

**2nd JOINT STRATEGIC NEEDS ASSESSMENT
20TH ANNUAL PUBLIC HEALTH REPORT
FOR STOCKPORT**

SECTION A
THE STRATEGIC
VISION

**A1: THE STRATEGIC CONTEXT & THE
NEW STRATEGIC VISION (written 2011)**

A1.1 THE STRATEGIC CONTEXT

The strategic context of this report is as follows:-

1. The strategy adopted in 2006 and set out in the document called Volume 1 of the 16th to 20th Annual Public Health Reports for Stockport remains valid. This document is reproduced as chapter A2 of the JSNA.
The strategy identified 10 outcomes to be pursued and it set 29 goals as the method of achieving them. From these, five priorities were identified – major killers, obesity, sexual health, tobacco, alcohol. Later a sixth was added – mental well being.
2. We were concerned in 2006 about the need to create a Smoke Free Stockport. Our priority was legislation to ban smoking in public places. That legislation is now in place and smoking rates have declined. It is however clear that we are now tackling a problem of users who have become addicted and find it very difficult to give up. There is also an ongoing uptake of smoking amongst young people who see it as part of the transition to adulthood. Our priorities must now develop to tackle smoking cultures. California has achieved success partly by being willing to attack the legitimacy of the tobacco trade, labelling it as the commercial exploitation of a death-bringing substance in extremely hard-hitting advertisements and partly by reaching out to young people as prospective adults rather than as children.
3. We were concerned in 2006 about the question of whether an ageing population would age healthily or would give added years of ill health. In 2008 we wrote a special report on this subject. By that time the 2004 data for healthy life expectancy had emerged and we knew that in the first part of this century the gap between healthy life expectancy and life expectancy had narrowed. In the Special Report we drew attention to the importance of healthy ageing in reducing the care costs of an ageing population. We advocated that the NHS should be careful not to consign people prematurely to the label “old” and that we should aim to create expectations of a healthy old age. This report is reproduced as chapter A3
4. We were concerned in 2006 that inequalities had ceased to narrow. We looked into this and discovered that inequalities in age-standardised mortality had narrowed but inequalities in life expectancy had not. This could only mean that there was an increasing cause of death in young people. In our report to tackling this subject in 2008 we perceived this as being partly a blip in infant mortality and partly the emergence of the alcohol and obesity epidemics. This report is reproduced as chapter A4. For reasons which will become clear in the next few paragraphs we would now place more emphasis on alcohol.
5. We wrote about the obesity epidemic in 2007 and reproduce this in chapter A5. Obesity is a systems problem. It is due to an imbalance between energy intake in food and energy output in physical activity. The present epidemic has been brought about by declining physical activity. Active travel (walking and cycling for short journeys) is a potential solution.
6. Our perception of the alcohol problem has emerged strongly over the last five years. In our analysis of causes of inequality in 2006 we saw alcohol as one of the factors undermining our success in closing the gap in life expectancy. By 2008 we saw it as one of the factors affecting the adverse movements in

mortality in young women. In chapter A6 we reproduce the 2006 special report on alcohol followed by a postscript indicating the various analyses that have led our thinking to develop since. We now see alcohol as an established epidemic which, if it is not tackled, could lead to a public health disaster with falling life expectancy, children dying younger than their parents and, by about 2040, the huge cost burden of two generations entering dependency at the same time.

7. As well as data on trends it is also necessary to have regard to evidence of what works. The 19th Annual Public Health report was devoted to this subject and is retained here as chapter A7.
8. Decisions need to be made against the background of the severe financial difficulties facing the Borough Council and the NHS. A strategy for resource utilisation in the NHS was included in the 18th Annual Public Health report and is retained here as chapter A8.
9. The problems of recession have emerged since the last JSNA. The report that was written in response as part of the 18th Annual Public Health Report is retained here as chapter A9. In the 19th report attention is drawn to the evidence that the strength of civil society plays an important role in mitigating the impact of economic dislocation on health, so much so that parts of Eastern Europe and the Soviet Union in which club and society membership was high avoided much (or, where membership exceeded 46% almost all) of the health damage that resulted from the economic dislocation surrounding the decline and fall of the Soviet Union.
10. This brings into sharp focus the issue of mental well-being, and the special report on the subject in the 18th Annual Public Health report is retained here as chapter A10.1 with an earlier report on empowerment forming chapter A10.2
11. Climate change is an important overall threat to public health – indeed to the survival of our species.
12. The current JSNA takes our understanding of our people and their health further forward in the following ways
 - Reinforcing the focus on alcohol, mental wellbeing and health inequalities. New evidence has emerged for all these priorities, for example new data shows that 60% of our most vulnerable children (those with Child Protection arrangements) are from families where alcohol is an issue.
 - Highlighting the increasing levels of demand from those with complex care needs. This is an issue for all age cohorts, and is due in part to improved life expectancy for those with complex needs and improved diagnosis. More analysis is needed to give a full estimate of the possible future levels of demand.
 - Identifying carers as being a significant priority for the local residents of Stockport. Carers are a valuable resource for the health and wellbeing economy of Stockport, but being a carer can have adverse effects on mental wellbeing and financial stability.
 - Confirming the continuation of the ageing population trend, thereby reiterating healthy ageing as a key priority. Preliminary evidence has emerged in the 2011JSNA to support the theoretical analysis of healthy aging contained within Annual Public Health Report (APHR), but further analysis is needed. There is also new evidence linking the healthy ageing priority to the overall priority of mental wellbeing, as local consultation has

shown that maintaining social networks and activity are the best ways to maintain or improve mental wellbeing for older people.

A1.2 THE UPDATED STRATEGIC VISION

1. Alcohol is an established epidemic carrying the potential for a public health disaster in the future. It requires urgent and effective action.
2. Other major public health priorities include
 - Mental well being (especially the promotion of strong, empowered communities)
 - Obesity (especially the promotion of physical activity)
 - Poverty (especially ways to help people escape from poverty or its consequences)
 - Improving uptake of screening and early diagnosis (especially in deprived areas and men)
 - Parenting and early years
 - Tobacco control (especially work focussed on smoking cultures in deprived areas and in young people undergoing transition to adulthood)
3. Other major social care priorities include:
 - Complex packages of care (especially work to understand and respond to increasing demands from frail elderly, dementia and adults with disabilities)
 - Promoting healthy ageing and preventative support (especially independence and social networks)
 - Supporting carers
 - Providing choice and personalisation
4. Other major priorities for education and children's services include:
 - Child obesity (especially focusing on families and physical activity)
 - Prevention of poor lifestyle habits in early adulthood
 - Educational attainment in deprived areas
 - Safeguarding and supporting vulnerable young families
5. Other major priorities for the NHS include:
 - Identifying those with undiagnosed long term conditions
 - End of life care
 - Reducing the reliance on unscheduled care

A2: THE HEALTH AGENDA - 16TH TO
20TH ANNUAL PUBLIC HEALTH
REPORTS (Written 2006)

**A2.1 THE HEALTH OF
STOCKPORT**

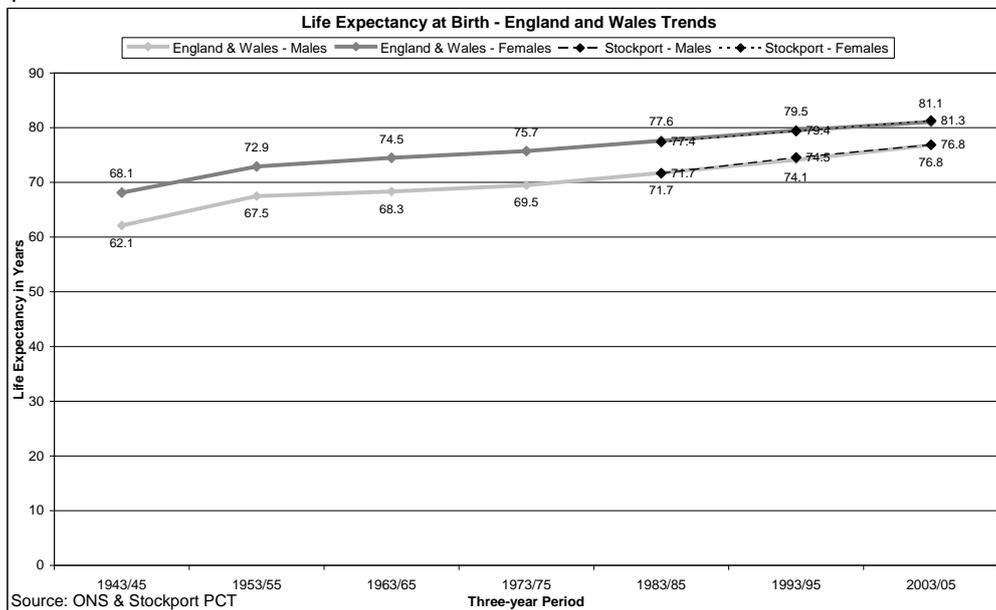
THE HEALTH OF STOCKPORT

A2.1.1 Life Expectancy

THE NATIONAL TRENDS SINCE WORLD WAR II

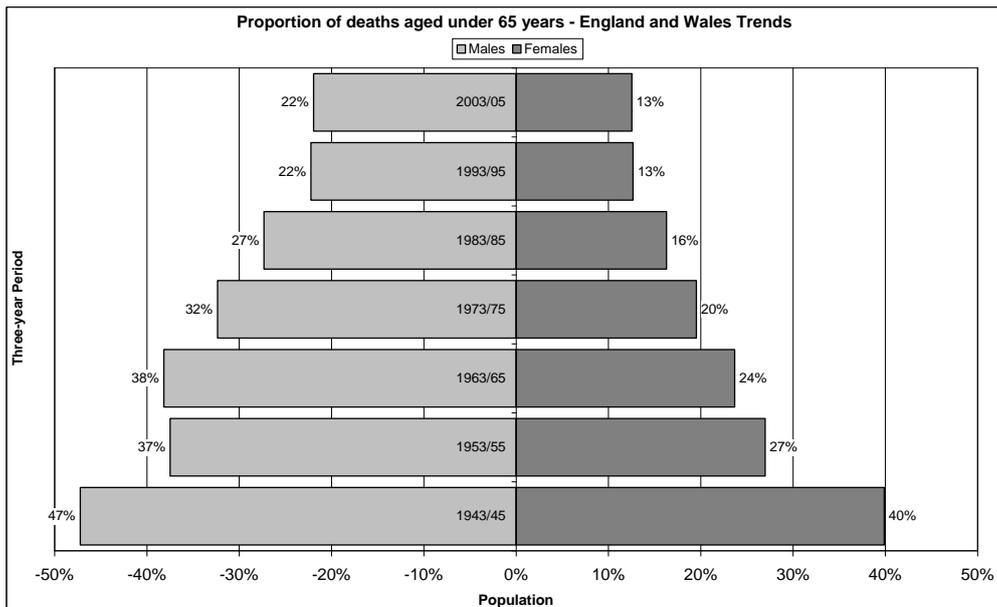
The following graphs show life expectancy at birth from 1943-1985 for England and Wales and for 1983 to 2005 for Stockport. It can be seen that life expectancy has improved by about 15 years for both women and men, with a particularly large increase in the post war decade but also a steady increase throughout the period.

Graph 1.1.1



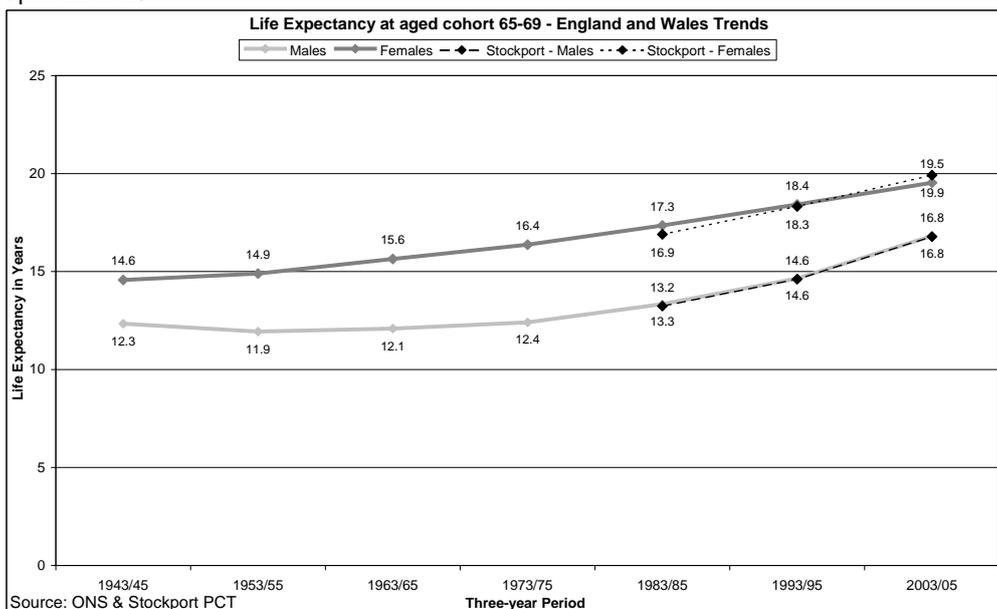
Much of this improvement in life expectancy results from the fact that fewer people die young. The following graphs show the chances of living until age 65. In 1943 almost half the population died before that age, now less than a fifth do.

Graph A2. 1.1.2



More people now live to be 65 but do those who live to that age then live longer? The following graph shows life expectancy over the same period at age 65.

Graph A2. 1.1.3



Life expectancy at age 65 has improved by about five years for women, about four years for men. This is obviously less than the corresponding increase at birth, but proportionately greater in terms of years of life remaining.

For women this has steadily increased since 1943 and in Stockport since 1983 has increased faster than the national average. For men there was very little increase in life expectancy at age 65 for 30 years since the war – contrasting with the increases in life expectancy at birth. This is because the main improvement in men’s health over this period was the reduction in deaths from industrial accidents and work-related disease.

The nature and quality of these additional years of life is a key issue and one it is hard to be precise about. There does appear to be emerging scientific evidence of the predicted

compression of “morbidity” (Fries 1980,1990) and “dynamic equilibrium” (Manton et al1982)¹. These theories predict that, as populations become healthier, life expectancy will increase but so will the proportion of life that is free of disability. It predicts active older populations who live their life to the full until they reach the maximum age they can biologically attain at which point they suffer a relatively short period of illness (months rather than years) before they die. In the 1980s and 1990s international data from Australia, Canada, France and Japan showed that, although chronic conditions increased in prevalence, there was a rise in disability- free life expectancy (Robine 2003). UK evidence is not so clear. Table 1.1.4 shows that life expectancy at age 65 increased for men and women in the UK between 1981 and 2001 but was accompanied by a rise in expected time in poor health i.e. healthy life expectancy has not kept pace with that of life expectancy and the difference is widening for both men and women. Unlike the optimistic picture of Fries’s Theory, with lots of active older people around enjoying their retirement and providing a ready source of wisdom, childcaring grandparents and volunteers for community activities we get a picture of an increasing proportion of dependent older people requiring services and care.

Table A2. 1.1.4 Gains in life expectancy and healthy life expectancy 1981-2001

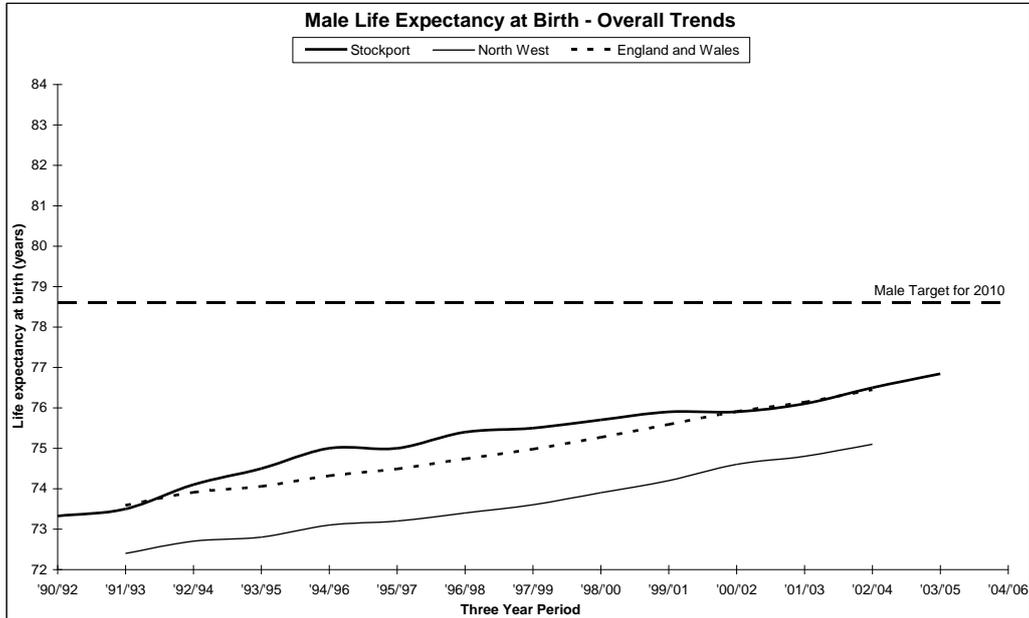
Life expectancy (LE) and Health Life expectancy (HLE) 1981-2001						
Year	Men at 65			Women at 65		
	LE	HLE	LE-HLE	LE	HLE	LE-HLE
1981	12.97	9.94	2.80	16.92	11.88	5.04
1991	14.15	10.84	3.31	17.91	12.97	4.94
2001	15.94	11.62	4.32	19.03	13.17	5.86
Gains in LE and HLE 1981-2001	2.97	1.68		2.11	1.29	
Source government actuary's dept 2005						

¹ Compression of morbidity- healthy life expectancy increases resulting in few years of ill health. Dynamics of equilibrium is a rise in years with a disability illness but a decrease in years with severe forms of illness and disability.

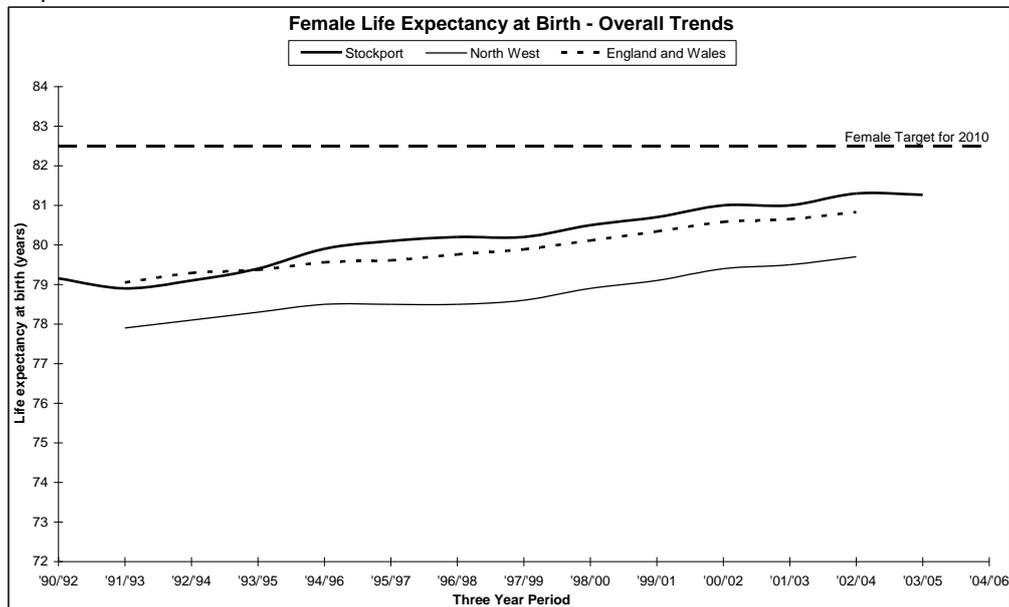
THE RECENT LOCAL PICTURE

The following graphs show the changes in life expectancy in Stockport over the last decade and a half compared with those for England & Wales and the North West.

Graph A2.1.1.5



Graph A2.1.1.6

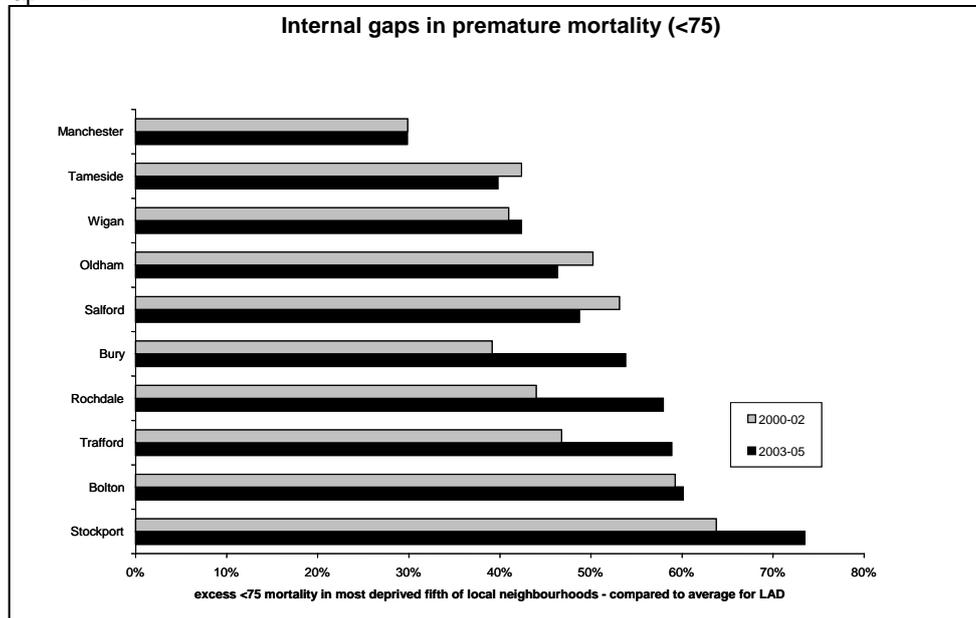


It can be seen that life expectancy in Stockport is better than that in the North West as a whole, but only about the same as England & Wales. In the 1990s it improved faster than in the country as a whole but around the turn of the century this improvement faltered. For women the gains were retained and our life expectancy remains greater than that of the country as a whole. For men, however, the rest of the country caught up with us.

A2.1.2 Inequalities in Health in Stockport

Stockport has the greatest health differences between its most affluent quintile and its most deprived quintile of any PCT in Greater Manchester and the gap is widening.

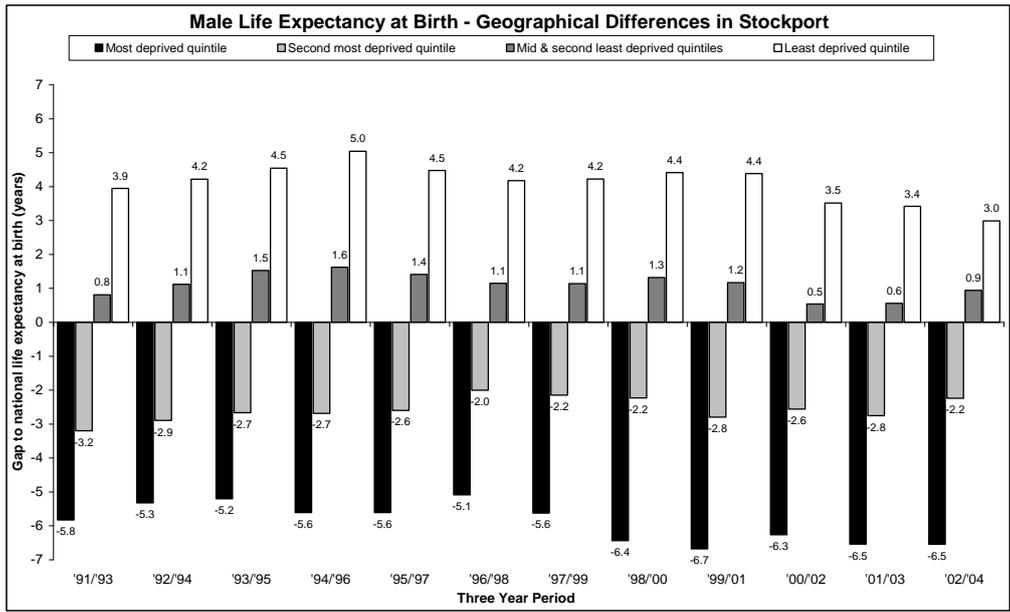
Graph 1.2.1



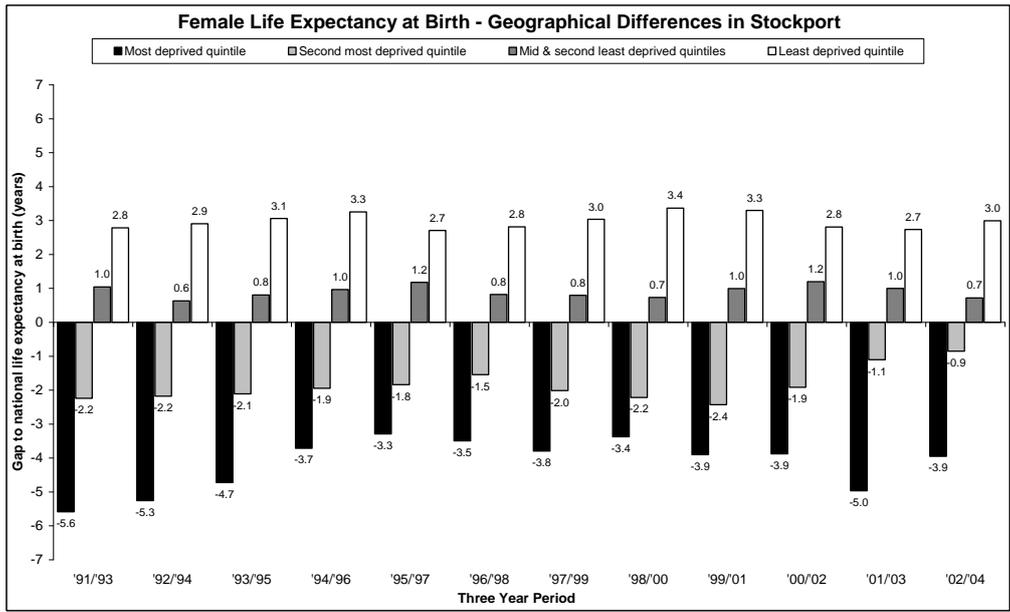
This is in keeping with indicators of deprivation which show Stockport to be one of the highly polarised local authorities in the country (polarisation reflecting the gap between the most deprived and most affluent within the authority) ranging from the 7th most polarised to the 25th most polarised depending on which indicators you look at (e.g. comparing best and worst ward, best and worst Office of National Statistics superoutput area, best and worst quintile, best and worst quartile).

The graphs on the next page show the gap in life expectancy between various sections of the population – most deprived quintile, second most deprived quintile, mid and second least deprived quintiles and least deprived quintile – and the national average. A figure above the line implies better health and a figure below the line implies worse health.

Graph A2.1.2.2



Graph A2.1.2.3



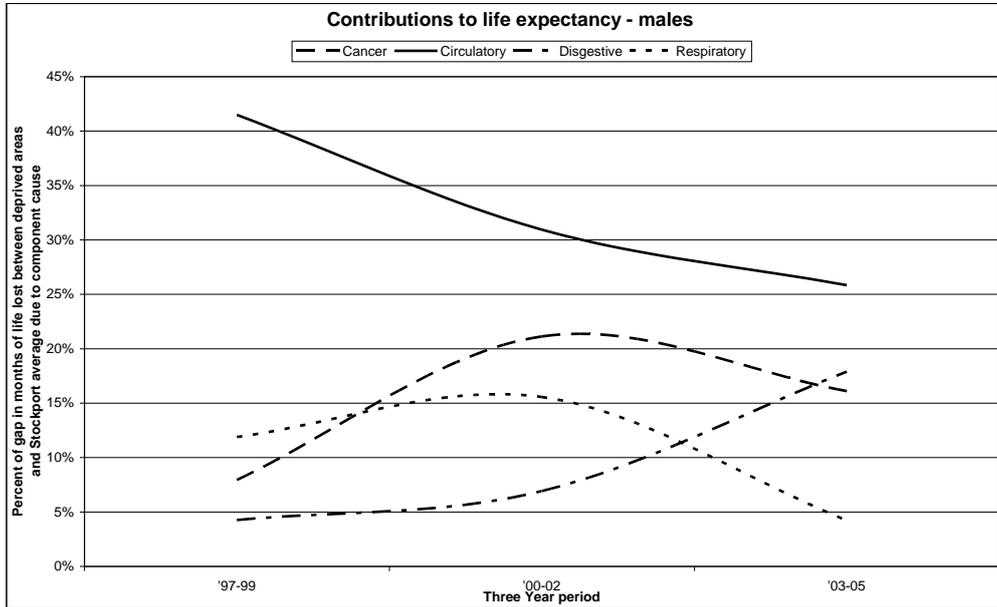
It can be seen that during the 1990s the life expectancy gap narrowed. Around the turn of the century it widened again and for men this eliminated the gains of the 1990s but for women it didn't and indeed in the second most deprived quintile the gap for women continued to narrow.

A2.1.3 The Causes of Inequality

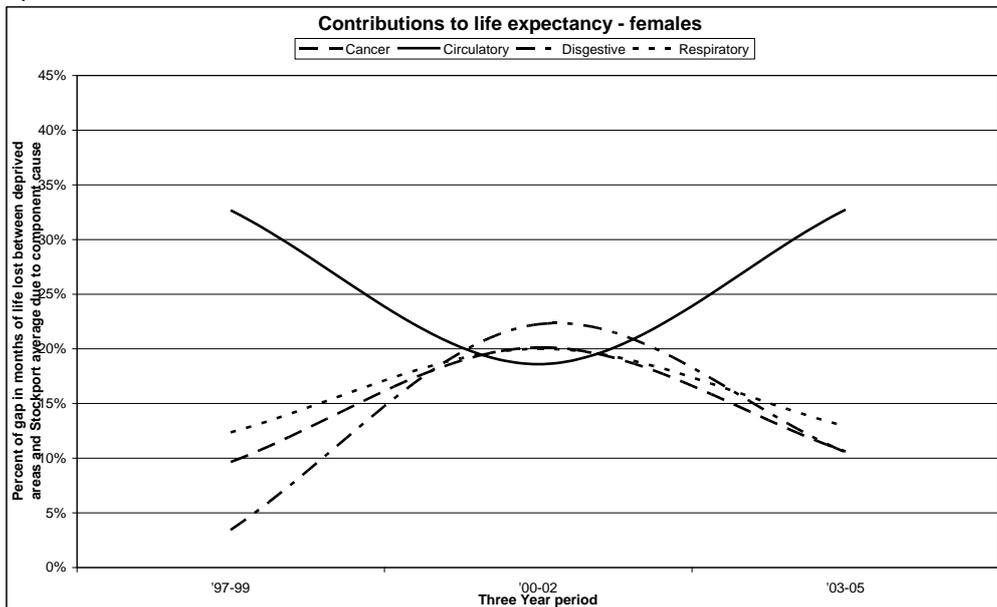
We know that part of the reason that the gap narrowed in the 1990s was the introduction of cardiovascular risk factor screening because this has been confirmed by evaluations of the programme. We also have good reason to believe that community development contributed because we have been able to see time relationships between the commencement of narrowing in a particular area and the introduction of community development.

However a revitalisation in 2002 of the mechanisms that had worked in the 1990s was only partly successful and this seems to have been because new inequalities in other disease areas emerged to undermine the effects, especially alcohol-related diseases, obesity and heart disease in women.

Graph A2.1.3.1



Graph A2.1.3.2



A2.1.4 Demography: An Ageing Population

Like the rest of England and Wales, Stockport's population is aging markedly. Between 1991 and 2001 in Stockport the number of people aged 65 and over rose by over 3.6%, the number aged 75 and over by 9% and the number aged 85 and over by 30.6%. After Knowsley and Sefton, Stockport has seen the biggest increase of people of retirement age in the North West.

Over the same period of time the total population decreased by 1.4%. The projections for the decade 2001/2010 show that the number of people aged 65 and over will rise by a further 7.8%, those aged 75 and over by 9.5% and those aged 85 and over by 17.2%

By 2011 there will be 50,718 individuals aged 65 and over an increase in 3,672 individuals. They will account for 18.3% of the total population compared to 15.8% in 1991. Similarly the population aged 85 years will increase by 53% in the 20-year period from 4,340 in 1991 to 6,640 in 2011.

The increases in the age group 65 and over are accompanied by a 13.9% decrease in the population aged 24 and under although it should be noted that in the last 2-3 years the birth rate in Stockport has increased slightly.

The population pyramid clearly demonstrates that those aged under 34 represent smaller five-year birth cohorts than those aged 35 and above. The 20-24's and 25-29's are particularly small birth cohorts representing the baby bust of the early 1970s when the birth rates were exceptionally low. Figure 3 shows that over the next five years two significant five-year birth cohorts, those aged 55-59 and those aged 60-64, will swell the numbers of those aged over 60 considerably. This group represents the post-war baby boom. In ten years time they will swell the population aged over 70, in twenty years time they will swell the population aged over 80 and in thirty years time they will swell the number aged over 90. After they age or die, to be replaced by a smaller cohort, the older population will enter a cyclical pattern in which the number of younger old people (60-75) will be falling in numbers when the numbers of older people (over 75) will be rising and then when the next baby boom (the children of the first baby boom) reaches old age the situation will reverse again.

The population pyramid also shows the current marked difference in the genders in the older age groups. Women outnumber men after age of 24. This difference between the genders will become less marked in the next 5-10 years. This is because the first generation of men not to be slaughtered in war and not to suffer high rates of death from industrial accidents and diseases are now reaching old age.

ETHNICITY

7.1% (20,275) individuals in Stockport classified themselves as other than British in the 2001 census, equivalent to the national average but a much smaller proportion than in Greater Manchester. The single biggest non-British groups are Irish (White) 4,155 (1.5% of the total population), Pakistani 2,951 (1.0%) and Indian 1,871 (0.7%). Typically the Pakistani population shows different population structure from the rest of Stockport being skewed to younger age groups. 33% of the Pakistani population is aged under 15 compared to 20.3% of the Stockport population with fewer people aged 55 and over (10.5% compared to 27.6%). The Indian population is broadly ageing in line with the rest of Stockport whilst the Irish community is ageing faster with only 6.2% under 15 years and 43.4% aged 55 and over. These populations account for less than 3% of the population aged 55 and over.

MORTALITY AND MORBIDITY

Around 3,000 people in Stockport die each year and 500 of these are classified as premature. Premature deaths in Stockport show a marked link with social inequalities. Of the 2374 deaths in people aged over 65 last year 38.5 % were due to disorders of the circulatory system, 24% were due to cancer and neoplasm and 16.2% were due to respiratory disorders.

Excess winter deaths in those aged 65 and above have dropped significantly from December 1999 to March 2000 when 25% of deaths were classified excess, to 13% in December 2005.

In the 2001 census there were 50,000 people aged 16 and over in Stockport who classed themselves as suffering from a long term limiting condition (18% of the population). Most of these were aged over 55 i.e. 30,891 or 40% of adults aged 55 or over. By the ages of 75-79, 59.9% of adults in Stockport describe themselves as having a long term limiting condition that affects their daily activities and this continues to rise to nearly 80% in those aged 90 and over.

The primary care QMAS prevalence data shows Hypertension, asthma, and CHD are the most prevalent. For all LTCs apart from diabetes the prevalence in Stockport is higher than the national figure. Prevalence is generally higher in those practices serving the most deprived populations; apart from cancer and stroke, which needs further investigation. The Stockport prevalence of diabetes is below the England and Wales average. Excluding hypertension, which has the largest number of people on the register and is on the whole symptomatic there are 55,758 registrations in asthma, CHD, COPD, diabetes, cancer, mental health and stroke. This will be inflated by some people being on several disease registers.

The census also asked questions regarding individuals' perceived health status. 8.8% of the total population in Stockport describes this as poor. It is unsurprising that there is a significant trend towards the older aged groups, with 28.1% of people aged 75-79 and 34.8% of individuals aged 85 and over describing their health as poor. The wards with higher social deprivation have higher rates of self reported poor health status are Brinnington, Reddish and Manor. Self reported poor health status in all age groups were lower than the GM averages.

Interestingly, while there are 54 General Practitioner (GP) practices serving Stockport, nearly 40% of older people (i.e. are those aged 75 years and over) are registered with just 10 practices, and over two thirds are registered with 22 practices. This is most likely due to the different sizes of practices and the location of nursing homes across the Borough. There are 7 practices with over 200 older people aged 75 years and over registered per WTE GP, compared to a Stockport average of 142 older people aged 75 years and over registered per WTE GP. 8 practices have list structures where more than 10% of the population are aged 75 years and over, compared to the average of 7.9%. This may offer opportunities for some locally based strategic joint purchasing around key practices.

HOSPITAL UTILISATION.

Trend data from 2001-2002 to 2005-2006 shows a steady increase in the proportion of inpatient secondary care services delivered to people aged 65 and over against a background of increasing utilisation for all ages. However, emergency admissions rose 6.5% in the 85 and over age group compared to 3.5% overall.

From the age of 20 the proportion emergency admissions of total admissions rises. In 2005/06 adults aged 65 and over accounted for 50.5% of all emergency admission whilst making up 16.6% of the population. Adults aged over 85 accounted for 9.4% of emergency admissions whilst comprising 2.4% of the population.

The most frequently recorded diagnosis in the 65 and over age group were categorised as symptoms and ill-defined conditions (21.1%) disorders of the circulatory system (17.4%), injuries and poisonings (13.2%).

The contribution of accidents and poisoning rises steadily until it accounts for one in five admissions of all people aged 90 and over.

Local data on managing Very High Intensity Users (VHIU) and delivering active case management show that VHI service users tend to have 3 or more long term conditions. The average age of an individual on a case managed caseload is 75 years. Using the King Fund Patients at Risk of Readmission (PARR) protocol there is an estimated 1400 people in

Stockport who are at greater than 50% of being admitted in the 12 months, the majority of whom will be elderly.

A2.2 THE HEALTH AGENDA

A2.2.1 Heart Disease and Cancer

Heart disease and cancer are the two greatest killers of our time.

Heart disease is caused by smoking, low fibre high fat diets, lack of exercise, and genetic predisposition. Stress, in the precise sense discussed below under the title “stress and emotional health”, is also a contributory cause. Moderate consumption of alcohol protects against it, as does aspirin, statins and other measures to reduce cholesterol, and eating fish (especially oily fish).

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

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

Breast cancer and testicular cancer are two of the very small number of diseases that are most common in the most affluent. Delayed childbearing contributes to breast cancer. Cervical cancer is commonest in women who have multiple sexual partners or who work in oily or dirty surroundings or with biological material or whose partner does any of these things. Skin cancer is increased by overexposure to sun. Gastrointestinal cancer is predisposed to by low fibre diets or by physical inactivity. Oesophageal cancer is increasing in incidence and is associated with reflux of stomach contents in the oesophagus whilst stomach cancer may be caused by an infection which also causes stomach ulcers and heart disease. Mouth cancers can be caused by smoking. All three of these cancers are also predisposed to by excessive consumption of alcohol or certain kinds of food

Because smoking, stress, physical inactivity and diet contribute to both heart disease and cancer it is sensible to consider the two diseases together.

A key contribution to tackling heart disease and cancer is the idea of a Smoke Free Stockport, discussed in a separate section. But what else can be done?

The NHS can help by leading the way with effective and innovative programmes of prevention, delivered in partnership with other agencies and by providing services to screen for early disease or risk factors for disease and advise on healthy choices. It can diagnose and treat existing disease. It can sponsor and empower the community.

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

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

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

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

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

People can 'SHINE'

'Can you meet the Stockport 'SHINE' challenge?'

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

Healthy shape (body mass index less than 30)

Invigorating activity (at least moderate activity on at least 5 days a week)

Non-smoker

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

Other things that would help are using stairs instead of lifts, making short journeys on foot instead of driving, covering up and using sun protection on holidays and when working in the open air in fine weather and making full use of screening services.

SMOKE FREE 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 young, often whilst they are under age and still at school, and then face a life long addiction. Were it not for the large number of addicts spread throughout all sectors of society there is little doubt that tobacco would be banned along with heroin and cocaine. Certainly it is every bit as addictive.

Tobacco is the only lawful product that kills one in four of those who use it in the way it is intended to be used. The only difference between smoking and playing Russian roulette is the delayed effect. Were it not for the large number of smokers spread throughout all sectors of society there is little doubt that smoking would be banned, just as duelling is.

There are a number of reasons why smoking should be prohibited in public places and workplaces.

One of them is the impact of tobacco smoke on those in the vicinity of the smoker. It is one thing to claim a right to poison yourself and quite another to claim a right to poison everybody in the same room. People have a right not to be poisoned at their place of work, and this includes bar staff. People also have a right not to be poisoned at the places they frequent for leisure, entertainment and social relations.

Another reason for avoiding smoking in public places is the impact that smoking has on those who are trying to give up smoking. If they are continually surrounded by smokers when they go out this makes it more difficult. People should be helped to overcome their addiction, not compelled to give up their social life with their cigarettes.

The overwhelming majority of Stockport people share these views. A survey of Stockport people has shown that

- 74% of all respondents are bothered by smoking in public places at least a fair amount.
- Non/ex smokers are five times more likely to be bothered by smoking in public places than smokers.
- Those that are bothered by smoking in public places tend not to like the smell, feel that it spoils their meal/drink and worry about the effect on health).
- There is strong support for a total ban on smoking in hospitals (82%) and public places with children on the premises (72%). It is also the majority view that smoking be banned in restaurants and cafes, enclosed shopping centres and shopping malls, offices, council premises and factories and warehouses (61%).
- Significant proportions of smokers support a total ban in most locations (with the exception of pubs and bars).

It is not always fully appreciated that pubs and clubs are workplaces, and the results are more equivocal in that area

- 90% of respondents agree that workers have the right to work in a smoke free environment and it is the majority view even amongst smokers. However a smoking ban in pubs and bars received less support (33%).
- The majority of respondents still want to see smoke free areas at these locations (58%). Only 7% wanted smoking to be allowed through out, whilst the majority (91%) wanted to see smoke free areas or total smoke free licensed premises

Despite these more equivocal results, I believe that the rights of pub and club workers and the rights of those giving up smoking must be given priority. Whilst smoke free areas, as favoured by the majority, may meet the latter of these points, it still exposes bar staff to a known carcinogen.

It is not always fully appreciated how much nuisance smoke is felt to be by many people. 60% of those surveyed had left a place because of the nuisance of tobacco smoke.

For these reasons Stockport PCT and Stockport MBC are committed to moving towards a Smoke Free Stockport.

A2.2.2 Accidents

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

WHAT CAUSES ACCIDENTS?

Most accidents occur in one or other of four settings - on the road, at work, at leisure or at home. There are some accidents in other settings - rail, air or weather accidents for example - but the four main settings account for almost all of them.

Some accidents are genuinely unavoidable. Others, such as bad luck with the inherent risks in excitingly dangerous activities such as mountaineering or motor racing, are avoidable only by constraining the human spirit. But many have readily avoidable causes, such as

- alcohol
- failure to warn about and protect against hazards
- unsafe systems of work
- defective equipment
- inadequate training
- inexperience in children and young people
- binge drinking in young people
- short cuts taken for convenience or profit
- people taking unnecessary risks out of
 - bravado

- carelessness
- lack of knowledge
- misjudgement of risk
- lack of self worth
- familiarity breeding contempt
- absurdly risk averse safety procedures which discredit the concept of safety and lead people to ignore advice (the "cry wolf" syndrome)
- poor housekeeping in workplaces
- failure to appreciate hazards in the home, including
 - fire risks
 - unsafe storage of dangerous substances, including both prescription and non-prescription drugs, where they may be misused, especially by children (deaths of children due to accidental paracetamol overdose is an example)
 - unsafe equipment and furniture, especially where deprived households buy cheaply

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

WHAT CAN WE ALL DO TO HELP?

The following will 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.
- 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. Not only will the message eventually get through if enough people do it, but it's fun watching their reactions.

SAFE OR RISK AVERSE

In a safety culture people who climb mountains follow good safety practice, use modern equipment which has been properly tested, have good communication systems so that help can be summoned.

If something goes wrong, they are properly trained and know their limitations, contribute to maintaining a mountain rescue service and keep an eye on the weather.

In risk averse cultures 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
- it asks too much of people and they fail so that absurdly excessive levels of precaution coexist with blatant danger.

We need to be very careful about the point where a safety culture becomes a risk averse culture. There are a number of areas where we are very close to that point or have already passed it - railway safety, medical negligence and pavement maintenance are just three examples. Current trends in accident litigation have every potential to increase these realms. For example in the United States it has become very difficult to obtain hot tea and coffee following a court award in favour of a woman who scalded her mouth. A drinks vending machine in a Los Angeles hotel stands beneath a large notice "Warning - Tea and Coffee From this Machine Are Hot." Sadly the notice was false!

A2.2.3 Mental Health

Mental health is a very important aspect of health and well being. Mental illness or distress is a serious and sometimes unaddressed problem.

An American study showed that about 1 in 3 of us will suffer some form of mental illness in our lifetime and about 1 in 5 of us will suffer active mental illness in any one year. Approximately 1 in 7 of us will have an alcohol abuse/dependence problem.

It is also a much more diverse problem than the other key areas and this section will be structured differently to reflect this.

ENHANCING MENTAL HEALTH

Addictive Behaviours

Addictive behaviours include drug misuse, alcoholism and eating disorders. The reason for the recent increase in addiction problems is not known - it may reflect underlying lack of emotional health, stress or declining social cohesion.

Stress and Emotional Health

Before discussing the promotion of mental health it is necessary to consider where mental health fits together with the concept of stress and the concept of emotional health.

Stress occurs when people are faced with threats to their well being which they cannot respond to by action to counter the threat. As a result the physiological changes that are created for "fight or flight" and that are normally used up in action persist instead and hence damage health.

Stress arises

- when threats hang over people
- when people are trapped in unsatisfactory situations, such as poverty, with few options and little control, hence no chance of escape
- when people constantly have to work under pressure to deadlines, whether in overworked managerial jobs or on the assembly line
- when people are inadequately trained or ill matched for responsibilities they have to carry
- during bereavement and other life changes
- in circumstances of emotional ill health.

Emotionally every one of us is a complex mass of strange mental processes behind a mask of learned normal behaviour.

Emotional ill health can be said to exist where these processes affect people's social functioning,

lead to damaging behaviour (such as, addictive behaviours) or lead to serious persistent unhappiness resulting in stress.

Emotional ill health arises from

- failure to learn social skills during upbringing
- complex emotional reactions in childhood
- distorted relationships with parents
- stigmatisation and discrimination
- lack of self worth
- lack of external support and personal affirmation.

Stress and emotional ill health are important as risk factors for physical illness, mental illness and irrational potentially damaging behaviour.

PROMOTING MENTAL HEALTH – KEY ISSUES AND PROGRAMMES

Community Development –

Promotes social support and social solidarity which protects mental health.

Stress Reduction –

Programmes of stress reduction should take place in workplaces and in local communities.

Counselling and Therapy –

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

Supporting Stigmatised Groups –

Stigma is an important cause of stress.

Supporting Isolated Groups –

Mental ill health is known to occur in isolated groups such as, carers and parents of young children without links outside the home. This is presumably because of lack of social support.

Raising the Human Spirit –

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

Arts for Health –

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

Destigmatising Mental Illness –

People with mental illness are themselves stigmatised and this is a vicious circle which creates stresses that cause recurrence as well as obstructing rehabilitation. We need a process of advocacy to overcome this.

WHAT CAN WE ALL DO TO HELP?

We can all

- treat mental illness as an illness like any other
- be as tolerant of minor mental abnormalities as we would be of physical disabilities
- avoid creating stress for others
- have mechanisms for coping with stress ourselves
- spend time in beautiful and tranquil surroundings
- spend quality time with our family
- have fun

STRESS IN THE WORKPLACE – A CHECKLIST FOR EMPLOYERS

1. The working environment should be pleasant.
2. Close supervision and control should be avoided – people should be motivated by being inspired and empowered.
3. Working under pressure to deadlines should be minimised whether in executives or on the assembly line.
4. Participative systems of management, which allow people to influence their destiny, should be adopted.
5. Threats should not be allowed to hang over somebody for a prolonged time.
6. People should be adequately trained for the responsibilities they bear.
7. People should be provided with adequate resources and authority for any responsibilities they bear and not be blamed for the inevitable failure of inadequate systems.

8. Working relationships should be human and personally supportive.
9. The higher human needs for self esteem, personal development, affection and opportunities to enjoy beauty should all be recognised.
10. Work arrangements should be sufficiently flexible to avoid stressful dilemmas of role conflict with other aspects of life.
11. Pay should be adequate to meet people's material needs and to afford them a reasonable degree of life choices.
12. Work should be fun
13. Geographical mobility should be expected only where absolutely necessary since it disrupts social support networks.
14. A sense of collective identity should be encouraged.
15. Work should be meaningful and the organisation's mission should be socially useful.
16. Life changes at work should be supported by counselling to minimise the period of adjustment and hence the harm.
17. Bullying and harassment must be prohibited.
18. Steps must be taken to counter long hours cultures.

SUICIDE

There were 122 deaths of Stockport residents due to suicide and undetermined intent in the past five years (2001-05) The groups with the highest rates were young (15-34 yrs) and middle aged men (35-49yrs) particularly living in deprived wards such as, Brinnington and Central ward. Risk factors for suicide include, being male, unemployment, living alone, having a mental health problem and experiencing a recent significant life event, such as, a bereavement.

We should not be unduly concerned about last year's apparent increase in the suicide rate because there are year to year variations in the numbers and a better measure, the three year moving average is basically unchanged. There were 72 deaths in the period 2003-05 (20 in 2003, 15 in 2004 and 37 in 2005). The figure for 2004 may have been unduly low due to some death registrations from 2003 being carried over to 2005 rather than 2004. 5 or 6 out of the 37 deaths in 2005 were carried forward from events in 2003 due to a delay in registration at the coroner's office. We need to continue to carefully monitor the statistics. The provisional half year figure for 2006 is 8 although last year the largest numbers were in the second half of the year and that pattern might get repeated. Nonetheless, we actually have the lowest suicide rates in Greater Manchester.

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

SUICIDE IN PEOPLE SUFFERING FROM MENTAL ILLNESS

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

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

There have been some concerns expressed recently by some of the Brinnington Health Centre GPs about the local mental health services (the latest figures show that at least 1 in 3 of our suicides and undetermined intent deaths have had contact with the mental health services in the 12 months before death - this compares to 1 in 4 nationally). Also the Health Care Commission is currently doing an inspection in Stockport particularly because of concerns about our community mental health and crisis services which have recently been rated as weak.

PARASUICIDE

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

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

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

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

SOCIAL SOLIDARITY

Social solidarity may reduce suicide. Suicides fell dramatically in both World Wars and have increased in Northern Ireland since the development of peace. The explanation often advanced for this is that periods of war or crisis induce social solidarity. If this is the case then other measures which induce social solidarity may also have the same effect. Our community development strategy may therefore reduce suicides. On the other hand there are other possible explanations for the relationship between war and low suicide rates. For example, war offers other more socially acceptable (even socially honoured) opportunities for self destruction.

INEXPLICABLE SINGLE PERSON ACCIDENTS

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

A2.2.4 Asthma, Traffic and the Environment

Traffic is a major problem for Stockport. The roads of the borough are approaching saturation point and there is an urgent need to find new ways of organising transport in Stockport. One of the consequences of this traffic situation is declining air quality and a substantial prevalence of asthma, now affecting adults and an even larger proportion of our children.

The issue of asthma must be considered against a background of other environmental issues. Stockport is a borough with a good record of preserving open space. It has the potential therefore to settle into an intimate relationship with countryside – to become a Country City. This will have many benefits for health, including exercise opportunities and raising the human spirit.

ASTHMA

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

Asthma is caused by

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

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

TOWARDS A COUNTRY CITY

We need to reach out for the ideal of a Country City and Civilised City in which people live and work in peaceful and beautiful surroundings, with a focus on improving urban living and with many benefits for health. The Country City provides exercise opportunities and helps raise people's spirits by forming a city of village communities in natural surroundings. The Civilised City focuses on peacefulness and social support with an emphasis on the importance of social interaction, opportunities to enjoy peace and beauty, and community spirit.

TRANSPORT

Transport can help keep people healthy because it allows access to employment, education, shops selling healthy food, leisure activities, health services and the countryside, and it opens up social support networks. Walking and cycling are very healthy forms of transport and can help prevent heart disease. At the same time, however, it can damage people's health due to accidents, pollution, noise, stress and anxiety, and the replacement of open space with roads. Traffic is responsible for a large amount of pollution in Stockport which, as well as damaging people's health, also contributes to acid rain and global warming.

New technology is expected to reduce the growth of traffic pollution in the future but traffic is predicted to grow to a greater extent than the benefit, so pollution will still get worse. People need to start using their cars less, and the only long-term solution to easing traffic congestion is to make walking, cycling and public transport in cities more attractive.

Heavy traffic reduces people's feeling of community and neighbourliness, and is a major cause of increasing limitations on children. Creating residential cells, areas without through traffic, would create opportunities for a cycle network and enable the use of streets for community purposes rather than just passing traffic. In Holland, "woonerven" or "living streets" have trees, street furniture and play areas, but traffic is still allowed to use the street. Similar developments should seriously be considered in Stockport, together with more speed restrictions in streets to make them safer, particularly for children.

Recreational cycling is an important means of exercise and can also be used as a serious means of transport. It is currently perceived as a fairly dangerous form of transport because of pollution and the risk of accidents, but creating safe cycle networks could change this. Trains are more effective at competing with cars, and the combination of frequent trains and cycling can be as flexible a means of transport as the car. As suggested three years ago, most of Stockport could be brought within 1km of a railway station by fairly minor changes to the rail system.

THE SEMMMS ROAD SCHEME

Stockport is currently seeking to build an Eastern By Pass linking the A6 at Hazel Grove with the M60 at Bredbury.

There is a widespread belief that this scheme will ease traffic congestion in Stockport but over the years I have made clear my view that, unaccompanied by other measures, it will not do this and in fact will make things worse.

It is now proposed that the scheme be built with a number of complementary measures designed firstly to capture the traffic reductions that will occur when the road opens and re-use the road space for cycle lanes and bus lanes so that it does not just fill up and secondly to ensure that the changes in traffic flows intended to be created by the road are indeed achieved and that some of the possible distortions that the road could create are prevented.

With such complementary measures the road may indeed be of value. This value will however be nothing like as great as could have been achieved if the money committed to the scheme was spent instead on alternatives such as cycle networks, rail schemes, park and ride schemes to mop up the traffic that currently flows along the A6 and public transport improvements. When these opportunity costs are taken into account the road is probably still a harmful development.

A linked scheme proposes to complete the MAELR route which has been partially built and to link it to the A6. The completion of the MAELR scheme is necessary because of the traffic problems created by the original partial scheme. Linking it to the A6 could provide a possible alternative way to redirect traffic from Derbyshire to Manchester away from Stockport and could therefore be an alternative to the Eastern By Pass rather than a linked scheme.

That part of the eastern By Pass and Stepping Hill Link Road which by pass Hazel Grove are more useful and less harmful than the rest of the scheme.

OPEN SPACE

Stockport is a beautiful town to walk around, but it is not so pleasant in a car. Replacing cars with public transport for long journeys and cycling and walking for shorter journeys would dramatically reduce traffic and improve health. Investment in off-road footpaths is needed to create a pleasant pedestrian network so that people can walk safely and pleasantly through the borough.

Open space can make an important contribution to public health. It provides opportunities for exercise and a green rural environment helps people relax and raises spirits. Health promotion through parks, integrated and co-ordinated with other health strategies in Stockport, could make a substantial contribution to the 'Our Healthier Nation' targets, especially for heart disease and stress relief. There are many sources of country walk opportunities in Stockport and areas of open space suitable for exercise.

Green gyms is a new concept which brings together health, community empowerment and open space, through practical conservation activities undertaken by local residents to enhance their local community while improving their own physical and mental health. Urban nature conservation improves the quality of life of people living in towns and cities and the attractiveness of local areas by adding trees and hedges, and roof gardens to preserve open space on land that has been built on. Traffic free estates could be an attractive addition to an area of open space, incorporating cycle ways, pedestrian networks and safe school routes.

Biodiversity is all living things, and creates a pleasant and healthy environment. The need to protect our biodiversity is more important now than it has ever been. Without plants and animals we would not be able to survive, and our physical, mental and spiritual wellbeing are improved by contact with nature.

LIVING AS A COMMUNITY

Community spirit is important both as an end in itself (lack of social support is a powerful risk factor for death and ill health) and as a means to an end (working together to make things better). Community development, community streets, healthy living centres, tackling crime, and public involvement are all highly important factors for improving community spirit.

In a sustainable community people respect the local environment and value quality of life and future generations above short-term thinking and material consumption. Resources and energy are used efficiently, pollution is minimal, and nature is valued and protected. Facilities, services, goods and other people are easily accessible, but not at the expense of the environment; opportunities for leisure and recreation are readily available to all; spaces and places are attractive and valued; and everyone has access to good quality food, water, shelter and fuel at reasonable cost. These principles are being applied neighbourhood by neighbourhood throughout Stockport.

UNREALISTIC DREAM OR PRACTICAL NECESSITY?

As we move into the technology-based culture of the future the economy will be centred around internet-based businesses, whose choice of location will be swayed by pleasant living conditions and an environment that feeds creativity. The Country City suggests a way to have the best of both worlds – beautiful living conditions close to the entertainment and shopping opportunities of a city, and the creative energy of a vibrant community. The creation of the Country City will not be achieved overnight and a number of obstacles will need to be overcome, but the report suggests that we work towards building it.

A2.2.5 Sexual Health

“Sexual Health is an important part of physical and mental health. It is a key part of our identity as Human Beings, together with the

fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.”

Acknowledging this important aspect of sexual health on our well-being, we are currently facing a ‘public health’ crisis in relation to the poor state of our sexual health. Since the 1990’s, rates of Sexually Transmitted Infections (STI’s) and HIV and levels of high risk behaviour have been rising alongside continuing high rate of unintended pregnancy and abortions.

We also know that poor sexual health continues to disproportionately affect those who are already vulnerable and suffering from inequalities, such as young people, gay men, black and minority ethnic groups and those in lower socio-economic groups. Poor sexual health can have serious longer term implications, including infertility and chronic health conditions.

SEXUALLY TRANSMITTED DISEASES (STIs)

STIs remain among the greatest infectious disease threats facing the UK today. The number of STIs has continued to increase year on year since the early 1990’s. Chlamydia infection is the most commonly diagnosed infection which affects on estimated 1 in 10 sexually active young women. While some STIs, if diagnosed early are easily treated, there are many that are lifelong – they can have recurrent symptoms and serious long term consequences, including infertility and cancers.

HIV

Of all the STI’s, HIV perhaps has the greatest long term impact on the individual and health economy. Treatment options for HIV related illnesses have advanced considerably in the past few years but despite this, it remains a serious, long term, life threatening illness. A recent worrying fact has been the rapid increase in the number of cases of HIV acquired through heterosexual transmission.

Prevention

As disease occurrence is subject to marked geographical variations, regional and local interventions to prevent HIV/STI should be targeted to meet local needs. There are excellent examples of prevention initiatives such as improved confidential HIV/STI testing; increase pre-natal testing to prevent maternal transmission of HIV; creation of Young Persons Sexual Health Clinics and national and local awareness raising campaigns. Sex and relationship education (see below) plays an important role.

PREGNANCY

Teenage Pregnancy

In England, we continue to have the highest teenage pregnancy rates in Western Europe, although the numbers are decreasing. There are very encouraging signs that the Teenage Pregnancy Strategy is working, and that good progress is being made towards our goal of halving the under 18 conceptions rate by 2010. However, we need to continue to work through schools, youth workers, and health professionals to raise the issues with young people and not let complacency set in.

ABORTION

Around one in three women will have an abortion at some point in their lives. While most of these abortions will be performed before 12 weeks and funded by the NHS, there are huge variations which exist across different locations. If women are to have an early medical termination then they need to be seen in a service in sufficient time to have their abortion at less than 10 weeks gestation. With nearly a quarter of all pregnancies in England ending in abortion, women need to have quick access to services and options in relation to the abortion which they choose.

WHAT CAN WE ALL DO TO HELP?

Services

- We need to increase access to diagnosis and treatment services for sexually transmitted infections. Particular emphasis must be on providing services which are appropriate and acceptable to the target populations e.g. 'youth friendly'.
- To implement in Stockport the National Chlamydia Screening programme targeting the under 25's.
- To provide a range of contraceptive methods, suiting individual needs and lifestyle.
- Support Teenage Pregnancy Partnership board in delivering their strategy in neighbourhoods with highest conception rates.

Individuals

- Act on the 'Safe Sex' message.
- Use condoms and Stockport's Condom Distribution Scheme.
- Take responsibility for your own method of contraception
- Remember that having multiple sexual partners increases the risk of STIs, of unwanted pregnancy, of cervical cancer and of domestic violence. .

Sex & Relationship Education (SRE)

SRE is one strand in preventing unintended pregnancies and STI's, as well as promoting healthy and fulfilling sexual relationships. There are calls from the government that SRE form part of PSHE and be located within a broader emotional and social framework. Effective SRE and PSHE in schools will

address attitudes and values: personal and social skills: and knowledge and understanding.

A2.2.6 A Strategy for Promoting Health in Young People

It is important that there should be a significant effort to promote health in young people. Adolescent years are years of anticipatory socialisation, in which young people are taking on new roles and learning the norms associated with them. They are years of changing personality and creating lifestyles. They are years of rebellion and questioning. They are often the most idealistic period of a person's life.

As such they represent opportunities to lay the basis for positive and healthy lifestyles and even opportunities for young people to do things to make society healthier. But they also represent dangers of making incorrect choices, perhaps out of inexperience or perhaps out of misplaced rebellion.

It is not possible to approach young people with an authoritarian or didactic style of health promotion. Those who are shaping their own adulthood are rightly sensitive about being patronised and those who are rebelling are likely to be strengthened in their resolve by a display of authority.

The Stockport approach, therefore, both in health promotion and in the youth service is that health promotion in young people must be carried out first and foremost from a standpoint of respect for young people and a desire to work with them rather than control them.

To achieve our ambition of respecting young people, we must therefore devise workable structures through which they can make their voices heard. Tokenism must be avoided at all costs and, instead, a viable and credible consultation route quickly established. The expansion this decade of peer education has highlighted the importance of listening to young people, letting them set the agenda and supporting them to take control over their own health.

Although there are some doubts about the viability of peer education in its pure form, where young people are recruited as volunteers to act as health promoters, the values which underline this approach are certainly essential.

It is important that the existence of communities of young people, focused on particular centres, is recognised.

Schools are one of the foci of these communities.

In Stockport, there currently exist good relationships with our schools, based on a long history of health education support. 79% of schools are involved in the National Healthy School Scheme, which supports schools to take a holistic approach to the health and well being of children and young people. It also involves the wider school community and provides a focus for recognising the good practice that exists in many local schools.

We need to build on these relationships, especially drawing schools into neighbourhood health strategies and ensuring that schools develop their own

local plans for health, which should be endorsed by and regularly monitored by Boards of Governors.

Schools can be seen by young people as representatives of authority and must play their part in respecting the autonomy of young people and helping them develop their own personal identity. These messages are certainly conveyed in personal and social education lessons but are they conveyed in the culture of the school?

Health promotion work outside of schools has increased and must be further extended. Where collaborative initiatives are developed, they must appear seamless to the user. Effective health promotion needs to happen in all the places where young people meet - on the streets, in cafes, pubs, clubs, through sport, the media and within the family.

Central Youth was the start of a process of locating young peoples' health facilities in centres of youth culture but only a start.

Further developments such as health promoting cafes, alcohol free pubs, and other leisure-based health promotion services are also called for.

Health promoters must be more creative in their thinking, more ambitious in their aims and more in touch with the fast changing needs and perceptions of young people.

We need to react to changes in youth culture as rapidly as those who operate businesses in the youth market. Indeed there may be scope for joint projects.

Outreach work is central to this approach, but it is only the core of a major initiative and a lot of innovative flesh needs to be put around the core.

What is needed is an outreach strategy not just a few outreach workers.

If we take our cue from local young people, if we listen and act on what we hear, and if we stay around to support what happens, then we can look forward to a bright future where Stockport's young people are empowered to take control of their health and lives.

A2.2.7 Disability and Dependence

A key health issue is to minimise the social exclusion resulting from disability and dependence. This can be done by reducing the amount of disability and also by changing the way that society excludes people with disability.

Although the problems created by disability in young people and in elderly people are different, and there are also differences between the disabilities caused by physical impairment, mental impairment and learning difficulties, the underlying goal is the same – to empower disabled and dependent people to live as normal a life as possible and be fully integrated into the communities in which they live and work.

The NHS and social services have an important role in rehabilitation but this is often made more difficult by the way that society places unnecessary hurdles in the way of disabled people. We can try to help people to jump the hurdle or we can lower the hurdle. All sectors of society need to examine how receptive they are to accommodating disabled people.

Do employers look at the abilities of disabled applicants or do they focus on the disability? Nobody suggests we should employ blind cricket umpires but all that is needed to employ blind people in a very wide range of jobs (including a Cabinet Minister) is a small degree of adjustment to the way the job is carried out. And there are some jobs, dependent on the use of senses other than sight, where blind people may have a head start because of the way they have developed those senses to compensate for their lack of sight.

Can we provide transport for disabled people? The Transport and Health Study Group recognises three levels of transport impairment:-

Level 1 – can get to the bus stop but cannot use traditional buses with high floors and no wheelchair space

Level 2 - cannot get to the bus stop but can use an accessible bus that comes to their door

Level 3 – needs help getting to their own front door or needs care in transit.

Level 1 transport impairment requires accessible buses with wheelchair space. Increasingly such buses are becoming the norm and when they are widespread Level 1 transport impairment will cease to create any disability. This is a classic example of the difference between impairment (the biological problem that prevents a person doing things that most people can do) and disability (the consequences that society creates for people who have a particular impairment).

Level 2 transport impairment requires dial a ride services and, although such services exist, we are a long way from providing the same level of flexibility in their use that is taken for granted by users of ordinary public transport.

There is no public transport currently available for people with level 3 transport impairment.

Can disabled people enjoy a full range of leisure pursuits? Is provision made, for example by loop systems, for hearing impaired people? Do we make provision for people with communication disabilities? When people need to be cared for do we approach that care from the standpoint of maximising independence, privacy and dignity or do we fall into an old model of just looking after people.

A2.2.8 An Ageing Population

DEMOGRAPHY

Over the last few decades we have seen a steady increase in the proportion of the population who are elderly.

The natural maximum longevity of the population seems to be about 85 years, with most people having a natural age of death in their 80s, a few in their 70s and 90s, and very few in their 60s and 100s.(I summarised the research supporting this statement in my 1998/9 report.)

Normal advances in medical treatment, or in public health, are unlikely to alter this. It probably improves by a few weeks or months each generation and it may in the future be susceptible to genetic manipulation, but it is otherwise unlikely to alter. What leads to a rising life expectancy is more people living to achieve their maximum longevity.

