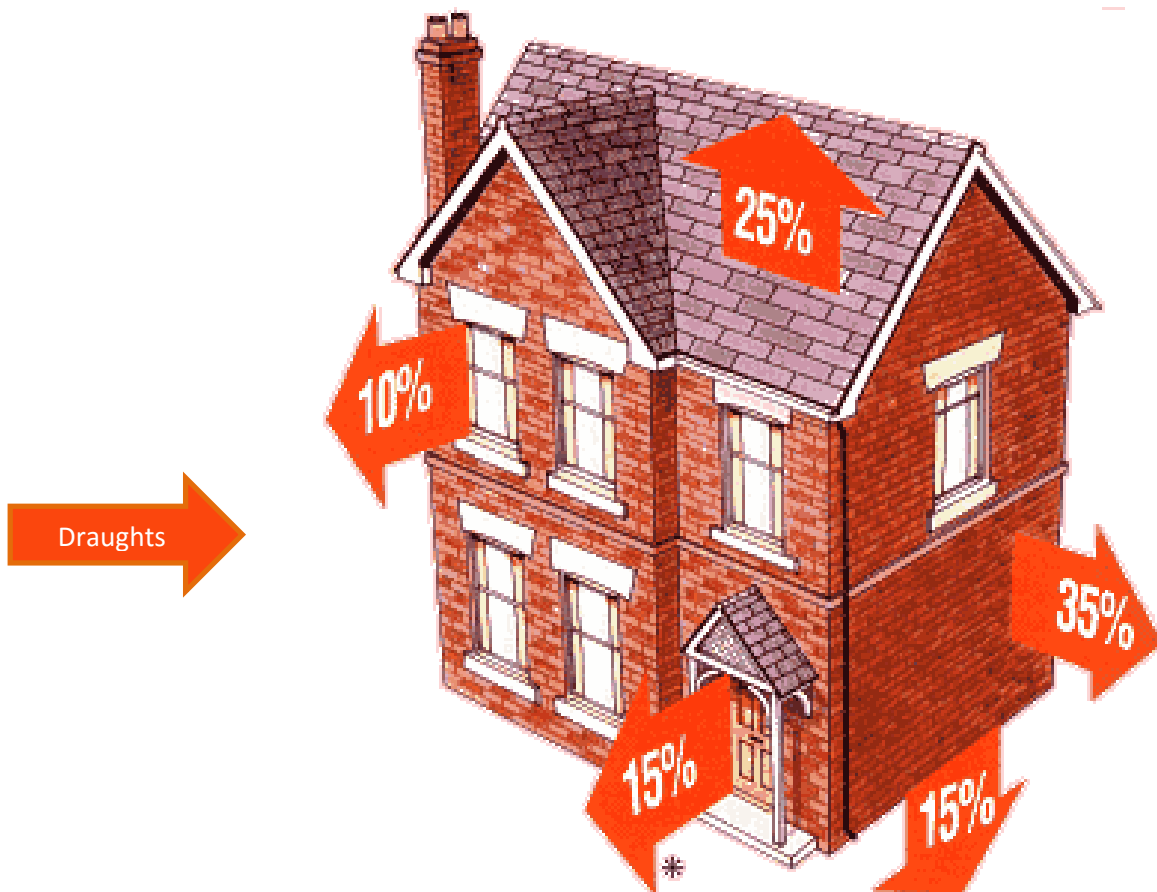
Affordable Warmth

How heat is lost in the home

Most heat is lost through the roof and walls

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[23] These are set out in a number of acts and regulations, including The Housing Act 1996; The Criminal Justice and Public Order Act 1994; and The Human Rights Act 1998

What can you do to keep your home warm?

Insulation – loft, cavity controls

Draught-proofing

Improved heating system /

Lifestyle changes

Check those bills

Fuel switching

Smart meters remove the need for estimated bills

Fuel poverty in England is measured by the Low Income High Costs definition (LIHC), which considers a household to be in fuel poverty if:

- They have required fuel costs that are above average (the national median level).
- If they were to spend that amount they would be left with a residual income below the official poverty line.

This has replaced the previous definition of a **fuel poor** household as one which needs to spend more than 10% of its income on all fuel use and to heat its home to an adequate standard of warmth. In England, this is defined as 21°C in the living room and 18°C in other occupied rooms.