What leads to an ageing population is rising life expectancy that result in an older generation being larger than its predecessor and falling birth and immigration rates that result in younger generations being smaller than their predecessor.

Towards the end of the 19th century infant mortality fell dramatically. Prior to that fall it was common for people to have many children in order that at least one would survive. It took some time for people to realise that this was no longer necessary and, as a result, a generation was created in which large families existed, most of whose members grew to adulthood. This was the cause of the ageing of the population in the last three decades of the 20th century.

As this effect was completed another effect replaced it. A long period of peace after the Second World War has meant that generations of men who have not been slaughtered in war are now coming to old age. These generations have also benefited from improved health and safety at work, which has also increased their life expectancy. This has produced a larger number of old men. This adds to the process of an ageing population and also changes the sex ratio in old age so that there is no longer as great a preponderance of women. This may in turn mean that fewer old people live alone which may in turn mean that levels of dependency on public services will be less.

After the Second World War there was a baby boom and ever since then there have been cyclical changes in birth rate with bulges due first to the children and then the grandchildren of the baby boom generation. This has hitherto affected planning for schools and for children's services but we will soon come to the point where it will start to affect services for older people. A person born in 1946 will be 60 in 2006, 65 in 2011, 75 in 2021, 85 in 2031 and 95 in 2041. We will get cycles in which in one decade there is a rising demand in services for independent older people (recreational facilities, pre-retirement courses etc) and then in the next decade that demand will fall but there will be a rising demand for services for dependent older people.

AGEING WELL

Clearly there is a need to focus our efforts on ensuring that healthy and active ageing is an attainable goal for the people of Stockport.

It is important to ensure that we provide information and initiatives that target people at different life stages and recognise their differing needs.

In Stockport we have a range of excellent initiatives, provided through Age Concern, that successfully engage those people who have already retired.

Yet one group of people who are often overlooked are those aged between 50 and 65 years, although the evidence shows that in order to achieve our goal we must engage with people well before they reach retirement age.

People aged between 50 and 65 years are particularly receptive to interventions aimed at improving quality of life in later years. They want the opportunity to reflect and consider their future and plan what they will need for a healthy and fulfilling older age. They want to take control of their own health and wellbeing and to have available a range of opportunities that allow them to do this effectively.

The ingredients for successful ageing are judged to be:

- High level of self-rated health
- Continued mobility
- Continuing residence in the community
- Using health services infrequently
- Good mental awareness
- Walking and having regular social activities

And the following six lifestyle issues influence people in their retirement:

- Attitude
- Health
- Finance
- Housing
- Role change
- Productive use of time

Healthy and active ageing is everyone's business, not just the NHS.

In Stockport we have a long history of excellent joint working between the NHS, the Local Authority, the voluntary sector and the workplace and we need to actively engage all these partners in this agenda.

Health and lifestyle events need to be broadened out to include advice and information about finance and employment.

Events should be held in venues away from mainstream health services so that they become more attractive.

We need to build on the good work that has taken place in specific localities, such as the Healthy Living Scheme project.

As the major employers in Stockport the NHS and Local Authority must take the lead in providing workplace based resources and events that can act as examples of good practice for the private sector.

The recently formed All Our Tomorrows Board, which has representatives both from the public and all local agencies, is ideally placed to drive forward this agenda. The challenge is to ensure that new initiatives are fully inclusive and appeal to people of all ages and abilities.

It is sometimes wrongly believed that health promotion and disease prevention in older people is too late, but in fact evidence shows that it is effective and prolongs the independent period of the person's life.

AGE DISCRIMINATION IN HEALTH SERVICES

Age discrimination in health services is unacceptable. This does not mean that everybody should be treated in the same "one size fits all" way. It means that everybody must be valued and treated as an individual.

The fact that somebody is a particular age does not, of itself, say anything about the kind of medical care that it is appropriate for them to receive. Some people in their early 70s are frail and elderly and should be treated as such. Other people in their early 70s have two decades of active life ahead of them and are in every respect young. There are appropriate ways to care for people who are frail and elderly and approaching the end of their life which are different from the way we should treat people who are in the full flush of life, but these are to do with the individual not with their chronological age.

This is the essence of the statement that we are opposed to age discrimination in health care. It does not mean that we should carry out heart transplants on people in the last few months of their life. It does mean that we should not assume that somebody is in the last few months of their life just because they are 81.

An issue that sometimes influences the care given to older people is research which suggests that people have certain risks or characteristics or respond in particular ways.

What such research means is that statistically people of that age have those characteristics to a greater extent than people of other ages. That does not mean that every individual in that group has that characteristic. Assuming that they do and applying the finding to individuals in that way is a well known error known as the "ecological fallacy".

To illustrate why it is a fallacy I would like to give two examples that are, by their nature, extreme and absurd, and that thereby illustrate the point.

Just because life expectancy in a particular geographical area is 76.8 years, it cannot be assumed that everybody in the area who was born 78 years ago is dead.

If a disease were more common in blonde blue eyed people than in black haired brown eyed people it would be more common in Swedes than in Italians. That would not mean that a blonde blue-eyed Italian was at lower risk than a black-haired brown-eyed Swede.

It is against this background that research of the kind we discussed must be applied.

This may, of course, be difficult when what we are considering is not the delivery of a service to an individual but the planning of a population intervention. The criteria for a call and recall system for example will need to be defined in a precise form which may not be able to include individualised assessment.

THE END OF LIFE

When people do become frail and in need of care it is important that care is oriented towards respecting their independence and maximising their opportunities still to enjoy their life and make it meaningful.

In the final weeks and months of life many people become totally dependent. It is almost always possible to relieve pain in dying people and there is no reason why anybody should suffer the discomfort of dehydration or uncomfortable sleeping positions in this period. Unfortunately public expectations are too low in this area and therefore, where poor professional practice does exist, it often goes unchallenged.

A2.2.9 Health Services – Optimising resources

The main purpose of a healthcare system is to improve the health of the people.

Health gain is achieved when

- years are added to life
- life is added to years

Health gain occurs through a wide range of activities, not just health care, which is why this report opened by asking what everybody can do to address the major health problems of Stockport. But health care services have the feature of being provided primarily for health gain – there is no purpose in carrying out a healthcare activity unless it lengthens somebody's life or increases somebody's capacity to enjoy the life they have.

Health care services are not unique in being provided primarily to provide health gain – the same could be said of environmental health, industrial health and safety services, certain regulatory systems and health protection services. All such services ought to subject themselves to the discipline of asking whether they are achieving, within their particular field, the maximum health gain that is possible from the resources they use.

This isn't a precise mathematical exercise because

- human reality is never precise
- there is no easy way to value one kind of health gain against another in a single currency
- we can't always measure health gain
- one of the benefits the NHS provides is the peace of mind of knowing it will be there for you when you need it so it would be entirely wrong to write off certain activities entirely on harsh cost/benefit analyses which neglected equity
- much experimental and research activity achieves little health gain at present but lays the ground work for developments which will achieve health gain in the future

Although it is not a precise mathematical exercise it must become a way of thinking. We must appreciate that we invest in health services in order to achieve health outcomes.

A useful model for assessing need for services is the Stevens-Gabbay model. This defines a health need as anything which will produce an improvement in health (i.e. will add years to life or life to years). It contrasts this with health demand (the services people ask for) and health supply (the services people get) and argues that the goal is to bring them together so as to discourage the supply of or demand for unneeded services and in their place carry out the activities that will improve health.

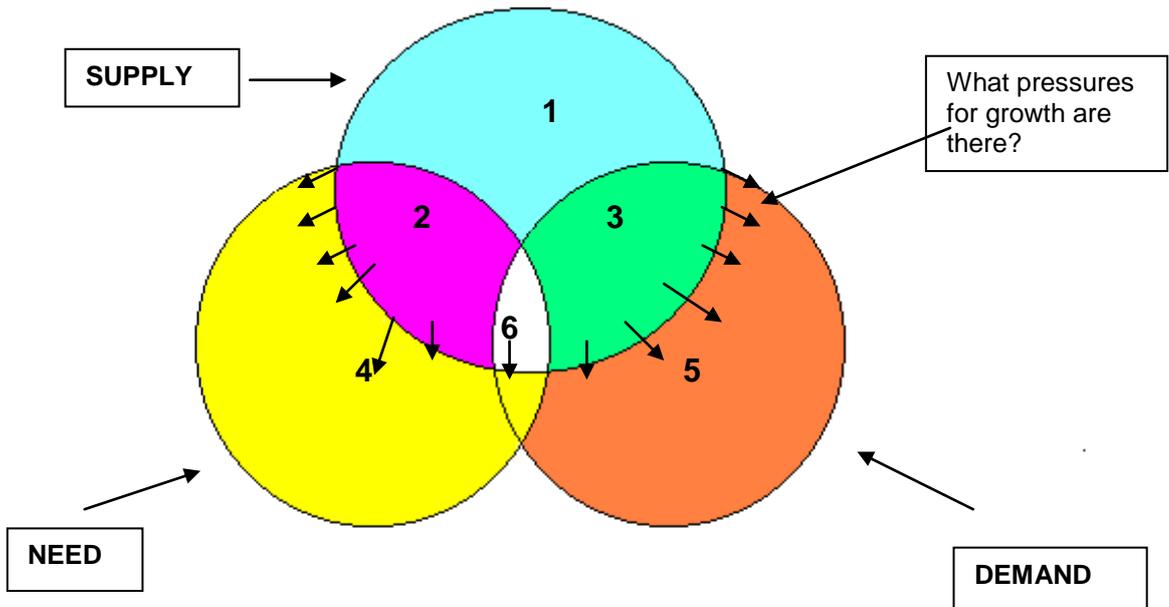
STAGE 4 – APPLYING THE STEVENS GABBAY MODEL TO THE PRESENTING

PROBLEM OR THE PRIORITISED PROBLEMS

- In this stage of the exercise we adopt a rigorous and disciplined approach to considering what will work best in the context of the resource constraints that apply. We carefully distinguish the concepts of supply, need and demand and look at mismatch between them as a cause of wasted resources. And we carefully distinguish the concepts of efficacy, effectiveness and efficiency as a way of thinking about what will work.

What is supplied? **What** do people currently do to address this problem? Is this:

- *efficacious?* i.e. a *treatment or change* is efficacious if it significantly lengthens the life or improves the quality of life of a significant proportion of the people to whom it is given or applied
- *effective?* i.e. a *service* is effective if it delivers efficacious treatment or change to the substantial majority of those who would benefit from it
- *efficient?* i.e. a *system* is efficient if it so uses its resources as to maximise the effectiveness of the greatest possible number of the services it supports.



WHAT IS NEEDED?

- What does the evidence suggest would work to address this problem?

WHAT IS DEMANDED?

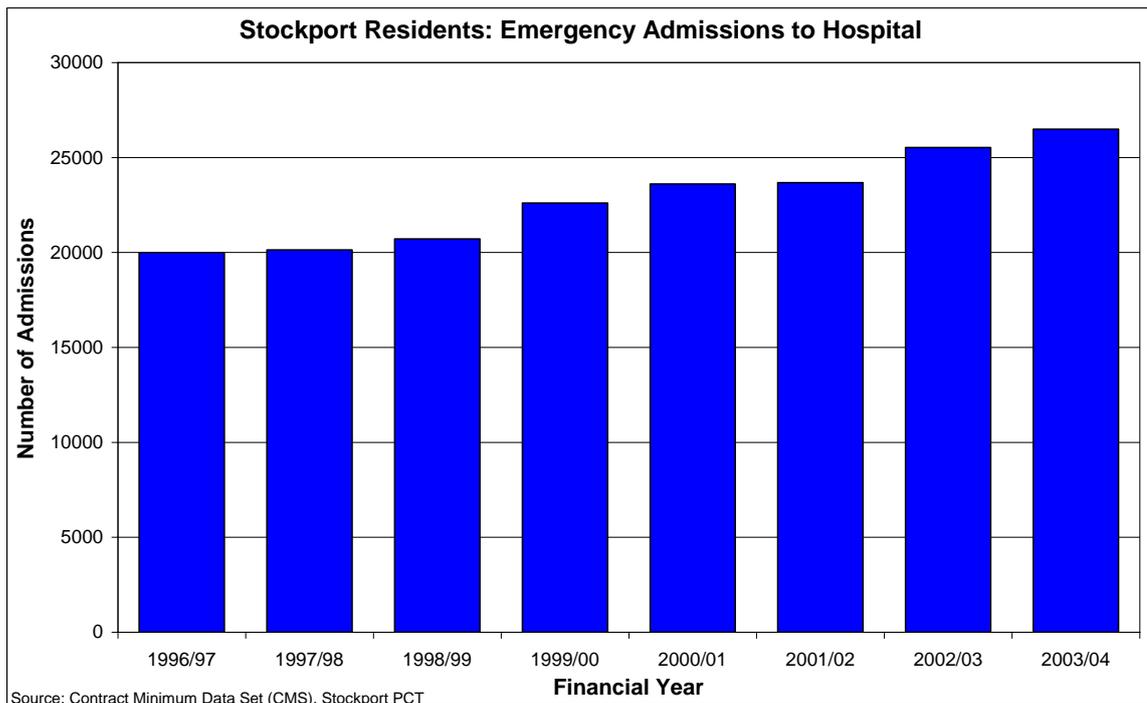
- What do people want to do to address the problem?
- Why is this what they want to do?
- Who have we consulted?
- How do we know this is what is demanded?

Graph A2.2.9.1

THE PROBLEM OF INCREASING USE OF HOSPITALS

There is a steadily escalating use of hospitals for emergency unplanned care.

Figure A2.2.9.2



At first sight this seems paradoxical – Stockport is getting healthier yet its citizens think they need emergency medical care more often.

This is a problem.

It is a problem for the hospital, because it means that facilities which are needed for planned care are pre-empted by emergencies.

It is a problem for the health economy as a whole because, under the system of payment by results, it attracts money that is needed for community services and redirects it into the hospital.

It must therefore be addressed.

The increase is predominantly in very short admissions and with non-specific diagnoses.

Table A2.2.9.3 **Stockport Residents: Emergency Admissions to Hospital**

<u>Financial year</u>	<u>Number of emergency admissions</u>	<u>Proportion of these episodes with a:</u>	
		<u>length of stay of 0 or 1 day</u>	<u>primary diagnosis of 'symptoms, signs & abnormal findings'</u>
<u>1996/97</u>	<u>19,992</u>	<u>35.8%</u>	<u>18.9%</u>
<u>1997/98</u>	<u>20,134</u>	<u>43.0%</u>	<u>18.2%</u>
<u>1998/99</u>	<u>20,708</u>	<u>35.8%</u>	<u>17.9%</u>
<u>1999/00</u>	<u>22,595</u>	<u>39.8%</u>	<u>20.9%</u>
<u>2000/01</u>	<u>23,601</u>	<u>40.5%</u>	<u>22.7%</u>
<u>2001/02</u>	<u>23,669</u>	<u>42.2%</u>	<u>24.7%</u>
<u>2002/03</u>	<u>25,528</u>	<u>43.8%</u>	<u>23.4%</u>
<u>2003/04</u>	<u>26,491</u>	<u>43.7%</u>	<u>23.8%</u>

Source: Contract Minimum Data Set (CMS), Stockport PCT

This suggests that the hospital is coming to be used as a primary care facility. This is also paradoxical as access standards in general practice have been established and generally achieved and so people seem to be inappropriately using hospital more often at the very time that it should be becoming easier to use general practice.

THE CHEST PAIN ISSUE

A substantial proportion of the very short admissions suffer from chest pain.

Table A2.2.9.4 **Stockport Residents: Emergency Admissions to Hospital**

<u>Financial year</u>	<u>Number of emergency admissions with a length of stay of 0 or 1 day</u>	<u>Proportion of these episodes with a primary diagnosis of 'chest pain'</u>
<u>1996/97</u>	<u>7,164</u>	<u>2.8%</u>
<u>1997/98</u>	<u>8,660</u>	<u>3.5%</u>
<u>1998/99</u>	<u>7,409</u>	<u>3.7%</u>
<u>1999/00</u>	<u>8,994</u>	<u>5.5%</u>
<u>2000/01</u>	<u>9,550</u>	<u>7.2%</u>
<u>2001/02</u>	<u>9,990</u>	<u>7.5%</u>
<u>2002/03</u>	<u>11,175</u>	<u>7.7%</u>
<u>2003/04</u>	<u>11,569</u>	<u>8.9%</u>

Source: Contract Minimum Data Set (CMS), Stockport PCT

We have increasingly been advising people who suffer pain in their chest to go directly to hospital so that we don't miss heart attacks. This is a rational strategy. Most deaths from heart attacks occur early after the attack, and the fatality rate declines with the passage of time after the attack, so it is a good idea to cut out the delays in getting people to hospital.

So we encourage people with chest pain to go to hospital. When they get there they will be given tests to show whether they have had a heart attack. These tests will take several hours to come through. In the interim period people cannot be sent home because if they have had a heart attack they will still be in the most dangerous period. Nor can they be kept waiting in A&E because it is not a particularly pleasant place to wait, nor will they necessarily be under direct supervision all the time. Government targets prevent us from keeping people waiting more than four hours.

So at the moment all that can be done is to admit people.

Most of those admitted will not have had a heart attack – they will have things like cramp in their chest muscles, severe indigestion, or severe heartburn.

Applying the Stevens-Gabbay model the health need of those who may have had a heart attack but probably haven't is to have a test to establish that they haven't a heart attack and then to be in the presence of people who can resuscitate them if they have a cardiac arrest until the negative test results come back. Everything else is unneeded. Indeed ideally they would be in as relaxed and normal an environment as possible.

So perhaps the solutions is to have some kind of facility, perhaps even laid out as a lounge, Cybercafé or something of the sort, staffed by somebody fully trained in emergency cardiopulmonary resuscitation and close enough to the hospital for the cardiac arrest team to be able to get there as easily as to a ward.

WHY DO PEOPLE DRIVE PAST THE PRIMARY CARE FACILITIES?

Chest pain is not the whole of the problem. Many people are using A&E as a primary care service.

During the day most people will be closer to their own GP's premises than to A&E and use of A&E has been rising at the same time that access to general practice appointments has been improving in response to Government targets.

Out of hours, the Mastercall out of hours primary care service (formerly called the Doctors' Deputising Coop) is actually closer to much of Stockport than the A&E Dept. so that for many patients who come to A&E it would be more convenient to come to Mastercall. It isn't a drop in facility but a single phone call will suffice to make an appointment.

For the West of the Borough the walk in centre at Manchester Airport is closer than either Mastercall or Stepping Hill. Why then do people who haven't had an accident and aren't an emergency drive past these facilities to go to the Accident & Emergency Dept?

Should we more actively promote the use of primary care facilities?

Would people be more likely to use Mastercall if it was formally a walk in centre instead of people needing to ring up?

Should we continue to let people use A&E inappropriately or should the triage system at the A&E Dept redirect people who are using the service inappropriately?

Should we establish a walk-in centre next to the A&E Dept so that those who come to the hospital inappropriately can more easily be directed into a primary care facility?

These questions need to be asked if our service for accidents and for emergencies is not to be overwhelmed by people who do not need it.

ALTERNATIVES TO ADMISSION

Often people go to A&E or are sent in to hospital as an emergency by their GP because that is a reliable way to get services that they think it would be difficult to obtain otherwise. Often people are treated in hospital because there is no alternative way of treating them.

For example somebody may be referred to a consultant because that is the only way to access a diagnostic test that is not available to GPs, or may be admitted under the care of a consultant when all a GP wanted was the consultant's opinion. A person may come to A&E because they cannot gain access to social care services at home out of hours.

We need to ensure that alternatives are available where they meet the need more cheaply.

THE BALANCE OF CARE

Emergencies are not the only area where hospitals are used for services that can be just as effectively provided in primary care.

Tier 2 services have been defined as packages of care that provide an appropriate alternative to secondary care consultant based outpatients and thereby support a reduction in secondary care wait times and reducing emergency admissions via programmes of care. The services are commonly delivered by GPs with specialist interests (GPwSIs) and PwSIs (Practitioners with Specialist Interest) for example Extended Scope Practitioners. These programmes are now part of our Integrated Clinical Assessment and Treatment Services (ICATS).

Stockport has a number of tier 2 services including:

- General surgery – local anaesthetic vasectomy service, thereby reducing GP referral, outpatient attendances and supporting reductions in wait times.
- General medicine –COPD /Heart Failure (including direct access to investigations) thereby reducing GP referrals to general medicine and emergency admissions, reducing outpatient attendances, wait times and achieving NSF targets.
- H Pylori Testing- has enabled the introduction of evidence based guidelines supporting primary care in clinical decisions and enabled the implementation of Direct Access Gastroscopy. It has been estimated that H pylori testing could lead to a reduction of up to 700 upper GI endoscopies per year and there are benefits to patients who will potentially avoid a non-invasive test.
- Orthopaedic Assessment Service has been taking referrals from all GP practices in Stockport since April 2003 via the Referral Information Centre. The number of referrals to secondary care orthopaedic services has decreased by approximately 30%.
- The Cataract Direct Access Assessment and Referral scheme has now been operational since May 2003. Full assessments are done by local optometrists with direct referral into surgery for suitable patients.
- Primary Care Mental Health Liaison Service: Screens all referrals into the service , manages the care of clients under Care Programme Approach (CPA – severe common mental health problems), refers

directly to counselling and cognitive behavioural therapy and services for common mental health problems, improves access and triage of referrals to prioritise needs to direct service users to the most appropriate levels of care, seeks to address historical inequalities of access across Stockport PCT

- Dermatology: The service is now providing: Triage of dermatology referrals, primary care management of eczema, psoriasis, rashes, acne. We are also part of a pilot of the telemedicine for plastic surgery and referrals which will commence in May 2005
- Gynaecology: Triage of referrals is currently in place and patient booking for insertion of coils and management of sterilisation, HRT implants and menorrhagia (in June 2005)
- Urology – Lower Urinary Tract Symptoms (LUTS): The service is due to be operational in May 2005 providing clinical assessment and diagnostics for patients with lower urinary tract symptoms.
- Minor Surgery: The PCT is currently accrediting a small number of GPs via the new locally enhanced service for management of minor surgery for the expedited service so that further additional capacity can be managed by the service and inappropriate referrals to secondary care deflected. Modernisation of the current enhanced programme will be implemented shortly which should lead to improved patient pathways and deflection from secondary care
- Dental: Triage and assessment of referrals into oral surgery is due to start in June 2005.
- Diabetes: a model is currently being developed.

There has now been agreement within Stockport and across Greater Manchester that the ICATS model will be adopted to support the implementation of choice and target the main seven areas of referral and demand in Stockport. PCTs are looking to work more collaboratively across the sectors with agreed models and pathways to support sustainability of services.

Prevention and healthier lifestyles can also reduce the demand on hospitals. The Wanless report suggested that with the “fully engaged scenario”, in which society and individuals focus on improving health hospitalisation could be reduced by 10%

The Wanless Fully Engaged Scenario: assumes a 25% reduction in CHD/stroke admissions for 15-64 year olds, a 15% reduction in other admissions for 15-64 year olds, a 10% reduction in all admissions for those aged 65 and above and a 5% reduction in births requiring special or intensive care. This would result in 6868 fewer admissions in Stockport residents each year by 2022/23.

The Wanless Solid Progress Scenario: assumes a 10% in CHD/stroke admissions for 15-64 year olds, a 5% reduction in other admissions for 15-64 year olds, a 5% reduction in all admissions for those aged 65 and above and a 5% reduction in births requiring special or intensive care. This would result in 1937 fewer admissions in Stockport residents each year by 2022/23.

The Wanless Steady State Scenario: assumes no change in admission patterns as a result of health behaviours. This would result in 1250 fewer admissions in Stockport residents each year by 2022/23 due to the expected population change.

Wanless may indeed have underestimated the potential because the elimination of health inequalities in Stockport, so that the whole of the Borough had the same health experience as the most affluent five wards now have, would have an even bigger effect.

The No Inequalities Scenario: assumes that admission rates for the whole of Stockport are the same as the admission rates in our most fully engaged areas (Cheadle Hulme South, East Bramhall, Heaton Moor, South Marple and West Bramhall). . This would result in 10216 fewer admissions in Stockport residents each year by 2022/23.

These figures are based on: Stockport Residents, Inpatient and Daycase Admissions, HRG of first episode.

**A2.3 STOCKPORT'S PUBLIC
HEALTH GOALS**

Table A2.3.1.1 Stockport Public Health Goals and Outcomes

Goals		Outcomes								
Measures	Reduce Inequalities in health	Reduce sickness and death from Heart Disease	Reduce sickness and death from Infections	Reduce sickness and death from Cancer	Reduce Sickness and death from Accidents & Emergencies	Reduce disability and dependency from old age	Reduce disability and dependency from Mental ill health	Reduce disability and dependency from Learning Disabilities	Reduce disability and dependency from physical disability	Reduce disability and dependency from asthma
Social & Environmental Factors										
Improve Air Quality										
Improve Social Support, Community Spirit and Empowerment	✓	✓	✓		✓	✓	✓	✓	✓	
Reduce Discrimination & Social Exclusion	✓	✓	✓	✓			✓			
Creating Pleasant Restful Environments	✓	✓	✓	✓			✓		✓	
Improve Health in the Workplace										
Reduce Prevalence of Poverty	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Affordable warmth	✓	✓	✓			✓	✓			
Reduce Traffic Speeds	✓				✓					
Improve Safety for people who live, work and play	✓				✓				✓	
Reduce Impact of Crime & Fear of Crime	Removes many barriers to healthy behaviour and addresses positive Mental health									
Improve Positive Mental Health	✓	✓	✓	✓		✓	✓	✓	✓	
Reduction in Stress	✓	✓	✓	✓		✓	✓	✓	✓	
Minimising Car Use and Increasing Walking and Cycling	✓	✓			✓		✓			✓
Services & Population Groups										

Goals		Outcomes								
Measures	Reduce Inequalities in health	Reduce sickness and death from Heart Disease	Reduce sickness and death from Infections	Reduce sickness and death from Cancer	Reduce Sickness and death from Accidents & Emergencies	Reduce disability and dependency from old age	Reduce disability and dependency from Mental ill health	Reduce disability and dependency from Learning Disabilities	Reduce disability and dependency from physical disability	Reduce disability and dependency from asthma
Improve Services for Heart Disease, Diabetes & Strokes	✓	✓				✓			✓	
Improve Services for Cancer	✓			✓						
Providing Life Change support		✓	✓	✓			✓			
Provide Community Development	✓	✓	✓	✓		✓	✓	✓	✓	✓
Improve the Health and Well-being of Children & Young People	✓	✓	✓	✓	✓		✓	✓	✓	✓
Improve the Health of Older People	✓	✓	✓	✓	✓	✓			✓	
Provide Health Protection			✓		✓					
Provide Screening Programmes	✓	✓	✓	✓					✓	
Individual Factors										
Reduce Smoking	✓	✓		✓	✓				✓	✓
Improve Diets	✓	✓		✓						
Reduce Obesity	✓	✓							✓	
Increase Physical Activity	✓	✓				✓	✓		Osteoporosis	✓
Improve Sexual Health	✓		✓	✓						
Reduce Alcohol Misuse	✓	✓		✓	✓		✓			
Reduce Drug Misuse	✓		✓	✓	✓		✓			✓
Improve Rates of Breastfeeding	✓		✓	✓						

A2.3.1 Air Quality

The goal in the strategy is “To improve air quality in Stockport”

Half a century ago the main cause of poor air quality was domestic and industrial smoke. The Clean Air Act with the smoke control orders that resulted from it cleaned the air and caused major reductions in respiratory illnesses saving many lives.

At the time of the Clean Air Act it was recognised that emissions from transport were the next largest source of air pollution and it was intended that these should be addressed once the problem of domestic and industrial emissions had been resolved. Transport emissions are now the major issue in terms of air quality.

The growth in road traffic since then has made matters worse. It has been partially offset by increasing engine efficiency which reduces emissions but nonetheless the impact of increasing traffic outweighs the beneficial effect of technological change.

Poor air quality causes asthma and other respiratory diseases.

Whilst the major cause of poor air quality is the volume of traffic, levels of congestion are also important. Emissions will be at their lowest for any given volume of traffic if the traffic is moving freely at a constant speed. For this reason it is important in traffic calming to position obstacles and humps sufficiently close together that vehicles cannot speed up between them.

Road capacity increases as the speed of traffic falls and the ideal is for traffic to travel at a constant but slower speed instead of rising above the road capacity and then being reduced sharply by congestion. Current methods for regulating this, such as phasing of traffic lights, are blunt instruments.

The Downs-Thomson Corollary of Pigou’s Theorem predicts that in a saturated road system congestion will increase until the speed of traffic is slowed to the point at which travel by car is just marginally more attractive than travel by public transport .Therefore the only way to reduce congestion is to improve public transport.

A2.3.2 Improve Social Support, Community Spirit and Empowerment

The goal of the strategy is “To improve social support, community spirit and empowerment in Stockport”.

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

According to the Alameda County study in California the effect of poor social support is as strong as the effect of poverty. Moreover because the strength of the effect increases with the length of time exposed it appears to be a causal relationship, rather than being due to, say, people who are ill withdrawing from social contact.

It is thought that the reason social support has this impact is that it provides protection against stress.

There are many sources of social support including families, friends, networks of people with shared interests, and faith groups. Neighbours also provide social support and research has shown that they do so to a greater degree in lightly-trafficked streets than in heavily-trafficked streets.

This demonstrates the value of a relaxed social environment in which to develop friendships. Crowded, noisy, urban environments make the growth of informal relationships difficult. These are the relationships which allow us to air problems and discuss solutions.

Opportunities for people to meet and discuss issues may need to be manufactured because these joint and informal approaches to problem solving help to nurture the social and organisational skills which many people lack.

In urban communities people often establish social networks on the basis of shared interests and such networks can often cover quite a wide geographical area.

However people with low self-esteem find it difficult to access the social opportunities that are based on common interests. Acquiring skills makes it easier to move towards greater self-reliance and self-respect.

So it appears that in urban communities it is very difficult for those who have fallen behind with social, organisational and educational skills, to get themselves back on the ladder. If they can be helped to do this, people can go on to acquire a range of skills which make them healthier and more productive. By overcoming these very fundamental barriers to social inclusion, community development workers help people to lead healthier and more productive lives.

However local communities are an important source of social support. Community spirit is an intangible but undoubtedly real factor and strong community spirit will not only increase social support levels in the community but it will also empower people, increasing the likelihood that problems affecting the community will be seen as shared problems, and effectively addressed, instead of becoming causes of stress affecting individuals.

It is to enhance social support, community spirit and empowerment that the PCT and the local authority maintain a community development programme. Voluntary organisations also play an important role in achieving these objectives.

A2.3.3 Reduce Discrimination and Social Exclusion

The goal of the strategy is “To reduce discrimination and social exclusion in Stockport”

Discrimination and social exclusion is harmful to health as it is a threat to a person’s identity and self-respect and therefore causes stress.

It is important to address not only direct discrimination and hate crime, but also sources of indirect discrimination.

Race, gender, disability, and class equality and the avoidance of age discrimination are important parts of the process of recognising and celebrating human diversity. Racial, cultural and religious differences and other differences in belief systems are a key element of the rich diversity of human beings. The differences between people in their skills and abilities are another such element as are gender differences, and differences in sexuality.

We aim to recognise that rich diversity because:

- a) it is good manners to treat people as individuals
- b) health professionals have an ethical duty to make their services available to all their patients in a way that reflects their individual circumstances
- c) health service providers have an ethical duty to make their services available to all without barriers
- d) the NHS Plan sets out a vision that places equality, fair treatment and social inclusion at its heart
- e) employers who do not draw upon the full range of available workers lose out on the skills and energies that could have been available to them
- f) full opportunities for participation in society is both a human right and an aspect of health.

The Race Relations (Amendment) Act 2000 which requires us to produce a race equality scheme merely formalises a commitment that we had already taken on, for example through

the analysis of racial access to our jobs and services in our first inequalities audit. We have chosen to adopt a similar approach to other aspects of diversity, indicating not only those (age and disability) for which the requirement is soon to become statutory, but also others.

The differences between “mainstream culture” and “ethnic cultures” are no greater than the other differences that exist within our national culture.

It is important that we do not come to think of cultural differences as something that only affects people whose ancestors were born in a faraway land, as this will create an impression that people from different cultures are an unusual problem group whilst at the same time it will prevent us seeing and addressing cultural differences within the mainstream culture.

Human beings differ in their abilities. All of us have things that we cannot do as well as most other people and all of us have things that we do better than most other people. Disabled people are simply people whose pattern of strengths and weaknesses has a serious impact on their capacity to participate in society because they cannot do things that are central to such participation. The aim is to overcome those problems so that, like the rest of us, they can concentrate on contributing to society by doing the things they do well.

A2.3.4 Pleasant and restful environments

The goal is “To create pleasant and restful environments in Stockport.”

Pleasant and restful environments contribute to raising the human spirit and to providing the tranquillity that eases stress.

Outdoors the maintenance of pleasant and restful environments is achieved through the process of creating and maintaining a green environment, discussed in chapter 1 in the section on “A Country City”.

Indoors we can all take responsibility for softening the environments in which we work through the use of plants, the creation of pleasant work layouts, the provision of attractive rest areas, and so on.

A2.3.5 Workplace Health

The goal is “To improve health in the workplace in Stockport.”

About a third of social class variation is attributable to work.

Occupational health affects both men and women but is partially an issue of male gender because men are more likely to work, and also because working men are more likely than working women to work full time and to work in heavy industry where occupational health issues are greatest. The gender difference in this issue is declining as gender differences in employment patterns decline and as heavy industry becomes less of a force in the economy.

Improvements in occupational health are one of the two main reasons for improvement in male life expectancy over the last 50 years – the other being the prolonged period of relative international peace which prevented men being slaughtered in large numbers in war as happened to generations born prior to the mid 1920's.

Individuals are healthiest both in the sense of enjoying the highest state of well being and in the sense of suffering the least mortality when:

- (a) Their physiological needs for warmth, food, shelter, water, air etc are securely met
- (b) their psychological needs for love, status, opportunities to enjoy beauty personal development and creativity etc are securely met
- (c) they are in secure control of their own lives
- (d) the environment in which they exist corresponds as closely as possible to that in which

- human beings evolved to live
- (e) their lifestyle corresponds as closely as possible to that which human beings evolved to live.

The process of creating healthy work is a process of meeting these five objectives in the work setting.

Work does not usually actively contribute to the deprivation of physiological needs and the situations in which it does so (work in cold conditions for example) will be readily recognised.

Work provides people with the money which they use to purchase things that are necessary for the meeting of their physiological needs (such as food, fuel, warm clothing) and low paid work is therefore a cause of ill health.

The contribution of work to psychological well being is discussed above in the section on stress.

Work provides people with many things. It provides them with:

- income
- structure to their day
- social contacts
- status
- a sense of contributing to society.

Work can also provide:

- fun,
- satisfaction,
- social support and group membership
- opportunities for growth and creativity
- a sense of achievement
- services available at the workplace
- education and information.

Work can facilitate other aspects of life or it can conflict with them. Work can take place in pleasant or beautiful surroundings or in unpleasant squalor.

It can be safe or unsafe, healthy or unhealthy, human or mechanistic. It can offer security or be a source of constant worry.

The distinction between good quality and poor quality work is possibly one of the biggest inequalities in our society. People who enjoy their work, have a significant degree of control over it, are able to integrate it into their total life and who work in pleasant safe surroundings with strong social support at tasks which they like and who are securely well paid for it enjoy dramatically better health than people who carry out mechanistic tasks under close control, in time which they see as separate from the main goals of their life, in unpleasant dangerous settings, alone and alienated, for low pay under constant threat of unemployment. Some factory closure studies especially studies of old fashioned "black site" work have shown health improve with redundancy. This is not to defend unemployment but to show that some kinds of work are even more damaging. The health damage of poor quality work and the health damage of unemployment are often counter-posed yet they are not alternatives - they are to large extent successive experiences of the same people. A large section of society securely enjoys good quality work and is unlikely to experience either poor quality work or unemployment. Another large section of society slips in and out of poor quality work and is unlikely ever to enjoy good quality work. In between these two groups are those whose tenure of good quality work is insecure and those whose work has a mixture of good and bad features (such as work that is well paid and meaningful but involves long hours with unpleasant settings).

It is the current Government strategy to help people out of unemployment into work as a way both

of reducing welfare expenditure and creating well being - a double gain for society and the individual.

A more ambitious objective would be to help people out of unemployment or poor quality work into good quality work. We should not debate the relative merits of unemployment and exploitation or move people between the two. Both are unacceptable.

Work is subject to important social trends which could enhance the availability of good quality work or could undermine it.

The trend from large enterprises to small enterprises and from manufacturing to services could improve working conditions and make work more human and meaningful. Or it could lower pay and increase insecurity.

The trend to flexibility and short term contract labour could lead to insecurity or it could widen choices and increase people's control of their lives.

The trend to home working could increase autonomy and choice and make it easier to fit together work and family life. Or it could lead to uncontrolled working conditions in cramped home offices that would never pass muster as a workplace and that create a lack of social support and social contact.

Consider for example the following dream and nightmare scenarios for the transition to technology-mediated home working.

A is an accountant holding a major position as a commercial negotiator with a large company. From the large purpose built study in A's house overlooking the Mull of Kintyre, deals running into millions - sometimes billions - are negotiated daily by e-mail. The study has a beautiful view across the sea and allows her to keep one eye on her children playing on the beach.

At five past six she closes a major deal, drinks a glass of champagne, calls to the children and still has over an hour to get ready for her dinner party at 7.30.

B and C live in a two bedroom terraced house in a Northern industrial town. Because of the high technology home working adopted by their employer they have had to fill the sitting room with computers, fax machines and other office equipment and have only the kitchen to live in. As C struggles to complete a long list of telephone promotional calls B changes the baby's nappy. B's computer beeps insistently. The door bell rings. The shopping C ordered on the Internet late last night has arrived. As C opens the door to collect it she realises that it is the first time the door has been opened for seven days. B notices that the order does not include any alcohol and shouts at C. B's computer beeps again. The baby starts crying and B sticks the safety pin in himself. B hits the baby. There is an ominous silence

The danger is that inequalities may widen - that A's experience of flexibility and the opportunity to live in beautiful surroundings will be the future for those who currently enjoy good quality work and that B and C's experience of unpleasant stressful work imprisoned in their own home will be the replacement for poor quality work.

As well as the contribution of work to life, and the role of good quality work especially, work is an important area for accidents.

Those who base accident prevention on the idea that human beings can, by education and exhortation, be prevented from ever making a mistake, base their strategy on an idea which everyday human experience and a welter of academic research shows to be untrue. The success of accident prevention depends largely on the extent to which this fallacy has been abandoned.

The prerequisite for accident prevention is a belief that accidents need not happen. So long as accidents are accepted as an inevitable part of life any attempts at their prevention will be half hearted. Accidents probably are an inevitable part of life, but they are not inevitable in anything like the numbers in which they currently occur and accepting the inevitability of some accidents can so easily become an excuse for accepting too many accidents and then merge imperceptibly into

accepting negligence, irresponsibility and sloppiness. Past generations accepted rail crashes, workers being sucked into unguarded machinery and deaths in pregnancy as part of the everyday hazards of life. Yet today when any of these things happen there is the horror of unexpected death and the anger of avoidable death. That is a symbol of the success of the preventive strategies targeted at each of these types of event.

If accidents are not accepted as inevitable it follows that every accident is something to be learned from. The highly effective fail safe approach of modern railway signalling did not just fall out of the sky like manna from heaven. It emerged from many years of investigating the cause of railway accidents and adopting improvements to prevent recurrence (121) A similar approach is followed in the civil aviation industry. Outside the transport field the same basic principle - investigating things that go wrong and seeing that the same thing does not happen again - has been one of the main instruments for the decline in maternal mortality to negligible levels.

It is not enough to investigate accidents if human error is to readily accepted as the cause. Sometimes human error will result from incomprehensible stupidity, negligence or irresponsibility, and it can legitimately be labelled as the root cause of the accident. But often this is not the case.

A human error due to a momentary lapse of concentration is not the cause of an accident - the cause is the system of work which failed to build in fail safe mechanisms that take account of the simple and well known fact that human beings have momentary lapses of concentration.

A human error due to lack of knowledge or skill is not the cause of an accident - the cause is inadequate training.

A human error caused by cutting corners in order to improve production is not the cause of an accident - the cause is the management system which places a greater emphasis on production than on safety.

A human error due to poor communication is not the cause of an accident - the communication system is.

A human error occurring in situations of overload is not the cause of an accident - the cause is the overload which made it impossible for people to do everything properly.

A human error occurring from struggling through in inadequately resourced conditions is not the cause of an accident - the cause is the management system which gave people responsibilities without the resources to cope with them.

A human error occurring from accepting too readily the non co-operation of others is not the cause of an accident - the cause is the management system which gave responsibility without the authority that was needed to discharge it.

A human error resulting from failure to seek advice is not the cause of an accident - the cause is the management system which embodied inadequate support and unreasonable expectations of self reliance.

The pre-requisites of safety are good housekeeping, management systems which recognise the potential and the limitations of human beings, training, use of technology, concern with outcomes, concern with learning from failure, and applying new knowledge to change the ways things are done.

The causes of accidents are lack of investment, poor management systems, sloppiness, cutting costs without regard to consequences, short sightedness, resistance to change, and avoiding management responsibility by putting the blame on workers.

The same prerequisites for success and the same causes for failure could be listed for most other industrial problems, such as poor quality, failure to seek new markets, low productivity and poor industrial relations.

Declining industries have the worst safety records. Is this because the pressures of decline cause them to put less emphasis on the non productive areas of management, or is it because the causes of accidents and the causes of industrial decline are the same?

Perhaps accidents are caused by incompetent management which cannot deliver safety for the same reasons that it cannot deliver quality, productivity, market sensitivity and a satisfied workforce.

Perhaps the manager who cannot make a workplace safe cannot make it work either.

Perhaps pressure for safety is pressure for competence, and is a needed discipline for industry not a burden.

A2.3.6 Poverty

The goal is "To reduce prevalence of poverty in Stockport."

One of the longest known facts of public health is that the poor die younger than the rich. Some of the local implications for Stockport can be found in the special report in inequalities at chapter 10.

There has been some academic debate as to whether the health consequences of poverty derive from:

- poor health producing poverty
- health being damaged by poverty in childhood
- material deprivation eg cold due to not being able to afford to turn the heating up
- difficulties in making healthy life choices eg finding it harder to choose healthy diets because the easiest way to choose healthy choices (substituting low fat low salt high fibre products for traditional food) is more expensive and cheap healthy diets are more difficult, or not being able to walk in the country because of the lack of transport
- the impacts alternately of poor quality work in good economic times and of unemployment in recession
- the psychological consequences of relative poverty and of not being able to enjoy lifestyles that are taken for granted in society generally
- lack of attention to longer term health consequences because of the greater pressure of the grind of day to day existence.

Each of these probably contributes to some extent.

In practical terms there is little doubt that we should both try to reduce the overall prevalence of poverty and also support people in coping with the problems it brings. Economic development, regeneration, the creation of community enterprises, credit unions and LETS schemes contribute to the former. Healthy living schemes, arrangements to help poor people access health-promoting facilities, health improvement projects targeted on areas of deprivation, the affordable warmth strategy and community development all contribute

A2.3.7 Affordable Warmth

For every 1 degree centigrade fall in temperature below that of a warm Spring day there is an increase in coronary heart disease mortality amounting to about one extra death in Stockport every ten days (based on extrapolating to Stockport research carried out elsewhere).

There is some debate as to why this occurs It may be due not only to the direct effects of ambient temperature but also to indirect effects if people give up physical activity they would otherwise have engaged in. However the clear relationship with actual temperature does suggest that at least part of the effect is direct.

This effect, coupled with the impact of winter flu, produce winter excess mortality.

There is a strong social class gradient in winter excess mortality. This may reflect the fact that more affluent social classes are more likely to warm their houses adequately, more likely to travel about in warm vehicles and more likely to have warm clothing. This explanation is borne out by the fact that winter excess mortality is less, and the social class gradient in the excess less, in colder countries. This presumably reflects the fact that the colder a country is the more prepared it is for cold.

Fuel poverty occurs when households are unable to afford sufficient energy for health and comfort due to the combined effect of low income, inadequate heating systems and a lack of insulation.

Affordable warmth is a solution to fuel poverty that enables householders to heat their homes to an adequate level for comfort and health without developing debt as a result.

Affordable Warmth in Stockport is addressed through the Stockport Affordable Warmth Steering Group. The group was established in 2004 and funding was secured from the local authority for the charity group National Energy Action (NEA) to produce a strategy on the group's behalf to address the issues surrounding Affordable Warmth. The PCT secured funding to support implementation of the strategy.

The strategy has been revised and the new strategy 'Warmer Homes, Healthier Homes 2007-2012' sets out an approach to enable all Stockport residents to heat their homes to an adequate level for both comfort and health without experiencing fuel poverty.

Cold, damp, thermally inefficient houses, which people cannot afford to heat sufficiently to protect their health, are a public health scandal. Approximately 20,000 households in the Stockport borough are likely to be affected.

The strategy focuses on measures to reduce the costs of fuel and improve energy efficiency for fuel poor households. Improving the energy efficiency of properties is the key – decent levels of home insulation will simultaneously improve health, cut fuel bills and reduce carbon dioxide emissions. At the same time working with the private sector everyone has access to the best deals when choosing fuel suppliers is also crucial especially in the current climates of fluctuating energy prices.

There are 4 key aims within Warmer Homes, Healthier Homes : to establish an effective partnership approach to deliver the affordable warmth strategy, to maximise the income and grant take up of vulnerable households in achieving affordable warmth, to meet the needs of the different housing sectors in Stockport, and to raise awareness of the issues relating to affordable warmth through training of front line staff and health promotion campaigns.

A2.3.8 Traffic Speeds

The goal is "To reduce traffic speeds in Stockport."

Speed contributes to causing accidents and it also increases their severity.

A pedestrian hit by a car at 40mph has a 95% chance of being killed, at 30mph this becomes 50% and at 20mph it becomes 5%.

Most child pedestrian road deaths would be averted if people drove at 20mph in side streets. As few places are more than a mile from a main road, few journeys involve more than two miles on side roads (a mile at each end). The difference between driving two miles at 20mph and at 40mph is 3 minutes. We are killing our children to save less than three minutes on our journeys.

In residential side roads 20 is plenty.

A2.3.9 Safety

To improve safety for people who live, work and play in Stockport is discussed in the relevant parts of Chapter 1.

A2.3.10 Crime

The goal is “To reduce crime, the impact of crime and the fear of crime in Stockport.”

To be a victim of crime is stressful, having effects comparable to those of a life change. It can indeed be seen as an example of the loss reaction – loss of a sense of safety.

Fear of crime is also stressful. It can also prevent people making healthy choices. It plays an important part, for example, in people’s reluctance to walk, and certainly in their reluctance to allow their children out unsupervised.

A2.3.11 Improving Mental Health

The goal of the strategy is “To improve positive mental health”

Raise awareness of how to look after our own and other’s mental health and to involve all communities and organisations, across all sectors, in taking positive steps to promote and protect mental well being.

There is currently a convergence of national, European and world opinion on the importance of mental health and well being and as a result there is a broadening of mental health policies to embrace improvement of mental health and well being and not just the treatment of mental illness. Furthermore mental health and wellbeing are emerging as a key priority within public health thinking because it is increasingly recognised that the skills and attributes associated with positive mental health which are:

- General capabilities to cope with problems of life, including common sense, energy, tolerance to frustration and considerable reality control
- Social competence- to sustain social contact and networks in a competitive social environment
- Sound self knowledge –knowing what we want and what we can get in a society where choice keeps on expanding
- Insight and ability to learn from experience¹ awareness of our own emotional reactions, so we know whether our choices are ‘best fit’ for us
- The ability to strike a balance between autonomy and self-control

Lead to: improved physical health, better quality of life, reduced crime, higher educational attainment, economic well being and personal dignity as well as contributing fundamentally to the extent to which people feel able and motivated to exercise choice and control and adopt healthier lifestyles. Even small improvements in mental well being can achieve significant cost benefits through improvement in physical health, productivity and quality of life.

Stockport has a dedicated mental health promotion specialist and is working to implement a comprehensive social prescribing service as a way of addressing the need for positive mental health services.

Social prescribing is: ‘A basic model of social prescribing, signposting seeks to link patients up with the non medical facilities and services available in the wider community that they can access to address the factors that influence their wellbeing.’ Stockport is seeking to implement a comprehensive social prescribing service as a way of addressing stress in people’s lives.

The service includes:

Art on prescription. Stockport art on prescription is now in its eleventh year. It has a proven track record of using art to promote and protect people’s mental health. The act of learning the art skills enables patients to see the world differently, to meditate on something outside of themselves and their problems and to develop self esteem. By introducing creativity into people’s life also helps build strength and resilience to stress and anxiety in people’s lives.

Exercise on prescription: there is unequivocal evidence that physical activity has positive effects on stress and anxiety. The social prescribing model is working to promote physical activity as a valid mental health intervention by linking the range of physical activity opportunities in Stockport to mental health services

Books on prescription. The Stockport scheme -Self health- is collaboration between Stockport libraries and information service, Stockport PCT and Pennine care. It is a scheme to facilitate the use of high quality self help materials (books, tapes DVDs and interactive CD ROMs and web-based treatments.) as a treatment for mild to moderate mental health problems.

2004 NICE guidelines on depression, anxiety and eating disorders concluded *'there was A-grade evidence for the effectiveness of bibliotherapy and recommended self help books as part of a stepped-care approach'*

The Stockport self health scheme has an accredited booklist which is taken from the national Cardiff books on prescription scheme. These titles however, provide only part of the self health collection there are also many other self help resources available including cassettes, videos and DVDs.

Stockport also now has a wellbeing website (www.Swellbeing.org.uk) which brings together all the Stockport Wellbeing Services and the valid information and support available on the World Wide Web is one port of call.

A2.3.12 Reduce Stress

The goal of the strategy is "To reduce stress in Stockport"

Stress arises when people face a threat to something which is important enough to them to seem to be part of their identity, and the threat remains without them being able to combat it.

All higher organisms demonstrate a reaction in which the efficiency of their functioning is increased when faced with a threat. This reaction is called the stress reaction, or the "fight or flight reaction".

The purpose of the reaction is to prepare the organism to cope most effectively with the threat.

Mental functioning is enhanced and speeded up – in the most serious of situations this can be seen in the apparent slowing of time that is perceived during serious accidents. It is the increased speed of perception and of mental processing of perceptions that is perceived as the slowing of time.

Physical strength is also increased. People who have been chased by bulls will tell you that they never knew they could run across the field so fast and they certainly have no idea how they vaulted the five foot hedge.

These changes in mental and physical functioning are brought about by widespread changes in physiological processes⁽¹¹⁸⁾. Blood pressure and pulse rate increase. Blood cholesterol increases. Immune systems are depressed by the high levels of circulating cortisone and also by the suppression of lymphocyte production. Gut motility is reduced and gastric acid secretion is increased. Glucose tolerance is reduced so that in those who are on the borderline of diabetes a high blood sugar may result.

The stress reaction as a short lived response to a threat is healthy. It would be astounding if it were not for it is of long evolutionary standing and fulfils an important biological purpose. But it can be seen that the changes which make up the stress reaction, if abnormally persistent, could be associated with ill health. The changes in gastric secretion and gut motility could be associated with ulcers and indeed digestive upsets are one of the commonest observed forms of minor ill health in stressful situations. The depressed immune

reaction could lead on to infections or cancer. The raised blood pressure and blood cholesterol and diminished glucose tolerance could lead to heart disease.

Here we have a biologically plausible explanation for the observed epidemiological relationships between psychological states and physical ill health. We also have the basis for a precise definition of the health hazard called "stress".

Contrary to the common statement that stress is something imprecise, the truth is that stress arises when people face a threat to something which is important enough to them to seem to be part of their identity, and the threat remains without them being able to use up the stress reaction in measures to combat it.

Maslow (¹¹⁵) has devised a taxonomy of human needs which includes:

physiological needs – the need for food, water, air, shelter

safety needs – the need for the secure continuance of physiological needs, perhaps through financial security

belongingness needs – the need for love and friendship

ego status needs – the need for status and recognition

self actualisation – needs for creativity and a driving purpose to life, which Maslow perceives as being the need actually to become oneself. I have always personally believed that Maslow's description of self actualisation is not a description of somebody actually becoming themselves (whatever that means) but in fact a description of somebody paying attention to the sources and processes of ego status and belongingness. I have therefore personally always regarded it as bearing the same relationship to ego status and belongingness that safety needs bear to physiological needs, and I would personally regard it as better named if it were called "relationship-security" needs. This is a personal view which the reader, if interested, must check out himself with Maslow's original meticulous description of the self actualiser

aesthetic needs – the need for opportunities to appreciate beauty

spiritual needs – the need to transcend human relationships and feel at one with the Universe.

Maslow suggests that the first five of these form a hierarchy of motivating needs and that human beings are motivated by the lowest level of need not yet actually satisfied. Whatever may be thought of this controversial hierarchical theory of motivation, it is beyond dispute that Maslow has provided, if nothing else, a taxonomy of human need.

A threat to any level of that taxonomy is capable of producing stress if its is serious enough to challenge personal identity.

Human beings recognise the presence of stress in themselves by a sense of nagging worry and by its physiological correlates of flowing adrenaline, described as being "tense" or "anxious" or "wound up".

They recognise the absence of stress by a sense of peace.

Human beings are also good at seeing stress in other people – at "seeing the worry" in other people's faces, at recognising irritability or reluctance to relax or loss of interest in hobbies as symptoms of an underlying loss of peacefulness.

Stress can also be recognised in organisations in such symptoms as increasing apathy and alienation, rising absence rates, increasing error rates and declining performance.

EXAMPLES OF CAUSES OF STRESS

The following is a list of some examples of causes of stress.

- a) **Uncertainty and threat hanging over somebody (the Sword of Damocles situation)**

Threat :- A serious threat to some aspect of well being existing without the individual being able to influence events, either because they are out of his control or because he lacks the skills to influence them.

Psychological Reaction:- Persistent worry and unease.

Resolution :- The threat resolves itself either by going away or by the event happening (when the Sword of Damocles has fallen Damocles can stop worrying and get on with healing his wounds) or alternatively the individual perceives a way of influencing events and turns the reaction into the classic stress reaction of a healthy challenge.

b) Responsibility without power

Threat :- The individual carries responsibility but is unable to carry it out adequately. This may be because of promotion beyond the level of competence, or because of inadequate training, or because the responsibility has been conferred without the necessary authority or resources, or because of overload.

Psychological Reaction:- Persistent worry and unease about what might go wrong and its consequences for the individual. This is really a form of the Damocles reaction.

Resolution :- The individual either sheds the responsibility or acquires the tools to discharge it properly.

c) The loss reaction

Threat :- Damaged self identity as a result of the loss of something which contributes to self identity.

Psychological Reaction:- a complex process of reactions, described in detail in various psychological textbooks and including periods of worry before the loss, paradoxical relief when it actually occurs, denial, despair, unhealthy adjustment in which people limit their lives to avoid facing up to the loss and finally healthy adjustment in which people, although deeply regretting the loss, nonetheless live a normal life unaffected by it.

Resolution :- Healthy adjustment, i.e. the construction of a new self identity without the lost element.

d) The type a behaviour pattern

Threat :- Working under pressure to deadlines.

Psychological Reaction :- Irritability, tendency to do two things at once, hurried eating, talking and sex, various rushing traits.

Resolution :- Removal of threat or adoption of coping mechanisms involving relaxation.

Chronic adversity or entrapment

Threat :- the individual faces a serious failure to meet basic needs, either higher or lower level needs, and this is of such significance as to damage the individual's self identity. The individual sees no prospect of escape.

Psychological Reaction:- Apathy and alienation.

Resolution :- The individual either discovers a way to combat the gap in their life, perhaps through an individual strategy of escape or through becoming part of a collective fightback, or else the individual acquires a philosophical acceptance of the adversity.

It can be seen that in some of these examples resolution will be quite quick but in others it could take many years. The longer the resolution takes the longer the health damaging effects will last.

ADDRESSING THE ISSUE OF STRESS

Stress can be addressed by:

- diminishing the extent to which major threats hang over people for long periods
- avoiding creating situations that are known to be stressful
- empowering people so that they are better able to turn the stress reaction into action against threats
- changing cultures so that people repose more of their identity in relatively secure things like values and faith and less of their identity in ephemeral things like possessions and status.
- helping people cope better with the stresses to which they are subject. Social prescribing has a role here.
- strengthening people's sense of security – the more areas of their life there are in which they feel secured and valued the less important the threats will seem. This may be how social support improves health.
- crying helps.
- various techniques do exist for managing stress either by countering the physiological correlates (e.g. by exercise) or by diminishing the importance attached to particular threats (e.g. by developing a philosophical attitude to adversity).

Organisational Change

The first two of the above are matters that all organisations can address. Organisations should remember that stress also affects productivity and staff turnover so that organisations which create stress are damaging themselves as well as their employees.

The following is a checklist for employers:

19. The working environment should be pleasant.
20. Close supervision and control should be avoided – people should be motivated by being inspired and empowered.
21. Working under pressure to deadlines should be minimised whether in executives or on the assembly line.
22. Participative systems of management, which allow people to influence their destiny, should be adopted.
23. Threats should not be allowed to hang over somebody for a prolonged time.
24. People should be adequately trained for the responsibilities they bear.
25. People should be provided with adequate resources and authority for any responsibilities they bear and not be blamed for the inevitable failure of inadequate systems.
26. Working relationships should be human and personally supportive.
27. The higher human needs for self esteem, personal development, affection and opportunities to enjoy beauty should all be recognised.
28. Work arrangements should be sufficiently flexible to avoid stressful dilemmas of role conflict with other aspects of life.
29. Pay should be adequate to meet people's material needs and to afford them a reasonable degree of life choices.
30. Work should be fun
31. Geographical mobility should be expected only where absolutely necessary since it disrupts social support networks.

32. A sense of collective identity should be encouraged.
33. Work should be meaningful and the organisation's mission should be socially useful.
34. Life changes at work should be supported by counselling to minimise the period of adjustment and hence the harm.
35. Bullying and harassment must be prohibited.
36. Steps must be taken to counter long hours cultures.

A2.3.13 Walking and Cycling

The goal is "To work to minimise car use and increase uptake of walking and cycling in Stockport."

It is important to minimise car use, partly because of the contribution that cars make to the production of greenhouse gases, the adverse effect road traffic has on air quality, and the findings of Appleyard and Lintell that people who live in heavily trafficked streets have less strong local social networks than people who live in lightly trafficked streets. This will affect their own health (as social support has a major beneficial effect on health, including reduced mortality) and will have knock-on effects through weakened community spirit.

The Government's objectives for the reduction in heart disease mortality could, according to calculations carried out by the British Medical Association be achieved entirely by switching a large proportion of car journeys under five miles from car to foot or cycle.

This is not a matter purely of individual choice because the facilities necessary for such a modal shift to occur are simply not in place.

We need

Safe cycle networks

People will not take up cycling if they perceive it as unsafe to cycle. Building safe cycle routes, including a combination of off road routes, quiet side streets and cycle lanes on main roads is essential to encourage the wider take up of cycling.

Many established cyclists disdain such networks preferring to assert their right to use main roads.

This is legitimate and must be supported, but the quiet network is important in attracting people.

Scope for using cycles in combination with trains

The cycle/train combination is the only form of transport currently in existence that offers the same flexibility as the private car. It is tragic therefore that instead of promoting this rail operators are locked into a vision of cyclists as a nuisance or as a minority market.

The successful Californian initiative by Cal Train has shown what can be achieved.
Aesthetically attractive walking networks with safe convenient crossings over major roads

There is evidence that people will regard walking as an option for longer distances if the networks are aesthetically attractive but aesthetic enhancement of pedestrian routes rarely figures in transport plans.

Encouraging employers to encourage walking and cycling

There need to be incentives for employers to encourage walking and cycling.
Decentralised public services so that people can walk to public services

The public sector should give a lead in maintaining easy access

Preserving public footpaths, instead of seeing them as security hazards

Public footpaths are an important facility if people are to be encouraged to walk and it is unfortunate that they have come quite wrongly to be seen as a security hazard. It would be far more reasonable to see roads as a security hazard as they allow burglars to make a quick get away by car. The route of a blocked footpath is often still usable by a burglar, with less chance of being disturbed by a passing burglar. A thronged footpath network would be an important security benefit as pedestrians are far more likely to disturb a burglar than motorists who drive past quickly with their eyes on the road ahead

Closing rat runs to all traffic except cycles.

There are several good reasons for closing rat runs, including air pollution and the reduction in traffic nuisance to residential areas. Another good reason is that it creates lengths of quiet open cycle route.

A2.3.14 Services for Heart Disease, Diabetes and Stroke

The goal in the strategy is “to improve services for treatment of heart disease, diabetes and stroke in Stockport.”

Services for heart disease begin with prevention – detecting and treating diabetes, high blood pressure and high blood cholesterol levels and giving lifestyle advice to those at high risk of the disease. Stockport led the way in population screening for high blood pressure and other cardiac risk factors, a process which we began over 15 years ago and which the rest of the country is only now following.

When people have heart attacks early responses are important. We would like to see a large proportion of the population trained in cardiac resuscitation so that they could help heart attack victims and we have started to place defibrillators in public places. These developments are at an early stage. Early use of drugs that dissolve the clots (“thrombolysis”) is also important and a lot of effort has been put into shortening the time from symptoms to receipt of these drugs.

People with chest pain are encouraged to come to hospital early so that we can check out whether the pain is cardiac and new tests are available which permit an early response. This can lead to a lot of people with other kinds of chest pain – muscle strains in chest muscles or oesophageal pain from food reflux, for example – waiting for results in Casualty, or even being admitted to hospital so they don’t detract from the A&E waiting time targets. We need to think of better ways to handle this.

If people do have a heart attack they will receive intensive support, and many people with heart disease will have surgery to replace blocked vessels, an operation which was first developed in the middle of the last century but over the last quarter of a century has become commonplace.

This operation will often make it possible to treat angina which would otherwise be disabling or to remove a high risk of a heart attack.

People who survive heart attacks or who undergo heart surgery are usually able to resume normal life and cardiac rehabilitation services are important to the total picture.

Cardiac rehabilitation services are being extended into the community setting to give people the support they need to sustain the lifestyle changes, such as taking more exercise, which will significantly reduce their risk of further problems.

Diabetes carries risks of heart disease, kidney disease, various problems due to diminished blood supply to various organs, infections, damage to the peripheral nervous system, foot problems (due to diminished sensation, and consequent damage accompanied by infection)

and blindness. There are also risks of life-threatening comas from too much or too little sugar in the blood.

The aims of treatment are to control the blood sugar levels through diet, drugs and insulin (the modern tendency is to try and mimic as much as possible the way in which a normal body supplies insulin in response to food) in the belief that better diabetic control will minimise complications, to address other risk factors for the diseases that diabetes contributes to and to monitor for warning signs of complications.

Stroke is a major cause of disability and dependency. Early rehabilitation is important and, as with heart attacks, we are increasingly recognising the potential for use of drugs to dissolve clots.

One of the problems with the use of thrombolysis for stroke is that there are too kinds of stroke – one caused by clots and the other by bleeding into the brain and what will help one would be harmful for the other.

This has led to the suggestion that stroke victims need a brain scan in the first few hours after the stroke to decide which kind of stroke they have had and whether it will benefit from thrombolysis. Setting up a service of this kind will be a major and expensive logistical exercise but it will save lives and will avoid save dependency which destroys the quality of life both for patients and their carers and absorbs millions of pounds of NHS and social services resources.

A2.3.15 Services for Cancer

The goal in the strategy is “to improve services for treatment of cancer in Stockport”, although it would probably be better if it were redrafted to read “To improve services for treatment of cancer for Stockport people” as it may be better to provide treatment elsewhere – an important element of the strategy for cancer is to ensure that all cancers are treated by doctors who see enough of that particular cancer to be expert and this often involves working across more than one district.

Stockport PCT’s goal for cancer services is to improve cancer care and treatment for the people of Stockport. An important element of the strategy for cancer is to comply with national guidelines for the treatment of cancer patients.

The National Institute for Health and Clinical Excellence (NICE) have developed Improving Outcomes Guidance nationally for most tumour groups. The guidance recommends which healthcare professionals should be involved in the treatment, management and care of patients and how services should be organised. This guidance also focuses on the importance of establishing specialist teams and ensuring the care of all patients with cancer should be formally reviewed by a specialist team so there is the benefit of a range of expert advice needed for high quality care. This also ensures that all cancers are treated by doctors who see enough of that particular cancer to be an expert, which often involves doctors working across more than one district at specialist centres. Action plans are being developed via the Greater Manchester and Cheshire Cancer Network to ensure local compliance with this guidance. This will involve some patients travelling to an associate cancer centre for treatment of more complex gynaecological, upper GI and other cancers (to be agreed as further NICE guidance is issued).

Improvements are also being made to reduce waiting times for treatment and comply with national targets, specifically:

- Maximum two week wait from urgent GP referral to first appointment for all suspected cancers
- Maximum one month wait from diagnosis to treatment for all cancers
- Maximum two month wait from urgent GP referral to treatment for all cancers

Faster diagnosis and quicker treatment will result in improved outcomes and survival rates. Significant work has been undertaken locally to ensure sustainable systems are established

and maintained to meet these targets. These include clinical engagement, development of a new cancer database, establishment of a patient tracker team, systems for transfer of patients to other hospitals and a number of policies and procedures.

In addition to these improvements, a programme of work is also underway across the Greater Manchester and Cheshire Cancer Network to develop and agree effective care pathways for all tumour sites. This will ensure all patients receive the same standards of high quality care within defined timescales. Locally pathways are also being examined to identify any areas for redesign which could shorten patients' journeys. This includes the development of straight to test, one stop clinics and increased diagnostic capacity.

A2.3.16 Life Changes

The goal of the strategy is "To provide support for key life changes in Stockport"

A life change occurs when people undergo a change in some aspect of their lives which strikes at the root of their identity – divorce, bereavement, changing their job or their home against their will, acquiring a disability or disfigurement are examples.

When people are undergoing an unpleasant life change their health deteriorates from the point at which they first start to anticipate the change to the point at which they are fully integrated into their new identity.

In the course of this adjustment they go through a number of stages, described above in the list of examples of stress.

Pleasant life changes, such as marriage, promotion, or moving to a house that you think is an improvement have the same effect and go through the same process but the adverse impact is less and the adjustment is much quicker.

Loss of a spouse, whether through bereavement or divorce, is a particularly difficult life change because the main source of social support is lost at the very time that it is most needed. Carers can experience the same sense of loss –both of their own independence and of the "normal" spouse they used to have – and can feel guilty about expressing this loss.

Unemployment is also particularly damaging because it is culturally unacceptable to adjust to being unemployed, unless the unemployment can be labelled "retirement". Indeed there is evidence that the health of unemployed people improves when they reach retirement age and can therefore reclassify their situation and adjust to it.

Victims of crime also experience a similar process as they feel a loss of some of their sense of privacy and security. This can be difficult as they find it hard to express and come to terms with what they have lost. In cases of domestic violence this is aggravated by the fact that the source of the problem would normally be one of the sources of support.

It is important to provide support to people in these particularly difficult life changes so services providing victim support and bereavement support fulfil an important and potentially life saving service. So, in times of high unemployment, do unemployed workers' centres.

Health services should understand and support the life changes of patients adjusting to a disabled or chronic sick role. Support for carers is also important.

A2.3.17 Community Development

Community development is a process which assists communities to address their own needs. Communities in this context can be geographical communities or they can be communities of interest (eg the Islamic community).

Community development is likely to be beneficial to health because it will promote social support (itself beneficial to health) and increase the likelihood that communities will take

action to solve their own problems; for example, it will mean that people are more likely to help each other or to work together to solve an environmental problem or to create an organisation providing local activities.

Community development was introduced into deprived communities in Stockport by the NHS in the 1990s. Substantial health improvements followed in the wards where it was introduced.

Table A2.3.17.1

<u>Ward</u>	<u>Date community development introduced</u>	<u>Under 65 standardised mortality ratio</u>		
		<u>1990/2</u>	<u>1993/5</u>	<u>1994/6</u>
<u>Brinnington</u>	<u>Late 1980s</u>	<u>198</u>	<u>158</u>	<u>150</u>
<u>Cale Green/</u>	<u>1991/2</u>	<u>138</u>	<u>120</u>	<u>112</u>
<u>Great Moor/South</u>				
<u>Reddish</u>				
<u>Other Inner City</u>	<u>1994/5</u>	<u>121</u>	<u>118</u>	<u>120</u>
<u>Wards</u>				
<u>Other Wards</u>	<u>Not introduced</u>	<u>80</u>	<u>80</u>	<u>79</u>

However these improvements were not sustained. This may be because the programme itself began to lose clarity.

Since 2003 we have committed ourselves to increase the population served at this level of intensity back to the 120,000 that reflects the need and we currently serve 70,000 people at this level.

Community development consists of three successive processes –

Pure community development - enhances a community's capacity to address its own needs. The goal is the strengthening of social networks, the enhancement of community cohesion and the strengthening of power for a community to act together. The underlying process is empowerment.

Purposive community development - helps a community address a particular problem. The goal is one of the specific goals of the organisation. The underlying process is facilitating and enabling.

Community involvement - helps a community make a clear contribution to a debate that is under way. The goal is to ensure that the community is heard. The underlying process is participation.

During the mid to late 1990s both the local authority and health authority moved community development resources from pure community development to purposive community development and community involvement. In harsher times these are easier to justify to sceptics.

But this is like investing in a bus service without first building the road on which the bus is to run. And increasingly those involved in these processes are reporting difficulties due to lack of the basic groundwork.

In the early 1990s in Stockport the local authority and health authority between them employed 12 patch-based pure community development workers. By 2003 this figure had shrunk to three.

We are professionally advised that a community development worker can support a population on a ratio of 1wte worker to 10,000 population. On that basis the part of our population to which we were able to provide a community development service fell in ten years from 120,000 to 30,000.

COMMUNITY HEALTH SERVICES TARGETTING

Throughout the early 1990s community health services resources were targeted to the inner city. It seems likely that the targeting of resources has declined recently. This is due to the pressures on community health services resources that resulted from the financial difficulties of other parts of the Stockport Healthcare NHS Trust (first the problems of mental health services and then the PFI costs of opening "The Meadows"), then the financial recovery plan of its combined Trust, and then of the PCT which inherited a deficit from Stockport Health Authority due to regional insistence in early 2001 on unrealistic prescribing assumptions.

INVESTMENT IN HEALTH DEVELOPMENT INITIATIVES

It was a feature of Stockport in the early 1990s that part of its development funds were directed into health development initiatives such as exercise on prescription and SWIMBUS. For several years this investment ran at around £100,000 of new investment a year, which is still small in comparison with the sums invested in hospital services but did allow some valuable projects to develop.

New investment in this field virtually ceased in 1997 when the incoming Government began to target development funds on its own priorities and directed them particularly towards access to hospital services.

A2.3.18 Improve Health and Wellbeing of Children and Young People

The goal is "To improve the health and wellbeing of children and young people in Stockport". Please see the relevant Section in Chapter A2.2.

A2.3.19 Improve the health of Older people

The goal is "To improve the health of older people in Stockport". Please see the relevant Section in Chapter A2.2.

A2.3.20 Health Protection

The goal in the strategy is "To provide health protection services in Stockport".

The concept of health protection embraces:

- control of infectious diseases
- control of hazardous chemicals
- control of physical hazards such as radiation
- preparation for meteorological hazards such as heatwave, floods or severe winters
- preparedness for major incidents and disasters
- business continuity planning to avoid incidents disrupting processes essential to health such as heating, water or health services

Current particular concerns in relation to infection control include MRSA and fears of a flu pandemic.

MRSA is an infection usually acquired in hospital which has become more widespread as a result of deteriorating hygiene standards and overuse of antibiotics. The former of these two interacting causes is now being vigorously pursued.

The flu virus periodically undergoes genetic change which circumvents the immunities that people have built up and allows the disease to emerge in its full terrifying potential. There are fears that such a process may be about to happen, although there have been similar fears in the past which have not materialised.

Diseases like typhoid and cholera are avoided by safe water supplies and are virtually unknown in Western Europe whilst diphtheria, polio, measles, mumps and rubella are kept at

bay through vaccination. Vaccination against the most dangerous form of meningitis is now in the process of being added to this list. Meanwhile measles and mumps have occurred again in some small outbreaks as a result of the irresponsible behaviour of those who caused the MMR scare.

Small scale chemical incidents occur in the Borough several times a year. Recent legislation, the Civil Contingencies Act, has increased the attention paid to major incident planning and business continuity planning.

A2.3.21 Screening

The goal of the strategy is “To provide health screening programmes in Stockport”

SCREENING

The screening programmes are major public health prevention programmes offered to all relevant healthy individuals in the UK and as such Stockport residents should be able to access such services and these services should meet nationally set quality standards.

The aim of health screening programmes is to detect illness early, when treatment can be more effective or to detect risk factors so that the disease can be prevented.

For example the breast screening programme aims to detect the cancer early when it can be treated more successfully (in particular to remove it before it spreads to other organs). In contrast the cervical cancer screening programme seeks to detect a pre-cancerous condition so that the development of cancer can be prevented. The coronary heart disease risk factor screening programme aims to detect individuals who are at risk of heart disease so that they can modify their lifestyles and take drugs that control their blood pressure and blood cholesterol.

It is important that screening programmes are evidence based. There is no point screening unless treatment can be given and will be more effective at an early stage than later. Local organisations must ensure clinical pathways and services are in place to meet the needs of those individuals with early disease or increased risk.

In considering whether to screen for a disease the benefit must be weighed against the dangers of false positives (which can harm people by subjecting them to unnecessary treatment) and false negatives (which can harm people by reassuring them). No test is perfect but screening is not done unless the test has very low rates of incorrect result.

One important group of screening tests are those that are done on new born babies. These include the phenylketonuria test which detects babies with this condition and allows them to be brought up on a special diet instead of, as happened prior to the test, being brain damaged by a substance in normal diets. The range of tests is being expanded to include cystic fibrosis screening and screening for sickle cell disease and thalassaemia.

We are also currently modernising the existing successful Diabetic Retinopathy programme, which achieved a 94% coverage rate, to a new modality (digital pictures), and collaborating with six other PCTs to provide a sector wide programme, although this has been delayed, and may be considerably over budget.

There have been some recent changes in the cervical screening programme but these have been successfully introduced and uptake remains high.

Two new programmes are being planned - Abdominal Aortic Aneurysm (AAA) screening for men and bowel cancer screening for both men and women.

Bowel Cancer screening will reduce deaths over time and contribute directly to life expectancy.

AAA screening will streamline access to the recent EUR policy review on best practice for surgical interventions, and reduce deaths in men from rupture.

A2.3.22 Smoking

The goal in the strategy is “to reduce the prevalence of smoking in Stockport”.

Smoking is the largest single cause of cancer and heart disease.

1 in 4 smokers will die of a smoking related disease so the only difference between smoking and playing Russian roulette is the delayed effect.

Tobacco is the only lawful product which kills such a high proportion of those who use it in the way the supplier intended.

Tobacco is the only drug of addiction that can lawfully be purchased without a prescription. There are other lawful products to which addiction does occur, such as alcohol or glue, but the term “drug of addiction” is used here to imply a drug in which addiction would be the normal consequence of using the drug in the way intended by the supplier. Most smokers are introduced to tobacco in their youth and often become addicted before they fully realise the risk they are running.

It is clear from the above discussion that if it were decided to ban tobacco this would merely treat it in the same way as other similar substances. Given the widespread nature of the addiction amongst ordinary people this may be inappropriate but if a total ban could be justified in principle it must follow that whatever lesser degree of control is politically thought to be appropriate can equally be justified. Libertarian arguments are relevant to tobacco only to whatever extent they are thought to be relevant to heroin and duelling. It is perhaps helpful to think of tobacco not as a “lawful” product but as a “tolerated” product.

In addressing smoking there are two main tasks – to discourage young people from taking up the habit and to assist existing smokers in giving up.

Neither of these is primarily a matter of education. Most smokers know the risks of smoking. In fact most smokers wish they could give up. The problem is how to help. It is necessary:

- to continue to put across the message about smoking and its consequences
- to ensure that smoking is not seen as the norm and that people do not need to inconvenience themselves to avoid it
- to provide direct help to those who are quitting.

The first of these points requires continued anti-smoking advertising, the second requires us to continue the process of making public places smoke free and the third is met through the NHS smoking cessation service.

Helping young people avoid taking up smoking is also more than just a matter of education. Most young people know the risks of smoking by the end of primary school. However a large proportion of them still experiment with tobacco in their early teens and many of these become addicted in the process.

This happens partly out of rebellion, partly out of curiosity, partly out of a sense that tobacco is an adult habit, partly from following the examples of parents, partly out of a desire to demonstrate style and partly in response to peer pressure.

We have yet to find an effective way of intervening in these cultural factors and we need to do so.

A2.3.23 Diet

The goal in the strategy is “to improve diets in Stockport”.

A low fat, low sugar, low salt, high fibre diet contributes to the prevention of heart disease, stroke, diabetes and cancer.

Most people know what a healthy diet is, although some confusion is caused by food fads and food scares. The low fat, low sugar, low salt, high fibre message is a constant and scientifically well established message and must not be confused with the transient scares that seem periodically to affect almost everything

There are a number of reasons why people do not eat a healthy diet even though they know what it consists of.

Firstly there is the inertia of changing established eating patterns. People who have become used to the cloying sweetness of sugar and cream may not appreciate how rapidly they can adjust to the crunch and tang of fruit and fibre, or how oppressively salty their present food will seem after only a few weeks of adjusting to the subtler flavours of a lower salt diet.

Secondly there is the difficulty of obtaining healthy processed foods and especially of obtaining low salt processed foods. British food manufacturers argue vehemently that the British like high salt food and that is why they provide it. It is, they claim, entirely a matter of taste and nothing whatsoever to do with such things as salt being a bulking agent. Interestingly Australians, of similar cultural heritage and genetic stock, but less willing politely to eat what they are given even if it kills them, are much better at demanding and obtaining healthier versions of processed foods.

Processed food is important as the time pressures of modern life lead to an increasing number of people not finding the time to cook for themselves.

Thirdly 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)
- add more fruit, vegetable and salad. Aiming for 5 portions a day or more

This simple way to change your diet costs more money and more preparation time.

It also requires you to shop at outlets where this food is available. Not only is such food less likely to be sold at all in corner shops and the cheaper supermarkets but turnover and shelf time will lead to it having a higher price. It is well documented that the price differential between healthy and unhealthy food is at its least in out of town hypermarkets readily accessible only by car.

Driving your car to the hypermarket, loading the boot with a few weeks' shopping, taking it home to the freezer and spreading the cost with your credit card is not a lifestyle that an unemployed single parent in an inner city area finds easy to choose.

Foods that are high in fat and sugar are traditionally used as rewards for children and maintain their desirability as treats for adults. In addition, these highly processed foods are heavily advertised, with millions of pounds being spent each year in the UK creating an image that appeals to young people, whilst fruit and vegetables are not advertised at all to this market.

If we are to address these cultural factors we need action at national level to tackle the food market and locally we need to address issues of availability, of the quality of institutional food (including school meals and other food supplied by, or sold from the premises of, public bodies) and of cooking skills. Encouraging the growing of food in local communities and tackling the food market, for example through food cooperatives, all have their place.

A2.3.24 Obesity

The goal in the strategy is “to reduce the levels of obesity in Stockport”.

Obesity contributes to heart disease, low self esteem, diabetes, back problems and joint problems.

There are metabolic and genetic factors contributing to obesity. It is probably the case that some people are more susceptible and others are lucky enough to enjoy a greater freedom. It may even be that in future we will be able to influence these mechanisms. We live in a society where on average we have access to plenty of calories, and increasingly do less and less physical activity than previous generations. We drive more, sit more, and our children play fewer physically active games. This “obesogenic” environment compounds the individual factors that affect people’s health and their attempts to control it.

However, for all that, the blunt fact is that obese people eat too much and exercise too little and that if they ate less and exercised more the overwhelming majority of them would not be obese.

Eating less is important but it must be accompanied by more exercise. Dieting can be valuable in allowing people to feel fitter and take up more exercise but dieting alone depresses the metabolic rate so that when the diet is relaxed the weight returns, often to a higher level than originally.

The epidemic of obesity has spread relentlessly in concert with the development of sedentary lifestyles and exercise is essential.

A2.3.25 Physical Activity

The goal in the strategy is “to increase levels of physical activity in Stockport”.

All of the populations with exceptionally high life expectancy have a number of things in common.

One of these is that they have a culture in which they are physically active every day.

Physical activity protects against heart disease, protects against osteoporosis, and improves mental health.

For most of history and prehistory most people have obtained adequate exercise in their daily life as hunters, gatherers, farmers, or artisans. This has been supplemented as they move around by walking, riding animals or (more recently) cycling and as they move goods around by carrying them.

Deficiencies of physical activity for large numbers of people has therefore been a product of the spread of the private car, of automation of industry and of the growth of the service sector as the predominant employer.

Addressing it entails:

- encouraging walking and cycling as the main transport mode for short journeys
- 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 swimming, and organised activities like fun runs
- special organised activities to overcome barriers to recreational exercise – special swimming sessions for women only or for obese people only are examples

- the development of “green gyms” which provide opportunities for people to contribute to the environment through physically active voluntary work
- encouraging people to build exercise into their daily life, for example by using the stairs instead of the lift or walking further as part of their daily journey to work
- exercise referral schemes which use physical activity as a treatment for illnesses that would benefit from people being more active
- rehabilitation programmes which help return to physical activity in those who have been put off by obesity, old age, sickness, frailty or disability
- encouraging walking and cycling to work or for business journeys through cycle parking, showers, changing facilities and generous walking and cycling mileage allowances.

A2.3.26 Sexual health

The public health crisis in sexual health which we are witnessing across the country continues to be mirrored in Stockport. Increasing levels of Sexually Transmitted Infections (STI'S), difficulties in access to appropriate and timely services, and the health inequalities which are visible in sexual health mean that this remains a priority area of action for us.

In order to tackle this crisis we need to have a comprehensive approach which incorporates health promotion and education through to suitable service provision.

We need to start with that old saying” prevention is better than cure” and therefore ensure key messages are translated in a variety of formats and targeted at those most at risk of poor sexual health, such as young people, gay men, women and those from particular ethnic backgrounds. Our health promotion and prevention strategy addresses this.

The levels of sexually transmitted infections are worrying especially for this next generation. Chlamydia, which is the most common STI, is especially prevalent in the under 25 year olds. Evidence tells us that as many as 10% of this population may be infected and many are not aware of their infection because they have no symptoms. The National Chlamydia Screening program was developed to ensure there is easy access to Chlamydia testing, diagnosis and treatment in a range of settings from health services, outreach clinics targeting young people, youth services, to more non-traditional settings like local pharmacies and colleges. It is a priority that Stockport is included in the Greater Manchester screening program in 2007.

We know that people who think they may have a sexually transmitted infection should be able to be seen, tested and treated as quickly as possible to reduce onward transmission or suffer any long term effects.

Access to Genito-urinary medicine (GUM) service is a major problem across all of Greater Manchester, including Stockport. We need to increase our service capacity in order to meet the demands on our current services. This need to increase capacity provides a golden opportunity to redesign our services which incorporate more community, primary care based provision. The ideal model for us is to develop more integrated, holistic services where all a persons sexual health needs can be addressed at one time. Our contraceptive and sexual health service(CASH) is a prime example of how we can develop this service from being a service mainly dealing with a persons contraceptives needs to offer some STI testing and treatment services. This model has already been adopted successfully in one of our clinics with a plan to develop this further.

This is also scope to start developing services in more non-traditional settings such as the voluntary and independent sector. We currently have examples of HIV testing in this setting which is proving to be a very acceptable service to particular client groups such as gay men.

Ensuring access to reproductive health service for the sexually active population is vital to the successful delivery of any local strategy to improve sexual health. The provision of contraception is an essential health care service which plays a pivotal role in protection of unplanned pregnancies and transmission of STI's. It is our intention to make these services as accessible as possible and especially for the more vulnerable client groups such as young

people. We are also planning to ensure there is greater access to the long acting contraception as recommended by the NICE guidance.

In the cases where terminations are required, the earlier the termination is performed the lower the risk of complications. For women who can access services before their ninth week of pregnancy, they can have a choice of either early medical or surgical terminations. We must continue to ensure women and those referring into services are aware of these choices.

The sexual health agenda is one which must be addressed now and seen as a priority area for action if we are to halt this ongoing public health crisis.

Through a variety of approaches and offering choice of services and treatments to patients, we hope to see improvements in the sexual health of our Stockport population.

A2.3.27 Alcohol misuse

A Special Report on Alcohol misuse appears as Chapter 12.

A2.3.28 Drug misuse

The goal is to reduce the harm caused by drug use to the individual and the wider community.

The Drug Action Team and its partners aim to reduce this harm through four main work areas:

Young People: to enable young people to resist drug use by providing effective education and information to all – and where young people are involved in substance use, to provide quick access to treatment, help and support to ensure that today's young drug users do not become tomorrow's problematic adult drug users.

Communities: to protect communities from drug related crime and anti-social behaviour – by providing support to communities where drug use causes problems through reducing crime and supporting families and carers impacted by substance use.

Treatment: to enable people to receive treatment and to live healthy, crime-free lives – by developing a range of services across the borough to meet the needs of all members of the community, services which not only support people's physical needs for treatment (e.g. substitute prescribing where appropriate) but also meet people's needs in a holistic manner (e.g. anxiety management, relapse prevention, education, training and support towards employment)

Criminal justice: to support drug using offenders out of crime and into treatment, in order to create safer communities and healthier lives for those affected by substance misuse. By drug-testing offenders on arrest, those in need of treatment are identified and given immediate access to support services. Where this support is refused by the offender, bail may be refused and the offender's sentence affected.

Specific aims for Stockport are to:

- Develop a community based Tier 4 service for young people – to provide dedicated medical care, community detoxification and intensive, specialist support for young people with problematic drug/alcohol use
- Empower service users by developing service user involvement across Stockport and to develop carer involvement in order to promote well-being amongst those who live with and or care for substance users
- Develop a community based detoxification and aftercare service for adult drug users

A2.3.29 Breastfeeding

The goal is "To improve rates of breastfeeding in Stockport."

Breastfeeding contributes to child health. Its most immediate effect is that it protects against infections. It also seems to have metabolic effects which contribute to longer term nutritional benefits.

It is important that maternity units encourage women to breastfeed postnatally and that health visitors continue this after the mother has gone home. Society has a role to play in acknowledging women's right to breast feed and not making women feel embarrassed about doing so in public.

A3: SPECIAL REPORT ON
HEALTHY AGEING
(written 2008)

SPECIAL REPORT ON HEALTHY AGEING KEY MESSAGES

It is often said that increasing life expectancy leads to a greater need for care in old age and therefore inevitably creates financial pressures on the NHS.

However this does not follow. It is the gap between healthy life expectancy and life expectancy which creates the pressure for more services to care for older people.

- If life expectancy is 60 and healthy life expectancy is 55 then, dependent on population structure, about one twelfth of the population will be demanding care for frail dependent old age.
- If life expectancy is 80 and healthy life expectancy is 75 that figure reduces to one in sixteen.
- But if healthy life expectancy rises only to 70 then at a life expectancy of 80 the figure instead increases to one in eight.
- Achieve a life expectancy of 90 with a healthy life expectancy of 89 and care of the frail dependent elderly only affects one in ninety – it becomes less prominent in the health economy than care of diabetics. We could afford to do it superbly.
- It follows that promoting healthy ageing is an essential part of the process of accommodating to an ageing population and if we do not do it effectively we will find it difficult to afford the consequent burden of caring for those whose ageing we have failed to support.
- Some countries are successfully achieving increases in healthy life expectancy that are greater than the increases in life expectancy, i.e. not only are they lengthening life but they are also shortening the period of dependency at the end of it. The UK is not being successful in this goal.

Healthy ageing is promoted by:

- **remaining active** – the longest lived cultures in the world all evidence physical activity every day
- **retaining a meaningful role** – the longest lived cultures in the world all value older people or create a strong sense of self which survives into old age
- **expecting good health in old age** – one of the commonest causes of curtailment of healthy life expectancy is the acceptance of treatable conditions as “old age”
- **persisting with healthy lifestyles** – American evidence has shown that lifestyle changes are still effective in improving health in older people – it is not true that it is “too late”

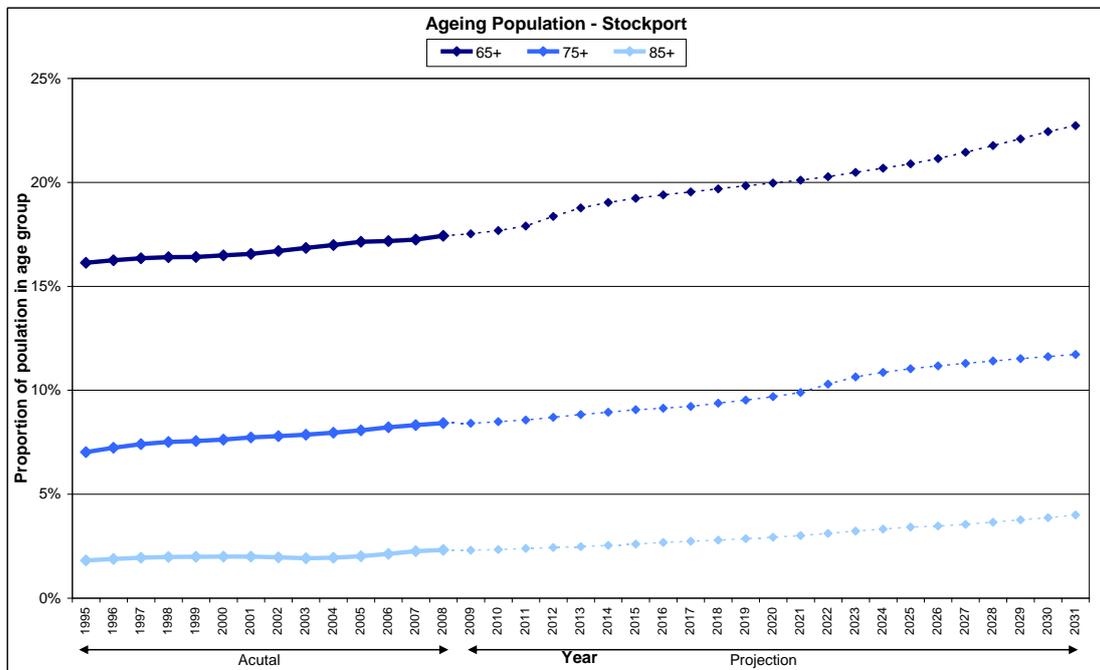
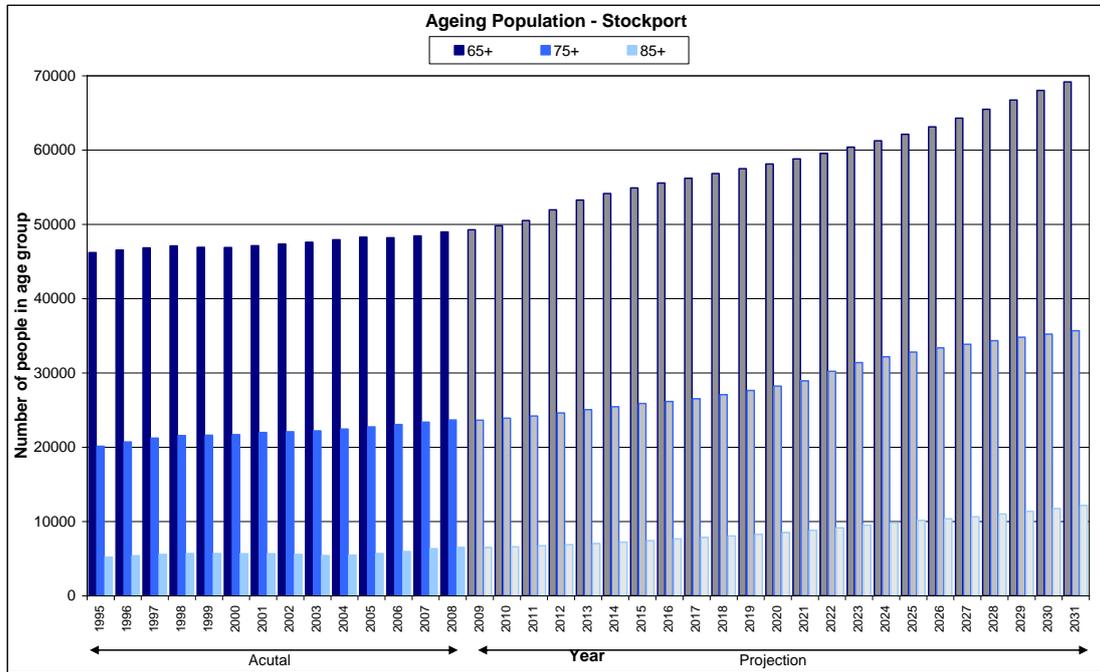
Our society is bad at all four of these

- We are becoming increasingly inactive with increasing obesity as a consequence.
- Our perception of old age is still a perception of dependency.
- There is still amongst our people and our health professionals too great a tendency to say that any symptom after the age of 65 (or perhaps even 60 or 55) is “just old age”.
- We have tended to focus lifestyle advice on younger people.

A key priority is to further within our health service understanding of the muted presentation of illness in old age as functional deterioration (declining mobility, increasing confusion) and increase commitment to seeing those as symptoms that need investigating for a treatable cause so that people are not confined to a dependent old age for lack of treatment of a treatable condition.

The Ageing Population

Stockport, like most of the country, has an ageing population.



Trend 1995 - 2008 - mid year estimates of population						
Year	Number of people aged:			Proportion of population aged:		
	65+	75+	85+	65+	75+	85+
1995	46,190	20,127	5,185	16.1%	7.0%	1.8%
1996	46,543	20,707	5,389	16.3%	7.2%	1.9%
1997	46,821	21,217	5,561	16.4%	7.4%	1.9%
1998	47,087	21,570	5,690	16.4%	7.5%	2.0%
1999	46,910	21,603	5,691	16.4%	7.6%	2.0%
2000	46,881	21,688	5,665	16.5%	7.6%	2.0%
2001	47,118	21,984	5,667	16.6%	7.7%	2.0%
2002	47,335	22,083	5,566	16.7%	7.8%	2.0%
2003	47,596	22,201	5,405	16.8%	7.9%	1.9%
2004	47,927	22,447	5,472	17.0%	8.0%	1.9%
2005	48,269	22,721	5,677	17.1%	8.1%	2.0%
2006	48,187	23,056	5,955	17.2%	8.2%	2.1%
2007	48,442	23,378	6,345	17.2%	8.3%	2.3%
2008	48,983	23,657	6,514	17.4%	8.4%	2.3%
Change						
1995-2008	2,793	3,530	1,329	8.1%	19.8%	28.0%
2001-2008	1,865	1,673	847	5.3%	9.0%	16.4%

Trend 2009 - 2031 - sub national projections of population						
Year	Number of people aged:			Proportion of population aged:		
	65+	75+	85+	65+	75+	85+
2009	49,269	23,645	6,476	17.5%	8.4%	2.3%
2010	49,808	23,898	6,579	17.7%	8.5%	2.3%
2011	50,521	24,189	6,728	17.9%	8.6%	2.4%
2012	51,953	24,611	6,881	18.4%	8.7%	2.4%
2013	53,261	25,047	7,031	18.8%	8.8%	2.5%
2014	54,147	25,450	7,210	19.0%	8.9%	2.5%
2015	54,901	25,883	7,422	19.2%	9.1%	2.6%
2016	55,560	26,155	7,654	19.4%	9.1%	2.7%
2017	56,190	26,521	7,862	19.5%	9.2%	2.7%
2018	56,836	27,071	8,046	19.7%	9.4%	2.8%
2019	57,493	27,622	8,274	19.8%	9.5%	2.9%
2020	58,121	28,208	8,522	20.0%	9.7%	2.9%
2021	58,795	28,918	8,796	20.1%	9.9%	3.0%
2022	59,536	30,220	9,147	20.3%	10.3%	3.1%
2023	60,390	31,380	9,501	20.5%	10.6%	3.2%
2024	61,237	32,166	9,823	20.7%	10.9%	3.3%
2025	62,132	32,817	10,150	20.9%	11.0%	3.4%
2026	63,123	33,358	10,363	21.1%	11.2%	3.5%
2027	64,290	33,846	10,622	21.4%	11.3%	3.5%
2028	65,497	34,333	10,991	21.8%	11.4%	3.7%
2029	66,723	34,803	11,359	22.1%	11.5%	3.8%
2030	68,033	35,229	11,731	22.4%	11.6%	3.9%
2031	69,165	35,672	12,162	22.7%	11.7%	4.0%
Change						
2008-2011	1,538	532	214	3.1%	2.2%	3.3%
2008-2021	9,812	5,261	2,282	20.0%	22.2%	35.0%
2008-2031	20,182	12,015	5,648	41.2%	50.8%	86.7%

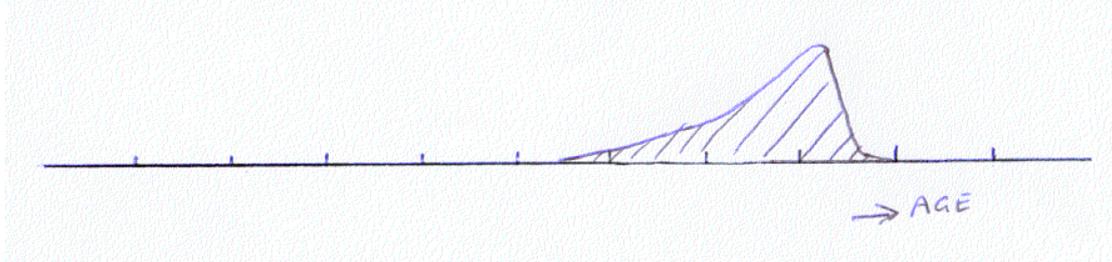
Older people use more health and social care resources than younger people. Currently local data showing the total health care expenditure of NHS Stockport for older people is not available. National evidence suggests that 40% of NHS expenditure is spent directly on services for older people. Based on NHS Stockport's expenditure of £400 million, we can estimate that £160 million is spent on service for older people.

Because of this relationship of age to health care utilisation it is often said that the consequence of an ageing population must be that the cost of health and social care will rise.

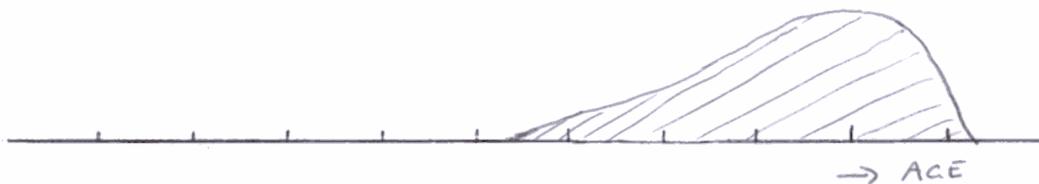
However the question arises of whether older people use more health and social care resources because they are older or because they are closer to death. If it is the former then an ageing population will use more resources. If it is the latter they might not. Indeed a lengthening life expectancy might reduce the burden of an ageing population because a smaller proportion of the population will be in their last few years of life.

Scenarios for Health and Ageing

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

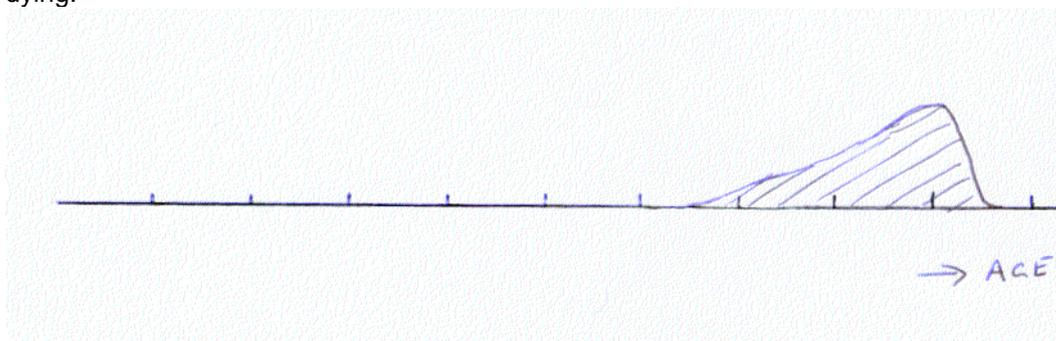


The fear is that increasing life expectancy does not delay the onset of disability, it simply makes it last longer. For every extra year of life there is an extra life of woe. We live longer, but the extra time is spent taking longer to die.



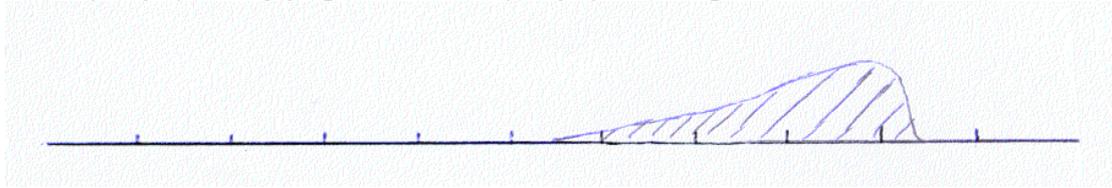
In this case there will be a huge increase in disease burden for the individual (and hence health and social costs for the population) as a result of an increased life expectancy

Another possibility however is that all that happens is that disability and death are both delayed. For every extra year of life woe is delayed by a year but there is no change in the amount of woe. We live longer and the extra time is spent living – we spend no extra time on dying.



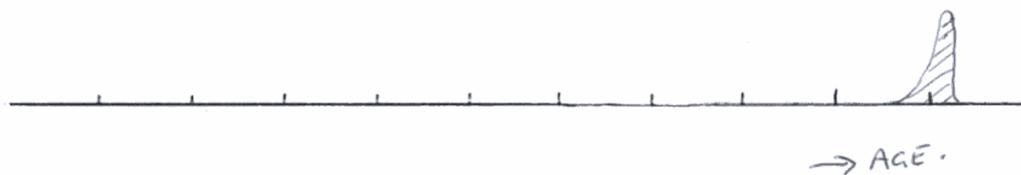
In this case there will be no increase in the disease burden incurred by the individual. At a population level the health and social care costs will be delayed and the proportion of the population incurring them at any one time may therefore be reduced.

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



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

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



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

The Theoretical Basis for the Scenarios

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

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

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

old age is, Fries argued, quick. Hence if more people survive to reach this maximum age the total amount of morbidity would be reduced.

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

The Population Financial Implications of the Scenarios

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

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

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

For example:

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

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

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

<u>Life expectancy</u>	<u>Healthy life expectancy</u>	<u>Proportion needing care</u>
<u>75</u>	<u>65</u>	<u>13.3%</u>
<u>75</u>	<u>68</u>	<u>9.3%</u>
<u>75</u>	<u>70</u>	<u>6.7%</u>

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

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

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

Applying this theoretical calculation to the figures for Stockport wards gives these figures:

<u>2001 Ward</u>	<u>1999-2003 Life expectancy</u>	<u>1999-2003 Healthy life expectancy</u>	<u>Theoretical proportion needing care *</u>
<u>Brinnington</u>	<u>72.3</u>	<u>60.5</u>	<u>16.3%</u>
<u>Cale Green</u>	<u>75.0</u>	<u>65.1</u>	<u>13.3%</u>
<u>North Reddish</u>	<u>77.9</u>	<u>68.8</u>	<u>11.7%</u>
<u>South Reddish</u>	<u>73.8</u>	<u>65.2</u>	<u>11.7%</u>
<u>Edgeley</u>	<u>76.3</u>	<u>67.8</u>	<u>11.1%</u>
<u>Manor</u>	<u>76.1</u>	<u>67.7</u>	<u>11.0%</u>
<u>Great Moor</u>	<u>77.4</u>	<u>68.9</u>	<u>11.0%</u>
<u>Bredbury</u>	<u>78.3</u>	<u>70.0</u>	<u>10.7%</u>
<u>Davenport</u>	<u>75.9</u>	<u>68.1</u>	<u>10.3%</u>
<u>Romiley</u>	<u>79.0</u>	<u>71.0</u>	<u>10.1%</u>
<u>Cheadle Hulme North</u>	<u>77.7</u>	<u>70.5</u>	<u>9.3%</u>
<u>Heald Green</u>	<u>80.5</u>	<u>73.1</u>	<u>9.2%</u>
<u>Heaton Mersey</u>	<u>80.1</u>	<u>72.8</u>	<u>9.1%</u>
<u>Hazel Grove</u>	<u>80.0</u>	<u>72.9</u>	<u>8.9%</u>
<u>Cheadle</u>	<u>81.3</u>	<u>74.3</u>	<u>8.7%</u>
<u>South Marple</u>	<u>82.3</u>	<u>75.6</u>	<u>8.1%</u>
<u>North Marple</u>	<u>79.4</u>	<u>73.0</u>	<u>8.1%</u>
<u>Heaton Moor</u>	<u>78.9</u>	<u>72.7</u>	<u>7.9%</u>
<u>Cheadle Hulme South</u>	<u>81.2</u>	<u>74.9</u>	<u>7.8%</u>
<u>West Bramhall</u>	<u>81.7</u>	<u>75.8</u>	<u>7.2%</u>
<u>East Bramhall</u>	<u>82.3</u>	<u>76.8</u>	<u>6.7%</u>

* the theoretical proportion may not correspond to the actual proportion due to the impact of migration, fertility and cohort effects.

This raises the rather startling prospect that the financial burden of an elderly population is actually greatest in those areas where people do not live as long.

One of the reasons that this has not been clear in the past is that the theoretical population we are discussing in these calculations is a population isolated from issues of migration and fertility. These issues also influence the proportion of the population in need of care and can, by creating cohorts of larger and smaller populations, affect the age structure of the population many years later.

In the 1970s and 1980s the UK experienced an ageing population not because of increasing longevity but because a cohort of increasing population had reached old age. This cohort was created because in the 19th century people used to have a lot of children in order that some of them would survive the high levels of infant mortality. In the 20th century reproductive behaviour adjusted to the much lower infant mortality. However there was a gap of about a generation whilst this happened and as a result there was a generation of large families most of whose children survived (although a lot of the men were killed in World War I). This generation grew into old age in the 1970s and 1980s. As this ageing of the population was not associated with longevity the above calculations do not fit it. This was the largest ageing of the population the country had ever experienced so it conditioned our expectations of what an ageing population would bring which explains why the pessimistic scenario is so widespread.

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

child population. These demographic changes in the numbers of old people will not show the same pattern as the ageing associated with increased longevity.

Migration also modifies the theoretical predictions of the above calculation. There is a tendency for rural areas to lose young people and gain old people through migration, whilst cities tend to gain young people both from rural areas and from overseas and lose old people as they retire to the country or the seaside. Seaside areas in the south of the country and the south of Europe gain older people but this does not necessarily apply to Northern seaside towns – Blackpool for example experiences net outward migration of older people.

These factors all obscure the above theoretical prediction.

So Which Scenario is True?

The existence of competing scenarios, each with their theoretical basis and their adherents, demonstrates that scientific understanding of ageing is still inadequate.

Nonetheless there is evidence that the most pessimistic predictions are not being borne out by reality. In France, Australia and the United States healthy life expectancy has improved faster than life expectancy. Until recently official figures have not shown this happening in England but between 2001 and 2004 the gap between life expectancy and healthy life expectancy narrowed by several months in both men and women.

The Healthy Ageing Strategy in Stockport

The All Our Tomorrows Partnership Board has for several years now been pursuing a healthy ageing strategy aimed at ensuring that people are helped to live a healthy old age thus narrowing the gap between healthy life expectancy and life expectancy.

The All Our Tomorrows (AOT) Partnership brings together representatives from the voluntary, community and statutory sectors to promote and support active independence, healthy ageing and improved quality of life for older people. The Partnership contributes to and leads on the Health and Well Being Partnership Board's priority of "The promotion of older people's independence in order to maintain their safety, health and well-being and to support them to remain at home where possible".

The AOT Partnership has a well developed Strategy based on direct engagement and consultation with older people. Implicit within the strategy are many activities with a strong focus on prevention of decline and promotion of wellbeing through a range of opportunities. The AOT Partnership is driven by the following seven key priority areas identified by older people themselves as the areas to make a difference. The following shows an example of progress and achievements in the last year:

1. Safer & Stronger Neighbourhoods: Older people feeling safe in, and part of, their neighbourhoods

- There are now 7 'No Cold Calling Zones' benefiting 1000+ households who may be vulnerable to Bogus Callers and rogue traders.
- The new Council supported Gardening scheme received 1200+ referrals between June and Dec 08 and worked in partnership with SIPS to improve safety in a number of neighbourhoods. For example by removing high hedges that created dark areas for individual properties and around roads and footpaths, or by removing tell tale signs for criminals of unkempt gardens.

- 2. Information: Older people getting the information they need in timely and accessible ways;**
 - The new My Care, My Choice website has been developed and now includes information about what is available in Stockport to offer support
 - FLAG (For local advice & guidance) is a new information project, delivered by a consortium of voluntary sector organisations, that will provide assisted signposting to the local community around health and social care activities.

- 3. Participation & Engagement: Older people being supported to achieve their personal aspirations for participation and engagement.**
 - An Older People's engagement worker based within Age Concern Stockport will work to strengthen engagement with older people and to develop more sustainable models of involvement and participation in both the agenda of AOT and wider developments.
 - 20 Nintendo Wii machines have been rolled out to resource and day centres and sheltered and extra care housing providing opportunities for older people to improve their engagement through physical activity and leisure opportunities.

- 4. Economic Aspirations and Income: Older people achieving maximum possible financial security and opportunities.**
 - Stockport Advice has reached their LAA target on take up of benefits for people aged over 60. This has secured £649k for Stockport Partnership. Altogether nearly 2000 benefits have been claimed for older people in the borough gaining £17.6m in for Stockport older people, plus additional benefits through third sector organisations.
 - In the last year £500k EU monies to tackle financial exclusion of older people working across the Council and Age Concern Stockport has been secured. The Managing your Money project has seen 200+ people and there has been 30+ business start-ups through the Silver Entrepreneurs Scheme;

- 5. Getting Out & About: Older people getting out and about on safe, accessible transport that is flexible enough to meet their needs**
 - Introduction of Stockport town centre shuttle bus.
 - Two schemes addressing safety on public transport through training of older people and staff and general awareness raising are about to go live across GM and Stockport are well involved as this is a key issue within the strategy

- 6. Housing & the Home: Older people feeling safe and secure in housing that is of good quality and range that is suitable, accessible and well maintained;**
 - In the last year a Joint Handy-Help scheme between Age Concern and Council Strategic Housing including property health check and has demonstrated good links with other initiatives and agencies.
 - Extra Care Housing will be in place from May 2009 with over 60 units which is in excess of original targets.

7. Health & Healthy Living: Older people feeling healthier and well supported. The partnership focus is improvements to the quality of life of local older people. Some of our practical achievements so far:

- Stockport Council in partnership with Age Concern Stockport and other organisations launched and ran a successful the Kill the Chill Campaign aimed at keeping warm, well and safe during winter. Included, leaflets, press releases, promotion of heater loans, and information were given to all front line staff; Winter Warmth Plaza event+ over 500 people supported with information and practical help such as 100+ dangerous electric blankets replaced.
- Through the Older People's Joint Commissioning Group key activities have been undertaken to develop a Stockport Dementia Strategy and have been successful for Department of Health monies to implement a Peer Support network in 2010.
- An increase in the use of and developments around telecare is being actively pursued and monitored as part of the future picture of care.
- Older People's Advanced JSNA digest was completed data was analysed and objectives for service improvements identified and developed. This information will be used by AOT to increase understanding and develop responses

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

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

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

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

The Role of Expectations and Age Discrimination in the NHS

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

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

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

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

Suppose that the health professional I had gone to see had said "Oh, it's just your age". I would have been a bit distressed that I was wearing out so quickly. I would have felt upset to abandon my ambition to be shot by a jealous lover at 104. But I would undoubtedly have resignedly accepted reality. Except that it wouldn't actually have been reality. Although it would rapidly have become so as I accepted it as such.

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

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

Experiential training of front line staff can assist with shifting cultural thinking. The All Our Tomorrow's Partnership and Age Concern Stockport have offered Through Other Eyes' training to 300+ staff 'training to encourage culture and attitudinal shift

The Role of Well Being

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

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

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

**A4: SPECIAL REPORT ON
CHANGE IN MEASUREMENT
OF INEQUALITY (written 2008)**

CHANGES IN MEASUREMENT OF INEQUALITY KEY MESSAGES

1. We have in the past measured our progress towards closing the gap on inequalities by the gap between Brinnington and Bramhall. However this focuses only on the extremes and it is proposed that in future we should examine the gap between the most deprived quintile and Stockport as a whole and between the second most deprived quintile and Stockport as a whole. ("Quintile" here means that part of the population of Stockport which are within that quintile nationally – 12% of our population are within the most deprived national quintile and 18% of our population are within the second most deprived quintile.
2. Nationally there is a move towards using age standardised mortality rate rather than life expectancy as the indicator.
3. As is normal when changing indicators a retrospective analysis has been carried out to identify likely impacts.
4. Usually these are slight but in this case the change of indicator dramatically alters our perception of our performance on inequalities over the last decade.
5. For men in the most deprived quintile and for both sexes in the second most deprived quintile there is a clear picture of continuing improvement although with some adverse blips along the way. This is a much more positive picture than the one painted by the old indicator.
6. For women in the most deprived quintile the picture is the same as for the former indicator – a fluctuating picture with some suggestion that an improving trend may have been established in the last few years but it is too early to tell.
7. Examining age-specific mortality rates it is clear that the reason for the difference in women in the most deprived quintile is a widening gap in women aged 30-59. We have previously recognised the impact of smoking related disease and alcohol in this age group.
8. The reason for differences between the two indicators in males is that life expectancy places a higher weighting on infant mortality and there was a sharp deterioration in the gap in infant mortality around the turn of the century which has slowly recovered but is still not quite back to the position in the late 1990s where the gap had been eliminated.
9. This deterioration in infant mortality results from deaths associated with prematurity and low birth weight. It is therefore a feature of maternal health and supports the evidence of a widening gap in age-specific mortality rates in younger women.
10. The link between these two indicators could suggest that the recently improving infant mortality supports the suggestion that we are now impacting on the problem which also emerges tentatively from the last few years of the mortality indicator for women.

Since I reported on trends in inequality in volume 2 of the 18th Annual Public Health Report at the January Board there have been two changes in the way we monitor our performance on inequality. Normally these might have warranted only a footnote in the Annual Public Health Report and the Joint Strategic Needs Assessment. However the changes have actually led to a changed understanding of our success on inequalities.

The Changes

Changing from Polarisation to Quintiles

We have hitherto measured our success by the gap between the most deprived and least deprived wards (polarisation). This method of measurement has the following drawbacks:

1. Polarisation is a context not an outcome. Stockport is one of the most polarised local authorities in the country only because its boundaries embrace the most affluent wards in Greater Manchester and also extend deep into the inner city. Moving Cheadle and Bramhall to any other district in Greater Manchester would make that district one of the most polarised in the country. Similarly moving Brinnington to any affluent district would make that district one of the most polarised in the country. Indeed Stockport did move from being the seventh most polarised local authority in the country to third because of boundary changes in four of the authorities previously above us.
2. Considering only the wards with the greatest and smallest rates ignores what is happening in between.
3. Performance is not comparable with other districts because their most affluent ward may not be comparable to Bramhall and their least affluent may not be comparable to Brinnington.
4. The gap may be widened because health in Bramhall has improved particularly well rather than because health in Brinnington hasn't improved well. It is true that inequalities inevitably involve comparison but they should involve comparison with an overall picture not with one specific population.

For that reason I recommended in volume 2 of my Annual Report as follows:

I recommend that, as polarisation is a context not an outcome, the Council and PCT set their goals for reduction in inequalities as improving the experiences of those Stockport residents who are in the lowest quintile of deprivation (and also of those in the second lowest quintile of deprivation) by more than the corresponding improvement in the population of Stockport as a whole and more than the corresponding improvement nationally in each of those quintiles, rather than in terms of narrowing the gap between best and worst without regard to the experience of those in between.

This recommendation has been accepted and statistics based on this analysis were prepared as a routine measurement for the first time for the latest monitoring report, although we have looked at such statistics from time to time in the past as part of the process of understanding the problem.

Changing from Life Expectancy to Standardised Mortality Rate

Death rates are influenced by the age structure of a population – the older the population the more people die. In order to compare different populations it is necessary therefore to find statistics which adjust for the age structure of a population.

The three most widely used of these methods are as follows:

Indirect standardisation (standardised mortality ratios, SMRs) calculate the number of deaths that the population would experience if each age group had the same death rates as the national population. It then divides the total number of deaths in all ages by this figure and multiplies by 100. A ratio of 100 is therefore, by definition, the national ratio.

Direct standardisation (age standardised mortality rates) use the death rates that the population suffers at each age group and calculate the death rate that it would have if it had the same age structure as the national population.

Life expectancy is the average age at which babies born today would die if there were no changes throughout their life in the death rates experienced by the population.

In the last decade national official targets have at different times used each of these measures – preferring SMRs until around the turn of the century, then preferring life expectancy until very recently and now preferring age standardised mortality rates.

SMRs have the advantage that the only figures from the local population that is used in calculating them are the age structure of the population and the total number of deaths. The number of deaths locally broken down by age is not involved in the calculation – age differences are taken into account instead in the calculation of the expected numbers which use national data. As a result the calculation is less affected by small numbers and can be used for smaller areas and for less common conditions. It would be the only method usable for areas smaller than wards or for conditions less common than the major killers. It has, however, no particular benefit in situations where the other methods can be used and it has the overwhelming disadvantage that it is a relative measure only and gives no indication of actual magnitude.

Life expectancy is a particularly graphic presentation of death rates and that is one reason for preferring it. However one feature of it is that it places particular weight on infant mortality and on deaths of children and young people. This may be seen as a strength of the measure because these deaths do indeed carry a heavy weight in people's minds. However they have different causes from the causes of the majority of deaths so it is perhaps better to have a measure of the health of the bulk of the population and then look separately at deaths of children and young people.

The Mortality Gap in the Most Deprived Quintile

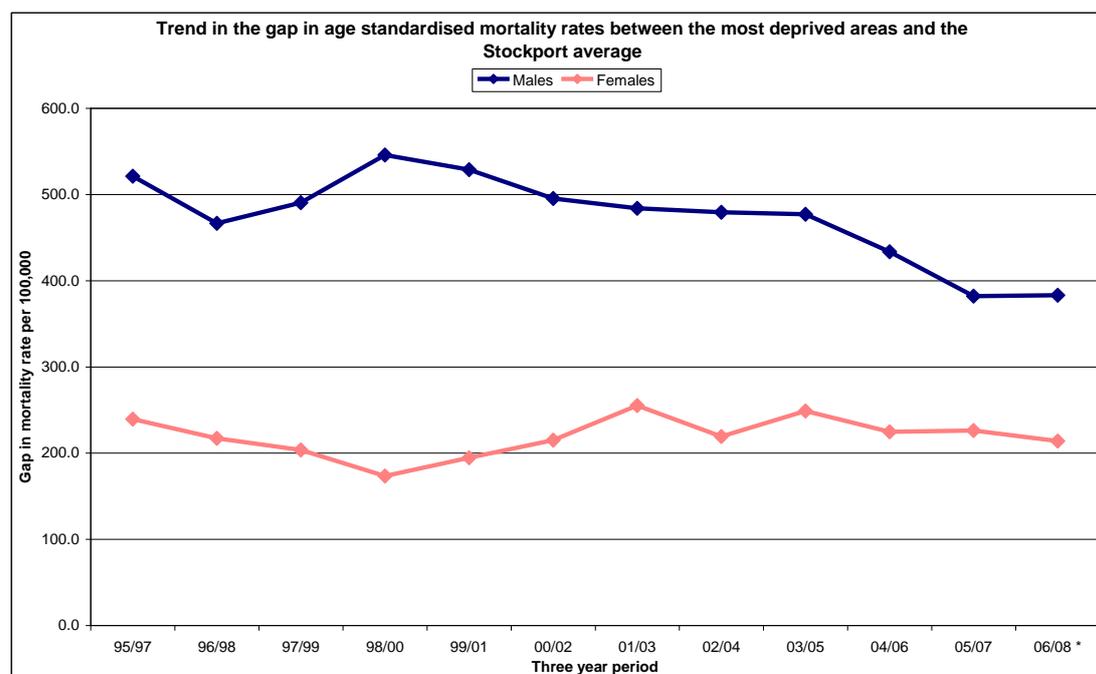
Using quintiles nationally defined by the Index of Multiple Deprivation 12% of the population of Stockport live in areas which are within the most deprived 20% nationally.

The Gap in Age Standardised Mortality

Inequalities gap directly standardised all age all cause mortality rates per 100,000												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
MALES												
Deprived areas ^	1414.1	1347.9	1356.7	1397.7	1368.7	1345.4	1316.1	1282.5	1250.4	1187.8	1116.9	1090.6
Stockport Average	891.2	880.6	865.7	852.0	839.9	850.1	832.1	803.1	773.3	754.3	734.8	709.0
Gap in deaths per 100,000	522.90	467.35	490.95	545.70	528.76	495.36	484.06	479.46	477.07	433.55	382.03	381.57
FEMALES												
Deprived areas ^	826.8	800.2	784.6	741.8	751.0	757.7	797.0	743.9	770.0	722.0	713.1	685.3
Stockport Average	586.2	582.0	580.4	568.2	556.3	542.7	541.8	524.7	521.3	497.4	487.0	472.4
Gap in deaths per 100,000	240.64	218.18	204.25	173.67	194.68	215.01	255.23	219.12	248.72	224.69	226.07	212.90

* Interim data

^ Index of Multiple Deprivation 2007 – most deprived 20% nationally (12% of Stockport population)



Like the figures we are more accustomed to this measure shows improvement in the 1990s, a deterioration around the turn of the century and a recent improvement.

The female figures show fluctuation in the first part of the century and a suggestion that sustained improvement has resumed in the last few years but that it is too early to be sure. This corresponds to the picture using the figures we are more accustomed to. Smoking and alcohol related diseases in women aged 30-59 is the main reason for the gender difference.

The male figures however are very different from the previous measure. The rates at the end of the last century are less clear in showing an improvement. Instead the most obvious feature is a steady year on year improvement since 1999 reducing the gap to 30% less than it was in 1999 and 20% less than its previous lowest point. This is a significant achievement of which we have been unaware due to our concentration on other measures.

The Gap in Life Expectancy

Inequalities gap in life expectancy at birth in years												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
MALES												
Deprived areas ^	69.1	69.7	69.5	69.1	69.2	69.9	69.9	70.1	70.1	70.8	71.4	71.3
Stockport Average	75.0	75.4	75.5	75.7	75.9	75.9	76.1	76.5	76.8	77.1	77.4	77.8
Gap in Years	-5.95	-5.67	-5.99	-6.61	-6.67	-6.00	-6.24	-6.38	-6.70	-6.35	-6.02	-6.52
FEMALES												
Deprived areas ^	76.5	76.5	76.4	76.9	76.6	76.8	75.9	77.1	76.5	77.5	77.4	77.9
Stockport Average	80.1	80.2	80.2	80.5	80.7	81.0	81.0	81.3	81.3	81.9	82.2	82.5
Gap in Years	-3.63	-3.66	-3.77	-3.57	-4.12	-4.22	-5.06	-4.19	-4.77	-4.33	-4.71	-4.58

* Interim data

^ Index of Multiple Deprivation 2007 National Quintile (12% of the Stockport population)

The gap in life expectancy shows a fluctuating picture with no secular trend. Essentially life expectancy in the inner city areas of the Borough has improved in line with improvements in the Borough as a whole but has not surpassed them so as to close the gap. Annual variations in the gap have simply represented unevenness in the rate of improvement of the two rates that are being compared.

The Implications of an Improving Trend in Age Standardised Mortality Without an Improving Trend in Life Expectancy

Life expectancy is an average age of death so it places a weighting on earlier deaths. Age standardised mortality rate is a death rate, adjusted for the age/ sex composition of the population, so this weighting is less. A situation where life expectancy does not improve but age-standardised mortality does is usually explicable by a difference between the performance on inequalities in middle aged and older people and the performance in children and young people.

Another theoretically possible explanation would be that life expectancy could move differently from age-standardised mortality rates if sharply rising death rates in middle age coincided with sharply falling death rates in old age, an unusual picture which is usually only seen in circumstances of deteriorating health where younger people experience cohort effects the older age group have escaped. There is no evidence of this occurring locally, except for the smoking and alcohol related diseases in women referred to already, affecting both indicators.

The following tables show mortality in infants (deaths in children under one) and mortality in children and young people from 1 to 29 inclusive.

MALES

Inequalities gap age specific mortality rates per 100,000 for those aged <30 - MALES												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
Stockport average												
Age 0	680.8	593.8	635.9	538.9	636.8	542.9	689.2	550.5	527.6	383.8	371.4	406.4
Age 1-29	52.0	44.0	44.0	46.6	45.1	45.0	31.7	31.9	24.3	29.8	29.0	30.9
Most deprived areas ^												
Age 0	649.4	793.0	1194.2	1107.0	1417.3	869.9	1335.9	1176.3	1127.3	809.3	522.0	646.1
Age 1-29	86.7	63.8	54.8	85.8	71.5	62.1	20.9	31.6	31.8	42.3	47.4	78.7
Gap in deaths per 100,000												
Age 0	-31.4	199.1	558.2	568.2	780.5	327.0	646.7	625.7	599.7	425.5	150.6	239.7
Age 1-29	34.7	19.8	10.8	39.2	26.4	17.1	-10.7	-0.2	7.5	12.5	18.4	47.8

* Interim data

^ Index of Multiple Deprivation 2007 National Quintile (12% of the Stockport population)

FEMALES

Inequalities gap age specific mortality rates per 100,000 for those aged <30 - FEMALES												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
Stockport average												
Age 0	656.7	591.0	534.1	461.5	499.3	381.4	418.3	481.9	699.0	558.2	464.3	388.3
Age 1-29	15.6	13.7	15.8	16.6	15.5	14.4	15.9	17.5	18.4	14.9	14.9	15.0
Most deprived areas ^												
Age 0	513.0	636.8	1155.5	1180.0	1492.6	841.4	1162.0	717.1	845.5	279.1	552.7	539.4
Age 1-29	18.6	18.6	18.8	23.8	29.1	24.5	24.9	25.1	30.4	20.3	15.3	15.3
Gap in deaths per 100,000												
Age 0	-143.6	45.9	621.4	718.5	993.3	460.0	743.7	235.2	146.6	-279.1	88.4	151.0
Age 1-29	3.0	5.0	3.0	7.2	13.5	10.2	8.9	7.6	12.0	5.4	0.3	0.3

* Interim data ^ Index of Multiple Deprivation 2007 National Quintile (12% of the Stockport population)

Deaths in children over the age of one and in young people are small in number and have fluctuated. No clear trend can be seen

In 1995/7 the gap in mortality in infants (deaths under one) actually favoured deprived areas, presumably as a result of the concentrated attention paid to them. Infant mortality in the most deprived quintile rose substantially in both boys and girls around the turn of the century with a consequent widening of the gap. Infant mortality in deprived areas has now fallen back to more normal levels but the gap has not returned to earlier levels because infant mortality in Stockport as a whole has fallen to new lows.

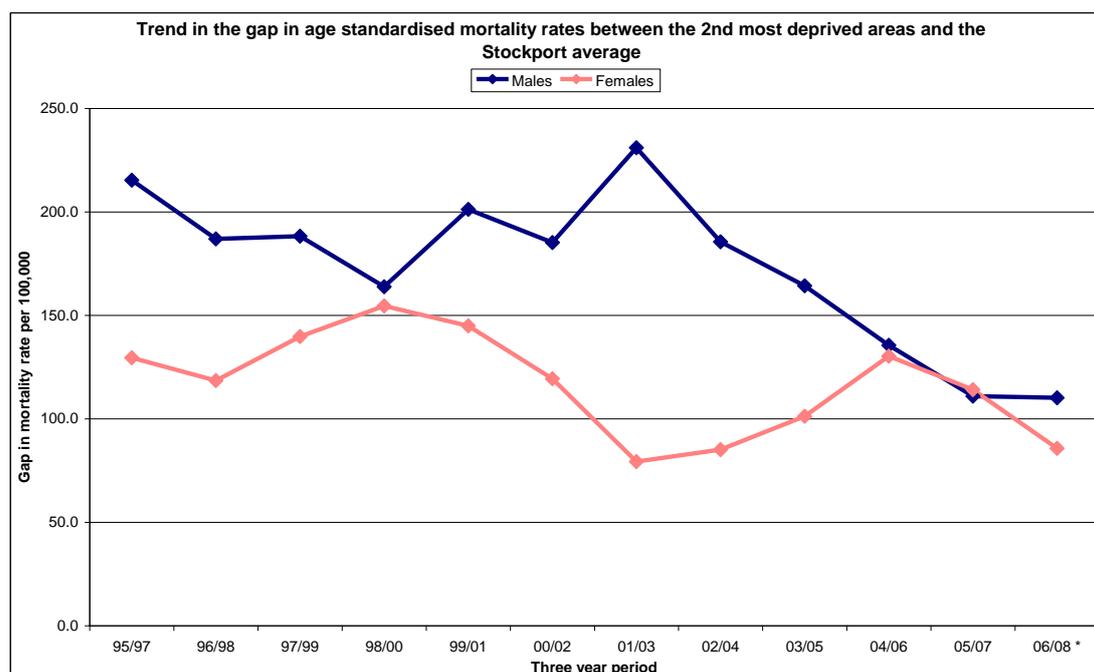
The Mortality Gap in the Second Most Deprived Quintile

30% of the population of Stockport live in areas which according to the Index of Multiple Deprivation lie in the nationally defined most deprived two quintiles (40%)
 18% of the population of Stockport are within the second most deprived quintile rather than the most deprived.

The Gap in Age Standardised Mortality

Inequalities gap directly standardised all age all cause mortality rates per 100,000												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
MALES												
2 nd most deprived area^	1106.5	1067.5	1054.0	1015.8	1041.1	1035.3	1063.1	988.6	937.5	889.8	845.8	819.2
Stockport Average	891.2	880.6	865.7	852.0	839.9	850.1	832.1	803.1	773.3	754.3	734.8	709.0
Gap in deaths per 100,000	215.3	186.9	188.3	163.8	201.2	185.2	231.0	185.5	164.2	135.5	110.9	110.2
FEMALES												
2 nd most deprived area^	715.7	700.5	720.1	722.8	701.2	662.1	621.2	609.8	622.4	627.6	601.1	558.2
Stockport Average	586.2	582.0	580.4	568.2	556.3	542.7	541.8	524.7	521.3	497.4	487.0	472.4
Gap in deaths per 100,000	129.5	118.5	139.8	154.6	144.9	119.3	79.3	85.1	101.2	130.3	114.1	85.7

* Interim data ^ Index of Multiple Deprivation 2007 – second most deprived 20% nationally (18% of Stockport population)



The picture is similar to that in the most deprived quintile. The downward trend in the gap for males is clear. That for women is more fluctuating but with a suggestion of a downward trend. Indeed the suggestion of the downward trend is stronger than it is in the most deprived quintiles. The dates of the setbacks in the early 21st century are different in this quintile from the most deprived quintile and are different between men and women.

The Gap in Life Expectancy

Inequalities gap in life expectancy at birth in years												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
MALES												
2 nd most deprived area^	71.9	72.8	72.9	73.2	72.9	73.4	73.2	74.2	74.4	75.1	75.4	76.0
Stockport Average	75.0	75.4	75.5	75.7	75.9	75.9	76.1	76.5	76.8	77.1	77.4	77.8
Gap in Years	-3.1	-2.6	-2.6	-2.5	-3.0	-2.4	-2.9	-2.3	-2.4	-2.1	-2.0	-1.8
FEMALES												
2 nd most deprived area^	77.7	78.1	77.8	77.9	78.1	78.7	79.6	79.7	79.5	79.1	79.6	80.4
Stockport Average	80.1	80.2	80.2	80.5	80.7	81.0	81.0	81.3	81.3	81.9	82.2	82.5
Gap in Years	-2.4	-2.1	-2.4	-2.6	-2.6	-2.3	-1.4	-1.6	-1.8	-2.7	-2.5	-2.1

* Interim data ^ Index of Multiple Deprivation 2007 National Quintile (18% of the Stockport population)

Like the most deprived quintile both sexes show a fluctuating picture for the gap in life expectancy. In men however there is a clear downward trend with some sharp upward blips, unlike the picture in the most deprived quintile where improvement could not be seen. In women however the picture in this quintile, like that in the most deprived quintile, of a fluctuating picture with little evidence of secular trend. As in the most deprived quintile this picture focussed attention on mortality rates for children and young people.