	10% definition		Low income, high cost	
	No. of FP households	*% of FP households*	*No. of FP households*	*% of FP households*
England[1]	2,615,000	11.6%	2,502,000	11%
Scotland[2]	845,000	35%	*	*
Wales[3]	291,000	23%	132,000	10%
Northern	294,000	42%	*	*

	10% definition	Low income, high cost
Ireland [(4)]		

Figures relate to 2015, published by BEIS June 2017

Figures relate to 2014, published by the Scottish Government December 2015

Figures are projected for 2016, published by the Welsh Government 2016

Fuel Poverty – the perspective

- High rate of EWDs and morbidity issues in general
- Mental health and social well-being
- Social isolation

The 2013 Hills' Review concluded that fuel poverty is a distinct problem and a concern from at least three different perspectives

- Unequal ability to convert cash to warmth
- Pushed into poverty by high costs
- Poor pay more – Pre-Payment Meters (PPM)

- Capital investments out of reach for some
- Potential obstacle to carbon mitigation policy delivery, especially where costs go on bills

The key drivers behind fuel poverty are:
- The energy efficiency of the property (and therefore, the energy required to heat and power the home)
- The cost of energy
- Household income

19.7% of all households living in properties with the lowest energy ratings (E, F or G) are fuel poor – they make up 36.9% of all fuel-poor households. This is compared to only 3% of households that live in properties with the highest energy ratings (A, B or C) – they make up just 7.8% of all fuel-poor households.*

21.3% of households in the private rented sector are fuel poor – they make up 37.6% of all fuel-poor households.

79.1% of households in fuel poverty are classed as vulnerable, that is one containing children, the elderly, or someone with a long-term illness or disability.*

* Source: Department of Business, Energy and Industrial Strategy fuel poverty statistics, detailed table 2017, England. National Statistics

2.35M (10.4%) households in England were living in fuel poverty in 2013.[24] The calculated total fuel poverty gap per household in fuel poverty is £405 (based on the Hills definition of fuel poverty).[25]

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[24] Source: Annual fuel poverty statistics report 2015, DECC and National Statistics.

More than 1 in 5 households in Greater Manchester are in fuel poverty.[26] Greater Manchester schemes assisting fuel poor residents, for example Warm Homes Oldham have significant evidence to show the impact of cold homes on health and health service. Oldham CCG has conducted their own analysis of the Warm Homes Oldham scheme: from a sample of nearly 800 people that were supported through the scheme. A&E attendances for the participants had gone down by 2% and emergency hospital admissions by 32%, with an estimated saving of nearly £40,000 to the CCG. Total GP appointments went down by 8% while the cost of drugs prescribed increased by 14%; this may be due to the patients better managing their conditions at home.[27]

Stockport Council has three key priorities in helping to reduce fuel poverty in the borough, these are:

     i. Improve awareness and understanding of Fuel Poverty by bringing together key partnership approaches.
     ii. Increase the energy efficiency of Stockport's housing stock.
     iii. Improve the effects on health relating to fuel poverty.

Stockport Council assists residents, working in conjunction with Greater Manchester Combined Authorities (GMCA) & energy partners for the installation of replacement or repairs to heating systems, loft & cavity wall insulation, fuel debt/arrears support and advice on renewable energy. Stockport Council also supports community groups and attends events to promote energy efficiency within the Borough. Notable activities in reducing fuel poverty by the Council are:

- Installation of EWI on Park Homes site
- Targeted promotion of GM/Eon Replacement Boiler and Insulation Scheme
- Raising awareness of fuel poverty issues amongst service users/general public
- Raise awareness amongst front line staff from partner agencies in order for them to make referrals for home energy improvements
- Working in partnership will local organisations such as housing providers, private sector landlords, voluntary and community agencies, to ensure the maximum number of residents can obtain up to date and accurate advice;
- Working with the health and social care sector to reach people most at risk of suffering from conditions exacerbated by the cold and reducing excess winter deaths;
- Targeted promotion of GM/Eon Replacement Boiler and insulation scheme.
- Area base/street by street identification for the Replacement Boiler and insulation scheme.
    In addition Stockport Homes has:
- Successfully carried out area based heating upgrade which when surveyed after 12 months, reduced residents fuel bills and overall electric costs
- Submitted planning application for a biomass depot

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[25] 'Reducing the Health Impact of winter': Dr Angie Bone (Head of Extreme Events and Health Protection, Public Health England.)
[26] http://www.agma.gov.uk/cms_media/files/7_annex_gm_fuel_poverty_paper.pdf?static=1
[27] Oldham Council: Affordable Warmth Update, Quarter 2 2014-15.

➤ Carried out PV installation and external wall insulation to thousands of council owned properties.