Gaps in Mortality for Children and Young People

MALES

Inequalities gap age specific mortality rates per 100,000 for those aged <30 - MALES												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
Stockport average												
Age 0	680.8	593.8	635.9	538.9	636.8	542.9	689.2	550.5	527.6	383.8	371.4	406.4
Age 1-29	52.0	44.0	44.0	46.6	45.1	45.0	31.7	31.9	24.3	29.8	29.0	30.9
2nd most deprived areas ^												
Age 0	1341.1	1091.8	913.4	857.4	878.1	698.7	613.1	506.1	582.1	371.4	359.4	177.9
Age 1-29	51.2	42.5	46.6	64.2	58.3	48.7	28.2	28.4	25.0	28.5	31.8	24.6
Gap in deaths per 100,000												
Age 0	660.3	498.0	277.5	318.5	241.3	155.8	-76.1	-44.4	54.4	-12.4	-12.0	-228.5
Age 1-29	-0.8	-1.5	2.5	17.6	13.1	3.7	-3.5	-3.5	0.6	-1.4	2.8	-6.3

* Interim data ^ Index of Multiple Deprivation 2007 National Quintile (18% of the Stockport population)

FEMALES

Inequalities gap age specific mortality rates per 100,000 for those aged <30 - FEMALES												
	95/97	96/98	97/99	98/00	99/01	00/02	01/03	02/04	03/05	04/06	05/07	06/08*
Stockport average												
Age 0	656.7	591.0	534.1	461.5	499.3	381.4	418.3	481.9	699.0	558.2	464.3	388.3
Age 1-29	15.6	13.7	15.8	16.6	15.5	14.4	15.9	17.5	18.4	14.9	14.9	15.0
2nd most deprived areas ^												
Age 0	564.0	466.8	376.4	384.4	397.8	513.9	319.4	525.6	826.3	1022.7	911.5	691.8
Age 1-29	31.3	18.8	19.0	19.3	16.4	16.6	13.5	17.1	13.8	20.7	24.2	31.2
Gap in deaths per 100,000												
Age 0	-92.7	-124.2	-157.7	-77.1	-101.5	132.5	-98.9	43.7	127.3	464.6	447.2	303.5
Age 1-29	15.6	5.1	3.2	2.7	0.8	2.2	-2.5	-0.4	-4.6	5.8	9.3	16.2

* Interim data ^ Index of Multiple Deprivation 2007 National Quintile (18% of the Stockport population)

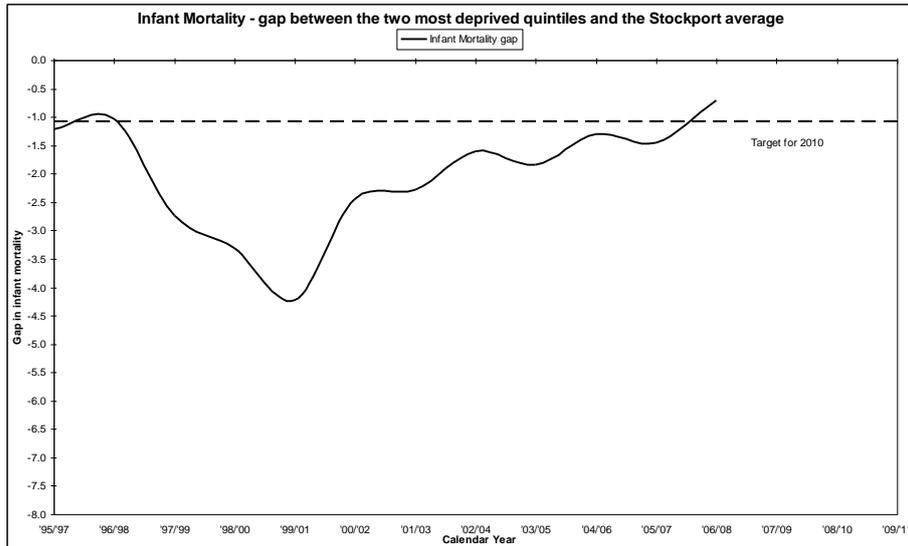
In boys the gap in age specific mortality for infants in this quintile shows a steady improvement. In girls the reverse is true - negative gaps in the period 1995-2001 have been replaced by positive gaps in the period 2002-2008. Unlike the most deprived quintile there is no evidence that the deterioration in the gap for girls has passed. In fact the last four years

have shown the highest age specific mortality for infants in girls in this quintile in the whole of the period being examined.

Routine Monitoring of Infant Mortality

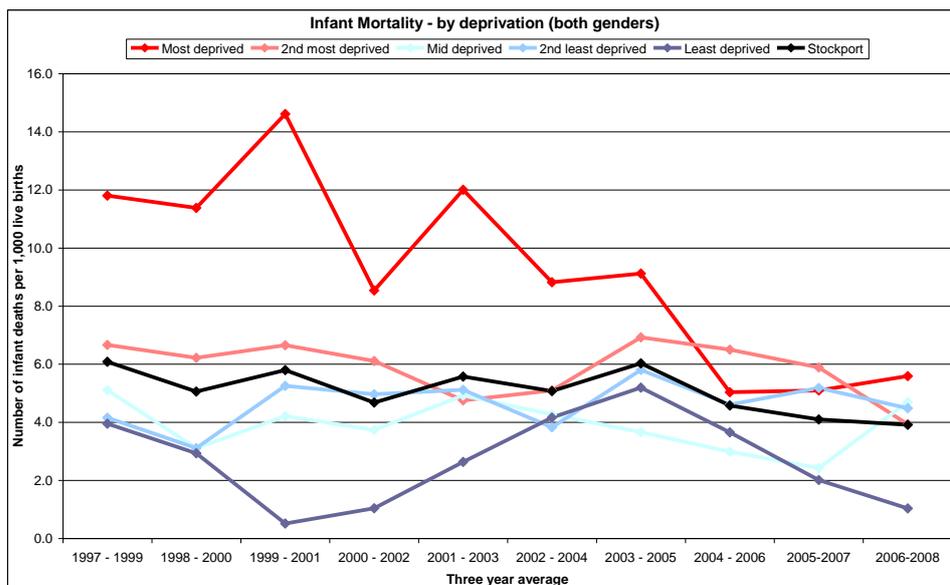
We do, of course, monitor infant mortality in our health monitoring statistics. Infant mortality is a slightly different statistic from age specific mortality in infants because the number of deaths is divided by the number of births rather than by the mean population. There is very little difference between the two but the numbers will be slightly different.

We monitor the gap for both boys and girls in the two most deprived quintiles as a single measure and the following results have been seen.



We have therefore been aware that deterioration in the infant mortality gap occurred around the turn of the century and has steadily improved since but has only recently achieved former levels. We have however seen this as consistent with our perception of inequalities generally – we did not realise that this was the main statistical explanation for the life expectancy picture we were seeing.

The following graph shows infant mortality for each quintile



Conclusion

By 1995 our strategies for addressing inequalities in child health (including weighting of health visitor allocations, the introduction of first parent visiting and the pursuit of UNICEF Baby Friendly status by the Maternity Unit at Stepping Hill) had so reduced inequalities in infant mortality that the gap between deprived areas and the Borough as a whole was actually negative. It was entirely correct therefore that the inequalities strategy since then should have focussed on the health of middle aged and older people.

That strategy has been successful. It has achieved progressive and sustained reductions in the gap between deprived populations and Stockport as a whole in age-standardised mortality rate for both men and women in the second most deprived quintile and for men in the most deprived quintile. The picture for women in the most deprived quintile is less clear due to the effect of alcohol and smoking related diseases but could perhaps have established an improving trend in the last few years after considerable fluctuation.

We have not clearly perceived this success because we have used an indicator based on polarisation of life expectancy. This indicator has been more volatile because of movements in health specific to the most extreme two wards including health improvements in Bramhall.

Also this indicator has placed greater emphasis on an area where we have not been so successful. It has been affected by a failure to achieve continued improvement in infant mortality. This took the form of a sharp increase in the gap around the turn of the century since when it has been steadily narrowing back towards the previous figures.

In worrying about the fluctuations in measures of the gap in life expectancy we have been worrying about the wrong component of the life expectancy statistics. It was not our inequalities strategy which we should have been worrying about, it was the sharp deterioration in the infant mortality gap at the turn of the century. As this was predominantly due to the incidence of prematurity and low birth weight it was our maternal health strategy that should have concerned us.

We were aware of the movements in infant mortality but saw them as a feature of the overall inequalities problem. In fact they were the main component of the problem and concealed the improvement in other areas, although smoking and alcohol are, of course, a link between the maternal health issues that produce the infant mortality problem and the gender difference in the inequalities picture in the most deprived quintile.

**A5: OBESITY (written
2007)**

A5.1 OBESITY

Summary

Obesity levels are rising rapidly presenting a major health problem for the future. Many factors have led to this – changes to our environment such as the job market, family structures, modes of transportation, home entertainment and availability and marketing of foods, have led us to eat more energy-dense foods and do less activity than generations before. Children are now more constrained in their play – battery-reared children who play in cyberspace have replaced free-range children who played in greenspace. As smoking levels decrease, obesity is replacing smoking as a key risk factor for disease: most adults in Britain are overweight and increasingly so, and this contributes to many chronic health problems including the major killers of coronary heart disease and cancer. Many people try to diet and take up exercise programmes, but most dieters put their weight back on whilst gym memberships lapse.

The most difficult challenge with obesity is to create an environment where people are more active and do not put on weight to begin with. Stockport has developed an Obesity Action Plan that will coordinate actions to change the environment into one that promotes physical activity and a healthier diet, and supports individuals and families in their attempts to live a healthier lifestyle.

This paper describes the health problems linked to obesity, the situation in Stockport, and the work being done locally to address the issue.

Introduction

Overweight and obesity are terms used to describe increasing degrees of excess body fatness which lead to adverse effects on health and wellbeing. Obesity is rising rapidly in both developed and developing countries, with an associated rapid rise in rates of diabetes and other illnesses. There are metabolic and genetic factors contributing to obesity. It is probably the case that some people are more susceptible and others are lucky enough to enjoy a greater freedom. It may even be that in future we will be able to influence these mechanisms. We live in a society where on average we have access to plenty of calories, and increasingly do less and less physical activity than previous generations. We drive more, sit more, and our children play fewer physically active games. This “obesogenic” environment compounds the individual factors that affect people’s weight and their attempts to control it.

The challenge is to halt this rise by changing the “obesogenic” environment – that is, to change our current environment from one that encourages us all, children and adults, to eat more calorie-dense foods and do less physical activity, to one that helps individuals and families choose to be more physically active every day, eat less calories and maintain a healthy weight from birth onwards.

However, for all that, the blunt fact is that obese people eat too much and exercise too little and that if they ate less and exercised more the overwhelming majority of them would not be obese. Eating less is important but it must be accompanied by more exercise. Dieting can be valuable in allowing people to feel fitter and take up more exercise but dieting alone depresses the metabolic rate so that when the diet is relaxed the weight returns, often to a higher level than originally. The epidemic of obesity has spread relentlessly in concert with the development of sedentary lifestyles, and increased exercise is essential in tackling it. 7 out of 10 women and 6 out of 10 men in Britain are not active enough to benefit our health. Most of

us think we are fit enough and active enough to be healthy, but in reality, 70% of us are not fit and certainly not active enough to be healthy.

Our challenge is to make the social and environmental changes that will make it easier for people to choose a more active lifestyle. The challenge is very difficult. It has been known that obesity is a significant contributor to individuals' health problems since the 1930s, and that population levels are rising rapidly for the last twenty-five years. There have been warnings and plans, locally and internationally. Yet the prevalence of obesity is rising globally, but especially in the developed world. Obesity amongst adults in the UK has trebled since 1980: by 2002 70% of men and 63% of women were overweight of whom 20% were obese. The latest figures (Health Survey for England 2005) show that 22% of men and 24% of women are obese. The picture is even more stark for children. Obesity prevalence is steadily and rapidly increasing, trebling in one decade from 5% to 16% in 6 - 15 yr olds between 1990 and 2001. By 2004, 19% of 2 - 15 yr olds were obese.

Nationally 9,000 premature deaths per year are estimated to result from obesity: an obese person loses on average 9 years of life and an overweight person loses 3 years of life compared to someone of normal weight. Body fatness leads to highly increased risks of high blood pressure and diabetes, leading in turn to heart disease: certain types of cancer especially hormonally-related cancers and bowel cancers are associated with obesity, as is gallbladder disease. Obesity is also linked to respiratory difficulties, back problems and joint problems, infertility, depression and relationship problems. As obesity becomes more common, society paradoxically places greater normative value on slimness, so obesity damages self-esteem causing stress. Childhood obesity is linked to the early onset of preventable disease including diabetes, and obesity and overweight in childhood persists into adulthood.

Neither individuals nor the health service can tackle obesity alone. The causes of obesity and the obesogenic environment are complex, and the ad hoc treatment of individuals has not resulted in a change in the rate of increase. Strategically, there is no clear example, internationally, of a programme to prevent and reduce obesity that has led to success – “no country has successfully reduced the overweight and obesity burden” (Foreword to “Lightening the Load”, National Heart Forum, 2007). On the other hand there is much scope for trying to implement good practice and monitoring its impact. This requires the identification of resources both for trying out ideas and to undertake this evaluation and monitoring.

A number of recent national reports and plans, including comprehensive guidance from NICE in December 2006, have put more emphasis on the whole economy addressing the interrelated actions that may combine to have an impact on obesity rates. Stockport has a good history of innovative programmes improving community access to physical activity and healthy food, and is responding to rising obesity by bringing together different agencies and sectors to address the challenge at two levels for both children and adults: changing the environment to one that promotes healthier eating and more physically active choices, and providing services to people who are already overweight and obese to help them lose weight and maintain a healthier lifestyle.

What is obesity?

Body Mass Index (BMI), though not a direct measure of body fat, is generally used to measure whether a person is an appropriate weight for their height because for most people it correlates with their proportion of body fat. It is calculated as their weight (in kilogrammes) divided by their height (in metres) squared. “Obesity” represents a BMI over 30 whilst “overweight” is used for those with a BMI over 25. Further terms such as morbid obesity are sometimes used to differentiate those who are heavily overweight with BMIs of 40 or 50+.

Alternative measures representing weight problems are also used, such as waist circumference or waist-to-hip ratio - these do not take height into account but give equally valid indications of health risks as they are in part a measure of “central adiposity”. This is the tendency to store fat in the upper body (and be “apple-shaped”) as opposed to on the hips and thighs (“pear-shaped”): being apple-shaped has a higher association with the main health risks of excess weight. A waist circumference in men above 102 cm (40 inches) and in women above 89 cm (35 inches) confers increased health risks. For people from some ethnic minorities it is suggested that lower BMI or waist measurements for treating excess weight should be considered, as the health risks - particularly for South Asians - appear at lower thresholds.

Obesity rises with age except in the oldest groups over 75. Overweight and obese parents tend to have overweight and obese children; having two obese parents substantially increases the chances of a child being overweight. If current trends continue, 1/3 adults, 1/3 girls, and 1/5 boys will be obese by 2020.

WHY IS IT A PROBLEM?

Obesity accounts for £1 billion per year of direct NHS expenditure and a further £2.3 to £2.6 billion in the indirect costs to the economy of shortened lives, reduced productivity, and lowered incomes. Acknowledging the importance of obesity as a health issue, the Government have set a Public Service Agreement (PSA) target to halt the year on year rise in obesity among children under 11 years by 2010, within the context of a broader strategy to tackle obesity in the population as a whole.

The burden of obesity is not spread equally across society. The trend data suggests the link between obesity and socioeconomic class is weakening, but some groups still have a greater proportion of obese individuals. Whilst deprivation is not strongly linked with obesity, nationally 14% of those classed as professionals were obese in 2003, compared with 19% men and 28% women classed as unskilled. In terms of ethnicity, obesity is 50% more common in black Caribbean women than women in general, and 25% higher amongst Pakistani women, and four times more common in Asian children than white children. In fact it is more of a health problem for South Asian groups because individuals are more likely to have centralised fat distribution (i.e. be apple shaped).

As with cardiovascular disease, there is likely to be a combination of genetic and environmental factors at play in producing obesity, but the rapid increase points to the impact of the environment where calories are cheap and plentiful, whole foods are less common in the diet as a whole, and physical activity is diminishing with labour saving devices, screen-based entertainment, motorised transport and over-protection of children. Although there is regular interest in the genetic components of obesity, combating obesity for the population as a whole can't just be about better treatments for individuals; it has to be about tackling our increasingly “obesogenic” environment.

OVERPROTECTION OF CHILDREN

A quarter of a century ago most children walked to school. A typical child of 8 or 9 would be allowed to roam up to 800 metres from home. Today, most children are taken to school by car, and a typical child of 8 or 9 will be confined to the immediate vicinity of the house and garden. This shift from free-range to battery-reared children has been motivated by a desire to protect them from the real risk of motor traffic and the exaggerated risk of stranger-danger – there are only a handful of child abductions annually, with children far more likely to be murdered or abused by members of their immediate family than by strangers. Whilst there is no doubt that these restrictions

are well-intended and loving, the fact is that they are causing far more harm than the risks they address.

IS OBESITY A PROBLEM IN STOCKPORT?

Stockport data currently shows that Stockport has lower rates of obesity in all groups compared to the national picture. However, there is no room for complacency as there is a general rise in the figures here as elsewhere. In addition, the data sources are fairly new and data is not yet available to show trends reliably.

Lifestyle survey data from the Stockport Adult Lifestyle Survey, 2006, shows the pattern in Stockport:

54% men and 41% women are overweight (BMI over 25); nationally the figures are 64% and 56% respectively

12.2% men and 12.6% women are obese (BMI over 30); nationally the figures are 22% and 24%

Proportion with BMI over 25 increases with increased deprivation

Link to deprivation not present for men but present for women

The figures show the same trends for age and deprivation as the national averages, but at lower levels. This may possibly be due to self-selection of responders. In contrast, figures collected through General Practice suggests the proportion of obese people of those measured is around 26%, more similar to the national picture.

Childhood measurement data collected by School measurement statistics, 2006 shows the picture for primary school age children:

11.2% (combined Reception and Year 6) children in Stockport are obese; the national average was 13.2%

This figure is based on a large data collection, but is subject to annual fluctuation, and a clearer estimate will emerge as this exercise is repeated and trends can be observed.

There is some indication in the latest local data that the most obesity amongst children is found geographically in the second-most-deprived quintile of wards. For all children, time spent in the car, junk-type dietary patterns and TV viewing in the pre-school years are causes of increased obesity risk at age 7: it has been suggested that this group of children may have a larger proportion of processed foods and snacks in their diet than other groups, whilst having greater access to cars for travelling in comparison to children living in the most-deprived quintile.

WHAT ARE WE DOING ABOUT OBESITY?

Nationally, NICE guidance was issued in December 2006 on obesity prevention, identification, assessment and management. Stockport's obesity work programme strongly emphasises the contribution of the environment to tackling obesity and making healthy choices easier.

An obesity task force was set up in Stockport in 2005 to develop a multi-agency approach to tackling obesity. This produced an action plan adopted by the SMBC Social Care and Health Scrutiny Committee in February 2006 focusing on the themes of childhood obesity, physical activity, food and healthy eating, and primary care.

CURRENT WORK ON OBESITY IN STOCKPORT

A set of indicators is being developed to monitor and demonstrate improvement in tackling obesity, ranging from better knowledge about local prevalence (e.g. the

school childhood obesity measurement), through improved service delivery (e.g. referral rates to Physical Activity on Referral in Stockport (PARiS)), to demonstrating environmental change (e.g. kilometres of cycle lane developed).

Childhood Obesity

Stockport is prioritising Childhood obesity with a number of initiatives. Breastfeeding is shown to be a key strategy in preventing the development of obesity in children. We have set a stretch target under the Local Area Agreements and have appointed a Breast Feeding Coordinator to help replicate the doubling of breastfeeding rates achieved by some local support groups, and make Stockport a breastfeeding-friendly borough as exemplified in aiming for UNICEF Baby-friendly Status for Stepping Hill Foundation Trust Hospital.

Local Maternal and Infant Nutrition guidelines and Healthy Snack guidelines for preschool settings raise awareness amongst staff groups about what can be done to promote an environment that encourages healthier eating and more physical activity from the earliest stages. Later weaning, low weight and slower weight gain in infancy are positively associated with less childhood obesity at age 7.

The school setting is very important for encouraging a healthy diet and a physically active lifestyle amongst older children: Stockport schools are supported to work towards achieving the National Healthy School Status which promotes healthy eating and physical activity as two of the four themes of the National Healthy Schools Programme. Support includes development of breakfast clubs, promoting the uptake and improved quality of school meals, enhancing the environment creating safer routes for children to walk or cycle to school, and achievement of two hours of good quality PE per week.

Physical Activity

Addressing obesity through physical activity entails:
encouraging walking and cycling as the main transport mode for short journeys
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 swimming, and organised activities like fun runs
special organised activities to overcome barriers to recreational exercise – special swimming sessions for women only or for obese people only are examples
the development of “green gyms” which provide opportunities for people to contribute to the environment through physically active voluntary work
encouraging people to build exercise into their daily life, for example by using the stairs instead of the lift or walking further as part of their daily journey to work
exercise referral schemes which use physical activity as a treatment for illnesses that would benefit from people being more active
rehabilitation programmes which help the return to physical activity in those who have been put off by obesity, old age, sickness, frailty or disability
encouraging walking and cycling to work or for business journeys through cycle parking, showers, changing facilities and generous walking and cycling mileage allowances.

Recent work in Stockport has included a new local Play strategy which focuses resources on improving the opportunities for children of all ages to play, increasing both physical activity and social networking through variety, adventure and stimulus.

A Stockport Sport and Physical Activity Alliance (SPAA) has been established in the last year, which has identified health as one of the main areas to benefit from new resources to promote physical activity. A physical activity strategy for Stockport will provide a focus for prioritising work to tackle obesity both by offering individuals more opportunities for physical activity, and by improving the environment to encourage exercise and active travel.

Promoting Walking and Cycling

American research has shown a 6lb difference in mean body weight between those living in pedestrian-friendly (“permeable”) street designs and those living in street designs that “loop and lollipop” – that is, those where walking journeys are long, circuitous and indirect. A 6lb difference in mean body weight applied across the population of Stockport would equate to 335 deaths per year. This demonstrates the life-saving potential of walking and cycling.

The British Medical Association has calculated that walking and cycling for short journeys could **alone** meet national heart disease prevention targets.

Food and Healthy Eating

Stockport Community Food Programme has shown how a local project committed to working with local people can have a significant impact in improving the diet generally, and particularly on increasing the consumption of fruit and vegetables amongst target groups across the age range. The Community Food Programme has worked in Reddish and Brinnington under the Healthy Living Scheme, and in Adswold and Bridgehall under Surestart, to employ and train local people and change targeted families’ diets through the use of cooking skills, individual support, weaning workshops and fruit and vegetables on prescription. These pilot schemes are coming to a close and the challenge for the local health economy is to find the resources to mainstream this successful work.

A Food and Health Strategy for Stockport is in development, which will tackle obesity by bringing together all those aiming to improve the diet of local residents. Interests represented range from community access to healthy food (including food-mapping and encouraging new outlets), transport issues and questions of isolation, through raising knowledge about food and diet (including food safety and cooking skills), to local food production and supply, commercially, domestically and in institutional catering.

Primary Care and Health Services

We now have better measurements of BMI in primary care through the national Quality and Outcomes Framework for General Practice and Practice Based Commissioning audits. We are training primary care staff on brief intervention weight management techniques, including motivational interviewing and providing written information and follow-up to support patients’ goals.

A new Obesity Care Pathway is in development, offering planned interventions to individuals at all levels of need from brief advice about weight management to

surgical treatment. This will include a new Care and Treatment programme to offer intensive support for those individuals with a severe weight problem, as well as the necessary follow-up to those who end up having surgery.

To back-up Primary Care staff and provide further support and motivation for individuals and families to address their weight problems, a new Brief Intervention Service is in development to support the new Obesity Care Pathway, using Health Trainers. This Service will also bring in the private and independent sectors to offer support such as weight management on referral, and will have the ability to target resources to those most in need.

TARGETS AND MONITORING

Indicators of the levels of obesity in Stockport and measurements of the effects of the programmes of work described above will be monitored by the Public Health Partnership Board, so that progress towards meeting the PSA target can be measured and additional actions planned and implemented if necessary.

The selected group of targets giving a snapshot of progress on obesity to be monitored by the Public Health Partnership Board are given in Table 3 at the end of this document. The selection of these indicators to measure obesity (and the impact of programmes to address it) has been undertaken this year; finding suitable and robust datasets has presented difficulties. It can be seen from the table that in many cases the datasets to measure impact on obesity are still in development with baselines to be established in some areas: reliable data on the level of obesity itself in adults and children in Stockport is only just becoming available. Broad knowledge about physical activity levels or diet and healthy eating in Stockport are provided by the recent adult lifestyle survey or the young people's lifestyle survey; these surveys have each been done once in recent years and are not part of the annual work programmes for any local agency. A further young people's lifestyle survey is in the planning stages, and it is hoped to do the adult lifestyle survey on a three-year cycle. However information on walking and cycling is available only from transport data which is not available over short periods, and information on children's freedom to play derives from ad hoc national research. Work is needed to develop local indicators in these two key areas. An attempt has been made to use existing datasets where possible to track progress on the obesity workstream, such as reporting on the increase in the number of referrals and compliance of participants in the Physical Activity on Referral in Stockport (PARiS) scheme. In further cases no local targets have been set, but work is progressing to improve the situation, e.g. the local Food in Schools group is considering a local target on increasing the uptake of school meals.

As will be clear from the preceding discussion of the causes of obesity, many activities and services will have an impact on the reduction of obesity and weight problems in the community, ranging from individual services delivered to overweight people, to actions that change the broader environment.

The targets and indicators in Table 1 are those that have relevance to those local workstreams addressing obesity and are extracted from current strategic plans in Stockport. These are mainly from the Stockport Partnership Local Area Agreement, with some additions from the Local Delivery Plan and the Public Health Partnership Board Public Health Goals.

Table 1 Targets and Indicators relevant to obesity workstreams in Stockport

Local Area Agreement (LAA) – Children and Young People

There are three relevant targets in this section of the LAA linked to obesity, given below (numbering follows the LAA).

Healthy Schools work (Indicator 2a and b) is progressing well and is on schedule to meet targets. Measurement of childhood obesity in schools (2c and d) is being undertaken at present and follows school years.

The second target given below, on breastfeeding, is reward target 1; meeting it will attract additional funding, and additional resources have gone into developing services in this field. As can be seen from the actual figures, we are meeting this target at present.

The third target (Indicator 5) links to the amount of physical activity undertaken in schools – the target details the percentage of schools providing pupils with two or more hours per week of high quality physical activity. This target is also on schedule, and is supported by School Sports Coordinators in Secondary Schools and link teachers in Primary Schools.

Indicator	Partners and funding	Baseline Position	Performance Targets		
			2006/7	2007/8	2008/09
2) An improvement in young people's access to healthy lifestyle choices: (a) % of Stockport Schools taking part in the National Healthy Schools Programme. (b) % of Stockport Schools achieving the new National Healthy Schools Standards. (c) Prevalence of overweight reception age children. (d) Prevalence of obese reception age children.	Stockport Council, Stockport Primary Care Trust, Stockport NHS Foundation Trust, Extended Schools (Standards Fund) Children's Services Grant Drug Action Funding Children's Fund Sure Start	(a) 93% (b) 0% (c) 24.1% (d) 9.8% (2004/05)	(a) 95% (b) 50% (c) & (d) (See comment below)	(a) 97% (b) 72% (c) & (d) (See comment below)	(a) 100% (b) 75% (c) & (d) (See comment below)

Department of Health are to issue Technical Guidance on Obesity by the end of the year. Targets c and d will be developed when the technical guidance is issued

Indicator	Partners and funding	Base-line Position	Performance Targets			Enhancement in performance
			2006/7	2007/8	2008/09	

Reward Target 1 – Increasing breastfeeding initiation rates.

This target links particularly to the health theme. It is a clear local priority in the Children and Young People's Strategic Plan and will address the low rates exhibited especially among lower socio-economic groups.

(a) Breastfeeding initiation rates.	Stock-port PCT, Stock-port NHS Foundation Trust LAA Pump-Priming Grant	(a) 60% (2004/05 and 2005/06 YTD)	(a) 66% Actual 72.4%	(a) 68%	Without Re-ward (a) 68%	(a) 71%	(a) 3 percentage points increase
(b) Continuation that is sustained to primary visit.		(b) 45% (2005/06 Q3)	(b) 50% Actual 51.8%	(b) 54%	(b) 53%	(b) 59%	(b) 6 percentage points increase
(c) Continuation that is sustained to 28 days.		(c) 37% (2005/06 Q3)	(c) 40% Actual 43.7%	(c) 44%	(c) 43%	(c) 48%	(c) 5 percentage points increase

Indicator	Partners and funding	Baseline Position	Performance Targets		
			2006/7	2007/8	2008/09
<u>5) The number of 5-16 year olds participating in two hours or more of physical activity per week: % of schools providing 2 or more hours of physical activity per week</u>	<u>Schools</u> <u>Connex-ions</u>	<u>64%</u> <u>(2004/5)</u>	<u>69%</u>	<u>76%</u>	<u>85%</u>

Local Area Agreement - Safer and Stronger Communities

Safer and stronger communities section of the Local Area Agreement includes targets addressing the physical environment and the perceptions of local residents. Indicator 15, Improving the quality of open space, and Indicator 22, residents of neighbourhood renewal areas who think the appearance of their local area is quite good or better, will have an impact on the readiness of local people to use local greenspace and their confidence to walk and cycle more often for short journeys in their local areas.

Targets for these indicators are currently being set. For the neighbourhood renewal areas Adswold and Bridgehall (ABC), Brinnington and South Reddish, these will follow surveys.

Indicator	Partners and Funding	Baseline Position	Performance Targets		
			2006/7	2007/8	2008/09
15) Improve quality of open space:	Stockport Council	(a) 1 (2005/6)	(a) 1	(a) 1	(a) 4
(a) Number of parks in areas of deprivation reaching Green Flag standard.	Stockport Council SSCF	(b) 1 (2005/6)	(b) 4	(b) 4	(b) 4
(b) Number of greenspaces in areas of deprivation benefiting from dedicated full time staffing.		(c) Baseline to be established by 30 Sept 2006.	(c) Target to be set Sept 30 2006.	(c) Target to be set 30 Sept 2006.	(c) 5% increase per annum until 2009.
(c) Usage of greenspace in areas of deprivation		(d) 1 (2005/6)	(d) 1	(d) 1	(d) 4
(d) Number of green spaces where CAFE criteria are met.					

Indicator	Partners and Funding	Baseline Position	Performance Targets		
			2006/7	2007/8	2008/09
22) % of residents in neighbourhood renewal areas who think the appearance of their local area is quite/fairly good or very good.	Neighbourhood Renewal Partnerships, Safer Stockport Partnership SSCF	49.8% in Brinnington, 2003 63% in ABC area, 2004 (Reddish baseline to be established through survey 2006 and confirmed by 30 Sept 2006)	55% in Brinnington % to be confirmed for Adswold and Bridgehall area (Reddish target to be established following survey 2006)		

Local Area Agreement (LAA) – Healthier Communities

The Indicators 3 and 4 in the Healthier Communities section link directly to the prevalence of obesity and the key individual risk factor of physical activity levels. The performance targets for these indicators are challenging, and achieving them will require concerted effort and new services to encourage and support individuals to take more physical activity.

In addition to these targets, recent NICE guidance on physical activity and on obesity recommends that health service staff use every opportunity to support individuals increase their physical activity and address weight management using brief interventions. This will require a programme of training for staff, and the development of indicators at a service level to monitor delivery of brief interventions. These indicators will however show the impact of these interventions.

Indicator	Partners and Funding	Baseline Position	Performance Targets		
			2006/7	2007/8	2008/09
3) Physical activity levels: Percentage of adults participating in at least 30 minutes of moderate intensity sport and physical activity 5 times a week on average over a year.	Stockport Council, Stockport PCT, Stockport Sports Trust Stockport Council, Stockport Primary Care Trust	Most economically deprived quartile (Rank 4) Baseline 25% (Remainder of the population 26.5%)	25.3%	25.6%	26% (Remainder of population 27%)
4) To halt the year on year rise in adult obesity rates (% over 18s with BMI over 30).		21.6%	21% (Actual 24.9%)	21%	21%

Additional targets from Local Delivery Plan

This indicator from the Local Delivery Plan supplements that in the LAA given above and details the work required from Primary Care teams to record obesity levels amongst adults, to give a better understanding of the local position against which to gauge performance. At present recording levels are below target, but a Practice Based Commissioning Audit is being put in place in addition to the Cardiovascular Disease Risk Factor screening programme to collect this information.

Indicator	Baseline Position	Performance Targets		
		2006/7	2007/8	2008/09
4b)Obesity Measurement- % of people aged 15 to 75 years on a GP register with BMI recorded in last 15 months	57.4%	Target 60.0% Actual 35.7%	65.0%	65.0%

Public Health Goals

The information on the next page details the latest draft of Stockport's 29 Public Health Goals and targets, as related to obesity. In some cases these goals and targets overlap with or duplicate those in the LAA, but they are given in full as the style in which they are written is different from the targets given above.

In some cases there are additional indicators to those in the LAA, as the Public Health Goals capture some of the broader public health issues related to obesity such as transport.

Public Health Goal	Indicator	Source	Trend/Level	Target	Status	
Social & Environmental Factors						
13	Work to minimise car use and increase uptake of walking and cycling	% of the daytime population who travel to work on foot	SMBC (Audit Commission)	8.1% (2001)	-	-
		% of the daytime population who travel to work by bicycle	SMBC (Audit Commission)	1.9% (2001)	-	-
		% of the daytime population who travel to work by car	SMBC (Audit Commission)	67.7% (2001)	-	-
		Ease of use of Public Rights of Way by the Public (BVPI 178)	SMBC (Council Plan)	81.4 (2005/6)	87% (2008/9)	
Individual Factors						
23	Improve diets	%age of adults eating 5 pieces of fruit and vegetables per day	PCT (Adult Lifestyle Survey)	19% of Stockport respondents reported consuming 5 or more portions of fruit & vegetables a day compared with 25% for England (HSE 2004).	No specific target (increase)	-
24	Reduce the level of obesity	Obesity rates for children in reception year	PCT (LDP)	<i>Baseline to be established 2006</i>	Target to be set in 06/07	-
		Obesity rates for children in year 6	PCT (LDP)	<i>Baseline to be established 2006</i>	Target to be set in 06/07	-
		BMI >30 in adults at GP practices	PCT (LDP)	04/05 = 22% 05/06 = 26%	04/05 = 21% 05/06 = 21% 06/07 = 20% 07/08 = 19%	
		BMI >30 in adults in community	PCT (Adult Lifestyle Survey)	12.6% of female responders were obese (compared to 23.2% in England) and 12.2% of males were obese (compared to 22.7% in England) (HSE 2004).	No specific target (reduction)	-
25	Increase levels of physical activity	Percentage of adults participating in at least 30 minutes of moderate intensity sport and physical activity 5 times a week on average over a year.	PCT (LAA)	25.6% Stockport respondents reported doing the recommended levels of physical exercise compared with 35.5% in England (HSE 2003)	No specific target (reduction)	-
		The number of schools providing 2 hours or more physical activity per week	SMBC (LAA)	64% (2005/6)	85% (2008/9)	
29	Improve rates of breastfeeding	Initiation	PCT (LAA)	04/05 = 60% 05/06 = 73%	08/09 = 71%	-
		Sustaining to primary visit	PCT (LAA)	Q1 05/06 (academic) = 45% Q2 05/06 (academic) = 50%	08/09 = 59%	-
		Sustaining to 28 days	PCT (LAA)	Q1 05/06 (academic) = 37% Q2 05/06 (academic) = 42%	08/09 = 48%	-

TAKING WORK ON OBESITY FORWARDS

The challenge of rising obesity levels is large, and will require concerted action by all sectors and agencies, to support real environmental and cultural change to support individuals and families so that they want to make changes in their lifestyles, find those changes have a positive effect on their lives and wellbeing, and find them easy to sustain.

The Obesity Task Force has agreed Principles, practices and vision for tackling Overweight and Obesity Stockport, given in Table 2. The challenge now is for individuals, staff and agencies in Stockport to implement actions in accordance with these Principles.

Table 2 Guiding principles for tackling overweight / obesity
Guiding principles for tackling overweight / obesity

1. Prevention must get more attention than treatment

At least as much attention needs to be spent on stopping people becoming overweight in the first place as on helping them lose weight.

Weight management is very difficult: 95% of dieters regain weight and the metabolic response to large weight loss is that subsequent weight gained is higher in fat which lowers a person's metabolic rate (leading to a "yo-yo" dieting cycle).

"Swimming upstream" - instead of continually pulling people out of the river to resuscitate them, we must swim upstream to see who's pushing them in and stop it.

2. Prevention of weight gain in children is most effective way of controlling obesity epidemic

It is never too early to prevent weight gain; both parents and health workers need educating that the image of chubby babies being healthy is out-dated - the greatest increase in weight gain is in 0-4 year olds

Breast-fed infants are less likely to become obese in later childhood; weaning is not recommended until 6 months; the diet of the mother pre-conception and during pregnancy is also important
Early infancy and puberty are critical periods for susceptibility to the obeseogenic environment

The more active you are at a younger age, the more likely you are to continue throughout your life

Similarly, the key to lifelong sound eating habits is to shape them as early as possible
Physical activity decreases with age, so we need to encourage people to get the habit young and sustain it

3. It is critical to tackle Obesity at a societal level rather than individual level

Most of the two thirds of the population who are overweight or obese have not chosen to be

People know they are supposed to eat less and be more active...

...but find this difficult in an obeseogenic society where

-access to calorie dense (and junk) food is increasingly easy, and
-there is little need to be physically active

4. We must allow children the freedom to walk, roam and play

Children have become increasingly constrained out of a desire to protect them, but the obesity that will result will cause far more harm to them than the risks they are being protected against

We need to restore to childhood the freedom to play out - booking children into organised physical activity is not the answer

There is a decline in children walking and cycling to school, but this can be reversed by school travel plans if the support of car-driving parents is secured

5. We must see physical activity as a normal part of daily life

It is easier to undertake physical activity if it is built into everyday life rather than finding time for special activities

The physical activity that most people do some of, and that people find easiest to do more of is walking

Walking and cycling to work is easier to fit into daily life than time for gym sessions

Parents are key role models, and interventions for children need to address the whole family

6. Plan and create environments to be less obeseogenic, to encourage physical activity and promote healthy eating

The Council and NHS should have model policies and practices for encouraging physical activity for clients and staff, and act as a model for other workplaces.

Care homes and residential settings should be designed and run to facilitate physical activity and promote a healthy diet amongst residents

Good practice should also be standard in Pre-schools, Nurseries, Schools and Colleges

We should be encouraging more people to use local Parks, green spaces, leisure facilities etc.
Neighbourhoods, town and district centres need to be planned in line with the Living Streets philosophy. (See www.livingstreets.org.uk)

We must address food deserts in parts of Stockport where no fresh fruit and vegetables can be obtained locally

Cafes in parks & leisure facilities, and food outlets in NHS & Council premises should promote healthier eating particularly if offering specific children's menus

Workplaces can adopt model policies for encouraging healthier eating and physically active environments, including promoting walking and cycling to work

7. Promote Walking and Cycling

We need to reduce the reliance on cars, and walk or cycle more

Promoting walking and cycling for short journeys has the potential to save hundreds of lives each year in Stockport from heart disease and other obesity-related illnesses

Promoting walking and cycling is not a minor environmental objective. It is a major public health goal

8. Improving diet involves a wider approach than simple education about what to eat – cultural, economic and issues of personal taste can outweigh healthier eating messages received

People lack cookery skills, equipment and often space for families to dine together at home

Access to healthy foods is often limited, especially in disadvantaged areas. Shops need to be within a buggy push (500 metres), sell fresh raw ingredients for food at a reasonable cost, and cafes need to offer healthy choices

Parenting skills that support food and healthy eating as an integral part of family life are important

Food and mood is an issue for many people. Mental health and self esteem need addressing especially for anyone with long-term weight problems

Alcohol is an important contribution to calorie intake and is influenced by wider mental health issues

9. Target high risk groups

Health educators need the skills to help sedentary people take more physical activity

Those at higher risk include people who are already overweight

Disadvantaged and/or unskilled people (especially women and girls, who are more likely to be sedentary)

Some particular ethnic minorities, for example Pakistani women, Afro-Caribbean women, South Asian children

People with disabilities, mental health problems, or suffering from chronic health conditions

We can predict risk of obesity before age 3: children need to be targeted early in order to establish healthy eating and physical activity habits from the start

10. Planning for the long-term is vital; there is no quick fix or overnight solution

Address the design / regeneration of neighbourhoods, housing, and commercial properties e.g. to promote walking routes, stair-climbing, communal dining

Address funding and workforce shortages for projects promoting healthier eating and physical activity community settings

Local Health Impact Assessments are recommended to assess the effect on obesity rates of major public policy changes

All planning applications should predict health impact, and encourage incorporation of features to support physical activity and healthy eating

11. Green Gyms Bring a Double Benefit

"Green Gyms" (where people get their physical activity by working in groups to improve the physical environment) have all the benefits of other forms of exercise but they also help improve the town

Physical activity has a positive effect on mental health and wellbeing, and undertaken in groups can increase both self-esteem and social networking

12. Joined-up Thinking

The health case for tackling obesity needs continually restating & acknowledging at highest levels

The complexity of causes of obesity means that joint working is essential

Table 3: Public Health Partnership Board Draft Performance Management Framework for the five public health priorities – Obesity

General context: Current obesity prevalence in Stockport is below the national average for adults and children, however, these rates are expected to rise. It is estimated that 1 in 3 children in England will be obese or overweight by 2010. The national emphasis on prevention targets children and indicators 1 & 2 reflect this, while indicators 3 & 4 focus on adults. Weight measurement and physical activity are the main focus of the indicators in the framework as these measure obesity most directly. While diet & nutrition are important factors in obesity, there are relatively few local indicators measuring this. The statutory requirement to implement the new food standards for schools is a starting point, however the broad purpose of this work – reducing salt, sugar and fat intake, improving the vitamin and mineral content of school lunches, minimising the use of convenience foods in school meals & limiting the availability of unhealthy snack foods – is outside the scope of this framework and the contribution of the food standards to reducing childhood obesity will ultimately be measured through indicators 1 a & b.

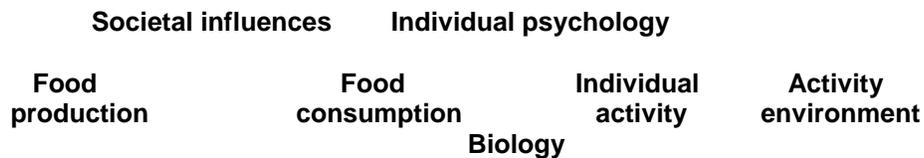
	Indicator	Frequency	Context / target	Previous performance	Current performance	Direction of travel
1 a	Prevalence of obese children in reception and year 6	Annual data update in September	LAA & LDP targets – prevalence is expected to rise	11.2% (Sept 06)		↑↓↔
1 b	Prevalence of overweight children in reception and year 6	Annual data update in September	LAA & LDP targets – prevalence is expected to rise	As above		
1 c	Number of Stockport schools achieving the 90% measurement target	Annually	Applies to reception and year 6 combined.	88.7% (Sept 06)		
Commentary / progress:						
Increase number of schools achieving National Healthy School Status – to 55% by Dec 07; to 65% by Dec 08						
Increase the number of pre-schools adopting healthy snack guidelines to 90% by March 08 (currently 75%)						
Increase the number of schools promoting breakfast clubs to 26 by July 2008						
Increase breastfeeding initiation rates and persistence levels						
School nursing service to increase number of schools measuring reception and yr 6 pupils to 100% by July 07						
School nursing service, CYP Directorate and schools to increase number of pupils being measured in reception and year 6 to 80% by July 07						
2	Percentage of Stockport schools providing 2 or more hours of physical activity per week	Annual but quarterly updates probable	LAA target is 69% 2006/07, 76% 2007/08, 85% 2008/09	64% (2004/05)		

	Indicator	Frequency	Context / target	Previous performance	Current performance	Direction of travel
	Commentary / progress:					
	Increase number of schools achieving National Healthy School Status – to 55% by Dec 07; to 65% by Dec 08					
	Increase number of primary schools providing organised play sessions					
	Increase number of schools working with School Sports Partnership Officers					
3	Number of referrals to the PARiS (Physical Activity Referral in Stockport) scheme on the grounds of obesity	Quarterly	Comparative data can be provided which shows the rates of referral to PARiS for different conditions	NA		
	Commentary / progress:					
	Analysis of PARiS referral rates for a range of different conditions as compared to obesity-related referrals					
	Increase number of referrals to PARiS to 500 by March 2008 (dependent on funding)					
	Increase sources of referrals to PARiS and number of opportunities to participate in Stockport – baseline to be established 07/08					
	Increase compliance of PARiS users (ideally measured via a suitable weight loss measurement) and physical activity levels at 12 months from referral					
4	Over 18s with a BMI of 30 or greater	Annual data update at end of financial year	LDP data sourced from GP obesity register	22% (04/05)		
				26% (05/06)		
	Commentary / progress:					
	Increase recording levels of adult BMI in General Practice - 65% of adults to be measured in General Practice within a 15 month period, by March 08 (currently 36%)					
	Of those recorded no more than 19% to have BMI >30 by March 08 (currently 25%)					
	Develop weight-management services in primary care setting for those with BMI of 30 or greater through the health trainers scheme and the brief intervention service					

**A5.2 : THE FORESIGHT REPORT
ON TACKLING OBESITIES**

THE FORESIGHT REPORT “TACKLING OBESITIES” KEY MESSAGES

- 25% of adults and 10% of children in the UK are now obese
- By 2025 40% of Britons could be obese. By 2050 this could rise further to 60% making the UK a mainly obese society
- This will lead to a seven fold increase in direct healthcare costs of overweight and obesity and overall costs to society and business of £45.5 billion in today’s prices
- Technological change has outstripped evolution – biological mechanisms which for millions of years served a physically active species threatened with periodic famine do not serve a society with sedentary work, motorised transport and the ready availability of high fat low fibre convenience foods.
- For many individuals the forces that drive obesity are now overwhelming and appeals to eat less and exercise more are not sufficient. We need to tackle an obesogenic environment
- Obesity affects all social groups but it has a greater impact on the more vulnerable groups and on certain ethnic minorities so it contributes directly to inequalities
- An obesity systems map identifies seven domains contributing to obesity –



The issues found to have the greatest impact on improving obesity were

1 Built environment and Transport

- Increasing the walkability and cyclability of the built environment

2 Health

- Targeting interventions on those at higher risk, within the context of public health interventions at population-wide level

3 Regulation

Controlling the availability of and exposure to obesogenic food and drinks

4 Workplace

- Increasing the responsibility of organisations for the health of their employees

5 Family

- Promote programmes of early interventions at birth or infancy

The implications for action on Obesity in Stockport of the Foresight Report: A Response to the Foresight Report “Tackling Obesities: Future Choices – Project Report”, Government Office for Science, October 2007

This paper summarises the recent Foresight Report on Obesity in Britain “Tackling Obesities – Future Choices”, and considers how far current strategies in Stockport fit with the report’s analysis.

The Foresight Report

Foresight projects are long term “horizon-scanning” policy projects sponsored and guided by Ministers but led by scientists to identify long term evidence based strategic policy directions. The obesity report has as its Ministerial sponsors Dawn Primarolo (Minister for Public Health), Kevin Brennan (Minister for Children, Young People and Families) and Gerry Sutcliffe (Minister for Sport). Its asks “How can we deliver a sustainable response to obesity over the next 40 years?”, involving 300 scientists and stakeholders from different fields, brought together by Sir David King, the Government Chief Scientist, within Foresight to produce an independent review (commissioned by the Government Office for Science, published by the new Department of Innovation, Universities and Skills).

The report paints a picture of the current and future situation regarding obesity (or “obesities” as it describes the different causes and consequences), and to spell out the whole-system approach that will be needed to change the situation from that predicted on current trends.

The Report is consonant with other recent government documents including the Wanless review (which called for a “fully-engaged” prevention-focused scenario to prevent the massive cost of predicted health problems in the future); the Choosing Health Public Health White Paper (which laid out plans to increase support for individuals’ healthy choices); and NICE Guidance – reviewing the evidence base for treatment and prevention of obesity in adults and children, and detailing good practice for different sectors. However it goes beyond those reports in the scope of the regulatory and environmental responses required.

The Foresight Report’s new contributions to the debate are

- its predictions of a society in which obesity could be the norm by 2050
- its diagnosis of a society moving towards “passive obesity”, by which is meant a society in which for many individuals the forces that drive obesity are overwhelming
- its recognition that an increasingly obesogenic environment is now a more powerful factor on the future than individuals’ abilities to control their own weight, outweighing increasing knowledge of the health risks of obesity, and people’s general desires to become thinner, more active and with healthier diets
- its use of systems mapping to define an “obesity system”
- its recognition that obesity results from technological change outstripping evolution – biological mechanisms which for millions of years served a physically active species threatened with periodic famine do not serve a society with sedentary work, motorised transport and the ready availability of high fat low fibre convenience foods.

The report also emphasises that the obesogenic society, whilst having an impact on everyone across the social and economic divide, has a greater impact on those living in disadvantaged communities, as they have less ability to resist the poor-health consequences of obesity.

The key message is that previous focus of encouraging and supporting individuals to control their own energy balance and weight, whilst important, is insufficient for tackling obesity in the modern environment. The report argues that a new long-term approach that addresses the complex system that produces obesity is urgently needed at all levels. Although a major undertaking, this

will have further benefits in policy terms, as it coincidentally will have beneficial effects on sustainable development and climate change, and will help to reduce inequalities in health.

What the Foresight Report Says

Scale of the problem

Rising obesity is a global phenomenon, with serious implications for the levels of chronic health conditions. In some countries including the UK, obesity rates have more than doubled in the last 25 years. The latest figures (2003-4) show that 2/3rds of adults were overweight or obese and the average adult BMI in Britain was 27kg/m² – i.e. it is the norm to be overweight.

The trend is across all sectors of society and all age-groups including primary school children.

The Foresight report uses various modelling techniques to forecast trends in the future. The trends studied were obesity levels within the population, the levels of chronic disease associated with these rises (especially diabetes), life expectancy, and the costs to the economy both directly in health and benefit costs, and indirectly in lost earnings. However, other costs such as social care were not included.

In the model the current (2004) level of obesity is 23.6% men and 23.8 women, projected to rise in 2050 to 60% of men and 50% of women. The cost of obesity to the NHS is currently estimated by the Health Select Committee to be £1 billion and the impact on employment estimated by the National Audit Office to be £10 billion – this is forecast to rise to £6 billion cost to the NHS (in today's prices) and £45.5 billion to the wider economy.

Causes of obesity

The Report argues that the “common-sense” view that obesity is rising because individuals eat too much and don't do enough exercise is insufficient, and ignores the innate biological mechanisms that lead to weight gain when coupled with the rapid changes in society over the last thirty years, where energy-dense foods have become cheaper and more accessible whilst labour-saving devices (especially cars) have become more prevalent.

The Report offers a system-mapping that tries to integrate the influences on obesity of a number of elements, often inter-related, but previously studied in isolation within different disciplines. The result is a diagram that attempts to show the links between factors operating within an individual during their life course (from maternal nutrition and the genetics of metabolism, to food preferences, activity levels, and perceptions of risk), and factors operating at a social and environmental level (e.g. family habits, working in firms that encourage cycling, current fashions, or the local availability of affordable fruit and vegetables).

The conclusion is that the accumulation of excess body fat for one individual may be the result of any of a number of causal pathways – a family of obesities. Any solution to rising levels of obesity in general therefore lies in a multifactorial approach implemented at all levels of society from the individual and family to communities, including business and the voluntary sector, coordinated by government.

Tackling obesity

This section of the report covers the evidence for obesity treatment and prevention, pointing out that whilst the evidence base for prevention is rather weak, there is a need to take action even where the evidence is incomplete or imperfect. What evidence exists shows that tackling obesity will require multidisciplinary approaches that stimulate behaviour change, establish new social norms, create a supportive environment, and engage parents. The report stresses the need to learn from innovative interventions, fostering a culture that builds on a virtuous circle of policy development, implementation and evaluation, coupled with a willingness to try interventions and possibly fail or refine based on experience.

For an individual, certain parts of the life course are more receptive to behavioural or metabolic change. Breast-feeding is a key period of development that is known to have long-term consequences, but other periods may also be important such as development of tastes for fruit and vegetables in early childhood, or exposure to alternative lifestyles on leaving home in late teens. Stress, habits, and counter-intuitively, increased choices have all been shown to have a negative effect on healthy eating; there is a greater chance of influencing behaviour change during major life changes (such as becoming a parent, or having an operation).

The implications for policy relate to creating an environment that fosters healthier choices and supports healthier behaviours. For example, providing information is insufficient to change behaviours, and can be counter-productive – social marketing techniques describe how we need to inform, shift motivation and provide individuals with the necessary skills to make changes.

To avoid increasing health inequalities, provision of some interventions – such as cooking skills - may need to be targeted, as generic provision may be adopted by those with higher health expectations and ignored by those with other priorities. With physical activity it is known that uptake of leisure facilities is greater amongst those from richer socio-economic groups, and campaigns to increase use can exacerbate these inequalities. For this reason, the report stresses the importance of changes within the built environment that will contribute towards greater physical activity for all.

Complex Systems

The key argument of the Report is that obesity is not just about individual's energy balance and urging them to eat less and do more. Although it is acknowledged that this equation is at the root of weight gain, it is insufficient to show the factors that promote or restrict individuals' choices and situations at different points in their lives. It is beyond a victim blaming approach, but even moving beyond an approach that locates the needed action solely within the individual, to one that addresses a much wider range of interacting influences.

The Report develops a superb model of the influences on energy balance of both the individual and any group of individuals. It presents this information as a complex diagram that shows the interactions between different mechanisms such as the media, economic conditions, activity levels and physiology, using thickness and type of arrow to indicate the strength and direction of the effect on energy balance and hence on weight gain. The diagram is then the basis for mapping the likely consequences of changing one part of the picture, and will be used to help to prioritise action at governmental level.

Future Scenarios

The Report describes scenario building workshops that took place to model the years up to 2050 and the likely impact on obesity of varying conditions, including 29 drivers for change including attitudes to obesity, business models of the food industry, consumer choices, attitudes to science, ageing population, and different community structures. The scenarios studied ranged from reactive to anticipatory, and from more individualist to more social responsibility-led.

The impact on obesity was found to be greatest where the scenario favoured anticipatory action (e.g. trying to implement population prevention approaches) in a socially-focused society rather than reactive action (e.g. treating those already obese) in an individualistic society.

The key message from this section of the Report is that although no scenario showed a reduction in obesity, action taken now may be able to limit the growth of obesity in any of the scenarios, provided the extent of action is broad and long-term and tackles prevention.

Managing the Consequences

This section models the impact of different policy options, using stakeholders and experts to quantify the impact of interventions on obesity, and on levels of chronic disease and NHS costs within the different scenarios studied.

The issues found to have the greatest impact on improving obesity were

1 Built environment and Transport

- Increasing the walkability and cyclability of the built environment

2 Health

- Targeting interventions on those at higher risk, within the context of public health interventions at population-wide level

3 Regulation

Controlling the availability of and exposure to obesogenic food and drinks

4 Workplace

- Increasing the responsibility of organisations for the health of their employees

5 Family

- Promote programmes of early interventions at birth or infancy

The models and simulations studied emphasised that obesity will have a massive impact on NHS costs and disease levels, and that success in limiting the growth of obesity requires a mix of interventions targeted at a combination of determinants.

Even the most optimistic success scenarios and intervention models predict that there will be a considerable time lag before benefits in terms of NHS costs, are achieved. To succeed in containing costs, any strategy must tackle those most at risk of health consequences now (the over-50s) as well as trying to prevent future obesity.

Sustainable Responses

The report argues that the growing scale of obesity demands a major programme of investment in preventive action and reform to tackle the wider environment. No country has yet managed to produce a long-term strategy to tackle obesity, and the report recognises the systemic shift in thinking that is required against the ordinary biological drivers that reinforce weight gain.

The challenges are grouped around those that change the environment to support and facilitate healthy choices, coupled with work to encourage and support individuals, within families or groups, to choose healthier behaviour.

The report counsels the need for national leadership but also is clear that local strategies must be clearly defined and given sufficient resources and skills to implement effective action. Such a strategy must build long-term sustainable change, as there are no realistic short or medium term solutions.

The elements of a national strategy to combat obesity are spelt out in a checklist for an effective obesity strategy. The following are the characteristics of a strategy emphasised in the report, and it can be seen that many of these are relevant at the local level too. Whilst these are in many cases simple messages, many of them require fundamental commitment and potential changes in cultural attitudes in relevant agencies such as the PCT:

1. Emphasis on environmental change that supports and reinforces behaviour change
 - Walk to school policies supported by employers tackling Work-Life balance (so that people feel able to take the time to walk or cycle with their children to school)
 - Local action on drivers in the cost and consumption of food and drink – e.g. adopting policies that promote healthy food/healthy portions
2. System levers act at multiple levels reinforcing each other (“joined up thinking”), e.g.

- Breast-feeding promotion initiatives must range from support for new mothers, positive breast-feeding policies in hospitals and local health centres and Surestart, to campaigns to make breast-feeding normal and legal in public places, to legislation to protect maternity and employment rights for mothers.

3 Actions need to work at different levels of impact, including amplifiers and enablers, as well as focused initiatives, e.g.

- Healthy School meals provision is a focused initiative to improve the national dietary habits, but it needs backing up with improved knowledge and education about food, better food-labelling, and consistent messages about what constitutes a healthy diet.

4 Couple population-level measures and more targeted interventions to tackle both prevention and treatment

- Offer focused programmes for those already obese or at risk, but at the same time tackle the environment e.g.
- Using planning to promote walkability of the built environment.
- Extend work on food in schools into pre-school environment, and to corporate situations affecting adults e.g. within NHS or occupational sectors
- Facilitate physically active living e.g. for young people leaving school, and for adults in the workplace

5 Take the life-course and generational effects into account – this may involve delivering initiatives in different ways for different age-groups

- Optimise maternal nutrition and infant feeding programmes
- Think about long-term goals such as how to integrate health more fully into food culture, values and habits – recognising that changes of this nature will take years.

6 Set interim targets as well as a long-term goal

- Monitoring BMI, diet and physical activity levels against goals
- Treat high risk adults in the short term, but also
- Set up longer-term approaches that limit the likelihood of children becoming obese

7 Align with other policy agendas, and acknowledge conflicts

- Do health impact analysis of all relevant policies
- Link up with action on sustainability, health inequalities, and other linked cross-cutting agendas.

8 Engage a broad range of stakeholders, including parents and children, from the food and leisure industries, town planning and construction, to the media, in addition to communities and the voluntary sector.

9 Take into account efficacy and cost-effectiveness

- Ensuring sustainability of programmes
- Looking at the overall impact of interventions on public health

10 Ensure health inequalities are considered when interventions are planned.

11 Measure and evaluate for continuous improvement

- Ensure that data is available about obesity in the population
- Evaluate existing and new activities.

12 Provide leadership and coordination across strategy formulation and different stakeholders

- Champion the work required to raise the profile of existing action, to and bring partners together

13 Manage unexpected consequences and undertake risk assessment and management

- Monitor interventions for impact and be prepared for unexpected consequences (e.g. the possible introduction of healthier school lunches leading to more children bringing packed lunches)

14 Provide sufficient resources to make a difference, including training as well as financial support.

How does Stockport's obesity strategy need to change to respond?

- **Taking a whole system approach**

Stockport already has an obesity strategy which focuses on food and on physical activity and with an especial emphasis on inequalities. The PCT takes the lead on issues of food and health and the local authority on issues of physical activity. It is one of the priority areas of the Public Health Partnership Board. It has not systematically built in the kind of whole system mapping recommended by the Foresight Report.

Stockport's current Obesity strategy, the Obesity Action Plan 2006, was drawn up two years ago, building on the Stockport Obesity Strategy of 1997 and the Obesity chapter of the 2001 Five-year Coronary Heart Disease Prevention Strategy. The 2006 Obesity Action Plan outlines the importance of obesity as a major health issue, and sets out in five chapters the activity underway or planned in Stockport to achieve the national target to halt the rise in obesity in children under 11 in the context of the population as a whole. The issue of obesity was also addressed in a section of the 16th Annual Public Health Report, which provides more detail on the importance of the issue to health, and develops the vision of a local environment that will help to combat rising obesity levels.

The 2006 Obesity Action Plan was drawn up by a wide range of stakeholders, and covers baseline measurement and auditing of obesity in Stockport, prevention and treatment, different life stages, and tackling healthy lifestyles including food, physical activity and creating an environment that makes healthier choices easier. It has both an adult obesity section (with a food and health emphasis for the PCT and a physical activity for the local authority through its walking and cycling measures and its plans for the development of parks) and a childhood obesity section which especially focuses on children and young people, and recognises that whilst treatment for those overweight and obese is needed, equal weight must be given to prevention and ensuring that the majority of children who are not currently overweight do not become so.

The Action Plan has a monitoring framework that is reported to the Public Health Partnership Board, and work identified in the Plan is making progress, including measuring the baseline, and developing care pathways for people who are overweight and obese. However, there is a need to update the Action Plan in the light of new NICE Guidance and the Foresight Report, to extend the scope of the Plan, to flesh out the details of broader actions needed, and to reinvigorate the stakeholders in their actions on Obesity.

Public Health Partnership Board should consider establishing a multi-agency working group under the auspices of the PHPB to review the local Obesity Strategy in the light of the system map from the Foresight report. It is important to move beyond thinking simply about individual programmes and the work of individual officers and departments. We need to raise the profile of obesity as an issue and get a "think active" philosophy into everything we do.

- **Promoting Walking and Cycling Through the Built Environment**

Stockport MBC has done a great deal to promote walking and cycling which has been a theme of the Council's public health work for some years

A great deal of work has been done on completion of the cycle network, and key walking routes have been identified: the Green A to Z has recently won a best practice award. Sustainable Transport Supplementary Planning Guidance has been produced.

We need to make active lifestyles more attractive and the easy option, building on the innovative work that has happened in Stockport and the local interest in greenspace. There were a number of recommendations as to future development of this work in my 16th Annual Public Health Report.

There are longstanding mechanisms for public health input into decisions about the built environment but they are not adequate and work is now underway to focus them better

Public health input into planning decisions was introduced in Stockport in the early 1990s and we were one of the first districts in the country to take this step which was commended at the time by the then Regional Director of Public Health as an example of good practice. However the system introduced then – making the DPH a consultee on planning applications and feeding public health advice into the process as an objection– is time consuming and repetitive.

Agreement has been reached with the Borough Council to introduce public health into the issues monitored in their annual planning outcome report and to extend the use of health impact assessment. These will be better systems and will reduce considerably the need for time-consuming individual planning objections.

- **Targeting interventions on those at higher risk**

Obesity has been part of the cardiovascular disease risk factor screening programme (CVDRFSP) and of the QOF but systematic and comprehensive support is not available to all those identified.

In General Practice, the cardiovascular disease risk factor screening programme (CVDRFSP) systematically screens asymptomatic adults between 35 and 70, and will identify obesity in those screened. The Quality and Outcomes framework provides an incentive for GPs to record and treat those whose BMI is over 30. However, many overweight and obese people are not receiving full support they need for several reasons – not attending for screening, not managing to get an appointment, not having their height or weight recorded, or not receiving appropriate advice. In addition, there are limited resources in Stockport to support those wishing to change their diet or lose weight, especially those on low incomes.

The improvements needed are: to increase uptake of the CVDRFSP – particularly targeting those more likely to be at risk such as people living in disadvantaged areas; to improve data collection and reporting; and to develop the resources within and outside General Practice to support those wishing to maintain or lose weight, including access to commercial weight clubs and physical activity providers.

Those not eligible for the CVDRFSP, such as those with a diagnosis of hypertension or heart disease, should also be monitored through QOF for their height and weight, and offered the same sources of support.

We are in the process of introducing health trainers in deprived areas

An investment of £190,000 was approved in the last LDP.

We will need to monitor the effectiveness of this scheme and build on it/reshape it in conjunction with other interventions to tackle obesity.

- **Controlling the availability of and exposure to obesogenic food and drinks**

We have conducted some local initiatives with supermarkets and have supported some initiatives to promote the availability of healthy food.

Training and advice to professionals and others about providing healthy food and drink options in many settings - especially linked to children's health and developing tastes – has been provided by the local Healthy Snack Guidelines for pre-schools, Infant and Maternal nutrition guidelines, and the community Food and Health Team. Local schools are being supported to adopt the new national School Food Trust nutrition guidance for controlling the availability of obesogenic food and drink, and providing healthier alternatives during the whole school day.

This is predominantly an area for national action but nonetheless the Public Health Partnership Board should review what action we can take locally.

- **Action in the Workplace**

The PCT had a health promotion adviser working with employers to promote workplace health for many years but this post was deleted in the reprioritisation to achieve Choosing Health targets during the years of financial stringency.

The rationale of this deletion was that a major priority of the work had been workplace smoking initiatives and healthy workplace awards. The former was being overtaken by legislation and the latter by a range of new accreditation processes such as Investors in People.

We need to reconsider the need for work in this area, with reference especially to the fact that workplace factors account for about a third of inequalities in health. Obesity should be a focus of any reinvestment in this area.

The PCT, MBC and NHSFT all have a good record of activity on the health of their workforce but have not been especially focussed on obesity.

All three organisations should aim to become exemplar employers to promote a sustainable approach to obesity. All three organisations should consider new policies for their impact on obesity and ensure policies have at minimum a neutral and preferably a positive effect on promoting healthier eating, physical activity and better workforce health. We should adopt the North West Food and Health Task Force Healthy Catering Guidelines for food provided at events in future and review the support given to staff for cycling and physical activity.

- **Early interventions at birth or infancy**

A number of successful initiatives have been tried in Stockport to promote healthy lifestyles with new parents, babies and young children. Those that have proved successful will be extended through the Children's Plan, but need the support of all the agencies involved.

Sure Start

The PCT Community Food and Health Team supports Adswold and Bridgehall Surestart in offering support around 5-a-day, cooking skills and healthy eating to local parents and children. The new Children's Centres will roll out the core work of the Surestart pilot to other parts of Stockport in phases, starting with Brinnington and Reddish. The food and health work will be helped in this area by previous groundwork of the Healthy Living scheme, including work with fruit and vegetables on prescription, and weaning support.

Efforts will be needed to ensure that the successful increase in healthy eating shown by the Surestart pilot and Healthy Living Scheme are maintained across the Children's Centre roll-out, as the staffing resource is spread more thinly.

Breastfeeding

Breastfeeding work in Stockport is being promoted by a breastfeeding coordinator, helping towards the achievement of the LAA target to increase breastfeeding initiation and maintenance, and to reach UNICEF baby friendly status for both the Foundation Trust hospital setting and for the community.

We need to ensure that the PCT creates and adopts the cultural change needed to promote and support breastfeeding, in line with the new national Breastfeeding Manifesto.

Weaning

In addition to the Surestart and Healthy Living scheme work on promoting healthy weaning, the public health nursing team and health visitors in Stockport have developed models of good practice around supporting parents in breastfeeding and weaning, with peer support as a major element of the programme.

Work is needed to take this model into other parts of Stockport.

A6: ALCOHOL (written 2006)

A6.1 SPECIAL REPORT ON ALCOHOL (written 2006)

12.1 General Health Impacts of Alcohol

The ideal pattern of alcohol consumption is to drink a small amount on most days, so as to gain the benefits of its cardioprotective effect without the damage that comes from alcohol excess. Safety margins are however small – the first two units a day are beneficial, the next two cancel out the benefit and thereafter they are harmful.

It seems that this ideal pattern is not the norm in Stockport, or indeed in much of the country.

- a) For some years now, public concern about the negative impacts of alcohol has been on the increase. This has been partly fuelled by media coverage of drunken behaviour in our town and city centres at night, but the perceptions of an increasing problem, to some extent, also reflect people's direct experience of the impact of drunken behaviour in and on local communities. Anti-social behaviour (and fear of such) has negative impacts on peoples' health, working against community cohesion and leading to some people becoming more isolated and frightened. However this report is concerned primarily with the more direct health impacts of alcohol misuse on the individuals involved.
- b) In recent years, many drinks have become stronger in alcoholic content and larger measures have become normal, and this has led to an increase in alcohol consumption in the population as a whole. The changes we are seeing in drinking patterns, will, if unchecked, have short, medium and long term negative health consequences. There is evidence of alarming increases in rates of alcohol related illness, and failure to act now would be a costly option for the health service and society as a whole.
- c) In an earlier section of this report I have highlighted the dangerous misconceptions about safe drinking levels. Traditionally people have been advised that a unit is a half pint of ordinary strength beer, a glass of wine or a pub measure of spirits. However, since this traditional advice became widely known drinks have become stronger and measures served have become larger.
 - i) The traditional guidance assumes ordinary strength beer is 3.5% abv. Such beers are now quite unusual. 4% to 4.5% beers are normal. 5% is not unusual and is not necessarily labelled as strong. Many people may drink 5.5% beer without it necessarily occurring to them to think of it as strong.

- ii) With wine the situation is even starker. The traditional guidance assumes wine is 8% alcohol, when in fact it is now usually 12% to 15%. The traditional guidance assumes a wine glass to be 125 mls. In fact most wine is now served in 175ml glasses and a glass of 125mls is usually called “small” if indeed it is available at all. Many bars serve wine in 250ml glasses. A 175 ml glass of 14% wine is not 1 unit – it is 2.4 units.

It is easy to see how people can be very seriously misled by this increase in the strengths and measures of alcoholic drinks, and inadvertently drinking much more than is safe.

- d) The effects of alcohol misuse in relation to liver cirrhosis are well-known, but its impacts are far wider than this, as it increases risk of a multitude of health and social problems. The current trend towards unhealthy levels and patterns of drinking is therefore likely to impact on many Health Service and Stockport Partnership targets, as well as increasing demand for services. The Department of Health’s Prodigy guidance identifies the following²
 - i) Alcohol-related mortality: estimates of alcohol-related deaths for England and Wales range from 5,000 to 40,000 per year, and 25% of these deaths result from accidents
 - ii) Cancers, including of the oropharynx, larynx, and oesophagus, liver, stomach, colon, rectum, lung, pancreas, and breast
 - iii) Cardiovascular disease: excessive alcohol consumption increases the risk of raised blood pressure (binge drinking may be particularly implicated), haemorrhagic stroke, coronary heart disease, cardiomyopathy, and arrhythmias.
 - iv) Liver damage, including fatty liver, alcoholic hepatitis and cirrhosis.
 - v) Risk to the foetus: including reduction in birth weight, intellectual impairment in children and fetal alcohol syndrome
 - vi) Psychiatric morbidity: including depression; suicide and attempted suicide; personality deterioration; sexual problems; hallucinations amnesia; intellectual impairment; and delirium tremens
 - vii) Social consequences: it has been estimated that 30% of divorces, 40% of domestic violence, and 20% of child abuse cases are associated with excessive alcohol consumption. Heavy drinking is also associated with workplace absenteeism, financial problems and homelessness.
 - viii) Other serious medical complications include gastrointestinal haemorrhage, pancreatitis, and neurological problems such as seizures, neuropathy, acute confusional states, subdural haematoma, Wernicke’s encephalopathy, and Korsakoff’s psychosis.
- e) Alcohol misuse is also associated with increased risk of violence either as a victim or offender, including sexual assault and rape, which often have long-term effects on mental health as well as the immediate physical health impacts. Sexual health problems, including STIs and teenage pregnancy, are also associated with alcohol misuse.

12.2 National Trends in alcohol use

- Overall alcohol consumption in the UK per capita increased by 121% between 1951 and 2001³
- HM Customs and Excise data⁴ shows that the amount of pure alcohol released for consumption in the UK increased from 10.01 litres per person (aged over-16) in 1990 to 11.44 litres in 2005/6 (following a decrease in the early 1990s). Over the same period, the average proportion of household income spent on alcohol fell from 6.5%

² http://www.prodigy.nhs.uk/alcohol_problem_drinking

³ Cabinet Office. Strategy Unit Alcohol Harm Reduction Project. Interim Analytical Report 2003

⁴ ONS; Statistics on Alcohol: England, 2006

to 5.5%, so in real terms, alcohol consumptions has increased as it has become more affordable.

- In 2005, total UK household expenditure on alcohol was £41.9 billion, and UK excise duty revenue from alcoholic drinks was £7.9 billion (2005-6)
- The number of alcohol-related deaths recorded in the UK has nearly doubled between 1991 and 2004, increasing from 6.9 to 13.0 per 100,000 population. Death rates among men are twice the rate among women, and the age group 35-54 had the highest death rate due to alcohol⁵.
- Alcohol Concern has estimated that currently, heavy drinking costs the NHS up to £1.7 billion each year, while the figure spent on alcohol treatment services amounts to just 5.5% of that figure.⁶
- The Government has responded to these concerns with its Alcohol Harm Reduction Strategy for England (AHRSE), published in 2004. This sets out a range of activity, including:
 - improved education and communication,
 - better identification and treatment of alcohol problems
 - better co-ordination and enforcement of existing powers against crime and disorder
 - encouraging the drinks industry to continue promoting responsible drinking and to continue to take a role in reducing alcohol related harm.

The Government has said it will launch 'the next phase' of the strategy in mid October, but at the time of writing no details are available.

12.3 Alcohol Misuse in Stockport

A range of data is available to help us develop understanding of the patterns and impacts of alcohol misuse in the borough. From the Regional Alcohol Indicators for the Northwest of England 2006 Vol. 1⁷, it can be seen that Stockport's prevalence of hospital admissions is uniformly lower than that for the Northwest as a whole. However, the Northwest rate is significantly higher than the national average, and worryingly, the rate of increase in Stockport is actually greater than that for the region as a whole. In particular, the increase in hospitalised admission for all conditions attributable to alcohol in men was 32% greater than the change for the region as a whole whereas the equivalent increase in women's admission was 88% greater than the change for the region as a whole. In addition, binge drinking seems to be a particular problem for Stockport.

Table 12.3.1

	Stockport	Variation from Northwest	Change from 03/ 04	Northwest change from 03/ 04
Synthetic estimates of binge drinking %	21.9	+1.1		
Prevalence of hospitalised admission for alcohol specific conditions amongst males.	4.28	-0.59	+0.54	+0.46
Prevalence of hospitalised admission for alcohol specific conditions amongst women.	2.11	-0.39	+0.26	+0.21

⁵ National Statistics news release 18/7/06: Alcohol-related death rates almost double since 1991

⁶ Alcohol Concern (2003) Commission on the Future of Alcohol Services

⁷ Regional Alcohol Indicators for the North West of England; M Morleo, D Dedman, K Hughes, J Hooper, K Tocque, M Bellis. North West Public Health Observatory 2006

Prevalence of hospitalised admission for all conditions attributable to alcohol in men	10.4	-0.51	+0.83	+0.63
Prevalence of hospitalised admission for all conditions attributable to alcohol In women	5.98	-0.02	+0.64	+0.34

The average annual standardised mortality rate in Stockport, for deaths where alcohol is identified as the underlying cause, has increased from 8.3 per 100,000 population in the three years 1995-7 to 14.3 in the years 2003-5. In the borough as a whole, over this period, there were a further 9.1 deaths per 100,000 population per year in which alcohol was mentioned on the death certificate, and the total number of alcohol related deaths, including these, was 621. Over the period 1995-2005, the total crude mortality rate in Brinnington was 36.4 per 10,000 population, compared to the borough average figure of 12.4.

We should bear in mind that there is a time delay between general increases in alcohol consumption and increased death rates, so the increase we are seeing now may be attributable to patterns of increased alcohol consumption adopted by people in the 1980s and 1990s.

Data from Stepping Hill Hospital's A&E Department shows that between 2000/01 and 2005/6:

- i) The number of attendances of Stockport residents due to intoxication or alcohol poisoning increased by 211% to 339 cases
- ii) The rate of attendance of Brinnington and Central ward residents at A&E as a result of the above complaints, (176.3 per 10,000 population) is over four times the borough average

Analysis of under-18 year olds attending A&E as a result of 'intoxication' or 'alcohol poisoning' over the same time period also shows Brinnington and Central ward residents were the largest group with 112.9 per 10,000 (under 18) population. This was more than double the borough average rate.

Analysis of admissions to Stepping Hill Hospital (Stockport residents) between 1998/9 and 2005/6, where the primary diagnosis is alcohol related, shows that

- i) While the numbers were fairly stable between 1998/9 and 2002/3, the last three years saw an increase of 102%, to a total of 417 admissions in 2005/6. 85% of such cases were emergency admissions.
- ii) Analysis of the above data by ward shows that Brinnington and Central ward had the highest rate of such admissions, at 217.5 per 10,000 population. This is nearly three times than the Stockport borough average rate.

The 2005-6 Stockport Lifestyle survey is the most accurate available indication of patterns of alcohol consumption in the Borough. A total of 8,904 survey responses were received, and 8,844 of these had answered the questions on alcohol. 1373 respondents (15.5%) were non-drinkers.

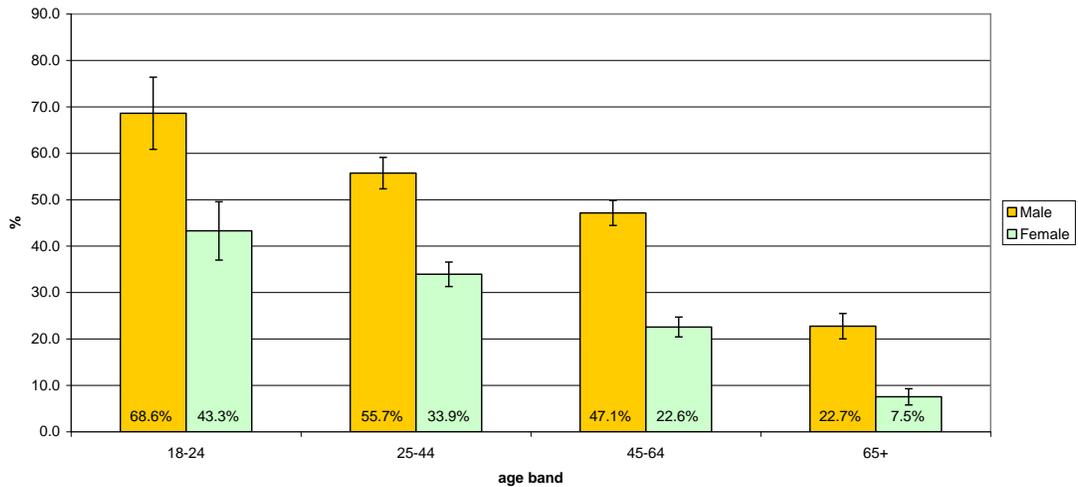
- i) Superficially, the survey appears to show much higher levels of hazardous and harmful drinking in Stockport than the national figures published by the Office for National Statistics (ONS). However, the ONS research is based on out-dated estimates of units of alcohol in drinks, (such as a glass of wine containing one unit) whereas the Stockport survey has used more accurate estimates, and therefore presents a more realistic picture of the true levels of alcohol consumption.
- ii) The average consumption among drinkers in the preceding week was 20.7 units for males and 9.3 units for females. However, younger people tend to drink more than

older people. While men in the most deprived quartile drink most, average women's consumption tends to increase with wealth.

- iii) The survey indicates that 8.1% of males and 3.0% of females are 'heavy drinkers' (more than 50 units in the last week for men, 35 units for women). Again this appears highest among the most deprived men, and the least deprived women.
- iv) Overall, 43.4% of male and 24.1% of female drinkers had drunk over twice the recommended daily amount in the previous week. The chart below shows clearly the relationship between age and 'binge-drinking' in Stockport.

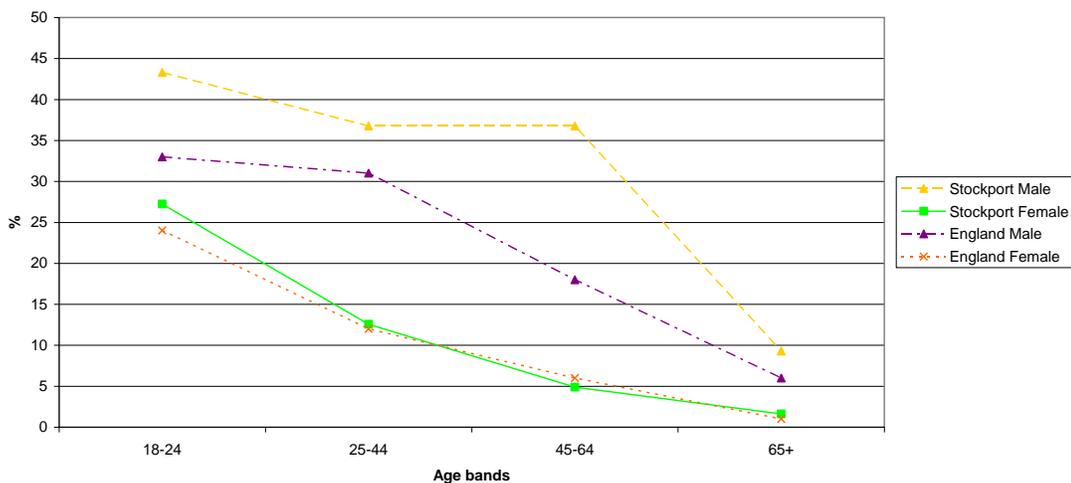
Graph 12.3.2

Percentage per age band, of males drinking more than 8 & females drinking more than 6 units of alcohol on at least one occasion in the preceding week (of those respondents that replied "Yes" to the question "Do you ever drink alcoholic drinks?")



- v) The survey found that 14.8% of men and 5.4% of women had drunk four times the daily 'limit' in the last week. Binge drinking is positively related to deprivation, and, even more so, to age, as shown in the chart above. In the age band 18-24, 33.6% of males and 16.0% of females had drunk more than four times the daily limit in the preceding week.
- vi) Based on Stockport's population profile, it is estimated that around 69,000 people in Stockport drank more than twice the recommended daily limit and 23,000 of these drank four times the daily limit, in the week prior to the survey. Around 11,000 are probably drinking heavily on a weekly basis (over 50 units per week for men and 35 units for women).
- vii) Re-analysis of the Stockport Lifestyle survey data, using the ONS estimates of alcohol content of drinks, enables a comparison with national drinking patterns, as shown in Graph 12.3.3 below.

Percentage of drinkers who drank more than twice the daily recommended daily limit on at least one occasion in the preceding week for the Stockport Health Survey compared with the General Household survey 2004



- viii) This analysis indicates that Stockport men of all ages are more likely to have drunk twice the recommended daily limit in the last week, while for women, the proportion is in line with the national average.
- ix) It is important to appreciate that people who engage in binge drinking on a few days of the week are as far as it is possible to get from the ideal drinking pattern, suffering the damage of excess alcohol and the dangers of drunkenness but without the cardiac benefits which require regular use.

The recent Health inequalities Scrutiny Committee report highlighted concern about the level of alcohol-related harm in Brinnington, which is contributing to the alarming gap in life expectancy between Brinnington residents and other parts of the borough. Comparing the patterns in Brinnington with Stockport as a whole, the most notable points are:

- i) Brinnington and Central ward male respondents reported the highest average (mean) number of units of alcohol consumed in the last week, at 28.2 units, while the average for females is the same as the borough rate.
- ii) Males in Brinnington and Central drink more than the average across all measures, except the proportion drinking 5-7 days per week. This ward is highest in the borough for the % drinking heavily (>50 units/week) and second highest for binge drinking, (including more than one in five men drinking 16 or more units on at least one day).
- iii) Females on average in this ward tend to drink at Stockport average levels or less, in relation to recommended weekly and daily limits, but Brinnington has the highest proportion of females who are 'binge drinkers' (including one in eight women drinking 12 or more units on at least one day, which is more than twice the borough average proportion).

It has been estimated that 40% of violent crime overall, 78% of assaults and 88% of criminal damage incidents are alcohol-related⁸. The Safer Stockport Partnership's Strategic Assessment indicates that, in 2005/6, Police recorded 2,350 woundings in Stockport, down 7% from the previous year, and 4,481 domestic violence incidents, up 11% on the previous year. Stepping Hill Hospital A&E dealt with 1,729 attendances due to assaults in 2005/6, down 3% compared to the previous year. The main hotspot for assaults and woundings in

⁸ www.crimereduction.gov.uk Home Office Crime Reduction Toolkit: Alcohol Related Crime

Stockport is the Town Centre. Brinnington residents are affected by high levels of domestic violence, assaults, woundings, criminal damage and arson. Comparing the rate of the crimes and incidents most commonly associated with

alcohol in the Brinnington SRB regeneration area with the borough averages, (for 2005-6) shows the aggregated rate of assaults, woundings and criminal damage is 60.8 per thousand population in Brinnington, compared to 36.2 for Stockport as a whole.

In Stockport at present around £350-400,000 is spent annually by the PCT and Stockport Council on specialist alcohol treatment services. The cost of excessive alcohol use on a health and other public services' budgets is difficult to measure for a number of reasons:

1. Alcohol is second only to smoking in the variety of conditions in which it is a predisposing factor. This means that the true financial cost of alcohol is buried in the budgets for cancers, liver disease, gastric conditions etc. (see page 3)
2. Most health care and other public service providers do not keep information that is detailed enough to attribute their spending to alcohol.
3. Health care professionals often overlook alcohol as an aggravating factor and it is therefore not documented and hence spending cannot be apportioned to it. An example is the under reporting of the relationship of alcohol to treatment in Emergency Departments.

The spending on alcohol related conditions can be broken down into three main areas:

- Secondary care
- Community care
- Criminal Justice system

It is believed that a large proportion of the spending in secondary care is attributable to the spending in the Emergency Departments. In 2003 an interim report to the Cabinet Office⁹ estimated that 40% of all A&E cases are alcohol related and that this rises to 70% of those occurring between the hours of 10.00pm and 5.00am.

Given that 80,000 new cases are seen per year at Stepping Hill and assuming that the 2003 Cabinet Office Interim Report figure can be applied (Stockport's demographic and socio-economic profile being close to the England average), then we would estimate that 32,000 alcohol related cases have been dealt with by A&E. If this number of cases were all low cost cases, requiring minimal treatment, the total cost would be £1,120,000, while if they were standard cases, the cost would be £1,952,000.

In 2005-6 there were 379 unplanned admissions at Stepping Hill Hospital, in which the primary diagnosis was alcohol related, and the total cost of these cases has been calculated at £394,000.

In 1998 the Medical Research Council commissioned the UKATT¹⁰ trial which was to be by far the largest trial of the treatment for alcohol problems ever conducted in the UK. The trial reported in 2005 and looked at those patients with an alcohol use disorder who had been assessed and referred for specialist care.

⁹ Cabinet Office. Strategy Unit Alcohol Harm Reduction Project. Interim Analytical Report. 2003

¹⁰ Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT) UKATT Research Team BMJ 2005 331: 541.

The UKATT cost effectiveness study estimated the use of public sector resources by its trial population in the six months prior to randomisation into the trial and compared this to their use in the six months prior to the follow-up. In addition they worked out the costs incurred for each of these resources based on how they were used by their trial population and the costs as indicated by a national resource¹¹.

Estimates of the prevalence of alcohol dependency vary widely. The Government's Alcohol Harm Reduction Strategy Interim Analytical Report, in 2003, estimated that 7% of the over-18 population are alcohol dependent, and some studies have put the figure as high as 10%. However, the Alcohol Needs Assessment Research Project¹² report published in 2004, estimated that an average of 3.6% of the population aged 16-64 are alcohol dependent. If we use this lower estimate (which of course excludes dependent drinkers among the 48,000 over 65 year olds in the borough), it would indicate that around 4,700 16-64 year old Stockport residents are alcohol dependent. In the absence

of definitive data, these cost estimates and usage prevalence can be used as a broad indication of the costs incurred to Stockport, by its most heavily drinking population only. Based on these figures it is estimated that the annual costs, excluding specialist alcohol treatment services, amount to £14,983,000, including:

While some of the costs incurred by A&E and admissions referred to above would be included in this figure, we should assume that in reality these costs are the tip of the iceberg, given that the numbers involved in hazardous drinking are so much larger. Habitual binge drinking is actually more harmful to health than chronic heavy drinking and the number of binge drinkers in Stockport indicated by the lifestyle survey findings (see above) was 69,000. This pattern of drinking is still fairly new and so it could be assumed that some of the longer term adverse health impacts have not yet become apparent. In addition, these figures do not include many other costs, such as mental health services, policing, probation service and prison costs, and the impacts of crime on victims.

Alcohol misuse affects whole families and wider communities, and it has been estimated that around 4,000 children in Stockport are affected by alcohol dependence of a parent, and many more will be affected by hazardous or harmful drinking of parents.

The Stockport Alcohol Strategy was launched in November 2005, at Robinson's Brewery, reflecting the partnership approach to tackling alcohol-related harm. The strategy sets out a broad range of activity to address alcohol related harms in Stockport, involving many local services and organisations, under the themes of:

- i) Communication and Communities
- ii) Treatment and Care
- iii) Crime and Disorder

This is complemented by the Young People's Substance misuse Plan, which includes alcohol, and includes a set of Outcome Performance Indicators for monitoring the impact of the strategy. As we approach the first anniversary of the launch it is appropriate to reflect on the key priorities within the strategy and how we should address these.

¹¹ Netten A, Dennett J, Knight J. *Unit costs of health and social care*. Canterbury: Personal Social Services Research Unit, University of Kent, 2002

¹² Alcohol Needs Assessment Research Project (ANARP): Department of Health 2004

12.4 How should we respond?

It is clear that the negative health and social consequences of alcohol misuse are growing and if these trends continue, we will also be paying a high price financially, for current patterns of drinking.

However, research published last year¹³ indicated that every £1 invested in specialist alcohol treatment saves £5 in costs to public services, in terms of health, social care, and criminal justice costs. Therefore, while we are clearly presented with a challenge, in the form of an increasing burden of alcohol related ill-health and health inequalities, we also have an opportunity to make a positive impact on many people's lives, while at the same time saving money.

An important part of the Government's strategy for alcohol is the recent publication of Models of Care for Alcohol Misuse (MoCAM), which describes an integrated and comprehensive alcohol misuse treatment system, including a flexible, tiered, range of interventions delivered in a range of settings. The PCT are expected to play a leading role in development of such systems, in working in partnership with other public sector, voluntary and community organisations.

A key feature of MoCAM is the need for a range of interventions, not only with the relatively small population of dependent drinkers, but also with the much larger number of people who are drinking at hazardous or harmful levels, but who are not dependent on alcohol. There is considerable evidence that simple screening and brief interventions, undertaken at minimal cost, can really make an impact on the level of drinking by these

groups within our communities, and therefore preventing further harm to the individuals and their families and communities.

At the same time as addressing such interventions and treatment however, we clearly have a responsibility to seek to influence the drinking behaviour of the whole population of people who are drinking hazardously or harmfully in Stockport. At present many people are probably oblivious to the potential harm of their drinking patterns, and we surely have a duty to enable them to make informed choices, and to encourage them to make the more healthy choices.

Given the weight of the case for investing in tackling alcohol misuse, it may seem strange that the issue has not been better addressed before now. Clearly there are complex reasons for this, and we need to be aware of these if we are to change things for the better. We may well wish for a clearer lead to be taken by the Government, in funding and target setting, to encourage and enable the NHS and other public services to better address the issues. However, we should recognise that there are other barriers to addressing the problem operating at a local and national level, and we all need to take some responsibility for addressing these.

We, as a society, have rather mixed up and inconsistent attitudes to alcohol. Most of the population drink alcohol and a very large proportion, including politicians, clinicians, police officers and managers, misuse alcohol. Getting drunk is often seen as harmless fun and widely condoned and even celebrated. However, those who become 'problem' or dependent drinkers are often vilified as having brought their problems upon themselves, and seen as undeserving of our support, or as 'lost causes' who are beyond helping, and therefore not worth spending our time and energy on. Despite this, there are many examples of people

¹³ Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT); UKATT Research Team; BMJ 2005;331:544,doi:10.1136/bmj.331.7516.544

who have overcome drink problems and contribute very positively to society. Research has shown that the success rate in reducing harmful drinking is considerably higher than, for example, that in stopping smoking. The Mental Health Foundation has recently published an excellent report, 'Cheers'¹⁴, which sets out the way alcohol and mental health issues are intertwined. It explains the two-way relationship between alcohol and depression and anxiety, as well as the issues around alcohol misuse among people with psychotic mental illnesses. The report concludes that, 'Methods of dealing with alcohol misuse must be linked very closely to emotional well-being programmes in schools, parenting initiatives, mental health promotion, public health policy and the identification and treatment of underlying causes.'

Alcohol misuse is only one of a number of consequences of poor emotional health, including other addictive behaviours (such as drug use and eating disorders), mental disorders, and stress related physical illnesses.

Recommendations

We are faced with a major challenge, but it is a challenge that presents opportunities to change things for the better and perhaps there is more we can do than immediately seems apparent. In fact, tackling alcohol misuse could be a strategically key lever to improve our effectiveness in addressing many of the important social and health issues in the borough. And at the same time work to tackle the issues that lead to people drinking unhealthily will be a key to reducing alcohol related harm. It is not an easy task, but by working together, the public and voluntary sectors in Stockport have could make a real difference in tackling this problem, by changing the way we deal with the issues now. If so, we can reduce the many costs of alcohol misuse in future years.

There is considerable evidence that screening and brief interventions can make a significant impact on people's harmful or hazardous patterns of drinking. These should be targeted at people who can be identified as being at higher risk of alcohol misuse problems, such as people seeking treatment for falls, those who have been arrested for offences often

¹⁴ Cheers: Understanding the relationship between alcohol and mental health. Mental Health Foundation 2006

associated with alcohol or Probation Service clients. Often contact with public services, such as attendance at A&E or the GP's surgery, or being arrested, provides an opportunity for agencies to identify and intervene in a problem to prevent future presentations. This is sometimes referred to as a 'teachable moment'; it is a time when people may be receptive to the suggestions that they should consider changing their drinking habits. The resources and expertise required for simple screening and brief interventions are minimal, and, if we are effective, we can anticipate considerable savings in the resources required to deal with further criminal justice and health costs.

Therefore

I recommend that simple screening and brief interventions be introduced in appropriate situations including GP surgeries, A&E, and police stations.

As well as dealing with people who are currently displaying the effects of unhealthy drinking, it is essential that we seek to inform and influence the drinking behaviour of the estimated 78,000 people in Stockport who are 'binge drinkers' and those drinking more than is good for them on a weekly basis. At the moment people are subject to many influences and perceived incentives to drink more, through a mix of marketing techniques, their own internal motivations and social pressures. It is time we began to empower people to resist these influences and pressures, beginning by providing people with clear and simple information about how much alcohol they are drinking and its potential detrimental effects on their life. We need to look at developing innovative and effective ways of identifying and communicating meaningfully with the groups of people who are drinking hazardously. By adopting 'Social Marketing' techniques we can learn from the well-developed expertise in the private sector, and use this to influence the people's behaviour positively towards more healthy drinking patterns.

I recommend the adoption of social marketing techniques in addressing alcohol use and promoting safe drinking.

Having said that, we need to be clear that our goal is not to damage the legitimate businesses that depend on the licensed trade. We certainly don't want to stop people enjoying a drink, and indeed to do so would have negative impacts on the health of the population because of the protective effect of alcohol on coronary heart disease. Licensed premises often represent important social amenities, and, of course, provide a livelihood for many of our residents. Licensees and managers can sometimes be caught up in the middle of conflicting demands of the pressure of competition and the need to increase sales, versus the legitimate pressure exerted by Police and licensing authorities to avoid irresponsible drinks promotions, and not to serve drunks or under-age customers. Managing licensed premises is a challenging task in many ways, and we should seek to support the people and organisations involved as far as possible, to ensure our evening economy in Stockport develops further to provide a well-managed, welcoming and diverse range of opportunities for socialising.

I recommend that the Borough Council, in conjunction with appropriate partners and through appropriate partnerships, takes active steps to develop the evening economy so as to make a night out in Stockport safer, healthier and more attractive.

We also need to recognise that this problem is linked to emotional health and therefore to other consequences of poor emotional health.

I recommend that the PCT and the Borough Council develop a strategy for the promotion of emotional well being.

There are also implications for the commissioning of drug and alcohol services. I have not brought forward detailed recommendations on this point at this stage as further discussion is needed with those directly involved. For the moment I simply **recommend that the implications of this report for the commissioning of drug and alcohol services be identified and addressed.**

A6.2 SUBSEQUENT DEVELOPMENTS IN OUR UNDERSTANDING OF THE ALCOHOL PROBLEM

1. Work by the Government Office North West showing that death rates in the 1970-90 birth cohorts were higher than the corresponding death rates at the same age in the 1950-70 birth cohorts. This alerted us to the possibility that if this trend continued as the birth cohort ages we might be facing a deteriorating life expectancy with the 1950-70 birth cohorts experiencing not only better health than any previous generation but possibly better than succeeding generations also. At its worst we could see a situation similar to that in Russia in the decline and fall of the Soviet Union where life expectancy fell sharply.
2. Work undertaken during the refresh of the PCT strategy in 2008/9 which showed that we were experiencing particularly high rates of increase in alcohol-related disease. Although our rates were not particularly high by comparison with neighbouring districts we had moved from being towards the lower end of the problem to being just above the middle.
3. Work which showed that the rates of increase were particularly high in indicators which would respond earliest to a change in alcohol consumption, so that it looked as if we were seeing the early signs of an unfolding epidemic.
4. Work undertaken as part of the refresh of the alcohol strategy which shows the impact of alcohol-related admissions on the hospital.
5. Work on the costs of alcohol to Stockport
6. Greater Manchester work on the potential impact of a minimum price.
7. A greater understanding of the practice of preloading whereby young people drink cheap alcohol before going out so that they can get drunk more quickly and at less cost when they get out to pubs and clubs. This suggests that getting drunk is seen as the goal of a good night out rather than as an unintended side effect of inadvertent overindulgence.
8. Healthy lifestyle survey results showing extremely high levels of unhealthy drinking of various kinds (binge drinking, harmful/hazardous drinking)
9. Segmentation of the Stockport population so as to identify different drinking cultures and the way to impact on them.

**A7: 19th ANNUAL PUBLIC HEALTH
REPORT FOR STOCKPORT (written
2010)**

19th ANNUAL PUBLIC HEALTH REPORT FOR STOCKPORT 2010

The Annual Public Health Report is an independent professional report on the Health of the People of Stockport commissioned by Stockport Primary Care Trust from the Director of Public Health. As it is a report to the PCT and partner organisations rather than a report of the PCT it follows that views expressed within it are not necessarily the view of the PCT.

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The volume of routine information published towards the end of each year will in future be regarded as part of the following year's Annual Public Health Report, whose recommendations it influences, rather than as part of the report whose recommendations have already been made. There will be such a volume as usual in 2010, e published on the JSNA website, but it will be designated as part of the 20th Annual Public Health Report 2010-11.

A7.4 INEQUALITIES

INEQUALITIES KEY MESSAGES

1. Life expectancy in Stockport is considerably better than in the North West but only slightly better than England and Wales as a whole.
2. Stockport has the greatest health differences between its most affluent quintile and its most deprived quintile of any PCT in Greater Manchester.
3. This is in keeping with indicators of deprivation which show Stockport to be one of the most highly polarised local authorities in the country.
4. In the 1990s the health of Stockport improved faster than that of England & Wales as a whole and this was due to the narrowing of health inequalities.
5. More recently however life expectancy has improved only in line with the country as a whole and inequalities have widened. However age standardised mortality rate has continued to show the improvement that started in the last century.
6. The narrowing in the 1990s (and presumably the continued improvement in inequalities in age standardised mortality) was contributed to by the introduction of cardiovascular risk factor screening and by community development.
7. The lack of progress in narrowing inequalities in life expectancy this century has been due to new inequalities in other disease areas emerging, especially alcohol-related disease, obesity and heart disease in women. These are occurring at an earlier age and are therefore affecting life expectancy more than age standardised mortality. If this pattern continues as the birth cohorts now in their 30s and 40s age then the problem will start to show itself in age standardised mortality as well as in life expectancy and in overall life expectancy as well as in inequalities.
8. Healthy life expectancy also shows a deprivation gradient, so that people in deprived areas begin to suffer ill-health while they are of working age. They spend twice as many years in ill health at the end of their life than those in affluent areas and die before the health of those in the affluent communities begins to decline.

CAUSES OF INEQUALITY

- **SMOKING - about 50%.** (Some studies suggest more than this but this is probably due to indirect association of smoking with stress and with other unhealthy lifestyles)
- **WORK – about a third 30 years ago and research not repeated.** Includes stress and work-related cultural illnesses as well as direct occupational injuries/diseases so it overlaps with other categories
- **ALCOHOL - about 10%**
- **PHYSICAL INACTIVITY – about 10%.** Physical inactivity causes more ill health than this – perhaps as much as smoking, but it is not as inequitably distributed.
- **FOOD & STRESS –.** Raised blood cholesterol causes about 15% of inequalities and is mainly caused by food and by stress with scope for debate about how much each contributes. Food and stress also each cause other disease conditions as well as raised blood cholesterol.
- **INADEQUATE HEALTH SERVICES –** Impact unclear. May contribute to reduced survival rates for major killer diseases but so may other things.

TARGETTING SERVICES TO AREAS OF DEPRIVATION

Public Health Projects are strongly targetted. Hospital services, screening and primary care are universal. There is significant targetting of community health services.

A7.5: OBESITY

Obesity Key Messages

Obesity is increasing dramatically both in the UK as a whole and in Stockport.

- About a quarter of the adult population is obese, and over half of women and nearly two-thirds of men are either obese or overweight. By 2050 this could be 60%

Childhood obesity

- Obesity causes high blood pressure and diabetes (and hence heart disease), respiratory difficulties, back, hip and knee problems, psychological problems and sleep disturbance.

- A 6lb increase in average weight across the whole of the population of Stockport would cause 335 extra deaths per year.

The increase in obesity is due to a complex range of factors. The Foresight report Tackling Obesity: Future Choices (2007) highlighted that there are over 100 different variables which influence obesity. This includes changes in diet and reduced physical activity due to sedentary occupations, less walking and cycling, less physical recreation and the growth of convenience foods. For many individuals the forces that drive obesity are now overwhelming and appeals to eat less and exercise more are not sufficient. We need to tackle an obesogenic environment.

Promoting walking and cycling is a potential major contributor to addressing the problem. US research has shown a 6lb difference in average weight between those living in a pedestrian friendly street design and

Children are increasingly constrained in the independent play they are permitted. This has been characterised as a shift from “free-range” children playing in greenspace, to “battery-reared” children playing in cyberspace. This shift has resulted from a desire to protect children, but in fact is causing them more harm than the risks avoided.

Other helpful measures include development of recreational facilities, more physical recreation in schools, green gyms, measures to promote healthy eating (including cooking skills and better access to healthy foods particularly fresh fruit and vegetables), the promotion of breast-feeding, improved and later weaning, better housing design to include play areas and dining rooms, and promoting more physical activity at work (such as incorporating workplace shower facilities, cycle-parking, cycle mileage allowances and encouraging the use of stairs rather than lifts). We also need to provide help to obese and overweight individuals, and tackle the negative environmental factors such as junk food advertising.

Green gyms (where people obtain their physical activity by helping with physical tasks to improve the environment) bring a double benefit of addressing obesity and improving the environment

Specialist Weight Management

The SWMS is designed to treat multi-component weight management in patients with BMI 50+ or BMI 40+ with significant

Patients who meet the referral criteria are added to the Stockport adhoc list of morbidly obese patients or are referred to the service from

GP Practices. Once all patients from the adhoc list have been invited to attend the SWMS, GP Practices will form the sole referral route. Once referred, patients have a one-to-one consultation with the Weight Management Coordinator for a full assessment where they are fully informed of the treatment options available.

The Weight Management Co-ordinator works with each patient to develop a personalised, multi-component non-surgical treatment programme which centres on attendance at a behaviour and lifestyle change programme. A mental health screening tool is also used at the initial consultation, and if necessary, patients are referred to the North West Centre for Eating Disorders or to other appropriate mental health service providers (to be determined).

Weight Watchers vouchers

12 weeks of vouchers offering free access to a local Weight Watchers group. Self referral service promoted through GP Practices. A limited supply of vouchers is available.

The cost effectiveness of Weight Watchers, in terms of weight loss is as follows:

Cost of Weight Watchers compared to no treatment is £1, 022 per QALY
Costs of anti-obesity medication ranges from £3,200 to £24,431 per QALY

Keep It off For Good

12 week weight management course set up as alternative to slimming clubs. Not a diet, encourages a long-term approach to changing your lifestyle, only making small changes that you can keep up for life. The course is led by a suitably qualified instructor and covers healthier eating, increasing physical activity and increasing confidence and motivation.

The evaluation found that:

- **120 of 149 participants (81%) lost weight over the duration of the 12 week period of the course.**
- **137 out of 149 (92%) participants decreased waist circumference.**
- **Cost per successful outcome at 12 weeks is approx £166 per successful outcome (weight loss)**

Childhood Obesity

Childhood obesity is increasing and is an independent risk factor for adult obesity. In 2009 Brown and Summerbell published an update to the NICE obesity guidance, reviewing school-based interventions focusing on changing diet and activity to prevent obesity. This review identified fifteen new studies, however these remained heterogeneous with inconsistent findings, making it still difficult to generalise about efficacy of interventions reviewed. The authors concluded that overall, combined diet and physical activity school-based interventions may help prevent childhood obesity in the longer term, whilst physical activity interventions may be beneficial in preventing short term weight gain, particularly in primary school aged girls. Other reviews point to the potential benefit of multi-component interventions to prevent childhood obesity, although the literature contains inconsistencies. NICE recommends that schools introduce sustained interventions to encourage pupils to develop life-long healthy habits. Short term,

'one-off' events do not appear to be effective on their own. Effective interventions appear to be those which are multi-faceted and which include characteristics such as: teaching based on behavioural approaches; teaching levels which are developmentally appropriate; training for teachers in delivering the intervention; activity-based teaching; opportunities to taste and handle foods; family involvement and reinforcement of learning from the classroom in the cafeteria and at home by parents.

The most recent Cochrane review (Dobbins et al, 2009) examining school based physical activity programs for promoting physical activity and fitness in young people aged 6-18, overall found no significant impact on BMI, despite demonstrable positive effect on other lifestyle behaviours (such as reduced TV viewing, an increase in duration of activity, and improved VO2 max and blood cholesterol). These findings were supported by Benson et al (2008), who was unable to identify a significant impact of BMI after reviewing the effect of resistance training; and Kelley et al (2008) who found no significant impact on BMI, after examining studies evaluating the impact of aerobic exercise in children, despite observing significant improvements in percentage body fat. Further reviews have addressed active travel to school, providing evidence to suggest that: 1) parental and child attitudes to active travel is affected by fears over safety, perception of risk, dislike of the local environment and cultural preference for car usage, despite more young people showing a desire to walk and cycle more (Lorenc et al, 2008); 2) active travel is associated with increased activity levels in young people, although the relationship with weight status is far less clear (Lee et al, 2008; Faulkner et al, 2009).

Few school based food policies have been evaluated, but for those that have been, some were able to show efficacy in improving the food environment and dietary intake within school, although evidence on their impact on BMI was very limited. A review of school fruit and vegetable programmes was undertaken by de Sa and Lock (2008). Whilst the authors found evidence to suggest that school fruit and vegetables schemes can be effective at increasing fruit and vegetable intake and can contribute to the reduction in diet inequalities, there was very little evidence examining the impact on child weight status.

A cost benefit analysis by the School Food Trust of breakfast clubs in London estimated a total ratio of benefits to costs of approximately 4.38. In reality the ratio of benefits to costs may be significantly higher.

A meta-analysis of longitudinal studies of depression and weight control was carried out by Blaine (2008). The findings demonstrate a significant correlation between depression and later obesity, particularly for adolescent females, thus highlighting the importance of depression screening and treatment in obesity prevention programmes.

Integrated commissioning to reduce obesity and encourage low-carbon lifestyles

Commissioning to reduce obesity also provides opportunities to integrate commissioning for sustainable, low-carbon lifestyles. For example, dietary habits, food purchasing and preparation patterns can be modified at individual, group or community level, particularly by influencing the food supply chain. Schemes to

support walking or cycling to work and school benefit health and reduce carbon emissions.

Physical Activity

Commissioned programmes of work are:

- Physical Activity Referral in Stockport (PARiS)
- Cardiac Rehab Phase IV Facilitator
- Walking for Health – led health walks, community group development
- Home Activity Programme (new investment, financed from the decommissioning of SWIMBUS)
- some residual expenditure from SWIMBUS (SWIMBUS has been decommissioned because the cost of £369 per user was not value for money but some residual expenditure remains for the protection of existing users and to achieve the initial goals)

Other work includes:

- Training to support brief intervention (through Weight Management Training)
- Strategy development with partners, ensuring the delivery of key national strategies
- Managing contracts, including quality assurance and governance

Costs of physical inactivity

DH commissioned the British Heart Foundation Health Promotion Research Group at Oxford University to prepare estimates on the primary and secondary care costs attributable to physical inactivity for PCTs across England.

The cost data were taken from the National Programme Budgeting Project (NPBP) and were related to five diseases, defined by WHO as having some relation to physical inactivity: ischaemic heart disease, ischaemic stroke, breast cancer, colon/rectum cancer and diabetes mellitus.

The overall healthcare costs of physical inactivity to NHS Stockport are estimated at just over £5 million per year.

Costs of Physical Inactivity for Stockport PCT per year (2006/07)

<u>Cancer Lower GI</u>	<u>Cancer breast</u>	<u>Diabetes</u>	<u>Coronary Heart Disease</u>	<u>Cerebro- Vascular Disease</u>	<u>WHOLE PCT COST</u>
<u>£365,920</u>	<u>£309,430</u>	<u>£687,300</u>	<u>£3,299 350</u>	<u>£593,520</u>	<u>£5, 225 520</u>

The DH announced in Be Active, Be Healthy that this tool will be extended to take account of the impact of generic interventions to promote physical activity upon prevalence and cost. This tool has not yet been published.

The DH also announced in the plan that they are working with the World Health Organisation and UK partners to produce a health economics assessment tool which will provide comprehensive justification for investment in walking.

Commissioned services

PARiS

3 month follow-up data

Measurement of outcomes will improve next financial year with plans to take a random sample of patients

Local Exercise Action Pilot findings

The Local Exercise Action Pilots (LEAP) were pilot projects funded by the DH at ten sites designed to improve the intervention evidence base for physical activity. The projects were located in both PCTs and local authorities and classified under seven categories: exercise referral; motivational interviews; classes and groups; training leaders and coordinators; campaigns and directories and outdoors and transport.

Each intervention targeted priority groups: those who are sedentary; those at risk of chronic health problems; those on low incomes; young people; older people; women and people from black and ethnic minorities.

The findings of the interventions were positive, however it should be noted that the majority of participants (60.2%) who took part were already meeting the physical activity guidelines.

Financial findings

- The future cost saving for the NHS per participant ranges from £770 per participant to £4900.
- The cost per participant of LEAP interventions ranges from £50 to £3400.
- The cost per Quality Adjusted Life Year (QALY) from LEAP interventions ranged from £50 to £510.
- The cost per participant improving their physical activity category ranged from £260 to £2790. There was no obvious relationship between LEAP intervention themes and cost per participant improving their physical activity level.

Brief Intervention

NICE established that brief intervention for physical activity in primary care costs between **£20 and £440 per quality-adjusted life year (QALY)** (when compared with no intervention) with **net costs saved per QALY gained of between £750 and £3,150**.

The service provided by the Phase IV Cardiac Rehab is developed along a similar model.

A programme of training, to support the delivery of physical activity brief intervention in primary care is currently provided.

In comparison, the cost of statins is at between £10,000 and £17,000 per QALY.

In comparison, smoking cessation costs between £221 and £9,515 per QALY – a common and well accepted NHS service.

Cost effective interventions

The table below outlines the two initiatives – Let's Get Moving, and Dietary Advice Direct - which we believe would be worthy of further local investment. The Department of Health launched *Let's Get Moving* in 2009, a behaviour change programme that incorporates a physical activity care pathway. This is an evidence-based approach, based on the recommendations of NICE public health guidance, which endorses the delivery of brief interventions for physical activity as both clinically effective and cost-effective. *Let's Get Moving* incorporates detailed guidance for commissioners. To improve its impact and achieve long-term change in physical activity in the population, *Let's Get Moving* can be placed within a wider commissioning strategy which aims to make the wider environment more conducive for people to be physically active: making the healthier choices the easier choices.

<u>Public health initiative</u>	<u>Description</u>	<u>Evidence of effectiveness (key reference/s)</u>	<u>Evidence of cost effectiveness ?</u>	<u>Recommended in policy / guidance documents? If yes, which.</u>	<u>Health impacts short, medium or long term? Current evaluation up to 9 months.</u>	<u>Impact on health service utilisation ? Not known.</u>
<u>Dietary Advice Direct</u>	<p><u>Dietary Advice Direct will shortly available as part of the Stockport Adult Weight Management Pathway*.</u></p> <p><u>The service is an online service which offers personalised dietary advice and regular evaluation reports of patient progress for the PCT.</u></p> <p><u>All advice and support is provided by registered dieticians and is in line with NICE guidance.</u></p>	<p><u>Dietary Advice Direct evaluated their service provision to various PCTs in Manchester to overweight or obese patients. 350 users took part in the evaluation.</u></p> <p><u>Results are summarised below this table.</u></p>	<p><u>Maximum cost per patient is £18 for 1 year of support</u></p>	<p><u>In line with NICE CG 43 (Obesity)</u></p>		
<u>Let's Get Moving Physical Activity</u>	<p><u>The Department of Health published Let's Get Moving: Commissioning</u></p>	<p><u>See table below</u></p>	<p><u>See table below</u></p>	<p><u>Be Active, Be Healthy: A plan for getting the nation moving</u></p>	<p><u>See table below</u></p>	<p><u>Not known</u></p>

Care
Pathway

Guidance on A new
physical activity care
pathway for the NHS on
24th September 2009.

Let's Get Moving
provides a national,
standardised set of
training and tools for
brief intervention for
delivery in GP Practices
etc.

(DH, 2009).

Results of Dietary Advice Direct Evaluation:

30% of users were using the weight monitoring facility on the website (103 users)

- **An average weight loss of 2.8kg with a median time registered of 4.4 months (range 1 month to 9 months)**
- **4% of users have moved to a lower BMI category**
- **Initial results show a progressive weight loss over time with the provision of ongoing email support**

Latest user figures from Dietary Advice Direct show that of those monitoring their weight online:

- **Average weight loss is 3.2kg/user**
- **21% of users lost >5% BW**
- **6% users lost >10%**
- **12% have moved to a lower BMI category**

<u>Intervention</u>			
<u>For 500 patients</u>	<u>£16,000</u>	<u>£3, 250</u>	<u>£2,575</u>
<u>80% of patients undertake intervention = 400 patients</u>			
<u>Cost of support activity following brief intervention and follow-up</u>	<u>£5 per patient</u>	<u>£5 per patient</u>	<u>£5 per patient</u>
<u>For 400 patients</u>	<u>£2,000</u>	<u>£2,000</u>	<u>£2,000</u>

<u>Total cost for one year (including training and support)</u>	<u>£19,614</u>	<u>£6,864</u>	<u>£6,189</u>
<u>25% patients complete programme and achieve health gain = 100 patients</u>			
<u>QALY gain per patient undertaking intervention</u>	<u>0.17</u>	<u>0.17</u>	<u>0.17</u>
<u>Total QALY gain</u>	<u>68</u>	<u>68</u>	<u>68</u>
<u>Cost per QALY gain</u>	<u>£288/QALY</u>	<u>£101/QALY</u>	<u>£91/QALY</u>

Transport

The Marmot Review calls for policies and interventions to be prioritised that “reduce both health inequalities and mitigate climate change, by improving active travel across the social gradient.”

The importance of active transport in tackling physical inactivity is widely recognised in numerous strategies and policy documents.

‘Walking and cycling present practical, alternative forms of activity that can be part of the daily routine for most people’ (DH 2004c, p. 89).

The health benefits of cycling and walking are undisputed and well evidenced (Cavill and Davis 2003, CTC 2004).

Likewise the evidence base for the health benefits of walking is strong (Rippe *et al.*, 1988, La Croix *et al.*, 1996, Paffenbarger *et al.*, 1986).

Hillsdon and Thorogood report

“Brisk walking has the greatest potential for increasing the overall activity levels of a sedentary population and meeting current public health recommendations”

(Hillsdon and Thorogood 1996 cited by Cavill 2001p.37)

Hillsdon *et al* (2004) in their review of reviews of public health interventions for increasing physical activity conclude the effective interventions are those that promote moderate intensity such as walking and are those that do not require attendance at a facility.

A recent economic assessment of walking and cycling (Davis 2010) report highly significant benefits, the median benefit to cost ratio for the UK being 19:1.

A thorough review of the health impacts of transport has recently been completed by the Transport & Health Study Group (Mindell *et al*, 2010) They recommend the promotion of active travel. They examine cycle safety and conclude that

cycling is safe and will get safer the more people cycle— they warn that misleading publicity about hazards of cycling can cause a great deal of harm. They call for a rethink of the role of streets with an emphasis on their role in community interaction and they recommend the closure of rat runs to create cycle routes, reduce the adverse effects of street traffic and open the way to use of the street for community purposes.

The case for Public Health Advocacy on Transport Policy

To optimize health, public health interventions must address environmental, social, political and economic factors as well as individual behaviour (WHO, 1986). Public health's mission includes creating the 'conditions', and 'environment', in which people can be healthy (Wallack and Dorfman, 1996). Hence, contemporary public health practice involves not only attempting to change individual behaviour but also influencing the policies and practices that create the conditions for change.

The 2007 Foresight Tackling Obesities report laid bare the shocking scale of our obesity problem. Unless we act decisively and immediately, by 2050 almost 60% of the UK population could be obese, with the economic cost of overweight and obesity reaching £49.9 billion at today's prices.

Foresight concluded that the obesity epidemic cannot be prevented by individual action alone and demands a societal approach.

Foresight said "The top five policy responses assessed as having the greatest average impact on levels of obesity across the scenarios [include]: ... increasing walkability/cyclability of the built environment...."

A number of countries such as Holland, Germany and Denmark have high levels of walking and cycling. Such countries have benefited from decades of public policy in favour of pedestrians and cyclists (Gemzoe 2001, Pucher 2001). Common to the approach are policies of providing better facilities for walking and cycling, traffic calming of residential neighbourhoods, urban design sensitive to the needs of non motorists, restrictions of motor use in cities, rigorous traffic education of motorists and strict enforcement of traffic regulations protecting pedestrians and motorist. (Pucher and Dijkstra 2001, Hillman 2001).

A systematic review (Ogilvie *et al.*, 2004) of walking and cycling interventions as alternatives to car use suggested that publicity campaigns, engineering measures and other interventions have not been effective. It should be noted that the parameters of this review were narrow and did not for example include multi-component initiatives. The paper also ignores the socio-politico-cultural factors and seems to fall into the clinical trap of assuming car use is a disease, which can be remedied by a single cure or intervention. Evaluating the effect of a single intervention on levels of activity is not straightforward. The evaluation must not be too expensive as it makes little sense to set up an elaborate evaluation that is unlikely to provide a definitive answer and costs more than the intervention itself. Although important in evaluating the clinical effectiveness of therapeutic interventions the randomised controlled trial is seldom an appropriate tool for

assessing the health impact of an intervention with a population level outcome.(Davey Smith, 2001;Schwartz1999, Tones 1997).

Ogilvie et al did however conclude that targeted behaviour change programmes can change the behaviour of motivated sub groups for eg the “Walk in to Walk out” campaign-Glasgow (Mutrie *et al* 2002) and the Travelsmart programme-Perth (James and Brög 2001). This is also backed by further research of Smarter Choice programmes in the UK and evidence emerging from the Cycling Town demonstration projects . There is a dearth of literature around effectiveness of public health advocacy, however the campaign to end smoking in public places indicates how importance public health advocacy is in delivering population health benefits through policy intervention. The Greater Manchester Directors of Public Health have collectively decided to act as advocates for walking and cycling in Greater Manchester transport policy.

Cost effectiveness and Cost Benefit

Sustrans has gathered the evidence around health cost benefits around cycling and walking infrastructure schemes. The following examples indicate the considerable health benefits which could be gained should “Active Travel” be prioritised in Local Transport Plans.

Bike/Pedestrian Trails in Nebraska

From a Public health perspective, a cost-benefit analysis of using bike/pedestrian trails in Lincoln, Nebraska, to reduce health care costs associated with inactivity was conducted. Data was obtained from the city's 1998 Recreational Trails Census Report and the literature. Per capita annual cost of using the trails was U.S.\$209.28 (\$59.28 construction and maintenance, \$150 of equipment and travel). Per capita annual direct medical benefit of using the trails was \$564.41. The cost-benefit ratio was 2.94, which means that every \$1 investment in trails for physical activity led to \$2.94 in direct medical benefit.

Norway

The study presents cost–benefit analyses of walking and cycling track networks in three Norwegian cities. The cost–benefit analyses take into account the benefit of reduced insecurity and the health benefits of the improved fitness the use of non-motorized transport provides. In addition to reductions in health costs, the analyses also take into account that a change from travel by car to cycling or walking means reduced external costs (e.g. air pollution and noise) from motorized traffic and reduced parking costs. The benefits of investments in cycle networks are estimated to be at least 4–5 times the costs

London

DfT cites a canal towpath in London, transformed into a high quality route for commuter use between 2002 and 2004, with improved route surface quality and connectivity.

This, plus the introduction of the congestion charge, led to considerable increases in usage, resulting in:

- total present value of benefits£24,891,736

- of which £10,300,266 is attributed to increased physical fitness (based on numbers of preventable deaths)
- and £3,529,245 through reduced absenteeism
- a benefit to cost ratio of 22:1

Areas for further investment

- **Cycling Demonstration Town Initiative**

The Department for Transport and Cycling England has published a joint paper entitled: 'Analysis and synthesis of evidence on the effects of investment in six Cycling Demonstration Towns'. The paper provides a summary of evidence on changes in cycling and physical activity in six towns following the first phase of the Cycling England / Department for Transport Cycling Demonstration Town investment programme between October 2005 and March 2009. It draws on two separately published volumes of evidence: Cycling Demonstration Towns: Monitoring project report 2006 to 2009 and Cycling Demonstration Towns: Surveys of cycling and physical activity 2006 to 2009.

- **Sustainable Transport Town Initiative**

Key overall changes in personal travel behaviour in the three pilot towns include:

- Reductions in car-as-driver trips of between seven and nine percent;
- Increases in walking trips of up to 14%;
- Increases in cycling trips of up to 113%;
- Increases in bus use of up to 35%; and
- Increases in time spent travelling by active modes (walking and cycling) of up to 16% (or an additional 16 hours per person per year).

These changes in personal travel behaviour resulted in reductions in distances travelled

per car per day ranging between nine and 13%. As a result across the three Towns, a

total of around 84 million km of car travel was taken off the roads each year, equating

to estimated annual savings of more than 17,000 tonnes of carbon dioxide (CO₂).

<http://www.dft.gov.uk/pgr/sustainable/demonstrationtowns/sustainabletraveldemonstrati5772>

- **Call to Take Action on Active Travel**

Calling for a 10% of the transport budget to be spent on walking and cycling which has the endorsement of the Association of Directors of Public Health and a large number of other public health organisations.

A7.6 SMOKING

Smoking

KEY MESSAGES

- A fifth of adults in Stockport are still smoking
- Deprivation is a key risk factor for smoking across both sexes and all ages.
- A quarter of young adults are still smoking. There is some evidence that they will be less likely to give up in the future.
- 1 in 4 smokers will die of a smoking related disease so the only difference between smoking and playing Russian roulette is the delayed effect.
- Smoking related diseases are an important contributor to health inequalities. Although smoking is declining in most social groups this is not true of women in the most deprived quintiles.
- Tobacco is the only lawful product which kills such a high proportion of those who use it in the way the supplier intended.
- Tobacco is the only drug of addiction that can lawfully be purchased without a prescription. There are other lawful products to which addiction does occur, such as alcohol or glue, but the term “drug of addiction” is used here to imply a drug in which addiction would be the normal consequence of using the drug in the way intended by the supplier. Most smokers are introduced to tobacco in their youth and often become addicted before they fully realise the risk they are running.
- The new legislation, introduced in July 2007, banning smoking in enclosed workplaces and public places, is therefore very welcome. The enforcement of this legislation constitutes an important contribution by Stockport MBC to dealing with the scourge of smoking related diseases. Health benefits are already observable.
- Social marketing and smoking cessation advice and support constitutes an important contribution by the PCT.
- Most young people know the risks of smoking by the end of primary school. However a large proportion of them still experiment with tobacco in their early teens and many of these become addicted in the process. This happens partly out of rebellion, partly out of curiosity, partly out of a sense that tobacco is an adult habit, partly from following the examples of parents, partly out of a desire to demonstrate style and partly in response to peer pressure. We have yet to find an effective way of intervening in these cultural factors and we need to do so. There is some American evidence which suggests that peer education focussed on the question of how young people are manipulated by the tobacco industry can be effective. We should introduce such a scheme in Stockport.
- Locally we are achieving higher access rates to smoking cessation services in deprived quintiles but this achievement is undermined by the fact that success rates are lower. We need to tackle these lower success rates by considering what additional support we can give, including social and cultural measures delivered by community development. . Resources initially earmarked locally to do this have been frozen in the financial crisis

What Works?

Our current programmes are supported by NICE and Cochrane review evidence of effectiveness. Direct cost per life year gained was £684 in 2005 (now probably higher but still well below NICE cost per QALY threshold).

Smoking cessation services see about half of quit attempts.

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 a population. The Department of Health evaluation of the NHS Stop Smoking Services programme concluded current smoking cessation programmes contribute to a (modest) reduction in health inequalities, and even with a relatively low 15% of clients remaining quit at 52 weeks, the services are cost effective in helping smokers quit.

Priorities for 2009 onwards will be four main areas of new national DH tobacco control strategy (due to be published in 2009/10)

- Reducing smoking rates and health inequalities caused by smoking
- Protecting children and young people from smoking
- Supporting smokers to stop
- Harm reduction for people who cannot stop

Tax increases

Even if the health care costs in life years gained are taken into account and even if additional tax revenues do not flow to the health care sector a tax increase is a cost-effective intervention to increase public health from a health care perspective (van Baal et al. 2007).

Prevention with Children & 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 is due in 2010. Several school based interventions have been shown to be effective (e.g. the European smoking prevention framework approach, ASSIST [A Stop Smoking In Schools Trial], the Smoke-free class competition, and the US Truth Campaign).

California has been investing heavily in tobacco control since 1988. The California experience demonstrates that a comprehensive approach designed to change social norms has a much greater impact than a frontal attack designed to market cessation services directly to tobacco users. The goal of this “social norm change” approach is to indirectly influence current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible (California Dept of Health, 1998). California spends \$4 on tobacco control, marketing and community projects for every \$1 spent on smoking cessation. NHS doesn't. The Californian programme is effective in deprived areas as well as in affluent areas.

The Californian programme includes explicit attacks on the tobacco industry. There is evidence from California and from elsewhere in the United States that such attacks are especially useful in supporting young people in resisting the drift into smoking in their teens.

The Californian programme does not aim to operate specific programmes for young people; instead it aims to ensure that programmes aimed at adults are visible to young people. This is based on the belief that young people take up smoking as part of growing up, believing that it is an adult habit, and that this can only be prevented by addressing them as adults not as children.

Quitting in pregnancy

NICE guidance due out in 2010. Pregnancy increases abstinence, but preventing post-delivery relapse may require stress management and re-focusing of health concerns (Crittenden et al. 2007).

Tobacco Control Strategy

Just less than one in five adults in Stockport smoke (18%). Half of those who smoke will die prematurely from smoking related diseases. Tackling smoking is the single most effective thing we can do to improve health in Stockport. The overall prevalence masks a variance of between 6% and 54% between our most affluent and least affluent communities. Smoking prevalence is a key factor in the 12 years difference in life expectancy between our most affluent and least affluent areas. The 2007 legislation reduced exposure to second hand smoke but the impact on smoking prevalence is unclear. Far from the problem of smoking ‘being solved’ it is necessary to maintain the pressure on smoking prevalence, particularly by targeted work with communities where prevalence is highest.

The aim is to reduce the number of people who smoke and the number who take up smoking.

Our current programme includes a comprehensive smoking cessation support service with additional support targeted at NR priority 1 areas, a successful media strategy generating a high level of press coverage for tobacco issues and a smokefree homes scheme in priority 1 areas.

In 2009 a refreshed Tobacco Control Strategy, building on previous achievements under the umbrella of “Smokefree Stockport”, will aspire to meet the GM Health Commission’s challenging target to reduce smoking prevalence to 10% by 2015. Our vision is that fewer young people in

Stockport will be tempted to start or try smoking. High quality treatment support to smokers will be accessible to all those who want to stop. All smokers will know where to get appropriate support. Residents across Stockport will understand the importance of keeping their own homes smoke free, and that this will be seen as normal. A wide range of partners in all sectors will actively engage in promoting the smokefree agenda.

We will continue to work in partnership with the Greater Manchester Tobacco Alliance and Smokefree Northwest to campaign for further restrictions on tobacco, to raise public awareness of tobacco related issues via the media and to encourage people to make smoking cessation attempts with NHS support.

Our priority is to challenge social norms around smoking for both adults and young people.

The NHS and Stockport Council will lead the way with exemplar tobacco control commitment.

We will develop programmes to reducing the number of young people who take up smoking by working with them to develop ways to make smoking less attractive, providing a cessation service, training staff working with young people most at risk of starting smoking and joint initiatives with the Council and retailers to ensure underage sales legislation is enforced

For the adult population we will continue to provide and further develop accessible evidence based stop smoking treatments and support that is responsive to the needs of smokers. Smoking will be a component of the expanded lifestyle service described in the PCT Strategic Plan.

Current smoking in pregnancy rates have not recently declined and are only just below our adult prevalence rates at 16% (April 2007-8). We need to provide intensive support to pregnant women.

By rolling out successful interventions from the Brinnington social marketing initiative and learning from other countries (especially California) we will build on our community stop smoking programme to develop and sustain a “quitting culture” in areas with the highest smoking prevalence.

We will strive to minimise exposure to tobacco and second-hand smoke for Stockport residents by expanding our Smokefree Homes project borough wide and ensuring partners promote policies and initiatives that promote tobacco free environments and lifestyles

We will measure our progress via **Key Performance Indicators** including

- *Prevalence of smoking in young people and in adults
- *Smoking in pregnancy
- *Supported quit attempts
- *No. of smokefree homes
- *Smoking related health inequalities

Smoking in Films

There is American evidence that smoking in films plays an important part in presenting smoking as normal to young people. It estimates that as much as 50% of the uptake of smoking by young people might be attributable to this factor. The Greater Manchester Health Commission has identified this as an area of possible intervention.

A7.7 ALCOHOL



Alcohol Key Messages

1. Alcohol excessive use is increasing nationally and levels of alcohol misuse in Stockport appear to be higher than the national average. In part, this increase is due to the increasing strength of drinks.
2. Units of alcohol in a drink are calculated by multiplying the strength in percentage alcohol by volume by the number of millilitres (a pint is 568mls) and dividing by 1,000.
3. Men should not drink more than 28 units in a week (3-4 units per day) and women 21 units in a week (2-3 units per day).
4. For each unit people have drunk they should wait an hour before engaging in dangerous activities or activities requiring skill.
5. 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. Cohorts of people currently in their 20s and 30s have to date in their lives experienced death rates higher than those experienced to the same point in their lives by people now in their 50s and 60s. This is due to alcohol related diseases. If this continues as they grow older then life expectancy will decline.
6. Alcohol related ill-health and deaths disproportionately affect the more deprived communities, and are key factors in maintaining health inequalities in the borough.
7. The number of deaths in Stockport in which alcohol was identified as a factor reached a new high of 95 in 2006 and the three-year average directly standardised mortality rate has increased from 20.2 in 2002 to 26.4 in 2006.
8. The number of A&E attendances due to alcohol intoxication or poisoning increased to 442 in 2006-7, compared to 195 in 2001-2, and 60% of these came from the most deprived 30% of the population. However, the government estimates that as many as 35% of A&E attendances may be alcohol-related, which would equate to 23,800 attendances of Stockport residents last year.
9. 394 hospital admissions in 2006-7 were directly alcohol-related, compared to 221 in 2001-2, and 57% of these came from the most deprived 30% of the population.
10. Police recorded crime figures last year showed a 3.5% reduction in the total number of assaults and woundings (2,857 in 2006-7), while 'woundings' figures were 18.3% lower than in 2003-4.
11. The 2007 Stockport Citizens Panel survey found an increase in the proportion of people feeling safe in Stockport Town Centre at night, from just 10% in 2005, to 25% this year.
12. Based on the Stockport Lifestyle Survey (2006):

- a) 5% of the adult population (11,000 people) are drinking heavily (men more than 50 units and women more than 35 units in a week).
- b) 31.5% of the survey respondents admitted to drinking twice the daily guidelines at least once in the last week (equivalent to 69,000 people in the borough), and one third of these had drunk four times the daily limit.
- c) Binge drinking appears more prevalent in younger people generally and among men upto 65 in deprived areas.

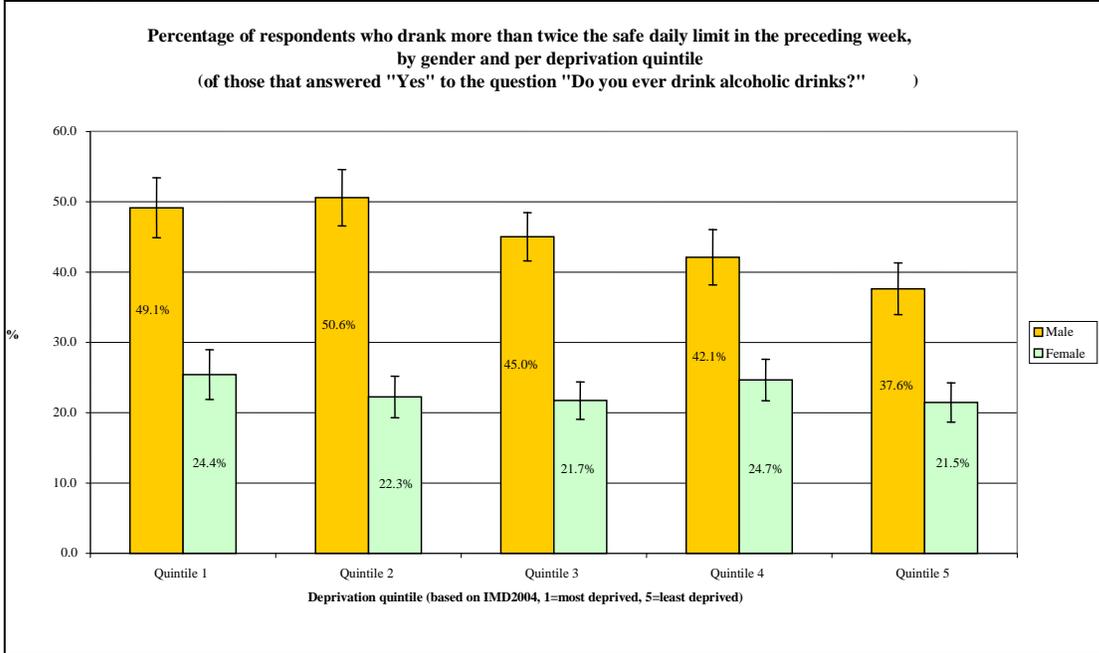
13. Stockport has shown one of the highest increases in the country in the rates of cirrhosis of the liver with an increase of 59% from 2003/4 to 2007/8.