Partnership working has been embedded throughout the implementation of the Fuel Poverty Strategy. Coordinated action from a wide range of agencies and organizations has generated a strong partnership, which has been vital in delivering the aims and meeting the targets contained in the Strategy to tackle fuel poverty. Partners include (but are not limited to); Stockport Council, Public Health, Stockport ,Partner Registered Providers, Stockport Homes Ltd, Age UK Stockport, Stockport Citizens Advice Bureau/Welfare Rights, Stockport Local Assistance Scheme, Stockport Credit Union/Stockport Food Bank and GMCA (Greater Manchester Combined Authority).

Recommendations

- I congratulate Stockport Homes on its commitment to health and recommend that this approach continues.
- I recommend that in adopting targets for housing development we recognise the particular kinds of housing that are in need instead of simply assuming that the total will be met entirely by family houses of a conventional type. We should recognise in particular the need for affordable housing, the need for housing for young single people, the need for extra care housing and the need for particular market niches such as traffic free developments and cooperative communities.
- I recommend continued attention to housing quality, and a continued recognition of the importance of enforcement.
- I recommend that Stockport MPs and political parties support the APPG Report on Quality of New Homes and in particular the creation of a New Homes Ombudsman.
- I recommend a continued focus on the creation of communities, using the principles laid out in this report.
- I commend the Council and its various partners on their work on affordable warmth and I recommend this issue continues to have priority
- I recommend the designation of sites for travelling families
- I recommend that we explore the scope for residential development above retail and (where appropriate) industrial development
- I recommend joint funding of supported housing between Adult Social Care and housing providers, including remodelling of existing low demand accommodation to create more flexible options for step up and down accommodation, as well as commissioning of new build schemes in areas of highest demand.
- I recommend the Council and Stockport Homes explore the scope for increasing the extent to which new homes are designed in such a way as to minimise the need for future adaptations if occupiers become frail or disabled
- I recommend recognition of the significant role non-health providers can play in reducing hospital admissions and speeding up discharge, particularly for older people. This would support and enhance the existing intermediate care work prioritised by Stockport Together and emphasise the positive impact of partnership working in delivering outcomes for health commissioners whilst saving money through prevention.

- I recommend greater commissioning of specific support for dual diagnosis patients who struggle to sustain tenancies but are frequently unable to access the support they need to cope with both their mental health and substance misuse issues. This should include both floating support such as H4/Positive Engagement Officers and building on learning from successful more dedicated accommodation to support recovery, such as the Acorn project.
- I commend Stockport Homes for its proactive work in preventing people from becoming homeless and engaging people who are homeless and addressing the related health problems, resulting in Stockport Council being one of the first ten authorities to achieve Gold Standard for its homelessness and housing advice service and I recommend that a high priority continues to be given to avoiding homelessness.

This chapter was written by Stephen Watkins with contributions by Sarah Clarke, Ian O'Donnell, Tanya King, Alison Ricketts, Andy Kippax, Adrian Fisher, Jennifer Connolly, Janet Golding, Vince Fraga, Mark Fitton and Shamim Miah.

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

SECTION C: The major risk factors causing disease, death and disability

LEVEL 5

Additional Analysis

LEVEL 5 (ADDITIONAL ANALYSIS) SECTION C: THE MAJOR RISK FACTORS CAUSING DISEASE, DEATH AND DISABILITY

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.

C5.1 HYPERTENSION
- JSNA briefing - Long term conditions

C5.2   SMOKING

For help to stop smoking go to http://www.healthystockport.co.uk/

- JSNA briefing - Adult Lifestyles

C5.3 DIET

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

- Chapter 12 of the 17th report – Foresight Report
- Chapter 18 of the 18th report – Fluoridation
- JSNA briefing - Adult Lifestyles

C5.4 PHYSICAL ACTIVITY

For help taking more exercise try walking more and go to http://www.healthystockport.co.uk/ or http://www.lifeleisure.net/ or http://www.stockport.gov.uk/services/leisureculture/walkinginstockport/ or http://www.stockport.gov.uk/services/leisureculture/cyclinginstockport/

- JSNA briefing - Adult Lifestyles

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

- Chapter 6 of the 15th report – The Western Stockport Cycle Trunk Road
- Section 4.6 of the 16th report – Protecting Walking Routes : Effect of Pedestrian Impermeable Street Designs
- Chapter 12 of the 17th report– Foresight Report

C5.5 ALCOHOL

- JSNA briefing - Adult Lifestyles

For help with alcohol problems go to http://www.healthystockport.co.uk/

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

- Section 4.1 of the 16th report – Units of Alcohol

C5.6 WELLBEING

- JSNA briefing - Mental health and well-being

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

- Chapter 10 of the 16th report – Empowerment

C5.7 SAFETY AND HEALTH PROTECTION.

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

- Chapter 8 of the 15th report – Housing and Health