14. 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 that we started in the 20th century.

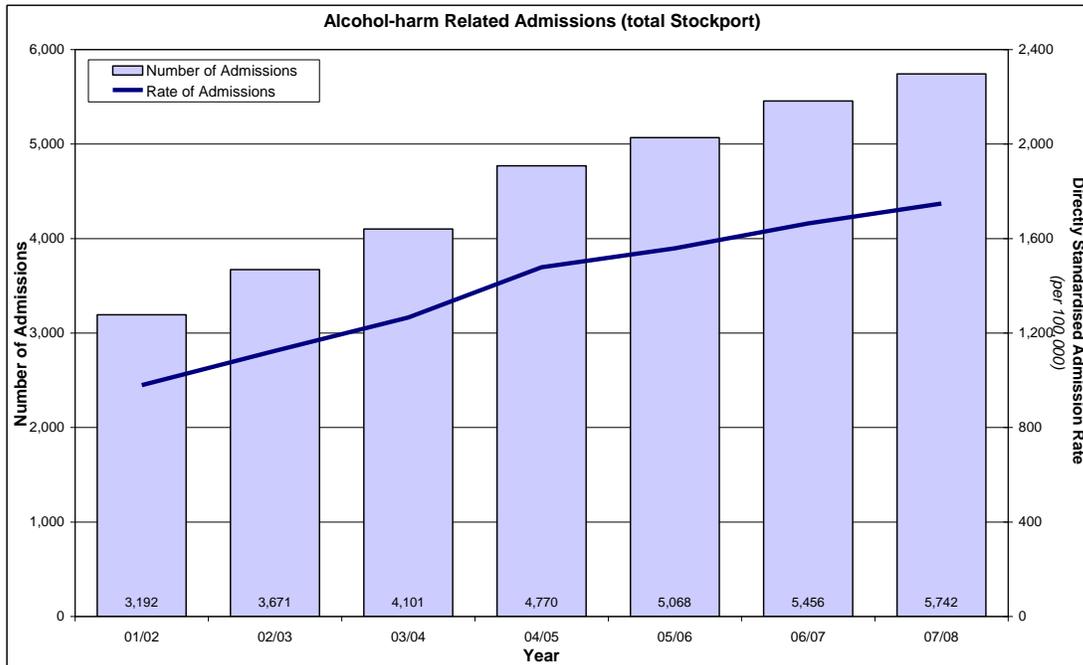
15. We have been seeing for some years now a steady reduction in heart disease and cancer death rates. Last year for the first time it worsened. We hope this was a blip. If it persists it could be the beginning of the manifestation of the declining health which we fear and predict if alcohol related deaths continue to increase as the cohort born in the 1970s and 1980s age.

Alcohol – Trend Summary

In Stockport the average weekly consumption of alcohol reported by adults is just below recommended limits. However, of those who drink, almost 40% binge drink on the day they drink most and 5.4% of people who drink, drink 'harmful' amounts over the course of a week. In 1993 only 1% of the female population and 4% of the male population drank harmfully. Rates of binge drinking are highest in deprived areas



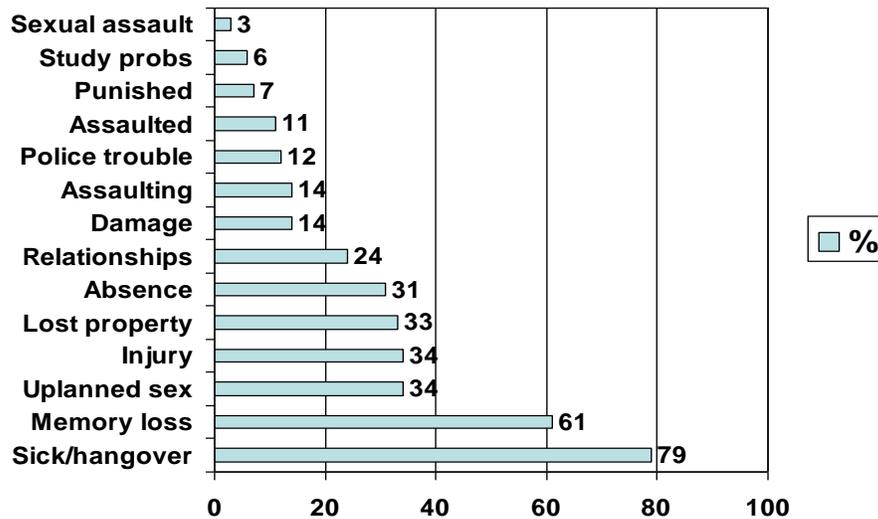
Alcohol misuse has serious impacts on health and alcohol related mortality, inpatient admissions and A&E attendances are all increasing in Stockport. In 2006 around 60 people died as a result of a directly alcohol related cause, a level double that of 2000.



The impact of alcohol on health inequalities is also significant and increasing, it is now a major driver of the gap in life expectancy.

Young people record a high level of problems with alcohol. 36% of Y10s, 46% of 16-18 year olds and 44% of 19-25 year olds said they had experienced at least one serious consequence in the last year (these included being in trouble with the police, physical and sexual assault).

Problems experienced due to alcohol (aged 18-24):



What Works?

The best evidenced measure to address alcohol problems is brief interventions – the provision of simple advice by a health professional.

NHS Stockport’s health strategy to date has consisted of the introduction of brief interventions – in the first instance into primary care and then into A&E and into criminal justice (arrest referral). However out of 69,000 hazardous drinkers, 2,000 will receive an intervention of whom 600 will adopt healthy drinking.

This has gone hand in hand with a strategy in the criminal justice system of tackling alcohol as a cause of social disorder.

This approach, although successful and evidence based, is not stemming the tide of alcohol problems.

There is considerable evidence that alcohol consumption is very price-sensitive. Trends in alcohol consumption have been carefully documented which show that cheap alcohol on sale in supermarkets is being consumed at home and the pub trade is in decline. There is a tendency for young people who are going out to “preload” with cheap alcohol at home so that they need to drink less of the “expensive” pub or club alcohol in order to get drunk.

Drinks are getting stronger and are being served in larger glasses which means that people who are drinking the same number of “glasses” as would once have been safe may find that it is now excessive.

It may well be that the most effective measures to address the alcohol problem lies in the hands of Government and relates to pricing and licensing policies. Councillors on Stockport’s Licensing Committee would like to do more but are constrained by inadequacies in legislation.

So far as future commissioning initiatives the following table shows measures which would be evidence based.

Public health initiative	Evidence of effectiveness (key reference/s)	Evidence of cost effectiveness?	Recommended in policy / guidance documents? If yes, which.	Health impacts short, medium or	Impact on health service utilisation?

				long term?	
Hospital based Alcohol Liaison Nurses	Signs for Improvement – commissioning interventions to reduce alcohol-related harm (DH 2009)	Safe. Sensible. Social. The next steps in the national alcohol strategy. (DH 2007) Liverpool, Salford case studies.	Signs for Improvement; Safe. Sensible. Social. The next steps in the national alcohol strategy.	Short, medium and long term	Yes: reducing demand on A&E, emergency admission and longer term costs of ill-health and disability due to alcohol
Integration of behaviour change intervention skills into KSF competencies and post outlines	Glasgow model	Safe. Sensible. Social. The next steps in the national alcohol strategy. (DH 2007)	Draft NICE guidance calls for NHS professional to routinely carry out alcohol screening as part of practice	Medium and long term	Yes - reducing alcohol-related hospital attendances and admissions
Increasing Capacity of Tier 3& 4 services to enable 15% of alcohol dependent population to access service per year	Safe. Sensible. Social. The next steps in the national alcohol strategy. Stockport Alcohol Reduction and Motivation Programme evaluation.	Signs for Improvement; Safe. Sensible. Social. The next steps in the national alcohol strategy.	Signs for Improvement; Safe. Sensible. Social. The next steps in the national alcohol strategy.	Short, medium and long term	Yes - reducing alcohol-related hospital attendances and admissions
Community / Voluntary / Mutual Aid capacity building	Health Empowerment Project business case: Dr Brian Fisher; Review of Effectiveness of treatment for alcohol problems: D Raistrick, N Heather and C Godfrey	Review of Effectiveness of treatment for alcohol problems: D Raistrick, N Heather and C Godfrey	Securing Good Health for the Whole Population: Derek Wanless 2004; Choosing Health DH 2005	Medium and long term	Yes potential to reduce demand on A&E, social care etc.
Improving offender mental health	Bradley report (2009)	Bradley Report	Bradley report	Short medium and long	Yes: reducing emergency attendances and admissions reducing demand on mental services.
Maintaining 'Stockport Safe' initiative involving joint prevention and enforcement	Local evaluation		Home Office guidance National Alcohol Strategy	Short, medium	Yes: reducing emergency attendances and admissions Medium term mental health service needs impact.

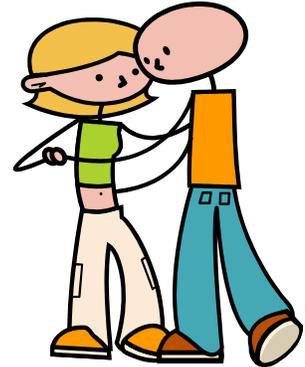
**work in the
Town and
district centres**

It is also plausible that the alcohol problem is a manifestation of a deeper malaise in society, a serious alienation, and that it would best be tackled by addressing that problem. The Secretary of State has indicated that the Government shares that view.

A7. 8 SEXUAL HEALTH

Key Messages

- Sexual health is an important part of our lives and impacts on our physical and mental well-being. It is a key part of our identity as human beings and reflects the diversity in our society in regard to acknowledgement and acceptance of people's sexual orientation.
- Essential elements of positive sexual health are equitable relationships and sexual fulfilments with access to information and services to avoid the risks of unintended pregnancy, illness and disease.
- We are currently however seeing a rapid decline in our sexual health in Stockport.



- Certain Sexually Transmitted Infections (STI's) are increasing in Stockport, with Chlamydia being the most common infection. It is particularly prevalent in people under 25 year olds. Many people may be unaware of their infection and if left untreated it can cause long-term problems such as infertility.
- Stockport has implemented a Chlamydia screening programme targeting 15-24 year olds. This opportunistic screening is available at various sites, including Central Youth.
- Some people are unaware that some STI's are incurable such as HIV and Herpes.

- The number of Teenage pregnancies has been steadily decreasing since 1998. However, although we are seeing a reduction in the numbers overall, there are stark variations across the differing neighbourhoods.
- There is a wide range of contraception methods available to suit all lifestyles. Long acting reversible contraceptives such as IUD's and Implants are most effective and the use of them has been steadily increasing.

- Despite access to a range of effective contraceptive methods, the number of terminations continues to rise.
- Terminations are taking place later than ideal with more terminations after 10 weeks gestation.



What can people do to enjoy positive sexual health?

- Access reliable contraception which suits your lifestyle via your GP, Central Youth and Contraception Services.
- Always use a condom. It's not just to prevent an unwanted pregnancy; it's the only method to prevent transmission of an STI.
- If concerned you have been at risk of an STI or possibly be pregnant, then seek advice and testing straight away.
- Recognise that alcohol and drugs can impair people's judgement and lead them to taking risks which they may regret later.

Progress in Sexual Health

There has been a steady increase nationally and in Stockport in sexually transmitted diseases over the last ten years. There has been a particular increase in Chlamydia in the under 25s and there was a particular increase in syphilis in Great Manchester in men who have sex with men in 2004/5. The measures that we are taking in response is the implementation of the national Chlamydia screening programme and steps to improve access to GUM services. Stockport started the Chlamydia screening programme a year late for financial reasons but was 16th nationally in terms of uptake last year so has almost caught up with the national picture despite the late start. .

There has also been a recent increase nationally and in Stockport in cases of HIV. The epidemic in the gay community has been on a downward trend for some time but recently this has been offset by an increase in new cases being transmitted through heterosexual activity. Prevalence in Stockport has increased from about 80 cases to about 135 cases but this increase is not solely due to an increasing rate of new cases, it is also due to increasing survival. There is a problem of late diagnosis of HIV in Stockport and this is being investigated.

In the 1990s Stockport performed extremely well in reducing teenage conceptions but the situation since 2000 has been one of fluctuation without any clear trend upwards or downwards. However this is one area where we have been successful in reducing inequalities but the variation remains considerable. Rates nationally are falling so that, although Stockport remains below the national average, its advantage is being eroded. We are increasing access to choice of contraceptive methods and to target attention on those at high risk. Work in schools remains a priority.

What Works?

Teenage Pregnancy

This is a complex issue that requires a change in both attitude and behaviour of some teenagers. PCTs should continue to support the National Pregnancy strategy. An evaluation of it has shown that it is making progress.

Interventions should focus on ensuring that young people are well informed about sexual matters including contraception, and have easy access to sexual health services that are non-judgmental and confidential. Surveys show that many teenagers are still unaware of services and feel uncomfortable with accessing services and many do not know about their confidential nature. Trust is a key issue. Whenever appropriate, sexual health services should offer long term, highly effective contraception to girls, hand out free condoms and increase awareness of emergency contraception.

Schools have an important role in terms of delivering high quality sex and relationship education and offering a place for walk in services. However the most at risk groups are those that tend to have the least interest in schools. It is important to target and **successfully engage** with the most vulnerable groups to increase knowledge and use of contraception and over time alter attitudes towards sex and teenage pregnancy.

Agencies providing services for vulnerable young people work better together providing multi-component interventions than they do alone, and this can increase efficiency and cost-effectiveness (DfES 2007: 4).

Interventions targeting young people at risk of future poor health outcomes seem rarely to address the range of risk factors associated with these poor outcomes (such as drug and alcohol misuse, NEET, and low attainment) (Thomas et al. 2008). Complex, holistic interventions addressing the wider socioeconomic

context to teenage pregnancy have historically lacked evidence of effectiveness; however a body of good evidence for the effectiveness of youth development programmes in preventing teenage pregnancy is now developing (Harden et al. 2009). The scope to reduce health inequalities and social exclusion is considerable. There have, however, been some notable examples of interventions in this field yielding the opposite of their intended outcomes (e.g. increases in crime, or rates of teenage pregnancy) so it is important that interventions are well evaluated.

Chlamydia Screening

The study evidence underpinning Chlamydia screening is weak. However in theory there is no doubt that identifying and treating a possible source of an infectious disease reduces the spread of the disease.

There is no strong evidence about the best way of increasing coverage of Chlamydia screening. Current advice from the national programme is to aim screening at locations where the target audience of 15-24 year olds are found. Encouraging GPs to offer tests appears sensible as is utilising contacts with sexual health services. Given the lack of study evidence it is appropriate to review local methods regularly with the aim of uncovering the most cost effective and acceptable ways of getting people screened. Sharing experiences and knowledge between services should be encouraged.

Ideally a screening programme should identify and treat all people with Chlamydia in the target population. In the absence of universal coverage Chlamydia screening can maximise case finding by screening those with the riskiest profiles for having Chlamydia. It is possible for a PCT to screen a proportion of its 15-24 year olds to hit the target but fail to screen a large proportion of those most at risk. From the public health perspective the most important indicator for opportunistic Chlamydia screening is the number of cases of Chlamydia identified. PCTs should therefore ensure that coverage is sufficient and that those screened are those in the population that are most likely to have Chlamydia. Although Stockport lags behind other PCTs in chlamydia screening uptake it does not lag behind in number of cases identified – suggesting that our services are well-targetted

**A7. 9 MENTAL
WELLBEING**

Mental 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 some evidence, although not quite as strong for:

A beneficial effect on health of aesthetically attractive surroundings and greenspace

An adverse effect from inequality (ie 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, 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 WEMWBS indicator which is increasingly being used.

Progress on Mental Well Being

Many agencies in Stockport are engaged in work which impacts on well being. The Parks for Health project, building on the previous Health and Greenspace Project, continues to develop opportunities to enjoy greenspace. Aesthetic attractiveness is also promoted by public art and by development control. Counselling services will help people cope with stress and life changes. The Investors in People programme addresses work quality. Schools play a role in helping children develop as confident resilient individuals. Community groups, faith groups and a wide range of voluntary organisations help maintain social support networks.

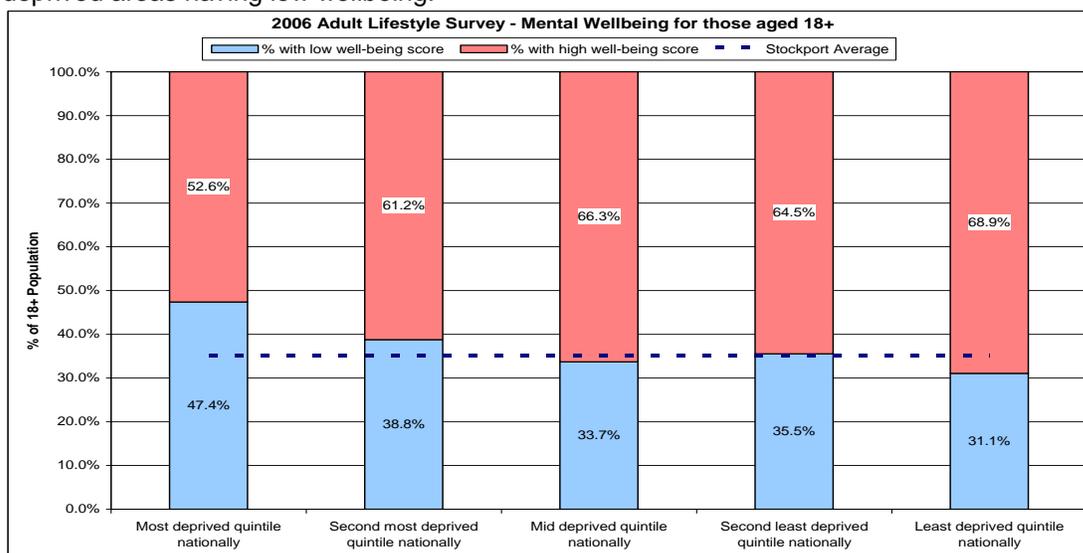
Mental well being was added to our list of public health priorities in 2007.

A review of work that contributes to supporting mental wellbeing across the borough took place during 2008. This identified that the main bodies within the statutory sector and a multitude of organisations in the voluntary and community (third) sector make valuable contributions to mental wellbeing.

Mental Wellbeing –Results from the JSNA

Although the majority of people have positive mental wellbeing there is a significant minority of people whose mental wellbeing status cannot be described as good. It is estimated that 79,300 adults in the area have low mental wellbeing.

Mental wellbeing follows patterns of known deprivation with almost half of adults in the most deprived areas having low wellbeing.



Fewer young adults have positive mental wellbeing compared to the older adult population. Depression, as the mental health condition with the highest prevalence affects more than 20,000 people in Stockport at any one time.

Mental Well Being Strategy

The Foresight Report on Mental Wellbeing (2008) highlighted 5 areas for action to enhance mental wellbeing, presenting these as the equivalent to the 5-a-day message for healthy eating:

Connect ... with the people around you ... family, friends, colleagues, neighbours

Be active ... walk, run, cycle ... find something you can do and enjoy it

Take notice ... be curious ... savour the moment

Keep learning ... something new ... rekindle an old interest ... set a challenge

Give ... do something nice for a friend ... smile ... volunteer

Following the review of the evidence concerning the general and specific approaches to supporting mental wellbeing, the PHPB selected 4 areas as requiring strategic focus in Stockport.

Mental Wellbeing in the Workplace.
Building Social 'connectivity' through Third Sector Activities.
Support for Parents and Early Years Development.
Physical Activity and Green Space

The key messages for each of these areas are below.

Mental Wellbeing in the Workplace

The links between work, health and mental wellbeing are very well established both in terms of working conditions and job control impacting on mental wellbeing and in relation to links between worklessness and health.

Therefore we need to:

Develop (strengthen) strategies on health in the workplace for the PCT and Council

Develop a strong borough-wide programme on health in the workplace with a particular focus on the needs of and benefits to small and medium sized enterprises.

Ensure the integration of physical and mental health support to initiatives on worklessness and supported employment.

Building Social 'connectivity' through Third Sector Activities

The term 'connectivity' is emerging as a useful concept that encapsulates the social elements in mental health and wellbeing. It encompasses the need to understand oneself, to feel connected to other people and to one's environment. Third sector organisations in Stockport have an excellent track record of engaging people in a wide variety of social activities, many of them through volunteering opportunities. These are valuable in themselves in building connectivity, as well as often leading on to further positive results in relation to work and health.

This can include an emphasis on the mental wellbeing of older people, ensuring their wealth of experience is acknowledged and valued, that they remain connected to wider society and maintain their independence.

Therefore we need to:

Expand the support provided to third sector organisations in relation to provision of voluntary activities with a wellbeing focus

Increase the financial security of third sector programmes, for example, by moving towards the use of 2-year rolling contracts

Embed the use of existing third sector networks into consultation and community engagement processes

Support for Parents and Early Years Development

Getting off to a good start in life is essential for the health and mental wellbeing of an individual.

The needs of Looked After Children require special attention to redress multiple disadvantages.

Therefore we need to:

Work across Stockport Partnership to raise awareness of the mental wellbeing elements within all programmes

Embed public health competence into existing programmes and new developments

Support expansion of voluntary sector activities and provision of secure funding

Physical Activity and Green Space

Being active enhances both physical and mental wellbeing. As well as organised activities and sports, there are many other opportunities for people to become more active in their everyday lives. Stockport has a great deal of green space throughout the borough. This means that a majority of people are within reach of such spaces, a factor that is known to reduce inequalities.

Therefore we need to:

Promote access to a wide variety of physical activity opportunities through Stockport Partnership to maximise uptake by the whole population

Work to build the evidence base concerning longer-term change in physical activity levels

Support ongoing development and promotion of access to green space within the borough, especially for those living in disadvantaged areas

What Works?

Commissioning public mental health and wellbeing

The recent consultation document published by the Department of Health 'New Horizons (2009) makes clear that there needs to be a programme of action to advance the twin aims of improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health. The New Horizons programme builds on a number of work streams and strategies, including the Foresight Report on Mental Capital and Well-being.(2008), the Marmot Review(2009) the National Dementia Strategy (2009), the forthcoming mental health and employment strategy and the Bradley review (2009). Although the detail of the programme is under review the new Government has indicated that it accepts the thrust of it.

This reflects the evidence that positive emotions and a sense of contentment can lead to a variety of positive benefits for both individuals and communities. These include better health and health-related behaviours, greater resilience, a greater capacity for creativity and innovation (Hubert et al 2005) stronger social networks and positive relationships and connected communities (Friedli 2008) These are important assets to enable us to adapt to the challenges ahead, particularly those of global economic recession and climate change and their consequences. Improving the mental health and well-being of the population has the potential to contribute to far-reaching improvements in physical health and well-being, a better quality of life, higher educational attainment, economic well-being and reduction in crime and anti-social behaviour (see Box 1).

- ★ Increased quality of life and overall well-being
- ★ Improved educational attainment and outcomes
- ★ Safer communities with less crime
- ★ Reduced health inequalities – both physical and mental health related and lower health care utilisation
- ★ Improved productivity and employment retention
- ★ Reduced sickness absence from work
- ★ Reduced levels of poor mental health and mental illness

Using the local data Stockport NHS and the SMBC with our partners are now in a position to commission interventions that have the potential to be 'more than the sum of the parts'.

Around 50% of lifetime mental illness starts before the age of 14 and continues to have a detrimental effect on an individual and their family for many years (Nurse et al 2009) leading Friedli and Parsonage to emphasise the significance of investing in early years – "from minus 9 months to 18 years" to achieve life time impacts. Strategic mental well-being programmes can lead to early intervention to ameliorate some of this.

Friedli and Parsonage (2007) have suggested that a provisional list of the most important investment areas would include: parenting skills training and pre-school education; health promoting schools; improving employment/working

conditions; lifestyle changes such as diet, exercise and reductions in alcohol consumption; and environmental improvements such as noise reduction and community safety.

The investments identified by Parsonage will be cost effective in the medium term and achieve large financial savings over the life course. They stress also the implications of untreated depression at any age and the implications this has for economic productivity and for physical health.

There is now good evidence that certain interventions are especially valuable as part of an overall strategy that will assist commissioners to achieve the economic and communitarian objectives described earlier. These are distilled into the **ten key examples** offered below.

	Key Examples of Specific Commissioning interventions ('best buys')	Outcomes achievable	Related domains	Delivery mechanisms
1	Universal routine enquiry and targeted treatment for <i>women at risk of depression</i> with home visiting therapist for post natal depression, as part of a package of measures to improve perinatal mental health.	Improved maternal mental health Improved infant and child mental well-being Reduction in incidence of maternal depression	Children and families Adults/Whole Population	Routine enquiry at antenatal clinics and early intervention, signposting to appropriate support. Third sector, maternity and childbirth organisations. Home visiting therapist prescribed by GPs/PBC IAPT programmes
2	Universal assessment of potential parenting problems and targeted <i>early intervention programmes for common parenting problems</i> , including school-based learning.	Improvement in parenting skills Improvements in emotional well-being of children and young people Build social and emotional resilience of young people	Children and Adolescents/Young People Adults/Whole Population	Children's Centres and whole school approaches. Requires well developed partnership working between LA social services, Education and Schools and with third sector community groups.
3	Early intervention programmes with individual home based programmes for conduct disorders	Improvements in emotional well-being of children and young people Improved family relationships Reduced incidence of conduct disorders and related incidents Improvements in educational attainment Reductions in anti-social behaviour and crime.	Children and Adolescents/Young People	Early identification and by Education/Primary Care/LA with fast track to appropriate interventions and support.
4	Build social and emotional resilience of children and young people through whole school approaches	Improvements in emotional well-being of children and young people Greater self esteem Positive impact on lifestyle choices in relation to smoking, drinking substance use and sexual behaviour Improved mental health awareness Reduction in incidents of bullying and conduct disorder	Children and Adolescents/Young People	Whole school approaches Sure start PCTs encourage NHS Trust to liaise closely with Education and youth services
5	Interventions to increase opportunities for participation, personal development and	Improved mental well-being and resilience	Adult/Whole Population	Social prescribing by GPs/PBC and local third sector.

	Key Examples of Specific Commissioning interventions ('best buys')	Outcomes achievable	Related domains	Delivery mechanisms
	problem-solving- specifically volunteering, including timebanks, exercise arts and creativity, learning and educational opportunities, green activity, bibliotherapy, employment and debit advice. Community development and empowerment	Increased levels of social support and community activity Increased opportunities for meaningful occupation locally Reduced demands on primary care Reduced levels of antidepressant prescribing	Older People	Place shaping role of LAs to create opportunities for people to come together and build community assets
6	Integrate physical and mental well-being through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity. This means that key groups may need to be specifically targeted, for example people with a mental illness or learning disability, older people and pregnant women.	Improved overall physical fitness and wellbeing Improvements in physical health leading to improved mental well-being Reduction in demand on primary and secondary care	Adult/Whole Population Older People Vulnerable Groups	Ensure primary care connects mental and physical health – and work with acute trusts, FTs, local authority programmes, schools and FE/HE providers. Establish <i>social prescribing programme to encourage physical activity</i> , sport and exercise for older people especially (e.g. dance, gym, walking). Work with PBC and third sector organisations, private gyms and local clubs. Requires a multi-agency approach with good local communication.
7	Improve working lives by: Early intervention to reduce risks of unemployment through primary care and Job centres. N Support NHS, LA and Third Sector organisations offering locally based interventions to improve healthy working lives and support occupational health schemes.	Improved working conditions and employee relations. Reduced levels of sick absence rates.	Adult Vulnerable Groups	Ensure primary care connects mental and physical health – and work with acute trusts, FTs, local authority programmes, schools and FE/HE providers
8	Implementation of initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse.	Improved mental well-being and resilience Improvements in relationships and may impact on lifestyle choices	Children/Young people Adult/Whole Population Vulnerable Groups	

	Key Examples of Specific Commissioning interventions ('best buys')	Outcomes achievable	Related domains	Delivery mechanisms
9	Ensure access to psychological therapies, including CBT, for people with long term conditions, disabilities and carers	Improved levels self reported psychological well-being and overall functioning; Reduced demand on primary care.	Adult/Whole Population Older People	Work with NHS Trusts, Practice Based Commissioning groups, and third sector organisations. Social prescribing Extend IAPT
10	Early intervention and targeted approaches for high risk groups, including suicide reduction programmes <i>Facilitate registration with GPs for homeless people;</i> Education programme for GPs to detect depression	Reduced isolation. Reduced substance use and mental health problems. Reduced levels of self harm and suicide	Vulnerable Groups	Training and workforce development Addressing stigma Partnership working to implement suicide reduction programmes Involve third sector organisations in developing social inclusion programmes.

Cost effectiveness of mental wellbeing interventions

Early intervention with Conduct and Emotional Disorders. Total value of benefits of prevention from treating a one year cohort of children with conduct disorder is estimated at £5.2 billion.

Promote good mental health as well as social & emotional skills in childhood (especially those with conduct disorders). Estimated lifetime benefit of £115,000 per case of child with conduct disorder. Cost savings for mental health promotion are £75,000 per case. Total value of benefits of prevention of promoting positive mental health in a one year cohort of UK children is £23.25 billion.

Early Intervention is cost effective in reducing the risk of re-offending: Every £1 spent on a prevention programme for those at risk of offending saves £5.

Later targeted parenting programmes with children with emotional and conduct disorders. (e.g. Triple P or Functional Family Therapy). Programmes cost £639-3,839 but a total cost of a child with conduct disorder is £70,000 by 28 years of age.

Family Intervention Programme: Cost of programme £8-20,000 compared to costs, if no intervention, of £250-350,000.

Refer and treat alcohol misuse problems in perpetrators of violence across health and CJS systems. Alcohol is a key risk factor for carry out and being a victim of violence and abuse. For every £1 spent on treatment, the public sector saves £6.

Cost Effectiveness of outcome focussed Interventions (UCLan 2009)

Suicide Prevention

Suicide prevention is important especially in terms of life years lost and requires a broad array of suicide prevention strategies addressing different risk factors at different levels. Such a strategy should be in line with national guidance. Even though evidence is not robust, interventions to support **high risk groups** such as those discharged from mental hospitals can be supported. Similarly, identifying “hot-spots” and common ways to commit suicide and undertaking pragmatic actions to reduce these risks is sensible. Although some particular risk factors can be identified, suicide occurs in all population groups and targeting one group will not substantially impact upon the total number of suicides in a PCT.

Suicide is a rare event and the role of contact with health professionals is limited. However the NHS should be at the forefront of creating positive attitudes towards mental health and supporting those with mental health problems.

In terms of targets it is important to note that in a PCT size population there will be about 45 deaths from suicide a year the 95% confidence interval around 45 is from 33 to 60 (assuming Poisson distribution). This means that the suicide rate for an individual PCT will vary substantially from one year to the next due to chance variation.

There is no strong evidence to support screening for risk factors.

It is often suggested that greater safety measures at suicide ‘hot spots’, and safety measures on railways are obvious preventive measures but measures which cannot be circumvented may be hard to implement. Measures to prevent impulsive suicides may include

reporting guidelines to prevent imitative episodes of suicide

Further limiting quantity and packaging of paracetamol

Limit size of individual prescriptions and dose per tablet of high risk drugs.

Regular reminders of media guidelines on the reporting and showing of fictionalised suicide.

Targeted Interventions:

Consider strategies and research into means of reducing suicide in those recently discharged from psychiatric care.

The Big Society

The Prime Minister has described the concept of a big society – a society in which people are empowered, involved and mutually supportive. The Secretary of State for Health has indicated the need to address the cultural determinants of health, to stop presenting unhealthy behaviour as the norm but to present health as the norm and to understand and influence the social forces that lead people to adopt unhealthy behaviours.

This approach fits very much with the locally preferred approach to public health in Stockport – the neighbourhood-oriented empowering community development approach which we applied so successfully in the 1990s and which we were increasingly distracted from in the first decade of this century by nationally dictated initiatives.

Our biggest public health threat is alcohol. At the end of the alcohol section of this report I pointed out that the alcohol problem could reflect a deeper malaise. As the Secretary of State put it in his speech to the Faculty of Public Health in July of this year

Public health efforts, which only try to control supply, will fail. We have to impact on demand. That means we have to change behaviour, and change people's relationships with each other and with drugs, alcohol, tobacco and food.

And where behaviour change has been the aim of recent initiatives, the outcomes have been patchy at best.

It seems to me that awareness campaigns have too often sent the wrong messages – when they're screaming at you to drink less, many people are just having their behaviour reinforced – the message doesn't come out as 'drink less' but as 'everyone drinks, so don't worry about it'. It tells people that the norm in society is misuse of alcohol.

How often have all of us been frustrated by a system which 'does' alcohol, drugs, smoking cessation, STIs, and obesity, but doesn't seem to get it that there may be an underlying reason, or a set of factors, why our young people develop a dependent or distorted relationship with drugs, alcohol, tobacco, food or sexual relationships in the first place.

Common factors like dysfunctional families, poverty, worklessness, weak family and community structures, lack of good parenting, or mental illness are all identifiable causes. But, most of all, I would argue that the reason underlying all of this, especially amongst young people, is a lack of self-esteem.

Just as leadership drives organisational success, so self-esteem drives personal fulfilment.

I agree with this fundamental statement by the Secretary of State.

Empowering people to have the self esteem to take charge of their own lives and their own communities is a central feature of community development and it is also a central feature of many of the theories of well being. Public health is not about a nanny state. It is about an inspirational state that holds out to people the taste of nutritious food, the refreshing well being that follows physical activity, the joy of giving and the fellowship of social interaction and communal endeavour.

**A7.10 SCHOOLS,
CHILDREN AND YOUNG
PEOPLE**

8. SCHOOLS / Children / Young People

The table below outlines the initiatives which would be worthy of further investment.

Public health initiative	Evidence of effectiveness (key reference/s)	Evidence of cost effectiveness?	Recommended in policy / guidance documents? If yes, which.	Health impacts short, medium or long term?	Impact on health service utilisation?
Child Accident Prevention.	The evidence for what works in this area is being developed. NICE are currently doing a series of evidence reviews.	Not yet developed.	Healthy Child Programme (pregnancy to 5 years), DH, 2009.	Medium.	In 2008 / 2009 there were 784 admissions to hospital of Stockport children (0 – 17) due to unintentional and deliberate injury. At SHH in 2008 / 2009 there were approximately 9000 attendances of children (0 – 16) due to accidents. There is a bias towards areas with high levels of deprivation. A proportion of these will be preventable.
School nursing (public health role). NHS Stockport invests in school nursing but currently due to pressures on the service it is able to deliver little of the broader health promotion role. (note that I have drafted details of what that role	Healthy Child Programme (0 – 19). This is a recommended evidence based programme to be delivered by multi agency school	Not specifically stated. The Healthy Child Programme takes the position that costs can be saved by investing in what has been	Healthy Child Programme (5 – 19 years), DH 2009.	Medium and long term.	Instilling health patterns in children and young people has the potential to reduce childhood illnesses and also instil patterns of healthy behaviour which can reduce rates of long term conditions in later life

would involve)	health teams. It is recommended that the teams are led by school nurses. The school nursing capacity is currently not sufficient for them to fulfil this role. The programme also recommends similar teams in colleges. Currently NHS Stockport doesn't invest any resources in nursing capacity in colleges.	shown to work.			(e.g. CHD).
Unicef Baby Friendly Initiative (community award). Promoting breastfeeding is a role of the health visiting service but progression BFI would require a dedicated worker within the service.	World Health Organisation / Unicef (1989) published a 10 step evidence based plan for successful promotion of	Breastfeeding has been shown to have numerous benefits which will reduce costs to the health economy including reductions in	Healthy Lives, Brighter Futures, 2009 Healthy Child Programme (pregnancy to 5 years).	Short, Medium and Long Term.	It is recommended that babies are exclusively breastfed until they are 6 months old. Breastfeeding provides all the nutrients a baby needs for healthy growth and development during the first 6 months of

	<p>breastfeeding. This is the recognised international gold standard. It has been adopted as the recommended template in the UK. Numerous studies have shown that BFI is associated with significant increases in breastfeeding initiation and maintenance (e.g. Presad and Costello 1995, Catteano and Buzzetti 2001, Kramer et al 2001, Philipp et al 2001, 2003).</p>	<p>childhood infections, obesity in later childhood and juvenile onset diabetes. It can also reduce the risk of developing pre-menopausal breast cancer. (Infant feeding Recommendations, DH 2004. North West Breastfeeding Framework for Action, NW Regional Public health group, 2008)</p>		<p>life. Breastfeeding has been shown to have numerous benefits which will reduce health service use including reductions in childhood infections, obesity in later childhood, juvenile onset diabetes. For the woman it can also reduce the risk of developing pre-menopausal breast cancer.</p>
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Disenfranchised, out-of-school young people can have a range of health problems (smoking, alcohol and drug abuse, unintended pregnancy, sexually transmitted diseases, suicide, sexual and economic exploitation, eating disorders, violence, and poor life chances). The evidence suggests that successful programmes can tackle these tough challenges:

1. **Address not only the behavioural issues of young adults themselves, but also environmental factors** (social and economic conditions) and social norms that greatly influence behaviour. Young people's immediate social needs must be met, and they may need much practical assistance regarding housing and money, and training in coping skills and interpersonal negotiation
2. **Involve gatekeepers and stakeholders** at the outset, i.e. key opinion-formers and community leaders
3. **Involve young adults in all aspects of the interventions** to enable their needs and wants to be well understood. More effective messages and materials to be designed and greater insights to be gained into the contexts within which young people practice behaviours (social marketing techniques are invaluable here). The use of peer educators has been very successful. Involving young people directly provides ownership of the project by the target audience, generating a sense of the urgency and importance of the issues
4. **Participatory approaches** harness the creativity, energy and resourcefulness of young people and getting involved in itself promotes their health
5. **Seek to influence parents** and other social role models
6. **Mobilise communities** to provide alternative attractive places to go and things to do, including alcohol-free clubs, sports, crafts, music-making etc.
7. **Open up cultural, religious and societal dialogue** about key adolescent health issues to shift community norms and provide opportunities for marginalised young people
8. **Invest in support networks** and training activities throughout the life of the project
9. **Provide access to the necessary products and services** to practice the behaviour change, e.g. condoms, counselling services, clean needles
10. **Provide services that are confidential**, with staff trained to deal with young people, convenient opening hours, accessible to transport etc.

The most effective projects are born out of important community alliances. They involve some combination of non-governmental organisations, health and education teams, individual youth, local clubs, sports organisations and other cultural groups. Any one sector or group could not possibly have reached a group of young people as dynamic and complex as those who are out-of-school. Only cross sector collaborations ensure that access is gained and impact can be achieved.

(Source: Guide for World Class Commissioners – Promoting Health & Wellbeing: reducing inequalities RSPH 2010)

A7.11 MAJOR KILLERS

Major Killers

Key messages

HEART DISEASE

Heart disease was the biggest killer in the 1990s but as heart disease death rates fall cancer replaced it as the biggest killer around the turn of the century.

Heart disease is caused by smoking, low fibre high fat diets, lack of exercise, and genetic predisposition. Diabetes, high blood cholesterol are major predisposing factors. Stress is also a contributory cause. Moderate consumption of alcohol protects against it, as does aspirin, statins and other measures to reduce cholesterol, and eating fish (especially oily fish).

A cardiovascular risk factor screening programme was introduced in Stockport in 1990. This identified people who had high blood pressure, high blood cholesterol or lifestyles that seemed likely to induce heart disease. Lifestyle advice, statins for high blood cholesterol and treatments to address blood pressure were given.

Smoking, nutrition and physical activity have been tackled as described above in “progress on smoking” and “progress on obesity”.

As well as these local activities there has been a great deal of national attention paid to disseminating information about heart disease prevention.

There has also been considerable improvement in the treatment of heart disease including the introduction of “clot-buster” thrombolytic drugs.

From this combination of factors heart disease death rates have fallen steadily and substantially over the last decade and a half.

- We are reviewing the cardiovascular risk factor screening programme to improve its effectiveness
- The steady progress in cardiology treatment will continue
- Smoking and obesity will be addressed as already discussed.

CANCER

Cancer has been the biggest killer since the start of the century.

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

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

Breast cancer and testicular cancer are two of the very small number of diseases that are most common in the most affluent. Delayed childbearing contributes to breast cancer. Cervical cancer is commonest in women who have multiple sexual partners or who work in oily or dirty surroundings or with biological material or whose partner does any of these things. Skin cancer is increased by overexposure to sun. Gastrointestinal cancer is predisposed to by low fibre diets or by physical inactivity. Oesophageal cancer is increasing

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

The most common cancer is lung cancer and the largest single cause of lung cancer is smoking. Progress in addressing smoking has been given above in the section "progress on cancer".

Breast cancer, the commonest cancer in women, has been addressed by screening to detect cancer early and treat it before it spreads. Cervical cancer has been addressed by a screening programme which is intended to identify a precancerous condition of the cervical cells and eliminate it before cancer can develop at all.

Recently there has been considerable attention to the clinical pathway for cancer with the objective of ensuring that people receive the best available treatment without unnecessary delay.

Cancer death rates have fallen but not to the same extent as those for heart disease.

- Work on improving the cancer clinical pathway will continue
- Late presentation in deprived areas and amongst men are a major problem and we need to find ways to overcome this
- Smoking will be addressed as already discussed.
- We will continue to work to improve uptake of breast cancer and cervical screening
- The introduction of HPV vaccination will eventually reduce cervical cancer dramatically
- Bowel cancer screening is being introduced.
- There is discussion of prostate cancer screening but the rates of false positives and false negatives and the slow natural progress of the disease have led nationally to the conclusion that this would not be desirable.
- Our alcohol strategy will contribute to addressing mouth, stomach and oesophageal cancer.

ACCIDENTS

Accidents are not a major killer in terms of the numbers of deaths but, because they are the largest cause of death in young adults they are significant in terms of the number of years of life lost.

Most accidents occur in one or other of four settings - on the road, at work, at leisure or at home. There are some accidents in other settings - rail, air or weather accidents for example - but the four main settings account for almost all of them.

Some accidents are genuinely unavoidable. Others, such as bad luck with the inherent risks in excitingly dangerous activities such as mountaineering or motor racing, are avoidable only by constraining the human spirit. But many have readily avoidable causes, such as alcohol, failure to warn about and protect against hazards, unsafe systems of work, defective equipment, inadequate training, inexperience in children and young people, binge drinking in young people, short cuts taken for convenience or profit, people taking unnecessary risks out of bravado, carelessness, lack of knowledge, misjudgement of risk, lack of self worth, familiarity breeding contempt, absurdly risk averse safety procedures which discredit the concept of safety and lead people to ignore advice (the "cry wolf" syndrome), poor housekeeping in workplaces, failure to appreciate hazards in the home, including fire risks, unsafe storage of dangerous substances, or unsafe equipment and furniture, especially where deprived households buy cheaply.

A variety of agencies are responsible for accident prevention. Road safety has been pursued in Stockport by a number of local engineering schemes addressing accident hot spots. Across Greater Manchester it has been pursued largely by speed cameras. Industrial safety is the responsibility of the Health & Safety Executive which has pursued a bureaucratic style of hazard-removal that has earned some public opprobrium. A variety of information campaigns have been conducted on home safety by police, fire and environmental health authorities. Product safety has been a major element of the work of trading standards.

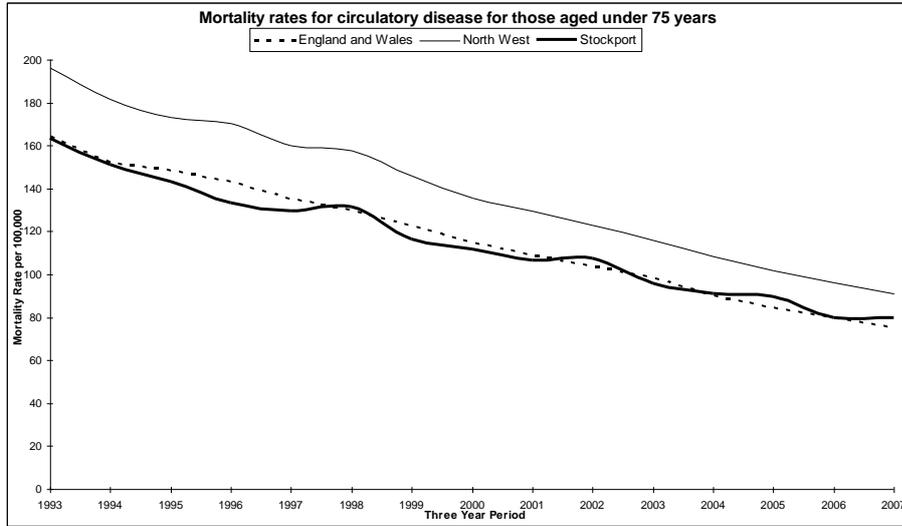
Accident mortality has remained stubbornly resistant to these processes. It should be noted that the mortality rates quoted are for deaths of people resident in Stockport whereas local

activity would be better assessed by rates based on where the accident occurs. No such statistics exist for overall mortality as there is no population estimate for people physically present in particular areas and NHS data sources do not record the site of the accident. Such rates do however exist for road accidents and for industrial accidents and are showing improvements, although there are some doubts about data quality.

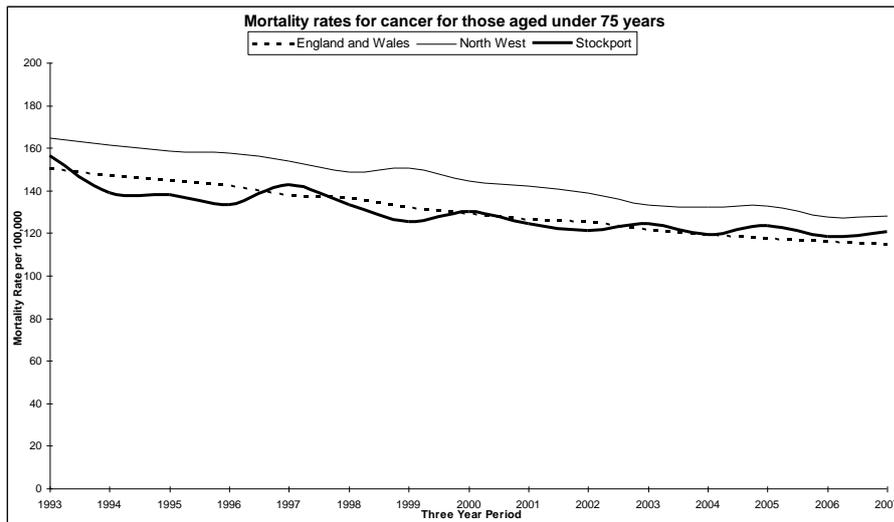
- At Greater Manchester level a Casualty Reduction Partnership has been set up to develop a comprehensive approach to road safety. This will include approaches based on neighbourhood regeneration and community development as well as traditional engineering and enforcement approaches.
- We need to have a safety culture rather than a risk averse culture. In a safety culture people who climb mountains follow good safety practice, use modern equipment which has been properly tested, have good communication systems so that help can be summoned, are properly trained and know their limitations, contribute to maintaining a mountain rescue service and keep an eye on the weather. In risk averse cultures 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, they 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. It is noticeable that the growth of risk averse health and safety systems in the late 1990s and the start of this century corresponds to an upturn in what was previously a declining accident mortality.

Major Killers- Trend Summary

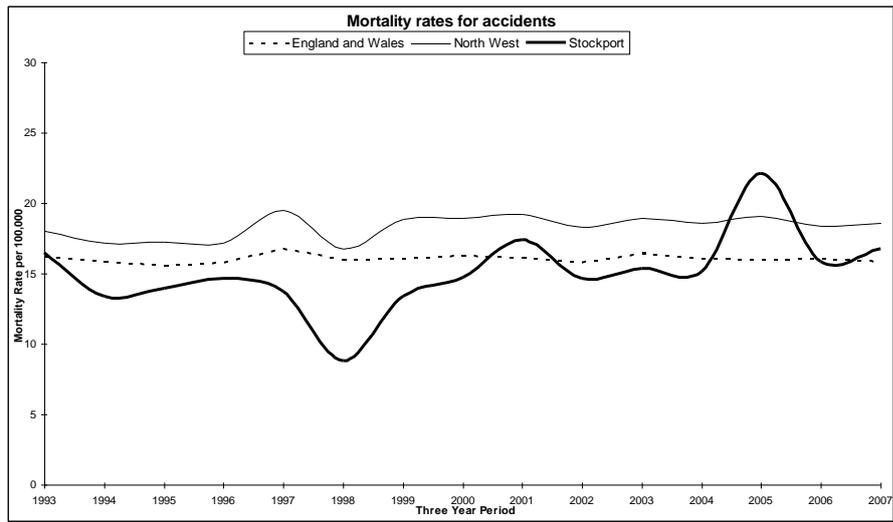
HEART DISEASE



CANCER



ACCIDENTS



All mortality rates shown on this page are age-standardised.

**A7. 12 RECESSION AND
HEALTH**

RECESSION AND HEALTH

Key Messages

Recessions have a number of negative effects on health

Unemployment is harmful to health. Work provides income, structure to the day, social contacts, status, sense of identity, sense of contributing to society. For every 2,000 unemployed people each year there will be two extra deaths caused by unemployment in those people themselves and one extra death amongst their spouses.

Fear of unemployment is harmful to health and so is fear of other adverse life changes affecting personal identity such as loss of house or loss of status

Quality of work often deteriorates in recession

So does employment of disabled people

Household incomes suffer and poverty increases, not only as a result of unemployment but also due to other changes

Those running businesses are likely to suffer severe stress

Economic instability will subject many families to severe stress and to unpleasant life changes

The way recessions are handled can add to these problems if

There is a relaxation of pressure for good employment practice, health and safety and environmental awareness

Unemployed people are isolated and stigmatised

Public services are cut to balance the budget.

Comparisons between Spain and Sweden have shown that strong welfare states mitigate the health impact of recession.

Comparisons between different Soviet republics and Warsaw Pact countries during the economic dislocations that occurred in the run up to and aftermath of the collapse of the Soviet Union showed that serious impacts, including deteriorating life expectancy due to alcohol related diseases occurred in many of them, especially European Russia and the republic surrounding it but that others experienced little or no health impact. The determining factor was the strength of community networks – countries where over 45% of the population were members of clubs or societies did not experience any adverse health impact.

Cuba, a country with very strong community organisations, experienced the worst economic impact of any country but showed an 18% improvement in mortality due to less use of motorised transport and consequent increased physical activity. This shows that recessions can also have beneficial health impacts by reducing the pressures of urbanisation, exposure to unhealthy working conditions and unhealthy consumption patterns. Most 20th century recessions have shown improvements in deaths from traffic accidents. In the 19th century recessions were associated with reduced mortality because of the reduced exposure to uncontrolled working conditions and the consequences of urbanisation. Quality of work and quality of living conditions are therefore important and one of the dangers of recession is that they might be neglected.

**A7. 13 HEALTHY
AGEING**

HEALTHY AGEING

Key Messages

It is often said that increasing life expectancy leads to a greater need for care in old age and therefore inevitably creates financial pressures on the NHS. However this does not follow. It is the gap between healthy life expectancy and life expectancy which creates the pressure for more services to care for older people.

If life expectancy is 60 and healthy life expectancy is 55 then, dependent on population structure, about one twelfth of the population will be demanding care for frail dependent old age.

If life expectancy is 80 and healthy life expectancy is 75 that figure reduces to one in sixteen. But if healthy life expectancy rises only to 70 then at a life expectancy of 80 the figure instead increases to one in eight.

Achieve a life expectancy of 90 with a healthy life expectancy of 89 and care of the frail dependent elderly only affects one in ninety – it becomes less prominent in the health economy than care of diabetics. We could afford to do it superbly.

It follows that promoting healthy ageing is an essential part of the process of accommodating to an ageing population and if we do not do it effectively we will find it difficult to afford the consequent burden of caring for those whose ageing we have failed to support.

Some countries are successfully achieving increases in healthy life expectancy that are greater than the increases in life expectancy ie not only are they lengthening life but they are also shortening the period of dependency at the end of it. The UK is not being successful in this goal.

Healthy ageing is promoted by:

remaining active – the longest lived cultures in the world all evidence physical activity every day

retaining a meaningful role – the longest lived cultures in the world all value older people or create a strong sense of self which survives into old age

expecting good health in old age – one of the commonest causes of curtailment of healthy life expectancy is the acceptance of treatable conditions as “old age”

persisting with healthy lifestyles – American evidence has shown that lifestyle changes are still effective in improving health in older people – it is not true that it is “too late”

Our society is bad at all four of these

We are becoming increasingly inactive with increasing obesity as a consequence. Our perception of old age is still a perception of dependency. We have tended to focus lifestyle advice on younger people. There is still amongst our people and our health professionals too great a tendency to say that any symptom after the age of 65 (or perhaps even 60 or 55) is “just old age”. **A key priority is to further within our health service understanding of the muted presentation of illness in old age as functional deterioration (declining mobility, increasing confusion) and increase commitment to seeing those as symptoms that need investigating for a treatable cause so that people are not confined to a dependent old age for lack of treatment of a treatable condition.**

**A7. 14 THE MARMOT
REPORT**

THE MARMOT REPORT

Sir Michael Marmot is a distinguished academic who has chaired Commissions writing reports on the social determinants of health for the World Health Organisation and on inequalities in health for the British Government. The latter commission also included the President of the Royal College of Physicians, Professor Ian Gilmore, and the Chief Executive of the Economic and Social Research Council, Professor Ian Diamond,

His reports show that inequalities in income are an important element in health inequality. Moreover this is not simply an issue for poor and deprived areas; if the population is ranked by decile of income, mortality is less with each rung of the ladder. However this relationship is not simply that more income is better for health. If countries are compared then above a level of income which all Western European and North American societies have long surpassed GDP per capita ceases to influence life expectancy – it is inequalities within those countries which have a greater effect. Cuba, a poor country economically, has life expectancy which is equivalent to North American countries.

His report contains a striking indication of the impact of early life on inequalities in life chances. Considering two children, one of above average intelligence born to a poor family and one of average intelligence born to an affluent family the latter will exceed the educational attainment of the former by the age of 7.

The review estimated the cost of health inequalities in England:

Productivity losses of £31 – 33 billion every year

Lost taxes and higher welfare payments in the range of £20 – 32 billion per year

Additional NHS healthcare costs well in excess of £5.5 billion per year

The review also predicts an increase in the cost of treating the various illnesses that result from inequalities. Obesity alone to rise from £2 billion per year to nearly £5 billion per year by 2025

Sir Michael considers that the pursuit of greater equality of health is a moral issue. He believes that if humanity has the power to prevent widespread premature death it has a duty to do so and should not sacrifice that duty to private greed.

The review calls for health inequalities to sit alongside tackling climate change as one of society's core priorities. Creating a sustainable future is, the review argues, compatible with action to reduce health inequalities: sustainable local communities, active transport, sustainable food production, and zero carbon houses will all have health benefits across society.

The six main recommendations of the review are:

Giving every child the best start in life

Enabling all children, young people and adults to maximise their capabilities and have control over their lives

Creating fair employment and good work for all

Ensuring a healthy standard of living for all

Creating and developing sustainable places and communities

Strengthening the role and impact of ill-health prevention

**A7.15 CONCLUSITONS,
RECOMMENDATIONS AND
ORGANISATIONAL
RESPONSES**

CONCLUSIONS, RECOMMENDATIONS & ORGANISATIONAL RESPONSES

There is macroeconomic evidence supporting the importance of public services to health. There is clear need for investment in programmes to address deprivation. There are undoubtedly unmet needs and requirements for quality improvement in existing public services. Public expenditure is likely to be cut substantially in the next few years with the NHS experiencing little growth in real funding and other areas experiencing cuts which, across the unprotected departments as a whole will average 25%. Although the NHS will enjoy a degree of relative protection the challenge will still be substantial and our protection will place greater burdens on other health-relevant services such as our local authority partners. It is therefore both an opportunity and a challenge for the Council / Health Partnership in Stockport. It seems likely therefore that in order to address all of these issues the NHS in Stockport may need to achieve efficiency improvements of as much as 30% (10% reduced funding due to anomalies in the inflation calculation, 10% improvement and growth without new resources, and 10% resources released for new programmes). The Local Authority is likely to face an even greater challenge. There is no evidence that such an efficiency improvement has ever been genuinely achieved by conventional budgeting. There is however some evidence from Australia and Japan that changes of this order might be feasible by participative methods which involve service users and staff in radical redesign

I recommend that

Participative methods involving service users and staff be used to pursue a strategy of making services better and less costly

Stockport MPs and political parties understand and address the extent to which transactional inefficiencies result from the current model of public sector finance and regulation

[Insert click to organisational response](#)

It is impossible to ignore the public sector pay bill when making changes of this kind. At the same time it is impossible to get the necessary degree of staff involvement if pay and conditions are under threat and redundancies are planned. There is strong evidence that for most workers (all but the very lowest-paid) job security, more autonomy and involvement in the planning of their work and a better work/life balance would make a greater contribution to their health and well being than more pay.

I recommend that in the public services (and in other sectors experiencing similar situations)

Employers aim to contain the pay bill more by reducing hours worked and wte establishment and less by reducing numbers employed or pay rates

Unions seek to maintain job security and obtain a better work/life balance rather than increasing take home pay

[Insert click to organisational responses](#)

A stitch in time saves nine and it is important to consider how far earlier interventions in pathways can save money further down the line. Screening programmes and secondary prevention play a part here. There is evidence, from

South Yorkshire and locally, of a strong positive impact of properly organised risk factor screening in primary care .Marmot has recommended attention to whether general practices are achieving their expected uptake of secondary prevention and whether their chronic disease registers are missing cases that would be expected from normal prevalences. (See also the later comments about healthy ageing).

I recommend that

Investment in health improvement continues to be recognised as a key element of the financial strategy not only because it is valuable in its own right but also because of its contribution to reducing future costs

All agencies should aim

To protect spending on preventive services

To project substantial further investment in preventive services when financial stability is achieved

To recognise the urgency of addressing the alcohol epidemic

Both before and after the availability of further funding to make all preventive services better and less costly and invest savings in expansion

In each clinical pathway and local government process steps should be taken to identify the burden on later stages of the pathway created by failures earlier in the pathway. There are a number of examples that deserve attention and the following are given only as examples

We should consider how far failures of heart disease prevention are the cause of our high rates of expenditure on cardiac services and also of the poor outcomes

We should consider how far failures to treat kidney disease at stages 1 and 2 creates demand at stages 3 and 4

We should consider the potential of HPV vaccination and tobacco control to reduce expenditure on cancer treatment

We should consider whether more vigorous chlamydia screening will diminish demand in areas like infertility

We should consider how far the “Supporting People” housing programme reduces adult social care spending on institutional packages and NHS spending on hospital admissions

We should pursue a programme as recommended by Marmot for ensuring that practices achieve their expected uptake of secondary prevention and prevalences on chronic disease registers

[Insert click to organisational responses](#)

There is good evidence that effective investment in tobacco control produces early benefits from reduced health care expenditure and that the most successful programmes (those in California) build up to a return of 50 times the investment with less effective programmes developing returns in the region of 20 to 30 times. The Californian programme is effective in inner city areas as well as in other parts of the state. A large part of the savings accrue within three years. Indeed savings are already observable from the smoking ban.

The British programme, with its emphasis on smoking cessation support rather than on measures to tackle tobacco control, is unbalanced and therefore likely to be less effective. The most effective programmes include community programmes to change normative behaviour and also include robust and controversial challenges to the way that tobacco companies attract people to addiction for commercial benefit.

I recommend that

Smoking cessation programmes be maintained. This recommendation is without prejudice to the implications of their incorporation into a comprehensive lifestyle service.

There be a commitment additionally to develop new local community initiatives (similar to Brinnington Lose the Fags) challenging smoking norms in local cultures as part of the existing community development, neighbourhood regeneration and health trainer initiatives

Existing communication resources be deployed to develop and promote robust messages critical of the tobacco industry

Stockport MPs and political parties debate the feasibility of a special supplementary tax on cigarettes to fund anti-smoking social marketing (akin to the 5 cents a packet tax that funds the California community and anti-industry initiatives)

Stockport NHSFT should expand its lifestyle services and agree with NHS Stockport to fund this by the decommissioning of the capacity to be saved in consequence

There is good evidence of the effectiveness of programmes which allow young people to understand the way that they are enticed into becoming addicted to tobacco. However that there is also evidence that programmes aimed at young people are less cost-effective than programmes aimed at adults but visible to young people, the reason for this being that young people take up smoking to demonstrate their adulthood so they are more likely to be influenced by addressing them as adults rather than as children.

I recommend that steps be taken to ensure that the programmes referred to in my previous recommendation are visible to young people and that discussions take place with the Youth Council to that effect

American evidence suggests that the proportion of young people's uptake of smoking attributable to the presentation of smoking in films as normal is 50%. It is plausible that the British proportion will be higher as America does not have our stringent advertising bans. However the British Board of Film Censors refuses to accept that this means that smoking in films is "harmful to young people" even though it is hard to see what could be more harmful than taking up the use of a product which will kill one in four of those who use it in the way the manufacturer intends (the only lawful product of which any remotely similar statement could be made).

I recommend that

Stockport MBC declare its willingness in principle to regard smoking in films as harmful to young people and to apply a local 18 category to films in which it takes place excessively, is inappropriately emphasised or is associated with positive role models. It would be legally sensible if, when it considers this recommendation its also considers the evidence on which it is based. It would be practically sensible if, before implementing it, it carefully considered the practicalities and it would be very sensible if that consideration took place at city region level in conjunction with an alliance of similarly-minded authorities

Stockport MPs and political parties debate the rationality of the British Board of Film Censors' refusal to act on this issue

Stockport Youth Council considers establishing links with young people in Liverpool campaigning on this issue

Alcohol-related diseases are a major contributor to inequalities in health and the main reason for the deteriorating health of young middle aged women which explains why inequalities in life expectancy are not improving as fast or as consistently as inequalities in age-standardised mortality rate. Potentially this is a very serious problem for the future – if the deteriorating health of young middle aged women continues as the cohort ages it will not be long before it starts to impact on age-standardised mortality and on life expectancy overall (rather than, as at present, only on inequalities in life expectancy).

There is good evidence of the effectiveness of brief interventions by health professionals and of arrest referral schemes. On a population level there is good evidence of the harm caused by the availability of very cheap alcohol and of the development of harmful drinking patterns in response to this.

Salford has saved admissions worth £1.5 million at tariff by investing £660,000 in a hospital alcohol nurse and assertive outreach services. Benefits accrued within 12 months. However unless the capacity saved can be decommissioned rather than re-used the saving to the health economy as a whole is only about £200,000

I recommend that

Stockport MPs and political parties support a minimum price for alcohol
Stockport Licensing Committee continues its participation (which I commend) in Greater Manchester discussions about the role of licensing in addressing the alcohol epidemic

Councillors on Stockport Licensing Committee bring their frustrations at the efficacy of licensing laws to the attention of their political parties and MPs

Stockport MBC continues to participate in the Greater Manchester discussions about possible bye laws relating to the sale of alcohol

Arrest referral should become a normal part of police practice

Brief interventions should become a normal part of NHS professional practice in areas such as A&E and maternity

We should invest to reduce waiting times in the alcohol team

We should ensure that there is an adequate range of activities alternative to drinking available to young people for recreation and social life

The Youth Council should debate alcohol

We should approach alcohol as an established epidemic containing the seeds of an impending disaster

Stockport NHSFT should introduce an alcohol service on the Salford model and should negotiate with NHS Stockport arrangements to fund it by decommissioning the capacity it is to replace,

Risky behaviours. There are common psychosocial issues underlying many unhealthy behaviours. This is particularly true in relation to ‘recreational’ drug and alcohol misuse and sexual health issues, where the risky behaviours are often engaged in simultaneously, and the underlying issues around wellbeing, such as self esteem and locus of control, are largely the same. Interventions to improve wellbeing, promote empowerment, and provide structured activity have been shown to be protective against a range of risky behaviours and should be provided alongside traditional approaches aimed at providing information and advice and treating dependency

See later recommendations on well-being

Prevention and healthy ageing carry considerable scope for reductions in health service demand. An analysis of the theoretical impact of healthy ageing was presented as part of last year's Annual Public Health Report and we are now doing analyses to see if the theoretical predictions are borne out – so far it has seemed that they have been.

I recommend that

Programmes of promoting more active old age be developed and receive investment building on the excellent start made by the Prevention Sub Group of the All Our Tomorrow's Partnership

There be a programme across the health economy for ensuring that the NHS and social services do not render people prematurely dependent by overlooking treatable illness in late middle age and old age and wrongly regarding them as ageing

There be a programme in the areas with the lowest healthy life expectancy to raise public expectations of health in late middle age and early old age

Physical activity programmes should not exclude people in late middle age and early old age. Indeed the maintenance of physical activity as late into the ageing process as possible seems likely to be particularly effective in reducing expenditure on care for long term conditions

Local MPs and political parties should oppose discrimination against older people in employment

Physical activity is a major contributor to good health. There is evidence for the effectiveness of measures to promote physical activity. Brief interventions for physical activity in primary care cost between £20 and £440 per QALY. This contrasts with the £30,000 per QALY which is NICE's current cost-effectiveness cut off for health care spending and the £10,000 to £17,000 per QALY of statins. NICE has issued guidance recommending that all agencies take simple measures in relation to their staff, buildings, grounds, organisation etc to promote physical activity with particular roles for schools, for parks and for active travel. The DfT has accepted American evidence that pedestrian permeability of street networks can cause a 6lb difference in mean population weight, equivalent to a difference in death rate of 1 per 1,000 per year. There is evidence of successful promotion of walking and cycling, for example a canal tow path scheme in London had a benefit to cost ratio of 22:1.

I recommend that

All agencies promote walking and cycling to their staff and visitors, adopt travel expenses policies which encourage active travel, make adequate provision of cycle parking and changing/shower facilities, and develop staircases as attractive and welcoming alternatives to lifts

Stockport MBC aims to make continued progress towards the completion of its walking and cycling networks

There be effective communication to dispel exaggerated perceptions of the dangers of cycling

Health Walks be better coordinated between agencies

Schools should promote active travel to school

Local MPs and political parties support the Take Action on Active Travel campaign which calls for at least 10% of transport spending to be committed to walking and cycling and for the development of living streets

I recommend that

- (a) Investment in physical activity be maintained, and there be commitments to substantially increase it when financial stability is achieved
- (b) In the meantime the Stockport Sports Trust be asked to make its services better and less costly and invest savings in expansion
- (c) Schools should continue the excellent local progress in making opportunities for physical activity readily available in the school setting.
- (d) The contribution of parks to promoting physical activity be maximised, and the excellent existing work in this area should continue and be intensified
- (e) There should be a drive to reduce the prescription of antidepressants by using physical activity as an alternative

Early years / Parenting. Early engagement pays a very high rate of return. Early years investment promotes economic growth by creating a more able workforce and, ultimately, reducing the costs borne by criminal justice, health and welfare systems. There is good evidence that early years investment is effective in tackling social exclusion and teenage pregnancy. US modelling studies have estimated a payback of between 3 and 7 times the original investment in high risk families by the time the young person reaches the age of 21.

There is increasingly strong evidence that parent training produces positive results in addressing child conduct disorder, including both children who already have behaviour problems and those at high risk of developing difficulties in the future (London Economics, 2006). Efficacy can be increased by involving both the mother and the father, and working directly with the child. Positive effects also extend to parental wellbeing. However, it seems the most disadvantaged families benefit less from parenting programmes than do more stable and affluent families (Hallam, A. 2008). There is a lack of cost-effectiveness analysis in this field; however, the long-term benefits of any parenting programme would only have to be small to make the very small investments in parenting programmes efficient.

Agencies providing services for vulnerable young people work better together providing multi-component interventions than they do alone, and this can increase efficiency and cost-effectiveness (DfES 2007: 4). Interventions targeting young people at risk of future poor health outcomes seem rarely to address the range of risk factors associated with these poor outcomes (such as drug and alcohol misuse, NEET, and low attainment) (Thomas et al. 2008). Complex, holistic interventions addressing the wider socioeconomic context to teenage pregnancy have historically lacked evidence of effectiveness; however a body of good evidence for the effectiveness of youth development programmes in preventing teenage pregnancy is now developing (Harden et al. 2009). The scope to reduce health inequalities and social exclusion is considerable. There have, however, been some notable examples of interventions in this field yielding the opposite of their intended outcomes (e.g. increases in crime, or rates of teenage pregnancy) so it is important that interventions are well evaluated.

I recommend that

There be increased attention to smoking and alcohol in pregnancy and to breastfeeding and that this includes the attainment of UNICEF Baby Friendly Community Status

In the context of a financial plan which sees maternity as a source for savings because of expenditure benchmarks, the need for the above be reflected in, and funded by, some moderation of the financial targets

Public buildings display signs indicating that breastfeeding is welcome

Employers should readily and without fuss make available facilities for the expression of breastmilk

Health workers should be willing to challenge the widespread negative attitudes about breastfeeding outside the home

(a) Stockport MBC has long provided high quality support for pregnant schoolchildren and Community Health Stockport is piloting the Family Nurse Partnership which supports teenage mothers although it does so in a particularly expensive way. There is an ongoing need for services of this kind.

In the context of a financial plan which sees maternity as a source for savings because of expenditure benchmarks, I am grateful to Stockport NHS Foundation Trust for accepting my recommendation last year to mainstream the teenage pregnancy services for which LAA funding was expiring and I recommend that this be reflected in, and funded by, some moderation of the financial targets

There should be more use of long acting reversible contraception

In the context of the Marmot emphasis on early years I recommend continued support for parenting and I commend the “Think Family” initiative

There is already considerable collaboration in addressing the problems of vulnerable young people. I recommend that this should continue or be intensified.

. Mental Health and Wellbeing. We are increasingly understanding the importance of mental wellbeing to health, and the Marmot report has reviewed the issues and identified healthy places and communities, fair employment and good quality work, empowerment and self development, reducing inequalities in early years and a healthy standard of living for all as the key objectives. The Alameda County Study suggests that the impact of the strength of social support networks could be as great an impact on mortality as poverty. The Department of Health advocates Five Ways to wellbeing – Connect, Be Active, Take Notice, Keep Learning, Give.

One of the problems of this area is that knowledge is emerging so rapidly and the impacts so far exceed what we have previously thought that there have been no evaluated programmes addressing this problem as fundamentally as it seems to require. Marmot calls for innovation and experiment. Nonetheless, ten best buys recommended by UCLan 2009 are:

Universal routine enquiry and targeted treatment for women at risk of depression with home visiting therapist for post natal depression, as part of a package of measures to improve perinatal mental health.

Universal assessment of potential parenting problems and targeted early intervention programmes for common parenting problems, including school-based learning.

Early intervention programmes with individual home-based programmes for conduct disorders

Build social and emotional resilience of children and young people through whole school approaches

Interventions to increase opportunities for participation, personal development and problem-solving- specifically volunteering, including timebanks, exercise arts and creativity, learning and educational opportunities, green activity, bibliotherapy, employment and debt advice.

Integrate physical and mental well-being through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity. This means that key groups may need to be specifically targeted, for example people with a mental illness or learning disability, older people and pregnant women.

Improve working lives by:

Early intervention to reduce risks of unemployment through primary care and Job centres.

Support organisations offering locally based interventions to improve healthy working lives and support occupational health schemes.

Implement initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse.

Ensure access to psychological therapies, including CBT, for people with long term conditions, disabilities and carers

Early intervention and targeted approaches for high risk groups, including suicide reduction programmes (e.g. facilitate registration with GPs for homeless people; Education programme for GPs to detect depression)

In the context of the Marmot emphasis on well being, on empowerment and on quality of work I recommend

There should be a widespread emphasis on the well-being messages

Give/Connect/Take Notice/Be Active/Keep Learning

All agencies should aim to support and make use of voluntary sector activity

All agencies should seek to work participatively and avoid disempowering overregulation and control

Well being, volunteering, and community involvement should be seen as integral not as add ons

The above best buys should be considered for investment as resources are available

A timebank should be established since not only is it a best buy but also it addresses the economic situation.

In connection with the fifth item from the above list of best buys it should be noted that we have local evidence suggestive of a strong positive impact from community development (the use of community organisers to strengthen and improve a community) but one district is too small a base for proper evidence.

I recommend

(a) that in their support of the voluntary sector agencies aim to support the community sector as well as the larger voluntary organisations and that appreciative inquiry, community development and asset-based working continues to be used to support sustainable health improvement

(b) Stockport MPs and political parties consider the potential health contribution of the Government's proposed community organisers

Diet is an important contributor to health. There is considerable evidence that people find it difficult to choose a healthy diet because of the contents of processed and fast food and lack of information. School meals make an important contribution to good nutrition in children.

I recommend that

There be continued efforts to increase the take up of school meals including steps to ensure that free meals may be taken without stigma (in which connection I commend the proposed introduction of a system of card payment) and including market research into which healthy foods children like

(i) Stockport MPs and political parties should aim to modify the law which makes it difficult for planning authorities to distinguish between healthy and unhealthy food outlets.

(ii) In my first draft of this recommendation I had also recommended that they aim to modify planning law so as to make it possible to prevent fast food outlets near schools. However that has been overtaken by events in the light of the recent High Court ruling that (contrary to previous assumptions) a Council considering a planning application for fast food outlets should indeed consider proximity to a school and impact on the healthy eating policy of that school as a material consideration. I recommend that full account be taken of this welcome High Court decision.

I congratulate Stockport MBC on its participation in the highly successful campaign to replace salt shakers in fish and chips with shakers that have fewer holes. This should continue.

All agencies should ensure that all food served by, on behalf of, or under franchise to, complies with healthy eating guidelines

Stockport NHSFT should recognise the contribution of nutrition to speeding up recovery

Stockport NHSFT should intensify its commendable efforts to ensure that patients who need help in eating receive it instead of food being removed uneaten

Stockport MBC seeks to secure the establishment within the town centre of a healthy eating outlet linked to community networking along the lines of similar outlets in Manchester and Liverpool.

Climate change is itself a major public health issue but addressing it can also save money

I congratulate Stockport MBC and Stockport NHSFT on their considerable contributions to the climate change agenda and urge all local agencies to match their performance

I recommend that low carbon communities be piloted.

NICE are currently considering guidelines on spatial planning. The Greater Manchester Directors of Public Health have produced their own guidelines based on an evidence review

I recommend that Stockport MBC incorporate the Key Messages on Spatial Planning produced by the Greater Manchester Directors of Public Health into their Local Development Framework

International evidence on the impact of recession on health shows that a strong welfare state can mitigate adverse consequences, that a high level of membership of clubs and societies can be wholly protective and that health improvement can result if the recession is used as an opportunity to increase active travel.

I recommend that Stockport MPs and political parties debate the implications of these findings and their significance to maintaining the effectiveness of the welfare state, introducing a Big Society and increasing active travel.

The Marmot Report has shown that inequalities of income, power and early life chances play an important part in maintaining health inequalities

I recommend that Stockport MPs and political parties consider the health implications of excessive inequalities in income.

I recommend that Stockport MPs and political parties welcome the Government's moves to empower local communities and press for this strand of policy to be pursued even more vigorously.

I recommend that Stockport MPs and political parties consider how best to address the problem of inequalities in life chances resulting from early life experience.

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**A8: FINANCIAL
PRESSURES ON THE
NHS: A POPULATION
PERSEPECTIVE (written
2008)**

FINANCIAL PRESSURES ON THE NHS; A POPULATION PERSPECTIVE

The PCT faces financial pressures arising from growing demand and tariff changes and these threaten to undermine its strategic financial planning and its financial stability.

The FT faces operational pressures from growing demand, and financial pressures from the risk of destabilisation due to its low level of surplus, and the Treasury's "efficiency" tariff deflator.

We can look at the health economy as a whole as facing the following annual pressures:-

Treasury efficiency savings w%

Rising demand x%

Demographic change y%

Essential improvements z%

Total (w+x+y+z)%

This is the problem that we need to address year on year.

Treasury efficiency savings have in the past been about 3% but may be higher in future.

Demographically, change runs at about 0.5%, but we know that the population of over 75's will increase by about 20% by 2020.

The bulk of the growth in health care costs has resulted from rising demands and the need to fund improvements in care. In the past growth funds have been available to address these but it seems likely that financial allocations over the years to come will, given the current state of the public finances, be of such a level as to aggravate this problem rather than resolve it.

It is tempting for NHS Stockport to attempt to recoup its share of this funding problem by reducing referrals to Stepping Hill. However where need is genuine it will usually manifest itself eventually, often more expensively than if it had been dealt with properly the first time. Moreover such a strategy deprives the SNHSFT of money at the average cost of a referral when it only saves the SNHSFT the marginal cost so it worsens the financial problems of the SNHSFT. It is the wish of NHS Stockport that its citizens should continue to have access to a local hospital of high quality with an A&E Dept. Even if an alternative provider was available the SNHSFT is also a valuable potential provider of community health services in a way which other hospital providers may not be, and its commitment to a health promoting hospital and to active corporate citizenship within the Stockport community both fit with the priorities of NHS Stockport strategies for delivering care are already aligning.

It is tempting for Stockport NHS Foundation Trust to seek to solve its financial problems by generating additional income from more activity. However this worsens the financial problem of NHS Stockport and ultimately it generates toxic assets – entitlements to money that doesn't exist.

We need to function together effectively with a good quality general practice and community services and strong local hospital. Each organisation needs to be part of solving the financial problem together and not at the expense of the other. It damages health services if we seek an accountancy solution which is based on a financial distortion rather than a real situation and that is not ultimately viable.

Strategically, the following are available ways to address this problem together without adversely affecting patient care:-

To eliminate misuse or unproductive use of healthcare resources

To reverse cost shifts which have added to the cost on the service as a whole

To eliminate over sophisticated and complex health care

To improve quality and to avoid the need to rectify mistakes

To pursue a lean and value added healthcare approach to all service redesign

To consider where NHSFT can reduce costs incurred by NHS Stockport out of area (e.g. pacemakers, infertility, PEGS, dermatology, AMD)

To reduce need through lifestyle services in the community

To reprofile demographic change through a healthy ageing strategy

To invest in unmet need and address health inequalities

To integrate healthcare across all interfaces so patient care is pathway driven end to end

The following table outlines some of the principles that can be used with built in flexibility as we accept that different approaches are needed in different circumstances., giving a description of 'what' and some 'examples' from different elements of the patient pathway.

No.	Short Title	Description
1.	Better triage	Much of the rising demand cannot be attributed to any obvious unmet need. Demand ≠ Need
2.	Reverse harmful cost shifts	We have put in place, for organisational reasons, measures which add to the cost on the system as a whole. We should reverse them.
3.	Simpler is better	A good example of this would be diagnostic creep whereby a drug which is useful in one setting comes to be used in others, or the use of a drug which is more expensive than an older drug even when the older one would, in this particular case, have worked
4.	Right first time	Readmissions, repeat appointments, litigation
5.	Integrated care across all interfaces	Poor coordination between health services in the community and hospitals can mean unnecessary admissions and poor follow up care
6.	Lean efficient healthcare/Service Redesign	This is a process which focuses on the efficiency of processes and uses the knowledge of waste that is locked into front line staff. (Often expensive care is offered because the simpler alternative is not available)
7.	Bringing back care from out of area	It may be possible to do more in Stockport saving out of area costs that are unproductive
8.	Lifestyle change	8,520 admissions a year in Stockport result from smoking, obesity or alcohol. Smoking costs 3.0% of the total NHS budget. Obesity costs 4.7% of the total NHS budget Alcohol costs 1.9% of the total NHS budget
9.	Healthy ageing	If the gap between healthy life expectancy and life expectancy were reduced from 7.5 years to 3.75 years we could halve our expenditure on care of the elderly saving 15-25 % of costs overall

If we start of all these now they might deliver as follows

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 12	Yr 13
Prog 1	X	X	?	Probably exhausted as a major contributor after yr 3 although some further contributions will still occur.									
Prog 2	X	X	We need to continue avoiding this into the future but the reversals of the existing examples should be done early										
Prog 3	X	X	X	X	X	X	X	X	X	X	X	X	X
Prog 4	X	X	X	X	X	Probably exhausted as a major contributor after year 5 although some further continuous improvement will always be possible							
Prog 5	X	X	X	X	X	X	X	Probably exhausted as a major contributor after yr 7 although some further contributions will still occur.					
Prog 6	X	X	X	X	X	X	X						
Prog 7	?	?	X	X	X	X	?						
Prog 8	Achieve lifestyle change			Lifestyles impact on morbidity				X	X	X	X	X	X
Prog 9	Will not bite until current cohorts age i.e. people in their 50s are in their 60s, people in their 60s are in their 70s, people in their 70s are in their 80s										X	X	X

The savings made by this process need to be shared by NHS Stockport and Stockport NHS Foundation Trust. It may be that some adjustments to normal contractual processes will be needed to achieve this through the development of more local tariffs or gain sharing agreements.

For example if investment in improved community services makes it possible for patients to be discharged earlier the SNHSFT will benefit from the savings but NHS Stockport will have to pay either the SNHSFT or some other provider for the community services and may not see any reduction in the contractual figure due to the SNHSFT for its hospital services. Conversely if the SNHSFT cooperates in processes of demand management to prevent admissions or reduce the frequency of outpatient appointments then it will reduce its income (to the benefit of NHS Stockport) considerably more than it will save on costs. It may be that these will balance out. If they don't compensatory adjustments will need to be made. Sometimes it will be the case that savings are not realised smoothly as change proceeds – initially savings accrue at marginal cost but then a point is reached at which an overhead can be cut.

**A9: SPECIAL REPORT ON THE
EFFECT OF RECESSION ON
HEALTH (written 2008)**

SPECIAL REPORT ON THE EFFECTS OF RESESION ON HEALTH

The world is now in a state of recession.

Out of 408 districts in Great Britain, Stockport ranks 55th for vulnerability to recession (City of London being first). This makes it the second most vulnerable in Greater Manchester (Trafford at 24th being the most exposed, with eight of the ten Greater Manchester districts being in the top half).

It is important therefore to consider the health effects of recession and whether anything can be done to prevent them.

Recessions have a number of negative effects on health:

Unemployment is harmful to health

Fear of unemployment is harmful to health

Quality of work often deteriorates in recession

So does employment of disabled people

Household incomes suffer and poverty increases, not only as a result of unemployment but also due to other changes

Those running businesses are likely to suffer severe stress

Economic instability will subject many families to severe stress and to unpleasant life changes

The way recessions are handled can add to these problems if:

There is a relaxation of pressure for good employment practice, health and safety and environmental awareness

Unemployed people are isolated and stigmatised

Public services are cut to balance the budget.

Recessions have some intrinsically beneficial elements:

Pressures of urbanisation are reduced

Industrial pollution and industrial accidents are reduced (unless this is counteracted by slacker regulation)

Some work is more damaging than unemployment – a few factory closure studies have shown this, mainly in old fashioned heavy engineering

In the 19th century recessions actually improved health, probably by easing the pressures of urbanisation. However this is unlikely to be true of recessions in a modern developed country (it may be in a developing country where pressure of urbanisation is a major health issue). 20th century recessions showed a substantial adverse health effect in developed countries. It seems likely that the same will be true of 21st century recessions, although there may be some differences if they are handled differently.

The Overall Effect of Recession

Based on the experiences of 20th century recessions and using unemployment rate as an indicator of recession the effect of recession builds up over a five year period until in the 5th year each 1% increase in unemployment sustained for five years produces

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

Unemployment rate is used here as an indicator of recession. Only about a tenth of the above effect is due to unemployment. The rest occurs in people who are not unemployed; some of it

due to fear of unemployment and much of it is due to other factors. It cannot be assumed therefore that managing a recession so that less unemployment is created will reduce the above effects in full proportion to the unemployment avoided, although it would undoubtedly be beneficial to some extent.

The management of the recession will be predominantly a national question. I would like to draw the attention of local MPs and political parties to the paper in appendix 1 which has been drawn up by the Directors of Public Health for the North West Region.

The Effect of Unemployment

It is remarkably difficult to analyse the pure effect of unemployment on health. There are over a thousand studies from the 1930s and 1980s about the effect of worklessness on health of which only about 10 are useful.

Unemployment correlates with poor health in time trend but this only shows the effect of recession on health

Unemployment correlates with poor health geographically but this only shows the effect of multiple deprivation on health

Unemployment correlates with poor health in individuals but this only shows that sick individuals are more likely to be without work

People's health deteriorates when they lose their job but this only shows the effects of life changes

Most spells of unemployment are short but this only shows that there is an underlying rate of people changing jobs.

To look for the pure effect of unemployment we need to look at long term studies following unemployed people over prolonged periods, and at studies which meticulously correct for the above errors. These studies show that worklessness is indeed bad for health. So does a study which shows that the effects of unemployment are eased when it is reclassified as retirement.

For every 2,000 unemployed people each year there will be two extra deaths caused by unemployment in those people themselves and one extra death amongst their spouses.

Work provides

Income

Structure to the day

Social contacts

Status

Sense of identity

Sense of contributing to society

Loss of work is a major life change. Whenever people undergo a change in their life which alters their sense of identity they go through a cycle of reactions in which health deteriorates from the moment that the change first starts to be seriously anticipated until they are securely settled into their new identity. This applies even to pleasant changes although the effects are less and the adjustment quicker. One of the problems of losing your job when you cannot quickly find another is that society does not expect you to adjust to your new identity as unemployed.

The health damage of unemployment is

greater the stronger the sense of commitment to the work ethic

less in those whose work involved responsibility for structuring their own time

reduced by strong supportive social networks

affected by the stigma of unemployment. Health improves when unemployment is redefined as retirement.

It is essential that we introduce measures which allow people who have lost their place in the mainstream economy to meet others in the same situation for mutual support and help. We

should give them practical help and facilitate them structuring their day so that they devote a reasonable proportion of time to seeking work whilst also engaging in meaningful activity which contributes to society. It is vitally important that we avoid emphasising the low status of unemployment by compulsory training and policing their use of their time offering forms of forced labour so that people are compelled to earn their benefit. It is gratuitously cruel to compel people to seek work, even though we know that it is not available.

Unfortunately the difference between the positive caring measures recommended in the first two of the above sentences and the gratuitous cruelty condemned in the third and fourth is almost entirely attitudinal. Freed of semantic implications the two statements describe almost identical approaches.

The Fear of Unemployment

In the anticipatory stage of the life change reaction – when the life change has not occurred yet but people are afraid of it coming – people experience increased rates of infection and gastrointestinal disturbance, raised blood pressure and raised blood cholesterol and diminished glucose tolerance increasing the risk of diabetes. These are the classic consequences of the stress reaction. Although increased risk of cancer in this stage has not been shown in the life change studies this is probably because they were too short – it is another consequence of the diminished immune response which produces the increased susceptibility to infection. These effects will be present in a significant proportion of our population during recession.

It is extremely important that we offer appropriate treatment both in addressing the increased cardiovascular risk and, if we cannot tackle the underlying economic problem, at least tackling the underlying risk process by offering stress management advice.

Quality of Work

A quarter of a century ago Adelstein and Fox compared the variance between industries of age/sex standardised SMRs and age/sex/social class standardised SMRs and concluded that between a quarter and a third of the social class variation in health was due to work. This amounted to some 20,000 to 30,000 deaths a year, much more than the few thousand deaths that could be attributed to industrial diseases and accidents. The difference was accounted for partly by unrecognised occupational contributions to common diseases and partly by work-based lifestyles (smoking at work, for example) but to a very large extent by the various psychological factors that we call quality of work and to the stress reactions that poor quality work produces. We have known since the 1950s of the adverse health effect of working under pressure to deadlines. We have known since the first Whitehall studies of civil servants in the 1960s of the adverse effects of lack of control over one's own work. We have also known for some time of the adverse effects of carrying responsibility without the training, authority and resources to discharge the responsibility properly.

The Adelstein & Fox study is an old study and it has not been repeated. This is unfortunate. The economy has changed and some of the factors that Adelstein & Fox detected will have changed with it. Work-related smoking, for example, is no longer the same issue. But the relentless disempowering meaningless deadlines of the assembly line have only been replaced by the relentless disempowering meaningless deadlines of the call centre. Poor quality work remains an issue.

The health damage of work and worklessness are not opposites. Both are deviations from the desirable state of having good quality work. Some people securely enjoy good quality work. Some people enjoy good quality work when times are good but suffer poor quality work or insecurity when times are bad. Some people suffer poor quality work when the economy is booming and unemployment when it isn't. Some people, especially people with disabilities or other employment problems, rarely experience work and when they do it is of poor quality. Good quality work has the following characteristics:

Meaningful
Significant autonomy
Enjoyable
Able to be integrated into life
Pleasant surroundings
Resources, power and training appropriate to responsibilities
No unnecessary deadlines
Good social support
No bullying

In times of economic growth it is easy to espouse a goal of improving quality of work. We can foster understanding of the importance of good quality work and ensure this is understood by those working to attract jobs, offer strong political leadership to pursue quality of work, encourage exemplar businesses to emphasise the benefits in recruitment, retention, morale and productivity and use the statutory sector as exemplars (although in the past they often haven't been!) We can emphasise the importance of developing knowledge based industries and view cultural and environmental factors as economic drivers.

All of this becomes more difficult in times of recession.

Employment of Disabled People

Disabled people should be employed for their abilities instead of being rejected for their disabilities. Yet disabled people suffer disproportionately high rates of unemployment. A programme of addressing this might include:

Moving people from incapacity benefit to work
Using health and social care resources to create work rather than day care
Commissioning from the third sector
Statutory organisations as exemplars
Political and business leadership to emphasise the good work record of disabled workers
Work for people with learning difficulties and mental illness can be an important element of investment in those services.

Such a programme will be much harder to pursue in recession. At the moment the Government is introducing a process of moving people from incapacity benefit to work which it initiated in economically more successful times. Locally the Greater Manchester Economic Commission intends a vigorous implementation of that same objective and there may well be implications for the NHS as listed above. If, as a result of recessionary pressures, the process fails it may be perceived as punitive and may have the very damaging effect of replacing the socially acceptable status of "retired sick" with the socially unacceptable status of "unemployed". However the Government appears to be aware of this and has pointed out that it will take at least two years of preparatory work before the scheme can be implemented so that it believes implementation will correspond to economic upturn.

Impacts on Household Income and Poverty

Some households suffer devastating falls in household income as a result of unemployment or loss of investment income (which can be the main source of household income for retired people). A much larger number of households will suffer a lesser form of income loss as a result of diminished bonus payments, diminished overtime working, pay cuts or below-inflation pay rises, and short time working. For some households this may only require some changes in choices – shopping at a cheaper supermarket, choosing different holiday destinations, or keeping the car for longer between replacements. For others it will involve changes that will be harmful to health such as restricting social networking by not going out, drinking cheap alcohol at home because you can't afford to stand your round in the pub, suffering cold to save on heating, or buying fatty, low-fibre food because it is cheaper. For some the difficulty

in balancing the household budget will be so severe that it will cause immense stress and involve adverse life changes such as loss of one's home. One difference between the current recession and previous recessions is that the growth of debt will have increased the proportion of households for whom reduction of income will be devastating.

The Stress of Managing Businesses

I have emphasised in previous reports that work-related stress does not fall predominantly on the most senior managers in a business. Responsibility that people have the power, resources and knowledge to discharge is healthy. It is responsibility that occurs without those essentials that creates health-damaging stress. Responsibility without power, resources and knowledge is a feature of lower levels of management and of supervisors. The other main work-related stress is lack of control over one's own work and this occurs again to the greatest extent at the most junior levels. In normal times therefore work-related stress is a feature of more junior grades.

This situation will change in recession. Managing businesses will become stressful as people no longer feel in control of the situation, and this stress will be aggravated in small businesses where self employed people will have their own personal wealth tied up in the business.

One of the features of Stockport's polarisation is that we contain not only some of the most deprived wards in Greater Manchester but also some of the most affluent. Those affluent areas may in recession become susceptible to stress-related ill-health which they have in the past avoided.

Recommendations and Work in Progress

I recommend that all agencies in the Borough carefully consider the implications of the recession for their services both in terms of the additional demands that it will create and in terms of the contributions that they can make to reduce the impact. I am aware that the Borough Council has already commenced such an exercise and, as Appendix 2 shows, that action planning is under way within the NHS.

I may make further more specific recommendations in the Key Messages and Recommendations volume of this 18th Annual Public Health Report.

I draw Appendix 1 to the attention of Stockport MPs and political parties.

LOCAL GREEN KEYNESIAN STIMULI

Principle

1. There is now widespread international acceptance that Government responses to the recession should involve a Keynesian stimulus in the form of an excess of public spending over tax income. .
2. Keynesian stimuli can at their best be self financing by generating the economic demand which pays back the money borrowed (the so called Keynesian multiplier). However they can fail producing inflation and debt rather than growth. Keynesian stimuli are most likely to fund themselves by a Keynesian multiplier and least likely to be dissipated in inflation or market distortions if they make money available to the poor (who are most likely to spend it), create employment where people would otherwise be unemployed or bring into use resources which would otherwise be idle.
3. Apart from bank recapitalisation the Government response has been cautious compared with the levels some economists have called for. It has included measures targeted on the financial situation of the poor coupled with employment-creation and public works (mainly capital projects brought forward). However it has also included more general measures such as tax cuts.
4. Insofar as any further response could usefully includes employment-creation and public works it is suggested that it might be more quickly established and more readily targeted on those in need if it consisted of a large number of small schemes instead of a small number of large schemes.
5. This paper suggests schemes which would benefit health, multiple deprivation or the environment and would draw on otherwise idle resources.

Proposal	Social Benefit	Employment Field Stimulated
Credit unions	Assists finances of more deprived families	Financial services administration.
LETS schemes	Assists finances of more deprived families and especially the unemployed. Strengthens community cohesion.	Financial services administration
Microcredit on the model of the Grameen Bank	Assists upward mobility of most deprived sections of society and promotes small scale enterprise.	Financial services administration.
Expand health trainers	Health promotion	Local employment
Create a right to connect microgenerated energy to the Grid on favourable terms as in Germany	Climate change	New industry. Also supports household finances
Loans for installing microgeneration, including solar panels, wind turbines on buildings, microhydros and geothermal. For householders loans to be repayable only out of proceeds of Grid connection.	Climate change	New industry. Also supports household finances

Proposal	Social Benefit	Employment Field Stimulated
Home Zones with local people paid to design schemes and supervise construction	Road safety Promoting walking and cycling Community cohesion Aesthetic benefits now shown to reduce health inequalities	Local employment Construction Garden furniture Horticulture
Greenery and public art on walking routes	Promoting walking by prolonging the distance people are willing to walk Aesthetic benefits now shown to reduce health inequalities	Gardeners Artists Could include mentally ill and learning impaired
Green security measures (thorny hedges etc)	Security Aesthetic benefits now shown to reduce health inequalities	Gardeners Could include mentally ill and learning impaired
Install modern shelters at bus stops and railway stations	Improves quality of public transport	Construction Solar lighting Information systems
New public conveniences	Hygiene and the promotion of independence for older people	Construction
Pay for public use of toilets in shops, pubs, offices	Hygiene and the promotion of independence for older people	Supports finances of local shops, pubs, local small businesses
Pay local communities to maintain areas of open space as community gardens.	Community cohesion Physical activity Aesthetic benefits now shown to reduce health inequalities. Promoting walking if situated on walking routes	Local employment Garden supplies In affluent areas, gardeners In non-affluent areas contributes to household finances Could include mentally ill and learning impaired
Plant public orchards	Healthy eating Community cohesion Physical activity Aesthetic benefits now shown to reduce health inequalities. Promoting walking if situated on walking routes	Local employment Garden supplies In affluent areas, gardeners In non-affluent areas contributes to household finances
Sensors to street lights in side streets so they only switch on for a person passing	Climate change. Reduces light pollution Security advantages	Installers
Bridgeworks and earthworks on potential extensions to heritage railways, potential cycle routes, and potential walking routes	Promotes walking, cycling and public transport	Civil engineering Unskilled employment
Cycle networks	Promote cycling	Civil engineering
Putting the right of way system into good order	Promote walking and access to the countryside	Unskilled employment Could include mentally ill and learning impaired
Cycle vans on trains	Promote cycling (Californian experience shows that this can be highly effective)	Railway vehicle manufacture
Cultural approaches to smoking prevalence reduction on the Californian model	Health improvement	Local employment
Theatre in education addressing road safety	Health improvement Road safety (NRSI successful	Theatre

Proposal	Social Benefit	Employment Field Stimulated
and health	pilot)	
Local procurement	Climate change	Local employment
Reopen recently closed Post Offices with enhanced community role	Community cohesion	Local shops
Tram/train services with low platform tram stops on underused railway lines NB Pilot scheme proposed in SE Greater Manchester	Public transport	Construction (stations) Civil engineering (trackwork) Railway vehicle manufacture (trams) Signal engineering (resignalling)
Establishment of Parry people mover services on reopened short rail spurs	Public transport	New industry Civil engineering
Railway electrification and resignalling	Climate change Enhanced rail capacity	Rail electrification industries Signal engineering
Modify excessive network specification for new railway stations and build using local construction firms	Public transport	Construction
Footbridges over high speed roads	Road safety Promoting walking	Civil engineering

**A10: MENTAL
WELLBEING (written 2006
and 208)**

A10.1 MENTAL WELLBEING
(written 2008)

SPECIAL REPORT ON MENTAL WELL BEING 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 some evidence, although not quite as strong 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.

Following the review of the evidence concerning the general and specific approaches to supporting mental wellbeing, NHS Stockport and Stockport MBC locally selected 4 areas as requiring strategic focus in Stockport

Mental Wellbeing in the Workplace.
Building Social ‘connectivity’ through Third Sector Activities.
Support for Parents and Early Years Development.

The Scientific Evidence

The first scientific evidence that mental well being may be a risk factor for physical ill health emerged in the 1950s with the demonstration that American accountants showed higher rates of heart disease in the busy period of the year when they were preparing accounts for filing with the Internal Revenue Service than in the quieter periods. From this study emerged a significant volume of material around so-called type A and type B behaviour patterns which essentially showed that working under pressure to deadlines evoked in many people a particular behaviour pattern which was associated with increased coronary risk.

Shortly after this a considerable literature began to be created, and to accumulate over several decades, associated with various permutations of the names Kasl, Cobb and Gore. This literature studied the effects of significant life changes on rates of self reported health and various measurements of physiological and biochemical parameters. A wide range of life changes were studied, including losing a job, divorce, imprisonment, bereavement, going into an old people's home, moving house, promotion, and getting married. A consistent picture emerged that life changes which strike at the root of a person's identity cause damage to health from the time that they first begin to be anticipated until the individual has fully adjusted to the change. This applies whether the change is beneficial or negative, and the impact on health is negative in either case, but beneficial changes have less impact and are adjusted to more rapidly.

Around the same time a study of outcomes of pregnancy in wives of US soldiers showed that the strength of social support networks was a factor that influenced the rate of complications of pregnancy. On the same topic the study of the Granville Train Disaster in Australia showed that weak levels of social support were a strong predictor of serious mental illness in survivors of this horrific accident where a train left the tracks and collided with the supports of a bridge bringing the bridge crashing down on the train. This led to further studies of the impact of social support on health culminating in the Alameda County Study which showed that strength of social support was associated with a four fold difference in all causes mortality. This difference, comparable to the effect of poverty, was so great that the researchers refused to believe it. They said that it must be an association due to reverse causality (illness causing deterioration in social networks) and they predicted that it would therefore decline as the cohort was followed for longer periods. It didn't. It strengthened as would be expected from a directly causal relationship and ultimately the researchers were convinced and presented it as a causal relationship. It is now clear that strength of social support is a major contributor to keeping up good health.

This adds to the concern at the finding by Appleyard & Lintell in San Francisco, now repeated in Bristol by Joshua Hart, that traffic levels in streets diminish the strength of social support networks in those who live in them, by diminishing neighbour interaction. It also suggests a downside to economic policies of labour flexibility which envisage workers changing jobs frequently.

Various studies of occupational mortality, including Marmot's study of civil servants have shown that social status is a positive factor in maintaining health and so is autonomous control of one's own work. Various studies of stress at work have shown that responsibility is good for health if it is linked to the training, ability and resources to discharge it, but that responsibility without training, ability and resources is bad for health.

Apart from one or two of the more recent studies all the above was known when I obtained my MSc in public health a quarter of a century ago. This isn't new knowledge – it is knowledge which has been present for some time but has only recently started to come to widespread prominence in practical policies.

Much newer, and so far not as firmly established, is the recognition that aesthetically attractive settings are good for health. The pioneering study for this work was the

demonstration that patients recovered quicker from a surgical operation if they could see trees from their window. Some other studies have since confirmed this association between views of greenery and physical ill health, including research which suggests that greenspace may diminish inequalities.

Also more recent and more controversial is the work of Wilkinson which suggests that the perception of inequality may be as important as its material consequences and that people may suffer health consequences from feeling that they do not share the lifestyles and opportunities of other groups of society.

There has also been research showing an 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.

These studies provide us with a clear scientific position that various aspects of well being will affect our susceptibility to disease and influence death rates.

The Stress Reaction

The stress reaction is the physiological reaction that occurs in all higher organisms whereby their body can move into a higher gear when they are faced with a threat. It prepares them for fight or flight. Mental processing increases in speed leading to a perception of slowing of time. Blood flow and energy is directed to the muscles leading to the individual being faster and stronger – the person who has just been chased by a bull has no idea how he crossed that field so quickly or vaulted that hedge. As part of this process various metabolic and cardiovascular changes occur – for example blood pressure, heart rate and blood cholesterol increase. Systems which are 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 is perfectly healthy. However if it were to become inappropriately persistent the stress reaction would become harmful. Persistent elevation of heart rate, blood pressure and cholesterol would cause heart disease and stroke. Depression of the immune system would cause cancer and infection. The impacts on gastrointestinal function would cause gastrointestinal illness. These diseases – cancer, heart disease, gastrointestinal disorders and infection are the diseases that have been associated with the various forms of lack of psychological well being that I have described above.

This is the biologically plausible link that could explain the epidemiological observations. A threat hanging over people (be it a conventional threat, or a life change, or a deadline, or a sense of entrapment in an unsatisfactory situation like low status, or a feeling that you are unable to discharge a responsibility) triggers the stress reaction. Because the reaction cannot be used up in immediate action to counter the threat it becomes persistent. Then it damages health.

This is biologically plausible. It is the most biologically plausible explanation of some very well established epidemiological findings. It is not, however, proved.

If this is the correct interpretation then social support and the tranquillity of green settings may be beneficial by moderating the impact of stress or may operate directly as factors that raise the human spirit and whose absence creates a sense of unease.

The Psychological Perspective

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

Maslow approached well being from the concept of needs and their role in motivation. He argued that there were five levels of need – physiological needs (air, water, food), safety, belongingness needs for love and friendship, ego-status needs for position, identity and standing, and self actualisation (a need to “be oneself” and to “have a task that you must do”). These formed a hierarchy and human beings were motivated by whichever was the lowest level of these needs to be under threat; a drowning man is motivated solely by the need for air but once he is no longer drowning the thought of 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 have suggested that they might be two dimensions of the same need – for acceptance and that self-actualisation bears to acceptance the same relationship that safety bears to physiological needs. Maslow himself later modified his hierarchy to add aesthetic and spiritual needs and modified his description of self-actualisers by dividing them into transcendents (who came to be motivated by spiritual needs) and non-transcendents. He also recognised that needs could sometimes be met by consciously deciding, in a greater cause, to accept their absence.

The four level version of the hierarchy with ego status and belongingness needs amalgamated into one tier bears some relationships to Galbraith’s four modes of motivation – compulsion (dig the ditch or be shot), compensation (dig the ditch and we’ll pay you), identification (dig the ditch because it needs to be dug) and adaptation (dig the ditch so you can decide where it goes). The later additions to Maslow’s hierarchy might suggest two additions to Galbraith’s theory – sensualisation (dig the ditch because digging ditches is great fun) or spiritualisation (dig the ditch to emphasise your one-ness with the earth/ to obtain the character building benefits of hard labour/ to break down the pride associated with your high status occupation/ to get an opportunity for meditation).

Some have suggested that Maslow was wrong to see a hierarchy in his needs – that they simply constitute a taxonomy of equally important needs. In this context the National Advisory Group on Mental Health, Safety & Well-Being have suggested the following fundamental psychological needs

- To have a secure and stable attachment to at least one significant other person who knows us well and on whom we can trust and depend (ATTACHMENT & TRUST)
- To have our attempts to communicate recognised and attended to by at least one other available person who is motivated to understand the meaning behind them (EMPATHIC COMMUNICATION & RELATIONSHIP)
- To belong to a family or other care-giving social group/system and to have a recognised and respected identity and position within that group (IDENTITY & BELONGING)
- To have secure, clear and consistent social boundaries and rules within which to live which are enforced in a firm, fair and containing manner (CONTAINMENT, SECURITY & DISCIPLINE)
- To have a sense of hope, belief, meaning, value and purposeful occupation in relationship to self and others (ESTEEM, BELIEF & PURPOSE)
- To develop understanding and influence over ourselves and the environment in which we live (SELF-DETERMINATION)
- To develop our capacity to tolerate frustration and fully experience pleasure (RESILIENCE & HAPPINESS)
- To learn reciprocal respect, regard and responsibility towards others (RESPECT & RESPONSIBILITY)

Others have approached well being from the standpoint of the psychological environment in which the individual must function. Cooper, for example, has produced a matrix of occupational factors from which to identify occupational stress.

An Occupational Stress Indicator is constructed using one biographical questionnaire and six questionnaires each measuring different dimensions of stress. The six questionnaires are focussed on four closely defined areas: sources of stress, individual characteristics, coping strategies and effects on the individual and organisation. Organisations are recommended to undertake a stress audit using the Occupational Stress Indicator and subsequently directing resources to reduce or eliminate the sources of stress.

Other approaches emphasise personal factors that create resilience. For example, Keyes distinguishes flourishing individuals (defined as those with 'enthusiasm for life, actively and productively engaged with others and in social institutions') and languishing individuals referred to having neither wellbeing nor mental illness. Data from the MIDUS prospective study in the USA found that 50% of the general population were moderately mentally healthy, 17% were flourishing, 10% languishing and 23% meeting criteria for mental disorder. There is no UK data on the prevalence of flourishing or languishing. When compared to flourishing individuals, moderately mentally healthy and languishing adults had significant psychosocial impairment and poorer physical health, lower productivity, and limitations in daily living and the absence of flourishing compounded risk of chronic physical disease with age (therefore, any state of mental health less than flourishing was associated with increased impairment and burden to self and society. However, only a small proportion of individuals free of common mental disorder were mentally healthy or flourishing confirming that the absence of mental illness is not the presence of mental health. Flourishing individuals had fewest missed days of work, healthiest psychosocial functioning (i.e. low helplessness, clear goals, and high resilience), lowest cardiovascular disease, lowest number of physical diseases with age, fewest health limitations of activities of daily living, and lower health care utilization. Flourishing, therefore, fits with a healthy ageing strategy.

Salutogenesis is contextually a social theory that has the additional merit of a psychological health component in which scores on the associated measurement scale (high/strong sense of coherence) have been epidemiologically associated with mortality.

Antonovsky first coined the phrase 'salutogenesis' after interviewing Israeli women with experiences from concentration camps of World War II who in spite of this hardship remained healthy. He asked what creates health and searched for "the origin of health" rather than look for the causes of disease. Three key aspects inform the salutogenic perspective, firstly problem solving/finding solutions, secondly, identification of what Antonovsky termed General Resistance Resources (GRRs) moving people in the direction of positive health and third, sense of coherence, a global and pervasive sense in individuals, groups, populations or systems that serves as the overall mechanism or capacity for this process.

It is the 'sense of coherence' (SOC) according to Antonovsky that explains why people in stressful/adverse conditions stay well and are even able to improve their health. A strong SOC is now empirically defined in terms of people's (individual or groups) ability to assess and understand the situation they are in (comprehensibility), to have the resources to cope (manageability) and to find meaning to move in a health promoting direction (meaningfulness). As more longitudinal studies are conducted they support empirically that the stronger the SOC the better the perceived good health in general, at least for people with an initially high SOC. This relationship was manifested in study populations regardless of age, sex, ethnicity, nationality and study design.

In Stockport we have a community development project in our most deprived localities where a salutogenic evaluation has been introduced. Our rationale is to reduce health inequalities through positive health change by enabling local people to attend and gain health literacy during a 3-day Health Defender course. The aim is to empower local people to become 'local' health advocates. The objectives include embedding messages that build clear understanding, strengthen access to health resources and bring positive engagement with existing and developing services in the heart of a community. This approach is salutogenic and draws from the evidence base for sense of coherence (SOC). The salutogenic nature of the Health Defender course allows measurement of its impact on the 3 core factors (comprehensibility, manageability, meaningfulness) understood to be associated with a strong SOC. After completing the course we find that motivation and coping resources have strengthened as measured by meaningfulness and manageability scores respectively. We are now planning to conduct follow-up (6 month) focus groups to further develop our understanding of how SOC is strengthened and the kinds of health actions this is associated with. In this way we aim to apply salutogenic principles and improve practice in our support for deprived communities to in the future

The Research Gap

It would be helpful if it could be demonstrated that the physiological features of the stress reaction, especially perhaps the biochemical features, were associated with indicators of the various states of lack of psychological well being that have been postulated in the psychological literature. This would not only confirm the stress reaction as the cause of the link but it would also validate as hard indicators those well being indicators that were shown to be so associated.

To date this experiment has not been done.

The Measurement of Well Being

There is much discussion as to how best to measure well being. Indicators may be selected at different levels and for different aspects associated with wellbeing.

At an individual level, indicators can include emotional intelligence, spirituality, learning and development, healthy living, physical health, various psychological measures of resilience including the sense of coherence indicator associated with the salutogenesis theory, a single "life satisfaction" question in a survey, various standard questionnaires addressing dimensions of disability, functioning and/or wellbeing or composite indicators such as WEMWEBBS.

At a community level or structural policy level indicators can include participation, social networks, social support, trust, violence, physical environment, working life, stigma / discrimination, debt / financial security, social inclusion, equality, safety.

Relevant Indicators within the National Indicator Set include EQ5D which measures disability and functioning with 5 questions, adults in contact with secondary mental health services in employment, % people who feel they belong to their neighbourhood, civic participation in local area, and participation in regular volunteering.

In workplaces sickness absence is a good indicator.

Other possible indicators include number referred to social prescribing in primary care (part of stepped care), reduction in IB claimants with mental health problem, Improving Access to Psychological Therapies (IAPT) measures, % people on Severe Mental Illness (SMI) register receiving annual health check / referred to physical health programmes and % people where health affects amount / type of work they can do

The Joint Strategic Needs Assessment used self reported well being. Regionally there is now a move to use the WEMWEBBS indicator.

The Impact of Recession

In an earlier chapter of this report I wrote about recession and its impact on health. I pointed out that it would have a number of adverse consequences.

Some of these operate through material factors but others operate through the factors that have been described here.

The impact of unemployment, bankruptcy and home/lifestyle downsizing on perceptions of status

The life change impacts of changing job, house or income level

The stress of fearing loss of job, home or income whether or not it materialises

The loss of autonomy for managers and for the owners of small businesses who no longer feel that their destiny is under their control

Many who once had the resources, training or authority to discharge their responsibilities may now feel that they lack the resources or that they have not been trained for the new climate
Loss of the social contacts of work as people lose their jobs and loss of the social contacts of leisure pursuits as people find themselves unable to afford to keep them up.

It is not surprising therefore that during recession well being levels fall.

It is important that we provide support to people in this situation.

Studies of war time settings have shown the positive well being effects of a sense of shared adversity coupled with hope that an opportunity will be taken to create a better future and it may be that this is the key to managing recession.

The Role of Empowerment

In the 16th Annual Public Health Report chapter 10 I wrote about empowerment and the WHO publication showing that empowerment is beneficial for health.

There are a number of reasons why empowerment would be important to well being.

It adds to the sense of status.

It leads to people feeling more in control of matters which might otherwise seem like an external threat

In the work setting control of one's own work has been shown to be a factor beneficial to health, and the same is probably true in other settings

The more experience people have of decisions and risk-judgments the less stressful they will seem 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 take, or at the very least be involved in, decisions about their lives, they need to be involved in processes of change, they need to be empowered to express their opinions and dissent and to work with others to bring about change for their communities. This is challenging for politicians and leaders of representative organisations who have been led to think of themselves as spokespeople for their constituents, for leaders of enterprises and public agencies who see it as their duty to chart their organisation's future and for professionals who may see it as an affront if their advice is not accepted. There is an ancient Chinese proverb which 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". Nye Bevan put it more succinctly, "The only good reason to seek power is in order to give it away".

The Mental Well Being Strategy

The recent Foresight Report on Mental Wellbeing (2008) highlighted 5 areas for action to enhance mental wellbeing, presenting these as the equivalent to the 5-a-day message for healthy eating:

Connect ... with the people around you ... family, friends, colleagues, neighbours

Be active ... walk, run, cycle ... find something you can do and enjoy it

Take notice ... be curious ... savour the moment

Keep learning ... something new ... rekindle an old interest ... set a challenge

Give ... do something nice for a friend ... smile ... volunteer

Following the review of the evidence concerning the general and specific approaches to supporting mental wellbeing, the PHPB selected 4 areas as requiring strategic focus in Stockport.

Mental Wellbeing in the Workplace.
Building Social 'connectivity' through Third Sector Activities.
Support for Parents and Early Years Development.
Physical Activity and Green Space

The key messages for each of these areas are below.

Mental Wellbeing in the Workplace

The links between work, health and mental wellbeing are very well established both in terms of working conditions and job control impacting on mental wellbeing and in relation to links between worklessness and health.

Therefore we need to:

Develop (strengthen) strategies on health in the workplace for the PCT and Council
Develop a strong borough-wide programme on health in the workplace with a particular focus on the needs of and benefits to small and medium sized enterprises.
Ensure the integration of physical and mental health support to initiatives on worklessness and supported employment.

Building Social 'connectivity' through Third Sector Activities

The term 'connectivity' is emerging as a useful concept that encapsulates the social elements in mental health and wellbeing. It encompasses the need to understand oneself, to feel connected to other people and to one's environment. Third sector organisations in Stockport have an excellent track record of engaging people in a wide variety of social activities, many of them through volunteering opportunities. These are valuable in themselves in building connectivity, as well as often leading on to further positive results in relation to work and health.

This can include an emphasis on the mental wellbeing of older people, ensuring their wealth of experience is acknowledged and valued, that they remain connected to wider society and maintain their independence.

Therefore we need to:

Expand the support provided to third sector organisations in relation to provision of voluntary activities with a wellbeing focus
Increase the financial security of third sector programmes, for example, by moving towards the use of 2-year rolling contracts
Embed the use of existing third sector networks into consultation and community engagement processes

Support for Parents and Early Years Development

Getting off to a good start in life is essential for the health and mental wellbeing of an individual. The needs of Looked After Children require special attention to redress multiple disadvantages.

Therefore we need to:

Work across Stockport Partnership to raise awareness of the mental wellbeing elements within all programmes

Embed public health competence into existing programmes and new developments
Support expansion of voluntary sector activities and provision of secure funding

Physical Activity and Green Space

Being active enhances both physical and mental wellbeing. As well as organised activities and sports, there are many other opportunities for people to become more active in their everyday lives. Stockport has a great deal of green space throughout the borough. This means that a majority of people are within reach of such spaces, a factor that is known to reduce inequalities.

Therefore we need to:

Promote access to a wide variety of physical activity opportunities through Stockport Partnership to maximise uptake by the whole population
Work to build the evidence base concerning longer-term change in physical activity levels
Support ongoing development and promotion of access to green space within the borough, especially for those living in disadvantaged areas

A10.2: EMPOWERMENT (written
2006)

EMPOWERMENT

The World Health Organisation has recently issued a scientific review of the impact of empowerment projects on the health of local communities. The report shows such projects as being beneficial to health.

There are a number of reasons why this might be the case.

The projects might have had other effects such as the promotion of social support. Empowerment of communities might have enabled them to address their health problems and address some of the factors that affect their health.

Empowerment of individuals might lead them to make better health choices.

Empowerment may be good for health in its own right by allowing people to address the stresses of life and to treat them as challenges rather than threats.

A10.2.1 Is Empowerment Good for the Health of Individuals

It is biologically plausible that empowerment could be health promoting. The stress reaction is produced when an organism faces a threat to its well being of sufficient severity to challenge something which the organism perceives as being of central importance to it. The reaction is designed to support fight or flight and if used in measures to counter the threat is entirely healthy. But if there is nothing that can be done to counter the threat, and it remains hanging over the organism for a prolonged period of time, then the reaction persists inappropriately and this causes health damage as some aspects of the stress reaction, such as the raised blood pressure, raised blood cholesterol, reduced gastrointestinal motility and reduced immune system reactions, are health damaging, leading to heart disease, cancer, gastrointestinal problems and increased susceptibility to infection.

It is plausible that an empowered individual will be more likely than a disempowered individual to respond to a threat positively by addressing it, and that liberty will therefore be a health benefit.

The work of Alfredsson et al has shown that people who have control of their own work experience lower mortality than those who do not, and this finding has been replicated in other occupational studies. There has been a randomised controlled trial of an educational instrument intended to increase personal autonomy in handling chronic diseases and it showed improved outcomes. Empowerment has been shown to affect the progress of various mental disorders.

So we have a biologically plausible relationship and some suggestive evidence that empowerment projects might act by a direct impact on the health of individuals.

A10.2.2 Empowering Individuals in Health Services

THE DOCTOR/PATIENT RELATIONSHIP

Until a few decades ago, power in the doctor/patient relationship has been with the doctor. The assumption has been that the doctor knows best and that the patient will not question that advice. The implicit bargain has been that doctors will use their skills and knowledge to the benefit of the patient, using their best endeavours and making the patient's interests the absolute priority, whilst patients will try their hardest to recover from their illness, following the doctor's advice.

When I was a medical student thirty five years ago this was still the assumption that underpinned the way we were taught. Issues like informed consent and patient autonomy were ethically acknowledged, but were seen as relevant only to that small minority of patients

(implicitly regarded as “awkward”) who asserted them. The obtaining of consent to treatment was seen as a bureaucratic chore.

Over the last few decades the medical profession has moved a long way from the concept of paternalistic professionalism towards a position where it aims to support people in making their own decisions. Informed consent has become a central concept of professionalism. It is necessary that treatments are explained to patients, that risks are set out and that options are explained. Alongside these changes in medical practice, patients have more information available to them through the press and the Internet.

However patient’s rights to choice must be balanced against the fact that health service resources are finite and it is unethical to waste a resource which is used to help people. What happens if a patient wants the NHS to pay for a treatment which the patient has become convinced will be effective but which the medical profession considers is not evidence-based? Which takes priority – patient autonomy or the need to optimise the health gain from NHS resources?

THE CURRENT “CHOICE” INITIATIVE

The Government currently seeks to promote patient choice through the “Choice” initiative. The aim of this initiative is that when patients are referred for specialist treatment by their GP they will be given a choice of five different hospital or community providers of the service they need. The system is being gradually expanded.

GIVING INFORMATION TO PATIENTS

Both of the above mechanisms of individual empowerment require patients to have good information about health services.

Who can determine what ‘Informed Consent’ means to an individual patient?

The difficult question still remains.....how much information does a patient need about a medical condition or disease, its pathology, prognosis, course of treatment and the various options, outcomes, risk factors, etc in order to engage with the process of decision making – resulting in ‘informed consent’?

The best answer available is that this will vary with each individual patient. There are no set formulae which, when punched into a computer, will provide the exact answer for any particular patient.

If informed consent has become a central concept of professionalism then health professionals must engage with the nuts and bolts of what each individual patient will need so they can derive the maximum benefit from the care and treatment agreed - through the information available to them as well as face to face dialogue and discussion.

Recognition that patients will at an individual level *need* a range of information, delivered in different mediums, languages and level of complexity - can be confounding for clinicians, who, nonetheless are genuinely trying to engage with the patient and respond ‘professionally’ to that perceived *need*.

A recent survey in USA revealed the internet closely runs behind pharmacists as a trusted source of accurate clinical information about medication for patients but it still lags a long way behind GPs. "The ease of access to online resources has improved, empowering patients to become more involved in choices about their healthcare and engaging their physicians in discussions about the information they have amassed".

A total of 13% of patients questioned for the Accenture-run survey said that the internet was the first place they turned to when they wanted to learn about medication, while 16% said they would go to pharmacists. Philip George, a partner at Accenture's Health & Life Sciences practice, said a total of 61% of the 1,000 respondents said GPs were their most trusted source.

There are of course many more sources of information available for patients to look at but the desire to introduce some standards and seek to provide 'good quality healthy information' readily available without researching too far is a welcomed trend.

The patient's rights to choice will always have to be balanced against the finite resources of an NHS. But the increase in empowerment of patients through improved access to quality information with clinicians positively engaging with patients through dialogue at the earliest stage appropriate, (which at one time was seen as unnecessary, unwelcome and costly in terms of clinical time) can contribute towards cost savings in the long run by improving the health gains and outcomes for patients.

Now more than ever there is a plethora of information out there; for those enthusiastic enough to trawl through the good, the bad and in some cases dangerous examples of 'patient information' there are some jewels to be found. Clearly some standards are needed to assist both the health professional and the patient in their quest for suitable quality information that forms the bedrock of 'informed consent'.

To that end, a number of examples of creative thinking around how to meet the information needs of patients have begun to produce some exciting new enterprises. Here are but a small example:-

Patient information Forum www.pifonline.org.uk/

This web site is a not for profit social enterprise company whose core values include taking a patient focused approach to their work and:-

Sharing expertise and experience around health information
Promoting **equity** in provision of and access to health information
Facilitating **access** to quality information for patients and beyond
Improving the patient **experience** through information
Encouraging a continuous **learning** culture around health information

Skills for Health Council www.skillsforhealth.org.uk

Working in partnership with PiF, Skills for Health are supporting a workshop to look at professional competencies as part of the Patient Educator Project.

The key objective of the event is elicit the views of members of the NHS, voluntary sector, health professionals and patients on the draft competencies proposed for the National Workforce Competence Framework for Patient Educators. The workshop will inform how these draft competencies are then developed and delivered.

Department of Health www.dh.gov.uk

Health Information Accreditation Scheme.

The Department of Health are considering implementing a scheme to accredit providers of health information. The aim of the scheme is to sign-post users/patients and health professionals towards information that has been certified as meeting a minimum standard of quality. In the first instance, the scope of information to be covered by the accreditation scheme will relate to treatments and diseases as opposed to comparative information relating to different providers of healthcare.

Dr Foster Intelligent Patient choice CD

To support Patient Choice in practices, a two stage Practice Toolkit has been produced for practice managers and GPs. It focuses on what is need to give patient's choice, but it is also a comprehensive web based training programme to give staff the skills needed to support patient choice.

.....and locally

Information on Prescription

In partnership with local agencies, pharmacists may direct patients to sources of health information and advice in order to enhance the patient's knowledge of and understanding of their condition and identify sources of support around changing life-styles to improve health outcomes. In Stockport the PALS (Patient Advice and Liaison Service) along with the Public Health department have been working with pharmacists to improve the range of health information available to patients. PALS developed a pro-forma for the pharmacist to complete with the patient requesting information on conditions or support groups locally. This is then sent to the PALS officer who will contact the patient, discuss their requirements and explore how and what is available for them. This may be a referral to an Expert Patient Programme, or Social Services, housing or benefit advice, or a local support group, social activities as well as researching information on the web site and local medical library.

Into Health

Stockport's one stop health information source launched several years ago as Into Health now functions as an integral part of our PALS service. This equips PALS in Stockport to offer a broader health information service than is normal.

THE LIMITS OF MARKETS

The use of market mechanisms to operate the economy is attractive to libertarians because it depends on the interplay of the activities of individuals rather than on any decision making body and it is therefore less susceptible to authoritarian interference. It can therefore be argued that markets empower individuals.

Current Government policy is to increase the role of markets in the NHS. Linked with the "Choice" initiative the idea is that patient control will thereby be enhanced.

It is important therefore that we understand market mechanisms.

The critical point of market theory is the effect of supply and demand. If supply is insufficient to meet demand then the price rises. This makes it more profitable to produce the good in question. For a transitional period windfall profits are made but these attract new suppliers which results in an increased supply to correct the imbalance. The market corrects the imbalance more efficiently and quickly than any alternative.

This is an attractive idea and across much of the economy it actually works. But there are areas where it doesn't and where attention to market theory would itself predict that it wouldn't. These areas can be found described in the footnotes of economic textbooks but are often ignored when practical decisions are being made.

Many of them are of significance to health and it is important that we are aware of them.

Situations where an increased price cannot produce increased supply

If an increased price cannot produce an increased supply then the supply and demand relationship cannot do its job. This applies when The amount of the commodity in question that can be supplied cannot be increased – an example would be land

The commodity in question is purchased because it marks status or confers advantage and it is this relative position that matters not the absolute – an example of these positional goods would be education which can be sought for its own sake but is far more often sought for the status it certifies

The commodity in question is sought after because it is rare. Collector's items would be an example.

Market entry costs may create a natural monopoly in which it is difficult for new suppliers to enter the field. Infrastructure would be a good example – we cannot have competing public water supplies because they would be too expensive to construct. This is actually an example of a broader problem with markets – Pigou's Theorem – which is that they underinvest in, and make inefficiently low use of, services in which the average cost is much higher than the marginal cost.

Situations where relevant factors do not impact on the market mechanism

Sometimes there are important factors which do not impinge on the market mechanism Externalities, where part of the costs fall on third parties, are an important category. Pollution is a good example. The market can only work properly if somehow these are brought into the equation – hence the interest in the “polluter pays” concept

The Tragedy of the Commons which will be described more fully later

Where marginal costs are lower than average costs it may be difficult to obtain the benefits of the potential economies of scale because a price set at marginal cost will not recover all the costs whereas a price set at average cost will price away the marginal users. This is called Pigou's Theorem and it predicts that markets will underinvest in goods and services where the cost curve is downward sloping (ie where there are high entry costs and considerable economies of scale)

If insurance becomes the norm then the consumer no longer feels the pressure of increased costs – a situation sometimes called “moral hazard”

Transactions driven by motives other than profit. Blood donation is a good example. The buying and selling of blood results in a fall both of quality and quantity as voluntary donation of blood is driven by a key set of values which direct payment cannot substitute for such as altruism

personal satisfaction

gratitude for a service received for a loved one

satisfaction on a charitable contribution

participation for the greater good

The Tragedy of the Commons

The Tragedy of the Commons is named after a hypothetical situation where there is a common which can only support the grazing of twelve cows. There are twelve commoners each with a right to graze a cow. Each of them is grazing a cow and each of them is considering whether to graze a second. Each of them reasons that if they graze a second cow they will get all the extra produce and yet they will lose only one-twelfth of the consequences of the overgrazing. So each of them rationally decides to graze the extra cow. Even if they realise that others are making the same decision it is still rational for them to graze the extra cow. They are going to suffer the consequences of the overgrazing anyway – why should they alone lose the benefits. The common is now seriously overgrazed. But it is still in the interests of each commoner to add a third cow. And so it goes on until the common is destroyed and the cows die or the Commoners get together and agree bye-laws for the common.

Situations where the market needs to be tempered by social justice

Sometimes market mechanisms may produce consequences which are so unjust that they cannot be tolerated

There are some commodities, such as legal justice and health care, where there would be a sense that it would be wrong if people could only have them if they could afford them

The transitional consequences as the market operates to produce balance may be unacceptable. Even if selling food at grossly inflated prices were the most efficient way to

bring a famine to an end (by creating a powerful incentive to import food) the transitional situation, in which those unable to pay the price die, is unacceptable. Many IMF prescriptions for developing countries are open to the criticism that they create unacceptable transitional consequences and these play a major role in the health crises of the developing world. The market uses the income that a person receives for their labour in two ways. It uses it as the price of the labour in the labour market. It also uses it as the consumption power that that individual has to meet their needs and this is the prime input into the market's function of meeting human needs. Market theorists who suggest that the market will effectively meet human needs overlook the key problem in this dual use of the one item. The prime consumer input into the market should be based on the distribution of human need coupled with some variation associated with reward and sufficient to allow a market in labour to operate. There is absolutely no reason to suppose that that distribution will correspond to the unmodified market distribution of the value of individuals' skills. Indeed it seems highly unlikely that it would. Minority needs may be insufficient as a niche to attract providers and may be neglected in favour of the majority. Pharmaceutical research is an example.

Situations where individual consumer sovereignty cannot drive the market

Market theory assumes that individual consumer decisions will send the "demand" messages that drive the supply and demand nexus.

There are situations where this is not the case
Where a good is enjoyed collectively not individually a collective consumer needs to be created. Many environmental benefits fall in this category
Where the consumer cannot judge their own need, for example in the case of professional services such as health care where the consumer is advised about their needs by their supplier, the supply/demand nexus is no longer a balance but is driven by the supplier. If important matters which consumers should take into account are concealed from them (e.g. the healthiness of the commodity) they will be unable to take them into account in their purchasing decision

The Health Significance of These Problems with Markets

These problems with markets are significant for health in a number of ways
Health care falls into several of the exceptions
It is a commodity which raises issues of social justice. So long as it is paid for by an NHS financed out of general taxation these are substantially tempered but there may still be an inequality in favour of those with better access to alternative sources of information and these may be worsened by increasing patient choice
If it is paid for by the NHS (as it must be to overcome problems of social justice) it will be subject to "moral hazard" – the patient will be indifferent to cost This underpins the conflict between choice and resource optimisation.
It is a commodity with significant issues of capacity. Where the supply of skilled professionals is short there is a limit on the number of people who can be treated.
It is a commodity where the transitional consequences of a market adjustment may be unacceptable
It is a commodity where the consumer is dependent on the advice of the supplier
Hospitals are an example of Pigou's Theorem. Marginal costs are significantly below average costs. This used to be taken account of in contract negotiation but the introduction of tariffs has removed this adjustment and restored the original market distortion. It is sobering to appreciate that our current recovery plans (and other similar NHS deficits) are the predictable consequences of the introduction of a market distortion.
New drugs are another example of Pigou's Theorem and the high prices necessary to recover research costs result in them being underused. It would be better if the NHS centrally were to pay a subsidy for the research costs so that the drugs could be available more cheaply. Pharmaceutical research for the treatment of rare conditions is an example of a niche that fails to attract investment.
Altruistic care represents an important component of the total health care system.

Many environmental issues fall into one or more of these problem areas

Land use is an area where there is a need for regulation because the supply/demand nexus does not work properly as the supply cannot be increased.

Pollution is a major externality.

Environmental improvements often require a collective consumer.

Transport is a Tragedy of the Commons situation. So is waste disposal.

Public transport investment is an example of Pigou's Theorem and the market will therefore produce a pattern of investment distorted in the direction of excessive car use

Education is another area where there is a legitimate health interest and where the supply/demand nexus does not operate properly because it is a positional good

Poverty is a public health issue and the distribution of income is an issue which the market is unable to handle adequately

Health-damaging commodities create an externality issue unless the flow of information is regulated so that the consumer is properly informed.

Water supply requires a collective consumer because it is impossible to have competing supplies.

A10.2.3 Empowering Individuals to Make Healthy Life Choices

A healthy nation is not only one which has an equitable distribution of resources but one which has active empowered communities, which are meaningfully involved in creating that healthy society themselves.

The concept of empowerment is central to the philosophy and practice of health promotion and public health. It is also both a desirable end in itself and a means to an end.

The role of health promotion in seeking to influence individuals' lifestyles is not to coerce, cajole or persuade, but rather to facilitate choice by providing people with empowering competencies and support.

Examples

In recent years there has been growing evidence of the success of the 'self care' or 'expert patient' approaches to people when they are ill. This approach helps people to learn more about their own illness, and how to manage it effectively without always depending on professionals for support. It helps to put patients in control of their plans for how they manage their own disease. We need to extend this approach into prevention, before people develop illnesses, enabling people to take greater control of their own health on their own terms.

Motivational interviewing techniques provide one approach for staff working with individuals making changes in their health behaviour. These techniques enable staff to empower individuals by acknowledging that change happens within the context and priorities of an individual's life. Staff learn appropriate methods to help individuals decide their priorities, set their own goals and achieve their desired changes.

The new role of Health Trainers also offers a significant opportunity to empower individuals to make informed lifestyle choices. Drawn from local communities Health Trainers will become an essential common sense resource in the most disadvantaged communities to help people make health choices. Health Trainers will be in touch with the realities of the lives of the people they work with, and have a shared stake in improving the health of the communities they live in: they will succeed by being understanding, supportive and helping people believe they are capable of achieving what they would like to achieve (i.e. acquire self-efficacy beliefs).

For individuals to be empowered requires healthy public policy that ensures that the healthy choice is the easy choice.

People's health is not just an individual responsibility: to cajole people into taking responsibility for their health, while at the same time ignoring the social and environmental circumstances which conspire to make them ill, is victim blaming - a fundamentally defective and unethical strategy.

The process of 'building healthy public policy' is at the very heart of health promotion/public health. Healthy public policy tackles the physical, social, cultural and economic environments in which we live and work, and which to a large extent govern our health. The following sections offer some examples.

A10.2.4 Empowering Individuals – the Local Authority Role

The local authority has an important influence on the lives of many people. It is a large employer. It provides care for many of the more vulnerable and dependent sections of our population. It provides basic services on which all of us rely. Its planning and licensing functions regulate activities that impact on our lives.

In all of these areas it is important that the local authority works with people, not at arms length from them, so that they do not feel that matters are out of their control. It should not leave people worrying for a long time about something which they feel unable to influence.

It is important, for example, that, when care is being arranged for vulnerable and dependent individuals, the council should work with those individuals to develop care plans which help them develop their own privacy, dignity and independence and leave them feeling as if they are making their own life choices, rather than feel that they have to fight for services which are decided by others. Licensing processes, planning applications and the like should be fair and transparent and when they are likely to cause stress to individuals they should not be unduly delayed. Housing should be managed in a way which recognises its significance as a key part of the lives of the individuals who live in it and which do not leave them feeling that decisions are being taken without them. Failures of council services can cause stress and complaints should be addressed promptly. Where people cannot be given what they want it is important that this is explained to them honestly and openly so that it is one of the vicissitudes of life rather than a perception of bureaucratic unreasonableness. Much of this will come automatically from a universal customer-focussed approach, and the Council is taking important steps in implementing such a focus, but empowerment is rather more than just a customer focus - the council's role in managing our collective services and expressing our collective choices is more central to people's empowerment and more interactive in its nature than a mere customer/service provider relationship.

A10.2.5 Empowering Individuals – the Role of Employers

As mentioned above, control of one's own work has been associated with improved health. There is also considerable evidence that organisations whose staff are empowered perform better than those which use old fashioned authoritarian methods of management.

A10.2.6 Collective Empowerment

There is a tendency to think of the liberty of individuals as in conflict with the power of the collective. In many areas of life however the reverse is the case. If we are to control our own destiny we must have the right to make collective decisions about the general state of our environment. Those decisions are not a constraint upon liberty but a genuine exercise of it.

This principle is of great importance in a set of situations called the Tragedy of the Commons, described above as one of the limitations on market mechanisms.

To prevent the commons being destroyed by overgrazing the commoners must get together and agree by laws for the common. None of them alone can bring about what each of them

wants – the preservation of the common. If each of them makes their own rational decision in their own self interest, what will result is what none of them want. To be able to control their own destiny they must have the freedom to make a collective decision and impose the constraints that secure their collective choice.

THE ISSUE OF SMOKING BANS

The case for smoking bans can be made even in the terms of a definition of liberty which permits constraints only where they protect others from harm. Such a case would be rooted in the harm occasioned by passive smoking. It is a powerful case even on the most traditional definitions of liberty. Why should people have a right to poison others? Do people not have a right to be protected from being poisoned at their place of work or at the place where they go for their recreation?

When we define liberty as the right for human beings to control their own destiny another equally important issue arises. Most smokers want to give up. They have become addicted to tobacco in their youth when they were ill informed of its long term consequences and now that they know the consequences, and wish rationally to avoid them, they find it very difficult to do so because of their addiction.

This addiction is a constraint upon their power to control their own destiny. We would enhance their liberty if we made it easier for them to implement the decision they wish to make. We do the exact reverse of helping them if we tolerate a situation where the vast majority of pubs and clubs permit smoking. If would be ex-smokers, who wish to avoid the reinforcement of their addiction, must give up most of their social life along with their cigarettes their liberty is diminished. Hence the smoking bans that are to be introduced next year are not a restraint in liberty – they are an empowerment.

THE ISSUE OF HEALTHY FOOD

Clearly people must have the right to choose to eat unhealthy food. It is the most fundamental principle of liberty that it must include the right to be wrong. If there is no right to be wrong then no freedom is meaningful.

It is a travesty of libertarian thought to use that statement as the end point of the discussion.

Do people eat unhealthy food because they choose to?

Is food so labelled that people can easily distinguish healthy from unhealthy food? The food industry is bitterly resistant to such labelling.

Is healthy food as readily available as unhealthy food? It is certainly very difficult to find low salt processed foods and such as do exist are often found only in large stores, often accessible only to those with access to a car.

What about the power of persuasive advertising? Far more money is spent persuading people to buy unhealthy products than is spent on informing them about their hazards. This is said to be the “commercial freedom” of the manufacturers. This concept deserves examination. It is one thing to say that people have a right to choose to harm themselves – quite another to argue that businesses should have the freedom, for purely commercial reasons, to try and persuade them to do so.

Tackling these issues is not interference in the people’s freedom to choose. On the contrary these issues must be tackled if that freedom is to be meaningful.

Australians, a group probably not dissimilar in their tastes from the English, believe they have a right to choose to eat low salt foods and so they have placed constraints upon the freedoms of food manufacturers so as to ensure that that right is meaningful. In doing so, they demonstrate a more sophisticated understanding of human liberty.

THE ISSUE OF FLUORIDATION

It is odd that the opponents of fluoridation speak of freedom of choice, for there can only be one composition of the public water supply.

There can be freedom of choice in bottled water and indeed you can argue a case for saying that steps should be taken to protect that choice by ensuring that where the public water supply is fluoridated, unfluoridated bottled water should be available, and conversely where water is unfluoridated there should be a supply of fluoridated bottled water.

But the choice as to the composition of the public water supply can only be a collective decision. That is a simple factual point.

What is so special about unfluoridated water that those who want to drink it believe that their right to be supplied with it should outweigh the wishes of the majority?

What is wrong with the American view that, in the home of the free, people have the right to drink fluoridated water?

The lovers of tooth decay, of course, present the argument in terms that fluoride is an alien addition to water. In fact fluoride is one of the natural minerals normally present in water. Like all natural minerals it has an optimal level and outside that range it causes harm – too much of any mineral will poison you, too little will give you a deficiency disease.

Why should we not adjust the level of fluoride in our water supply to that level which generations of experience of natural water supplies has shown us to be the one that is optimal?

ROAD TRAFFIC

For years the stock argument of anybody who wants to do something irresponsibly risky has been to say that it is safer than crossing the road. It usually is. I always wonder how long it will be before we accept the true logic of that argument and start to do something to make it safer to cross the road. We could save most pedestrian road accident deaths if we had more safe crossings of main roads and we drove at 20mph when we left the main road. Since few places are more than a mile from a main road, few journeys will involve more than two miles off main roads. The difference between travelling two miles at 20mph or at 40 mph is three minutes. We are killing our children to save less than three minutes on our journeys. This is not a legitimate exercise of freedom.

Road traffic is one of the most important current examples of the Tragedy of the Commons. Car users congest the roads thus destroying the benefits that they thought they had acquired with their car, whilst public transport users face a declining system. It would be in everybody's interest if everybody used their car only when they really needed to. Then the roads would be free of congestion and available to car users when needed and public transport would be more frequent and more extensive in response to the increased demand for it. But nobody can bring that about alone. Unless we act together our individual decision will be to add to the congestion. The idea that we cannot constrain that individual decision takes away from all of us the greater freedom to act collectively to stop the rot and bring about the better situation that the overwhelming majority would prefer. Once again an over simplistic idea of liberty disempowers. It is this disempowerment which is the true affront to liberty.

SO WHERE DOES REGULATION STOP?

So is there no end to the regulation that I am prepared to advocate in the name of human health, justifying it as libertarian in the name of empowerment?

Yes of course there is. The concept of liberty that I am putting forward sets that limit.

Regulation stops when it no longer gives people a collective power over their own environment that makes a greater contribution to their control of their own destiny than the lesser individual freedoms they give up. Until that point regulation is empowering and is an assertion of liberty. Beyond that point it starts to become an affront to liberty.

Where people are making collective choices, or they are removing barriers that prevent them making healthy choices, or are changing social norms so that the healthy choice becomes the natural choice, or are ensuring that the flow of information is not distorted by commercial

pressures for people to harm themselves then there is an act of empowerment that libertarians should support.

If those areas are properly addressed then I do not think we have any reason to see liberty as likely to be a threat to health. Our species would not have survived millions of years of evolution, many of them in conditions of great adversity, if it were equipped with a deep-seated instinctual drive to harm itself.

A10.2.7 Collective Empowerment in Health Services

The NHS does not have the local democratic accountability that local authority services do. This is mainly because it is seen as of national significance and so it has been thought to be right that it should be accountable to Ministers and through them to Parliament. In any case many groups for whom the NHS matters are underrepresented in the ordinary political process. Young people, old people, disabled people, housebound people, carers, and the parents of young children, are obvious examples.

As a result the NHS has sought alternative ways of making itself responsive to the people it serves.

The NHS Plan (July 2000) set out a vision of a service designed around the patient and where patients are at the centre of developing and shaping services. This vision was further bolstered by the modernisation agenda and commitments made by the government in response to 'Learning From Bristol – The Report Of The Public Enquiry Into Children's Heart Surgery At The Bristol Royal Infirmary' known as the 'Kennedy Report' (2001).

Further guidance contained in sections 7 – 11 of the Health and Social Care Act (2001) and its statutory instruments 'Strengthening Accountability – Involving Patients and the Public' together with 'Keeping the NHS local – A New Direction of Travel' (2003) and 'The National Service Framework for Children – Getting the Right Start' (2003) further defined the steps to be taken towards outcome, for those engaged in considering service expansion and design.

Increased public involvement and empowerment demands that a wide range of access points suitable to the needs of the diverse requirements of people within a population need to be made available. These access points should be capable of offering patients the information and knowledge at the level and intensity that they may require. Likewise, to assist patients to a greater power, the NHS is required to offer a choice to patients of how they want to participate with health service planners and providers, to influence their own healthcare or be involved in working with the NHS to plan, monitor or improve the care it offers.

Patient and Public Involvement (PPI) can be interpreted in different forms. For some it may be solely about their perception of a service received, for others it may be involvement in a group deciding how to improve a service and for others it may be being consulted on a major change of service or choosing which hospital to be referred to for possible surgery. Some may just wish to keep themselves informed of modern treatments or of the services that are available to them. Others like opportunities to debate or ask questions, these may be to the service givers or to the planners of services. Where there are planned reorganisations, many different groups of people may be involved to help the NHS to collect a wide range of views of how people think that the possible changes may affect them. Information for many pre-consultations and formal consultations will be used to ensure that the final decisions are made with the full knowledge of what people want.

Feedback is especially important for good patient and public involvement because people need to see that what they have said has been listened to and considered. This is vital where the decisions are contrary to the view held by the member of the public, as this member of the public should be able to understand the grounds on which the decisions were made. The NHS may choose to offer events or other methods to collect or offer information. Whatever method chosen, be it a research tool, an information website, minutes of a meeting or a newspaper, the NHS need to be aware that assistance may be required to enable people to participate fully. For example, assistance may be needed in terms of language, interpretation, explanation or choice of venue to encompass the needs of people with sensory impairments or those experiencing other difficulties.

Any NHS organisation using a high degree of patient and public involvement, are aware of the immense value added by involving people in the development and shaping of services and even though using PPI is very challenging and requires thought and planning, the rewards are demonstrated by that organisation having robust and well appreciated services.

A10.2.8 Empowering Local Communities – the Role of Community Development

There are clear links between the objectives of public health and those of community development. In particular these are strongest in the areas of community participation and addressing inequality and disadvantage.

Community development is concerned with strategies and mechanisms to enable people in disadvantaged communities to have a full say in the decisions made about their communities by local authorities and statutory bodies. It focuses on identifying and addressing the needs and priorities of community members and assisting them in communicating these to decision makers. The expectation is that the opinions and perspective of community members will be central to the decision making process. Community development is inherently involved in addressing inequality and exclusion and, as such, is a natural partner to public health.

It is helpful to think of different levels of community development work:

Primary or Generic Community Development – perhaps the most pure, but also most challenging – this works with communities to discuss and identify their needs and then seek ways to *help them* to meet these needs, either with agencies or through self-help. As the approach starts from the community and works outward, agencies are not the leading players. Where service providers become involved, the communities' expectation is that service provision will respond to meet the needs and priorities identified by the community. It is the community that sets the agenda and makes key decisions. In this regard, community development is concerned with the development of social capital and community assets, with multiplying the resources available within or to a community, as well as maximising its control over those resources.

Purposive Work – this is when a local authority organisation or statutory body seeks out the community's involvement in its programmes. The needs and priorities are identified by the organisation to meet its own targets, but may seek to increase community empowerment in running the project once it has been established by the agency. This is a more difficult process of empowerment, as the initiative comes from agencies and the community members start from a relatively passive position.

Community Engagement – this is when the community is approached by agencies to seek their views about an existing service to obtain feedback. There is no necessary follow-through to a change in the pattern of service delivery on the basis of what community members' say. The control and decision making rests with the organisations or statutory bodies seeking community support. The community role may be to endorse the decision made or bring about some adjustment to these but cannot affect the fundamental objectives or approach being applied.

Clearly there are challenges in working with a community development model. Firstly, identifying a 'community' can be difficult given the present levels of diversity in our society. Geographical definition may not be the most useful, and recent work has focused on 'communities of interest' as an alternative construction (see case studies).

Secondly, it can be hard to focus on the benefits of cooperation in the face of competitive threats, whether real or perceived. The case study on Stockport's joint credit union demonstrates how this can be true even within a community development activity itself.

Thirdly, it can take a long time for people to become confident in their own capacities and for those in power to trust the judgements of others. Democracy is hard work, especially in the current climate where so many feel abandoned by politicians and without any real voice. Of course, this is precisely why and where a primary community development approach can be so effective, but it is far from speedy in obtaining results and patience may be in short supply. In this respect it can be helpful to analyse community development further, as the Stockport CD department have recently done in their "Achieving Better Community Development" Quality of Life work. They identified four aspects of community development (or empowerment) to be attained: A Learning community; Positive action; an Organised community; and an Influential community. The box below provides more detail.

"Personal Empowerment"= Learning Community

How we enable people to develop their own knowledge, skills and confidence (capacity, social capital) and how we encourage people to believe in their potential to change things (morale, trust)

"Positive Action" = Community Cohesion

How the group is open to all, inclusive, respects diversity, and promotes social cohesion
How the group acts positively to remove barriers to participation

"Organised Community" = Sustainable Community

How the group is supported in developing its own organisation, from basic activity (eg. a single project) to advanced levels (eg. a Federation, a community business)
It may involve work on Needs assessment, vision, group formation, action plan, resources, action, evaluation, etc...

"Influential Community" = Community Participation

How the community participates in making key decisions about their communities
How the communities' agendas influence decision-makers and create change
How the communities develop own services and assets, and engages with other communities through networks

Case studies

Below are 5 examples where local communities and workers are involved in a range of community development projects.

One function of the local authority community development team is to bring together communities of interest. The Stockport Credit Unions Forum and Building the Black and Minority Ethnic (B & ME) Community Sector are examples.

STOCKPORT CREDIT UNIONS FORUM

Brinnington Community planned the first Credit Union in the Borough in 1987. by 2005, there were 4 community credit unions which became a single borough-wide credit union. The Credit Union is run by volunteers, building a high level of skills and mutual support within communities and between communities to tackle financial exclusion and related isolation and stress. It has

700 members,
53 active volunteers

11 collection points in disadvantaged neighbourhoods (Brinnington, Reddish, Woodley, Offerton, Cherry Tree).
a holding of £215000 in shares and giving out £135000 in loans.

The Forum is supported by two part-time Development Workers within the Community Development Team

BUILDING THE BLACK AND MINORITY ETHNIC (B & ME) COMMUNITY SECTOR

Background

The local authority community development team leads the Community Development Focus Group, a monthly forum for agencies engaged in community development work. The Focus

Group examined the current strengths and weaknesses in how we are all meeting the top 12 needs identified by Stockport's Community groups and decided that there was a need to develop a stronger B & ME community organisation for the Borough to enable B & ME groups to:

support each other,
send informed and accountable representatives to the Local Strategic Partnership (LSP) and engage with the public sector for example about the effectiveness of current services in meeting community needs.

Activities and achievements

A series of planning meetings identified the way forward
a public meeting was organised involving the Local Authority Chief Executive John Schultz
Over the next six months the fifteen B & ME community representatives have continued to meet to adopt a constitution, elect a management committee and obtain training to develop capacity for infrastructure.

The two B & ME representatives say they feel more representative of B & ME needs when they represent the communities at the LSP Board.

The Chair of the B & ME Network is now recognised as a key contact for agencies seeking to initiate consultations with B & ME communities.

A database of over 60 B & ME community contacts is now held by the Policy Unit

The partner agencies continue to collaborate positively in continuing to offer support to the Network to help it become financially sustainable – we are currently working with the Network on grant bids

The community development team feel the learning is that a stakeholder partnership of agencies and communities is essential to develop a borough-wide network by pooling information, contacts and skills, and modelling to the communities that the initiative is a serious and consistent initiative to improve the service to B & ME Communities

The Network has managed to maintain community cohesion amongst its diverse B & ME communities, ensuring that all ethnicity groups are represented in the management committee

COMMUNITY SUPPORT WORKERS AT SURE START – DECENT WORK OPPORTUNITIES FOR LOCAL PEOPLE THAT ENABLES HEALTH PROJECTS TO REACH DEEPER INTO COMMUNITIES

Community Support Workers work across the Adswood and Bridgehall_Sure Start programme in 10 out of 12 projects in a variety of roles. They are local residents employed by the PCT for between 5 and 10 hours a week. They are part of the Sure Start Social Inclusion project.

A total of 67 people had been through the scheme by June 2006 with 24 active and a further 6-8 due to start.

When the project started in 2001? recruitment was an uphill struggle
local people did not apply for the posts

Projects were hesitant to make openings for workers due to a lack of confidence on the part of project staff about employing local people and the roles they would have within the project.

There is now a high demand for places on the scheme and from increasingly diverse groups within the local population matched by an insatiable demand for community support workers from within the projects. This relates to two things:

people in the local community having a successful and supported experience as a worker and hearing via word of mouth that being a community support worker is something worth doing
the professionals working within the projects realising that having community support workers give them credibility in the local community and access to local people who

would not have previously been interested as well as accessing greater local knowledge and ideas.

For example, in Smoking Cessation, the main challenge was getting trust; 4 and a half years ago when the smoking cessation adviser started they were seen as, 'smoking police. A Community Support Worker has given the project credibility without a doubt. When I first started my role it would have been a hundred times easier going into a local group with a local person, I would have made an impact much quicker.'

Baby massage groups have been run by local workers now trained to facilitate sessions and numbers have dramatically increased by 500% in 3 months.

The Community Support Workers project has impacted on the culture of the whole Sure Start programme and created a genuine partnership with the community who are an integral part of its running and decision making. The community itself has, due to an increased confidence, now taken a lead on some initiatives such as a health and fitness project and community garden.

Projects like the Community Support Workers can provide knowledge and experience on which other projects can be built, for example the community based health trainers due to come on board in Stockport in April 2007.

OWN GRUB PROJECT – Green Roof at Reddish Vale Community Garden

The Own Grown Grub project helps people gain the knowledge, skills and confidence to grow their own food. It is part of the Parks and Recreation Department and the Healthy Living Scheme in Brinnington and Reddish

Own Grown Grub decided to build a green roof for the ecological benefits, to improve the appearance of the steel containers which is their base, and as an important educational resource. Volunteers were involved in every step of the construction.

A Green Roof is a layer of living, natural material build over an existing roof, to provide insulation, a natural habitat and a visual impact. Green roofs are common in Germany and Holland but there are very few green roofs in the North West of England.

The roof took 3 months to construct, involving 17 volunteers contributing a total of 630 volunteer hours. Volunteers have since been involved in the ongoing maintenance of the roof, removing tree seedlings and planting extra plants to cover bare patches.

The green roof has created a pleasant working environment, which is less noisy and warmer in winter. The volunteers are impressed with how it works and that they made it. It is very popular with visitors.

The completed roof gives a sense of permanence to the steel cabins and to the project itself. As the plants will take a few years to fully blanket the roof area, volunteers are keen that the cabins will stay in place to be used as a community resource after the Own Grown Grub project finishes.

The Mayor, local councillors and MP attended the launch of the roof and solar panels and it was reported in the local press. Both other community groups within Greater Manchester and individuals who want to build their own green roof have visited the community garden for advice on construction and funding.

The hard work by all the volunteers contributed to the community garden being included on the route for North West in Bloom and an international competition in July 2005.

DEVELOPMENT OF BREAST FEEDING IN BRINNINGTON (BIBS) SUPPORT GROUP – PEER SUPPORT TRAINING PROGRAMME

Primary community development workers who are geographically based have been able to work alongside local women within their community and other partners in midwifery, health visiting and the children's centre to help develop a support group for breast feeding mums.

Sometimes generic community development work within communities can provide useful interfaces with purposive approaches that are often trying to meet national and local health initiatives and targets.

In Brinnington local women identified their needs by expressing frustration at the lack of support ante and post natally for breast feeding mothers. Local primary care trust community development workers are ideally placed within established health networks to help support collective action for health improvement.

In an area where breast feeding rates were very low and had traditionally been so over many years; long held views are being challenged and women are empowered to offer support to each other by taking part in the training programme offered by midwifery partners in peer support training.

Benefits extend beyond the range of the well evidenced data regarding nutrition, physical wellbeing and bonding for mother and child. They begin to encompass extended social networks and increased skills and knowledge. These affect self esteem and enhance status.

A10.2.9 Empowering Local Communities – the Role of the Local Authority

If people are to control their own environments then it is important that the local authority listens to local communities and responds to their concerns. Area Committees, parish councils and local community groups have an important role to play in empowering and channelling local action.

However this does lead to some dilemmas.

Take for example the use of a piece of waste ground for recreation by young people. The local community immediately surrounding the piece of land may wish this to be prevented. They might even characterise high spiritedness or noise as antisocial behaviour. So, however, might other communities where the activity might be moved to. Young people, too, are part of a community with a need to shape their environment.

Take as another example the closure of a footpath which the adjoining residents think offends their privacy and security. Is the local community the adjoining residents who want the footpath closed, walkers in the broader community for whom it might be part of a network that they use or potential walkers who might in future use it if our transport strategies work. The first two groups may articulate their needs. The last group will not. Should the articulate and passionate minority have their needs met at the expense of the silent majority?

It is well known that schemes which restrict and slow down traffic will get majority support if consultation takes place by questionnaire or by interviewing individuals but not if it takes place at a public meeting. The vociferous minority will attend the meeting.

If we use systems of testing local opinion that rely on traditional debate there is a danger of delivering power to the most vociferous, and neglecting the young, the old, the inarticulate and those who have to stay in at night to look after the children. If however we try to overcome this by designing questionnaires and interviews then we lose the potential for new ideas to be sparked by debate and there is a danger that we will empower not the community but those who designed the questionnaire and interpret the answers.

A10.2.10 The Value of Debate

THE VALUE OF DISSENT

Never confuse loyalty with obedience.

If you are unsure of the difference imagine you are about to make a major blunder.

Those who are obedient will assist you in doing so.

Those who are loyal will do their utmost to stop you.

Some of the most serious blunders have occurred in conditions of Groupthink where a group of leaders came to believe that they were morally superior to their opponents and that anybody who disagreed with them was automatically wrong and probably pursuing a self-interested agenda.

Dissent is our only safety valve against our own errors.

When we stop valuing it we take ourselves a further step away from understanding reality.

THE LIMITS OF EXPERTISE

An experiment first carried out two centuries ago in connection with a "guess the weight of a bull" competition showed that

Expert opinions varied less than non-expert opinions

The average error in expert opinions was less than the average error in non-expert opinions

The average of all opinions was closer to the truth than the average of expert opinions only.

The first two points are unsurprising. The third point is surprising but it has since been demonstrated in many settings, such as the fact that the average performance of investment advisers underperforms the stock market as a whole.

There are a number of reasons for this, not least the tendency for experts to become risk averse when they find they disagree with their colleagues.

This isn't to suggest that we should ignore all expert opinion – the second point shows that experts are less likely to be wrong than non-experts and much less likely to be very wrong.

We should however be careful of closing down the realms of debate so that not all opinions get weighed in the balance.

THE LIMITS OF CENTRAL PLANNING

Marx presented central planning as the solution to the problems of free markets, to the oppressive and exploitative behaviour of 19th century capitalists and to the serious health and social problems of the urbanisation that was under way.

He did so in an overtly libertarian rhetoric – "Man is born free but is everywhere in chains" and "Man is the master of his own destiny but not in the circumstances of his own choosing".

Before central planning had been tried, and before the developments in mathematics and in organisational theory which would demonstrate its difficulty, it is easy to see how this could have seemed the best way forward.

In fact it did not produce the great improvement in human empowerment and in productive efficiency that Marx predicted. It produced the exact reverse.

Organisation theory now provides us with clarity about why the organisations needed to operate central planning will not work well

Large monopolistic organisations will become risk averse. Those who make mistakes will fail to progress professionally so only the risk averse will reach the top. As the Pennine saying goes “Them as meks no mistakes meks nowt else either”

Large monopolistic organisations will discourage dissent and will fail to receive adequate feedback about their errors. Bad news will not be passed on for fear of punishment. Criticism will be sotto voce. Ultimately Groupthink (in which any dissent is automatically characterised as wrong-minded and probably malicious) will take hold and will lead to major blunders.

If targets are set people are less likely to exceed them (Selznick’s dysfunction) so excellence is discouraged

If targets are set and people’s careers depend on meeting them they will be met if possible, even if this is sometimes by means of a distortion.

As well as the difficulties of creating an organisation capable of carrying out central planning we have in the last few decades discovered mathematical reasons as to why the task is in any case impossible. Central planning depends on the belief that if all relevant information is gathered the steps can be taken which will produce the appropriate outcome from the system. Chaos mathematics tells us that this isn’t so – that some systems are stable and predictable but others are by their nature unstable and unpredictable.

In its terminal state the Soviet planning system showed the following symptoms of its failure

Double think in which apparatchiks were thoroughly familiar with two different realities – the actual one that they worked in and had to make decisions about, and a different one which was given to the public

Dual statistics – an official set and an operational set

Bad news not passed on for fear of punishment

Risks not taken for fear of punishment

Vicious destructive personal attacks on dissenters

Services distorted by artificial methods of meeting targets, such as running empty goods trains in large circles to meet the train-miles target

Public services seeing it as their prime role to promote the interests of the governing party.

In 1992, I first pointed out that all of these characteristics were appearing in the NHS. At this time there was still a Conservative Government in place, a point which I think it is important to make as this is not intended to be an attack on the present Government.

Twelve years on the attempts to solve the problems of the NHS by the methods that destroyed the economy of the Soviet Union have continued. So are they showing the same adverse consequences?

Nobody would dispute that the NHS is dramatically improving but this is in response to a very large investment of funds. We used to be the most cost-effective health care system in the world and we dreamed of what we would be able to do if we were adequately funded. What we are delivering with the funds is less than we used to dream of. Is this a sign of a serious decline in efficiency? If so does this result from the planning systems that have been used by the Dept of Health not just under the present Government but for some considerable time before that?

A10.2.11 Empowerment and the current constitutional debate

There is a current debate about the way that the country should be run. The view is often expressed that people feel disempowered and that this is manifested in declining rates of participation in political processes. The view is sometimes expressed that the range of acceptable opinions has become narrowed, that important caveats and points are neglected, that decisions are made by weighing political risk rather than by rational debate and that those who disagree with a small political elite are excluded from all influence. Solutions are advocated such as decentralising power, introducing proportional representation, having fewer full time politicians and more part time politicians, using citizen’s juries, changing the

way political parties function, reforming the civil service, placing public services under the control of a partnership between their providers and their consumers, local control of services by social enterprises, wider consultation, better scrutiny etc. Although there is disagreement about what should be done, the Government itself acknowledges that something needs to change. Indeed it has taken some bold measures, such as devolution, the use of alternatives to the traditional polling station, the recent experimental introduction of panels to scrutinise legislation before it is presented to Parliament, and the extensive consultation on the recent White Paper on care outside hospitals. It has however been criticised for allegedly stage managing these processes.

I have my views as a citizen on those issues but they are not views that it is appropriate to include in this report.

What is appropriate, however is to emphasise that empowerment is a contributor to public health then it is important that the debate be conducted from the starting point of empowering people to control as much as possible of their own lives. This will include ensuring that they have the power collectively to change the factors that cannot be rendered susceptible to individual choice.

Recommendations

1. I recommend that the PCT understands the limits both of markets and of planning as described in this report.
2. I recommend that the PCT maintains its excellent programme of patient and public involvement and takes steps to ensure that the lessons learned are fully carried over into the decision-making process.

**A11: FAITH AND HEALTH IN
STOCKPORT (written 2002)**

A11.1 INTRODUCTION

Faith Communities – churches, mosques, synagogues – are an important part of our society. They can do great good. In the past they have also done great harm.

As Director of Public Health to Stockport it is my job to advise everybody within the Borough about what they can do to improve health. One of the ways that I do that is by writing an Annual Report on the Health of the People of Stockport. Although this is called an “Annual” Report in fact I write individual chapters or sections of it throughout the year addressed to particular problems or audiences. The decision to write a section of my Annual Public Health Report aimed at faith communities reflects my perception that we cannot address the health of the people fully without addressing some fundamental questions about the way that we live.

I start by setting out, in purely secular terms, the issues that are important for health. I do this because many who read this section of my report will not have read the previous sections and may be unfamiliar with the health agenda.

But then I turn to the sections of the report that are aimed specifically at faith communities. I address the role of morality in health, the spiritual concept of wholeness and peace (“shalom”) and the role of faith communities within the wider community, exemplified by the contribution they can make to environments.

In writing this material I have been greatly helped by Helen Pennington, who wrote the first draft of the section on ecocongregations, and the Rev. Tim Ryley who wrote the first draft of the section on shalom. They also commented helpfully upon the whole report. Helpful comments were also received from the Rev. Peter Tiplady, a part-time Anglican priest in Wetheral who is also a full time public health physician, and a former Director of Public Health, from Dr Rona Cruickshank, from Dr Susan Glicher, from Dr Peter Elton, from Dr Ellis Friedman, from Dr Noreen Khan, from Robina Shah, and from John Ellis. I am also grateful to the senior public health nurses and neighbourhood health strategy co-ordinators for producing the chapter on faith communities in neighbourhood health strategies. Nevertheless the responsibility for the report is mine and accepting help in no way diffuses that responsibility. The credit may belong to others but the blame is entirely mine.

APPENDIX TO THE INTRODUCTION:-

A PERSONAL STATEMENT OF FAITH

This appendix is included in the version of the report sent to faith communities. However as it is a personal statement, rather than a personal professional statement (a critical difference) it is not part of the Annual Public Health Report itself.

I have debated whether to share my own religious faith with the reader at the start of this report. The argument for doing so is that it allows my prejudices and

preconceptions to be recognised and taken into account. The argument against is that debate about my religious views, especially where they are unconventional, may detract from the points I am trying to make in the report. After careful thought, and with some misgivings, I have decided that the advantages outweigh the disadvantages. The deciding factors were firstly the belief that faith communities deserve the knowledge that they are being addressed from a background of faith rather than from a purely secular perspective, even if the purpose and authority of the report is secular, and secondly the advice that this would indeed render the report more acceptable, even to those who disagreed with elements of the personal statement.

As this personal statement is not part of the Annual Report it does not appear in this presentation.

A11.2 THE HEALTH AGENDA

The following is a summary of some of the major issues of the health agenda to help set the scene for the following sections on the role of faith communities. For a fuller account, including comments on health services as well as health, readers are referred to my full Annual Report.

HEART DISEASE

Heart disease is one of the two greatest killers of our time. It is caused by smoking, low fibre high fat diets, lack of exercise and stress. Moderate consumption of alcohol helps protect against it, as does aspirin.

What Can We All Do To Help

The NHS can

- help people give up smoking
- screen for risk factors so people know what improvements they need to make
- advise people about adopting healthier lifestyles
- invest resources in things which make it easier for people to adopt healthier lifestyles (past investment in SWIMBUS and in the health and greenspace project are examples)
- provide high quality treatment for heart disease
- provide a high quality service for diabetes
- screen for high blood pressure and high blood cholesterol and ensure that they are effectively treated
- play its role as an employer, a caterer and a landowner
- work with partners to help bring a comprehensive strategy into play
- teach resuscitation skills so that if people do have a heart attack bystanders will be able to help
- develop youth outreach programmes to tackle the epidemic of smoking amongst young people
- operate a stress prevention policy
- build social networks through a community development strategy.

The local authority can

- protect areas of peacefulness and tranquillity as refuges from a stressful world
- develop a transport strategy which makes more provision for walking and cycling
- encourage caterers to serve healthier food
- rigorously enforce tobacco legislation
- play its role as an employer, a caterer and a landowner
- promote exercise opportunities through leisure facilities, countryside management etc
- make information available in information centres
- develop youth outreach programmes
- operate a stress prevention policy

- build social networks through a community development strategy.

Employers can

- avoid people working under pressure to deadlines
- have policies to reduce stress
- provide cycle racks and showers to help people walk or cycle to work
- provide exercise opportunities
- have a smoking policy
- provide healthy food in the works canteen
- operate family friendly employment policies so as to support social networks and reduce the stress of conflict between family and work roles
- carry out health education in the workplace
- develop Green Commuter Plans
- teach cardiopulmonary resuscitation to their staff.

Caterers can

- adopt a pricing policy that encourages healthy choices
- develop imaginative menus which make the healthier choices attractive
- identify healthy choices
- ensure that all food is cooked in the healthiest way possible for that particular food
- operate smoke free areas
- serve food in tranquil and peaceful settings.

Landowners can

- create peaceful and tranquil surroundings
- support the development of rights of way and cycle routes that promote walking and cycling
- plan development in a way that encourages walking and cycling
- ensure that their land contributes to the sense of peace and tranquillity of the surrounding community by paying attention to the traffic flows it creates and to its external aesthetic appearance.

People can

- choose low-sugar, low fat, high-fibre versions of the foods you eat
- eat less red meat, substituting white meat or fish if meat is desired
- add less salt in cooking and at table
- drink grape juice, beer or wine every day. Choose grape juice rather than alcohol on at least some days, so that you don't drink alcohol every day
- take half an aspirin tablet with food on alternate days (ignore this advice if you have stomach trouble of any kind, are allergic to aspirin or have asthma which is made worse by aspirin)
- every day take some exercise that makes you sweat or makes you out of breath
- preferably every day, and certainly two or three times a week, take exercise that lasts at least 20 minutes
- use stairs instead of lifts
- make short journeys on foot instead of driving

- in fine weather, consider making shorter journeys of up to five miles by bicycle rather than car, but make sure you are a competent cyclist first, and route yourself over side roads. Most car journeys are less than 5 miles and could easily be made by bicycle
- swim
- give up smoking. If you can't give up, then try a Quit Smoking Group. If you really can't give up, then cut down, discard the last quarter of the cigarette, and use low tar cigarettes. If you are addicted to nicotine, consider other sources of nicotine, such as nicotine chewing gum or nicotine patches.
- make full use of the cardiovascular screening programme.
- reduce stress as described below.

CANCER

Cancer is now the commonest cause of death in the United Kingdom as a result of falling heart disease rates due to successful preventive measures and improved treatment and rising lung cancer rates due to the failure of anti smoking measures. In Stockport in 2001 there were 761 deaths from cancer as against 643 from ischaemic heart disease.

What Causes Cancer?

Cancer arises when a cell starts to multiply out of control leading to uncontrolled growth of particular tissues which ultimately spread throughout the body interfering with other organs.

This occurs as a result of

- factors which damage chromosomes
- factors which depress the immune system
- factors which stimulate cell multiplication.

These include

- old age
- smoking
- chemicals
- radiation
- stress
- genetic predisposition
- disorders of the immune system such as AIDS.

Lung cancer is mainly caused by smoking, although a small part of the total (perhaps about a tenth) is caused by chemicals, especially occupational exposure.

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

Delayed childbearing contributes to breast cancer.

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

Skin cancer is increased by overexposure to sun.

Gastrointestinal cancer is predisposed to by low fibre diets.

Oesophageal cancer is increasing in incidence and is associated with reflux of stomach contents in the oesophagus.

Stomach cancer may be caused by an infection which also causes stomach ulcers and heart disease.

What Can We All Do To Help?

The NHS can

- pursue an anti smoking strategy
- reduce unnecessary Xrays
- operate high quality screening programmes for breast and cervical cancer

- educate people about preventing cancer
- educate people about early symptoms so that they are treated early
- develop clear pathways to treatment so that delay is minimised
- maintain good quality cancer services
- make barrier contraception available since it protects against cervical cancer

- play its role as an employer, caterer and landowner
- operate an anti stress strategy.

The local authority can

- pursue cancer education across all its activities
- reduce pollution
- enforce regulations against misuse of chemicals
- pursue the tobacco and stress measures discussed above
- provide shade in school playgrounds and encourage children to use sun barriers.

Caterers can

- serve high fibre foods
- maintain smoke free areas.

Employers can

- promote the use of sunscreens by outdoor workers in summer
- operate stress reduction policies
- run screening programmes at the workplace or offer time off
- have a smoking policy
- apply rigorous safety regulations to chemicals and radiation.

People can

- use sun protection on holidays and when working in the open air in fine weather

- contact your doctor if you pass blood in your stools or urine or cough up blood
- give up smoking. If you can't give up then try a Quit Smoking Group. If you really can't give up then cut down, discard the last quarter of the cigarette and use very low tar cigarettes. If you are addicted to nicotine consider other sources of nicotine, such as nicotine chewing gum or patches
- make full use of cervical cytology and breast screening
- contact your doctor immediately if a mole changes shape, grows bigger, changes colour, becomes patchy, oozes, bleeds or itches.
- reduce stress as described below.

ACCIDENTS

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

What Causes Accidents?

Most accidents occur in one or other of four settings - on the road, at work, at leisure or at home. There are some accidents in other settings - rail, air or weather accidents for example - but the four main settings account for almost all of them.

Some accidents are genuinely unavoidable. Others, such as bad luck with the inherent risks in excitingly dangerous activities such as mountaineering or motor racing, are avoidable only by constraining the human spirit. But many have readily avoidable causes, such as

- alcohol
- failure to warn about and protect against hazards
- unsafe systems of work
- defective equipment
- inadequate training
- inexperience in children and young people
- short cuts taken for convenience or profit
- people taking unnecessary risks out of
 - bravado
 - carelessness
 - lack of knowledge
 - misjudgement of risk
 - lack of self worth
 - familiarity breeding contempt
- absurdly risk averse safety procedures which discredit the concept of safety and lead people to ignore advice (the "cry wolf" syndrome)
- poor housekeeping in workplaces
- failure to appreciate hazards in the home.

What Can We All Do To Help?

The NHS can

- provide high quality effective treatment of injuries
- maintain an information system which it uses as a base for accident epidemiology
- help develop understanding of sensible risk behaviour
- educate people about hazards
- operate safe health services and safe premises
- work with other partners to draw together a comprehensive coherent strategy.

The local authority can

- enforce safety legislation in offices, shops and railway premises
- educate people about hazards
- operate safe premises and safe procedures
- continue to monitor road accident trends and carry out work that creates safer roads
- enforce safety in its consumer protection, planning, building control and other regulatory functions
- develop a home safety strategy.

The Health & Safety Executive can

- enforce safety legislation in Factories Act premises and other premises within its jurisdiction
- educate people about hazards
- educate people about safe systems and sensible risk management
- help people understand the difference between a risk averse culture and a safety culture.

The Police and the Crown Prosecution Service can

- enforce road safety legislation
- enforce legislation about alcohol
- make clear their willingness to consider serious criminal charges, such as manslaughter, where serious irresponsibility occurs.

Employers can

- develop a safety culture and clearly distinguish it from a risk averse culture
- abide by safety legislation
- develop alcohol policies
- maintain effective training programmes.

Individuals can

- after drinking, allow one hour for each unit you have drunk before driving, using machinery or undertaking any other dangerous tasks requiring care (a unit is a glass of wine, a pub measure of spirits, or half a pint of ordinary strength beer. Beware of strong beers and of overgenerous hosts' measurers of spirits! Remember that drinks described as "low alcohol" rather than "alcohol free" do contain some alcohol).

- fit smoke alarms
- 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. Not only will the message eventually get through if enough people do it, but it's fun watching their reactions.

Safe or Risk Averse?

In a safety culture people who climb mountains follow good safety practice, use modern equipment which has been properly tested, have good communication systems so that help can be summoned if something goes wrong, are properly trained and know their limitations, contribute to maintaining a mountain rescue service and keep an eye on the weather.

In risk averse cultures 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
- it asks too much of people and they fail so that absurdly excessive levels of precaution coexist with blatant danger.

We need to be very careful about the point where a safety culture becomes a risk averse culture. There are a number of areas where we are very close to that point or have already passed it - railway safety, medical negligence and pavement maintenance are just three examples. Current trends in accident litigation have every potential to increase these realms. For example in the United States it has become very difficult to obtain hot tea and coffee following a court award in favour of a woman who scalded her mouth. A drinks vending machine in a Los Angeles hotel stands beneath a large notice "Warning - Tea and Coffee From this Machine Are Hot." Sadly the notice was false!

MENTAL HEALTH

Mental health is a serious problem.

An American study showed that about one third of us will suffer mental illness in our lifetime and about a fifth of us will suffer active mental illness in any one year. Approximately 1 in 7 of us will have an alcohol abuse/dependence problem.

It is also a much more diverse problem than the other key areas and this section will be structured differently to reflect this.

Suicide

Suicide caused 82 deaths in Stockport in the last five years.

SUICIDE IN PEOPLE SUFFERING FROM MENTAL ILLNESS

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

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

PARASUICIDE

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

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

There were 2 deaths from paracetamol overdose in Stockport in the last three years.

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

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

We need a programme of work which plans accordingly.

SOCIAL SOLIDARITY

Social solidarity may reduce suicide. Suicides fell dramatically in both World Wars and have increased in Northern Ireland since the development of peace. The explanation often advanced for this is that periods of war or crisis induce social solidarity. If this is the case then other measures which induce social solidarity may also have the same effect. Our community development strategy may therefore reduce suicides. On the other hand there are other possible explanations for the relationship between war and low suicide rates. For example war offers other more socially acceptable (even socially honoured) opportunities for self destruction.

INEXPLICABLE SINGLE PERSON ACCIDENTS

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

ENHANCING MENTAL HEALTH

The most effective way to reduce the remaining suicides will be to improve mental health.

KEY PROGRAMMES AND ISSUES

- Enhancing Suicide Prevention in Mental Health Services
- Community Development
- Stress Reduction
- Preventing Unintentional Success in Parasuicide.

Addictive Behaviours

Addictive behaviours include drug misuse, alcoholism and eating disorders. The reason for the recent increase in addiction problems is not known - it may reflect underlying lack of emotional health.

Apart from promoting emotional health, key issues include

- Awareness of Addictive Behaviours
- Implementing the Plans for Alcohol Services that include the introduction of brief interventions and of an enhanced rehabilitation programme
- Reviewing Services for Drug Misusers.

Services for eating disorders does not appear on the above list because a good quality service is already in place through the North West Eating Disorders Centre.

Stress and Emotional Health

Before discussing the promotion of mental health it is necessary to consider where mental health fits together with the concept of stress and the concept of emotional health.

Stress occurs when people are faced with threats to their well being which they cannot respond to by action to counter the threat. As a result the physiological changes that are created for "fight or flight" and that are normally used up in action persist instead and hence damage health.

Stress arises

- when threats hang over people
- when people are trapped in unsatisfactory situations, such as poverty, with few options and little control, hence no chance of escape
- when people constantly have to work under pressure to deadlines, whether in overworked managerial jobs or on the assembly line
- when people are inadequately trained or ill matched for responsibilities they have to carry
- during bereavement and other life changes
- in circumstances of emotional ill health.

Emotionally every one of us is a complex mass of strange mental processes behind a mask of learned normal behaviour. Emotional ill health can be said to exist where these processes affect people's social functioning, lead to damaging behaviour (such as addictive behaviours) or lead to serious persistent unhappiness resulting in stress.

Emotional ill health arises from

- failure to learn social skills during upbringing
- complex emotional reactions in childhood
- distorted relationships with parents
- stigmatisation and discrimination
- lack of self worth
- lack of external support and personal affirmation.

Stress and emotional ill health are important as risk factors for physical illness, mental illness and irrational potentially damaging behaviour.

Promoting Mental Health - Key Issues and Programmes

Community Development -

Promotes social support and social solidarity which protects mental health.

Stress Reduction -

Programmes of stress reduction should take place in workplaces and in local communities.

Counselling and Therapy -

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

Supporting Stigmatised Groups -

Stigma is an important cause of stress.

Supporting Isolated Groups -

Mental ill health is known to occur in isolated groups such as carers and parents of young children without links outside the home. This is presumably because of lack of social support.

Raising the Human Spirit -

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

Arts for Health -

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

Distigmatising Mental Illness -

People with mental illness are themselves stigmatised and this is a vicious circle which creates stresses that cause recurrence as well as obstructing rehabilitation. We need a process of advocacy to overcome this.

What Can We All Do To Help?

The NHS can

- improve its mental health services in conjunction with partners
- help finance mental health promotion initiatives
- implement its plans for brief interventions and alcohol rehabilitation
- develop an early intervention service for young people
- review its drug services
- contribute actively to the Drugs Action Team
- continue to develop the Arts for Health innovation
- put distigmatising mental health at the centre of its disability advocacy

strategy

- educate people about mental illness and mental health
- expand its stress reduction pilot programmes
- draw together all partners in a comprehensive strategy
- maintain community development programmes
- encourage closer working between the mental illness sector and mental

health promotion initiatives.

The local authority can

- improve its mental health services in conjunction with partners
- maintain community development programmes
- develop initiatives for supporting stigmatised groups

- review its drug services
- provide sheltered employment.

Employers can

- plan to tackle stress in the workplace
- provide employment for people with mental health problems.

Individuals can

- find time to relax
- share your worries with friends and partners
- demand training for responsibilities of which you are unsure
- avoid working under pressure to deadlines
- socialise
- have fun
- enjoy beautiful things
- create beauty in any space that you control
- think about how your work benefits society
- if you are out of work find other things to structure your time and to help you contribute to society
- get your worries in perspective by thinking about more important things

To avoid alcohol-related diseases, you should:

- consume no more than 21 units of alcohol per week if male, 14 units if female; (a unit being half a pint of beer, a glass of wine or an ordinary pub measure of spirits - see the earlier warning note).

A11.3 Towards a Country City

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

Transport

Transport can help keep people healthy because it allows access to employment, education, shops selling healthy food, leisure activities, health services and the countryside, and it opens up social support networks. Walking and cycling are very healthy forms of transport and can help prevent heart disease. At the same time, however, it can damage people's health due to accidents, pollution, noise, stress and anxiety, and the replacement of open space with roads. Traffic is responsible for a large amount of pollution in Stockport which, as well as damaging people's health, also contributes to acid rain and global warming.

New technology is expected to reduce the growth of traffic pollution in the future but traffic is predicted to grow to a greater extent than the benefit, so pollution will still get worse. People need to start using their cars less, and the only long-term solution to easing traffic congestion is to make walking, cycling and public transport in cities more attractive.

Heavy traffic reduces people's feeling of community and neighbourliness, and is a major cause of increasing limitations on children. Creating residential cells, areas without through traffic, would create opportunities for a cycle network and enable the use of streets for community purposes rather than just passing traffic. In Holland, "woonerven" or "living streets" have trees, street furniture and play areas, but traffic is still allowed to use the street. Similar developments should seriously be considered in Stockport, together with more speed restrictions in streets to make them safer, particularly for children.

Recreational cycling is an important means of exercise and can also be used as a serious means of transport. It is currently perceived as a fairly dangerous form of transport because of pollution and the risk of accidents, but creating safe cycle networks could change this. Trains are more effective at competing with cars, and the combination of frequent trains and cycling can be as flexible a means of transport as the car. As suggested three years ago, most of Stockport could be brought within 1km of a railway station by fairly minor changes to the rail system.

Open Space

Stockport is a beautiful town to walk around, but it is not so pleasant in a car. Replacing cars with public transport for long journeys and cycling and walking for shorter journeys would dramatically reduce traffic and improve health. Investment in off-road footpaths is needed to create a pleasant pedestrian network so that people can walk safely and pleasantly through the borough.

Open space can make an important contribution to public health. It provides opportunities for exercise and a green rural environment helps people relax and raises spirits. Health promotion through parks, integrated and co-ordinated with other health strategies in Stockport, could make a substantial contribution to the 'Our Healthier Nation' targets, especially for heart disease and stress relief. There are many sources of country walk opportunities in Stockport and areas of open space suitable for exercise.

Green gyms is a new concept which brings together health, community empowerment and open space, through practical conservation activities undertaken by local residents to enhance their local community while improving their own physical and mental health. Urban nature conservation improves the quality of life of people living in towns and cities and the attractiveness of local areas by adding trees and hedges, and roof gardens to preserve open space on land that has been built on. Traffic free estates could be an attractive addition to an area of open space, incorporating cycle ways, pedestrian networks and safe school routes.

Biodiversity is all living things, and creates a pleasant and healthy environment. The need to protect our biodiversity is more important now than it has ever been. Without plants and animals we would not be able to survive, and our physical, mental and spiritual wellbeing are improved by contact with nature.

Living as a Community

Community spirit is important both as an end in itself (lack of social support is a powerful risk factor for death and ill health) and as a means to an end (working together to make things better). Community development, community streets, healthy living centres, tackling crime, and public involvement are all highly important factors for improving community spirit.

In a sustainable community people respect the local environment and value quality of life and future generations above short-term thinking and material consumption. Resources and energy are used efficiently, pollution is minimal, and nature is valued and protected. Facilities, services, goods and other people are easily accessible, but not at the expense of the environment; opportunities for leisure and recreation are readily available to all; spaces and places are attractive and valued; and everyone has access to good quality food, water, shelter and fuel at reasonable cost. These principles are being applied neighbourhood by neighbourhood throughout Stockport.

Unrealistic Dream or Practical Necessity?

As we move into the technology-based culture of the future the economy will be centred around internet-based businesses, whose choice of location will be swayed by pleasant living conditions and an environment that feeds creativity. The Country City suggests a way to have the best of both worlds – beautiful living conditions close to the entertainment and shopping opportunities of a city, and the creative energy of a

vibrant community. The creation of the Country City will not be achieved overnight and a number of obstacles will need to be overcome, but the report suggests that we work towards building it.

The Good and the Bad Way to Preserve a Right of Way through New Developments
Photos 3.3.1 and 3.3.2

Photo 3.1.17.8	Photo 3.1.17.9
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Could your Office or Home be like these: Photos 3.3.3 and 3.3.4

Photo 3.1.17.2	Photo 3.1.17.3
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The Future of your Street Photos 3.3.5 and 3.3.6

Photo 3.1.12.6	Photo 3.1.17.1
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A Strategy for Promoting Health in Young People

It is important that there should be a significant effort to promote health in young people. Adolescent years are years of anticipatory socialisation, in which young people are taking on new roles and learning the norms associated with them. They are years of changing personality and creating lifestyles. They are years of rebellion and questioning. They are often the most idealistic period of a person's life.

As such they represent opportunities to lay the basis for positive and healthy lifestyles and even opportunities for young people to do things to make society healthier. But they also represent dangers of making incorrect choices, perhaps out of inexperience or perhaps out of misplaced rebellion.

It is not possible to approach young people with an authoritarian or didactic style of health promotion. Those who are shaping their own adulthood are rightly sensitive about being patronised and those who are rebelling are likely to be strengthened in their resolve by a display of authority.

The Stockport approach, therefore, both in health promotion and in the youth service is that health promotion in young people must be carried out first and foremost from a standpoint of respect for young people and a desire to work with them rather than control them.

To achieve our ambition of respecting young people, we must therefore devise workable structures through which they can make their voices heard. Tokenism must be avoided at all costs and, instead, a viable and credible consultation route quickly established. The expansion this decade of peer education has highlighted the importance of listening to young people, letting them set the agenda and supporting them to take control over their own health.

Although there are some doubts about the viability of peer education in its pure form, where young people are recruited as volunteers to act as health promoters, the values which underline this approach are certainly essential.

It is important that the existence of communities of young people, focused on particular centres, is recognised.

Schools are one of the foci of these communities.

In Stockport, there currently exist good relationships with our schools, based on a long history of health education support. Almost 50% have been involved in the Healthy School Award, a significant number of which have increased their uptake of health promotion support as a result of pursuing the award. All new contacts should be regarded as an opportunity to reach a wider audience.

We need to build on these relationships, especially drawing schools into neighbourhood health strategies and ensuring that schools develop their own local plans for health, which should be endorsed by and regularly monitored by Boards of Governors.

Schools can be seen by young people as representatives of authority and must play their part in respecting the autonomy of young people and helping them develop their own personal identity. These messages are certainly conveyed in personal and social education lessons but are they conveyed in the culture of the school?

Health promotion work outside of schools has increased and must be further extended. Where collaborative initiatives are developed, they must appear seamless to the user. Effective health promotion needs to happen in all the places where young people meet - on the streets, in cafes, pubs, clubs, through sport, the media and within the family.

Central Youth was the start of a process of locating young peoples' health facilities in centres of youth culture but only a start.

Further developments such as health promoting cafes, alcohol free pubs, and other leisure-based health promotion services are also called for.

Health promoters must be more creative in their thinking, more ambitious in their aims and more in touch with the fast changing needs and perceptions of young people.

We need to react to changes in youth culture as rapidly as those who operate businesses in the youth market. Indeed there may be scope for joint projects.

Outreach work is central to this approach, but it is only the core of a major initiative and a lot of innovative flesh needs to be put around the core.

What is needed is an outreach strategy not just a few outreach workers.

If we take our cue from local young people, if we listen and act on what we hear, and if we stay around to support what happens, then we can look forward to a bright future where Stockport's young people are empowered to take control of their health and lives.

A11.4 FAITH COMMUNITIES AND PUBLIC HEALTH

What Can Faith Communities Do For Public Health?

BACKGROUND

Within all neighbourhoods one can find *faith-communities* – that is, groups of religious people meeting regularly, often in purpose designed buildings. Within Stockport most of these are Christian, but there are also people of other faiths. I want to suggest how these faith-communities might play a part in improving public health in its broadest sense at a local level. For a faith-community to be involved in the health agenda what does it need to consider?

There are three broad issues:

The Emphasis on Neighbourhood

There is growing focus on local communities. The thrust of the Government's work with Single Regeneration Budget areas and Neighbourhood management are examples. Within health locally in Stockport we have Health Neighbourhoods. These are all intended to bring about improvements in public health which is at the centre of their agenda.

In this age of choice congregations are normally drawn from a wider geographical area than was once the case. When choosing where to worship people are now likely to put weight more upon issues of taste (theology, music etc.) than locality, but locality is still one factor in their decision. So, despite the growth of some very eclectic congregations, most faith-communities remain essentially local – they have a strong neighbourhood dimension.

This raises questions about what we mean by community. If we defined community as the area in which most of one's personal interactions take place we can see that for many people the reality is much closer to that of network than it is of geographical neighbourhood. I would suggest each faith communities' first task is to define its own wider community. This decision is not a neutral one. The relative poverty and vulnerability of individuals often sees the poorest relating to the neighbourhood and the richest to the network. In terms of Public Health relative poverty remains an important dimension. Addressing health inequalities should be part of the wider context in which faith communities work. Those wishing to be healing communities must bear this in mind.

The Emphasis on Partnership

Partnership lies at the heart of the present health agenda, partnerships between different statutory bodies and also partnerships between the statutory and voluntary sectors. Within Stockport we have a Health Partnership and a number of Joint Strategy Groups looking at a variety of issues involving people from the NHS, Borough Council and voluntary bodies working in Stockport. There is also an emphasis on user and carer and provider-client partnerships

within health and social care. There is a growing impetus to involve faith communities within the development of many of the agendas of government at a local level. There is a growing recognition of their knowledge of local areas, and the present and potential impact of faith communities upon their locality. I hope this report will demonstrate that there are issues in health which would be central to the work of a faith community

To enter into partnership faith communities need an approach that allows them to hold together their unique perspective of the world, whilst at the same time allowing them to work as equals with all others of goodwill to improve the health of their community. This approach needs then to be both theological and practical. It must be conceptually in tune with their faith view. It must also be comprehensible, and applicable to the daily lives of the wider community. Faith communities which lose sight of one or other of these risk either losing their distinctive contribution or becoming isolated and irrelevant.

The Emphasis on a Holistic Approach

There is a growing move away from seeing health as purely a clinical matter. The shift is towards prevention rather than merely cure, to seeing a person as a whole rather than merely a presenting symptom, to making connections between the physical, psychological, social and spiritual dimensions of an individual. Old barriers are coming down. This in many ways mirrors society.

Faith communities who have traditionally been linked with the spiritual and perhaps the social domains should look to rediscover or make more clear their theological approach in an equally holistic way if they are to participate in the improvement of public health. Indeed theology's contribution to the understanding both of what it means to be human and of the nature of the relationship of community and the individual could be faith communities' major contribution.

What is Needed?

To respond to the invitation to be involved in improving public health each faith community needs an approach that:

**Grasps the concept of neighbourhood
allows for partnership
forcefully speaks of human realities, and
is holistic**

I would like to suggest one particular concept that holds these together – the Jewish concept of “Shalom”, loosely translated as peace, is a good place to start. It seems apposite for a number of reasons.

The Concept of Shalom

Why shalom?

It is part of the language of the main faith group within Stockport, Christianity; yet at the same time it is not their word, it belongs somewhere else.

**It is very similar in concept to other ideas found in many world faiths and none
It is applicable across the range of ideas of community from neighbourhood to network**

It is holistic in its approach to life and health. As we shall see it is a concept robust enough to hold together theology and practical life, health and community, and the individual and society.

What it is and what it is not

There are two common understandings of the word “peace”.

The absence of conflict – “we are no longer at war, but at peace”, “the peace treaty”

The inner balance of the emotions – “she is at peace with herself”, “I have real inner peace”.

Within religious terms these are both often attributed to the individuals’ stance towards God.

The word shalom is much bigger than these definitions, although it includes them both. Its basic root meaning might be better translated as “totality” or “completeness”. It holds together ideas such as fulfillment, completion, maturity, wholeness, community, harmony, tranquility, security, well-being, welfare, friendship, success, and prosperity. Of course, such conditions are best developed in the absence of conflict and do lead to inner balance. Hence the greeting “shalom” is the expression of the desire for the addressee’s well-being in the broadest sense.

This concept of shalom always links the “shalom” of the community to the “shalom” of the individual. The harmony of one leads to the harmony of the other. The source of shalom is God and in one sense it is seen as his gift, but this never negates the part human beings are to play in its development. Even those who do not acknowledge God are acknowledged as contributing to shalom by their actions.

Practical realities

As we have seen the faith concept of shalom is not simply about the inner peace of an individual but has its basis in the wholeness and harmony of society. An individual’s well-being is seen as intrinsically related to his or her community’s well-being. There are numerous places within the Judeo-Christian tradition where such a community is described in visionary ways and yet with earthly terms. One of these describes it like this:

“ No more will be found the child living a few days only, or the old man not living to the end of his days. To die at the age of a hundred will be dying young;

not to live to be a hundred will be the sign of a curse. They will build houses and inhabit them, plant vineyards and eat their fruit. They will not build for others to live in, or plant vineyards so that others can eat.... The wolf and the young lamb will feed together.”

This identifies some simple statements that describe the minimum requirements of what I call a *shalom-community* and look at what they already mean and could mean for public health in Stockport, where possible using local examples. They each:

enable faith communities to engage those without faith with integrity
are universal but demand a unique local interpretation
are simple and minimalist not advocating excess
each relate to public health

However, in breaking down shalom into these constituent parts we must not lose sight of the interconnectedness of them all.

1. *Children and young people grow in safety*

The great improvements in longevity of the last 150 years have largely been because of the improvements in infant mortality rates. And yet there are still great discrepancies between areas, for example, in the numbers of children killed or injured on our roads. Similarly, many of the problems of middle and old age start with the impact of lifestyle patterns established in childhood. This statement is not just simply about keeping people alive, it is about growth in safety. This broadens the agenda as communities might work together to identify the types of growth they want to see and the threats to these. Each faith community might ask themselves two questions?

Which one of the communities we are in touch with is struggling most to reach this ideal?

What are we going to do to work with them to change this?

One example in Stockport of what can be done is the Norris Bank Youth Dance Project. This project teaches creative dance to a large number of children and young people of mixed social background. As well as weekly dance classes the group performs regularly across the borough and beyond. The health benefits delivered include physical activity and improved self-esteem, as well as a distraction from some of the dangers of boredom in that area. The project originated with the local Residents Association, but was supported by the local church with the offer of facilities, finance and some of the volunteers. Whilst, the residents association has ceased to exist, the project has continued to develop involving Stockport Arts Development, members of the local community and the Church.

People grow old with dignity

Dying at a hundred should not be seen as old. We are approaching this quite remarkable vision in the West, yet it is still not true in many areas. The

mortality rates vary enormously and the vision calls for old people to *live* to be one hundred not just to wait around. Again suggested questions:
Which groups around us are furthest from this ideal?
What is it that limits active later life in this community and how can we add *life* to those older people?

St Augustines' Cheadle Heath identified that there were a significant number of Older People living alone in their area. Through a meeting at the local impact group and in consultation with the community, the

Church and Age Concern Stockport decided to start a leisure and friendship club. Start up support came from the Community Development grant scheme, and there has also been money from the local impact group and Community health grants project. Among its aims were to reduce isolation and promote positive health and lifestyles. There are about forty-five people on the roll with twenty or so attending each month. A hot lunch and a range of activities are provided sometimes involving staff from the local authority and primary care trust.

3. Adults have the right to creative work

I believe that whilst this statement begins with the simple imperative of the chance for all to earn a living it goes much further. We need to consider what work does to the worker and to the community.

Faith communities have a long history of involvement in the world of work. Many of the pioneers against slavery and child labour were Christians, as were many of the founders of the trade union movement. Unfortunately, with prosperity there has often been a decrease in the connection between faith and work, and yet there remain numerous situations where work is damaging to individuals and communities. There are a number of ways that faith communities can work together with others to support people in this respect. They include a diverse range of projects such as education and re-training; low cost flexible childcare for working parents; helping those released from prison find work. In more affluent areas it might be stress counselling and helping people balance the enormous pressures they encounter in the work place. Or it might involve providing support to small businesses that do not have the capacity to give advice, support and training that larger business can provide their employees.

4. All have a right to adequate housing

Whilst the first aim must be a roof over each person, there is here an emphasis on the involvement of the individual in creating a place they can call "my home". Asking a few simple questions as the church interacts with the community of which it is part will soon reveal what the main issues are preventing this.
What are the housing issues in this community?
Is there stability, frustration, fear, or neglect?

In public health terms are homes safe, warm and dry?

Within Stockport there are two projects that have involved faith-communities. The first is the Wellspring project providing food, washing facilities, clothing and bedding to the homeless of the area on a daily basis. This project was started by local churches and still has a large number in support, financially and providing staff. It now involves the local authority and Primary Care Trust in meeting the wider needs of those who attend.

The Furniture Station in Hazel Grove collects, repairs and upgrades, and distributes second-hand furniture and electrical goods. It is based at Hazel Grove Baptist church, and services the community Stockport wide. It will collect furniture from anywhere in the borough, and then in partnership with Social Services, Health visitors and others distributes it to those most in need.

There are numerous other types of project that might be considered. For example a group of churches in South London run an emergency home repair service over weekends and bank holidays (including Christmas day) for anybody over 60 or with young children.

There is harmony within the natural surroundings

The vision is of peace within nature, all in balance.

What are the threats to the environment in our neighbourhood?

What are the needs for beauty and relaxation?

the eco-congregations project described later is one example of the ways churches can develop this dimension. Under pressure to support their local community in some of the ways identified above faith-communities are often tempted to focus purely on the utilitarian function of grounds and buildings. This is to forget the positive benefits to health and well being that aesthetics and beauty can bring to individuals and a community. Often Church grounds are one of the few green spaces left in an urban area and faith communities might want to consider how these and their buildings might be utilised not in a purely functional way but as an oasis of tranquility open to their community.

Healthy Living Centres

One of the challenges faith-communities face is that Shalom is not just about individuals or sections of the community, it truly exists only when the whole community is enjoying it. Whilst, it might be quite right to choose selectively from among the above practical concerns to target those sections furthest from the

ideal, this needs to be a thoughtful and considered process. The goal is that each community experiences all of the above. One practical concept that holds these together is that of *healthy living centres*. Within Stockport on a large scale we already have one in Tame Valley, and are likely to develop more in the longer-term (probably by expansion of the neighbourhood health strategies), but the principles that underlie it may be a model faith communities might consider in

partnership with local communities. Such a project would develop local goals fulfilling a few or all of the above goals.

THE NEED FOR VISION

The task of improving public health at a community level, as with any community transformation, is hard work. Motivation has a critical part to play. The concept of shalom, particularly in its visionary description above, has a future dimension. It is looked for, as well as worked out. The long-standing existence of faith communities within neighbourhoods bears testimony to the motivating power of vision. Vision can both harm or help those around. I believe the shalom-community is a vision that is in line with theological convictions and also motivates a beneficial promotion of public health. Where it does this faith-communities can play key role within wider communities.

The faith community can encourage improvements at three levels – the neighbourhood, the individual, and the social network.

Neighbourhood Leadership

Within its own neighbourhood the congregation is a key player, it is often a significant sized group as local community groups go, it often has a professionally trained leadership, and numbers of motivated volunteers. How can it lead?

By engagement. Working to discover the needs, hopes and aspirations of all those around them. The faith community is part of the neighbourhood, is it in touch with what is going on?

By example. An oasis of shalom in a far from peaceful world. No easy task, but whatever its vision it must be being worked out internally first.

By encouragement. Deliberately supporting anything that benefits the health of the community – this could be the time, finance, resources like buildings, campaigning or simply regular praise and encouragement.

By challenge. To support the neighbourhood in its battles with anything that threatens shalom. This is often the hardest and at times most dangerous task of all.

Individual Engagement

Many of those who worship within faith-communities have influence, within families, within workplaces, within other groups, and so on. The faith community needs to look constantly at creative ways of encouraging individual members to be people of influence within their wider network. This is further touched on in the section on faith and morality.

The Social Network

Linking the level of the individual and the level of the population is the concept of the social network – the way that individuals support, reinforce, encourage,

help and influence each other. This is an empowering process for the individual, but it also creates structure for, and give life to, the population.

Strength of social networks bears a direct causal relationship to good health – strong social networks save lives.

Community development works to strengthen social networks and is a key part of the NHS health improvement process in Stockport. Churches also develop communities and networks. Indeed the scientific study which documented the health benefit of social networks – the Alameda County Study – included church membership within its scoring system for strength of social networks.

Approaching the relationship of public health and faith communities with this concept of shalom may give a broader and more practical interpretation to the words of Jesus, the Jew from Nazareth, in his Sermon on the Mount.

“Blessed are the peace (shalom) makers for they shall be called the children of God”

Faith Communities in the Neighbourhood Health Strategies

Neighbourhood health strategies and Health IMPACT Groups have worked with leaders of local faith groups since their inception in 1994. One of the purposes of the Neighbourhood Health Strategies is to put health on the agenda of other agencies that come into contact with the general public. At the same time as health services are taking an increasingly holistic approach to tackling the issues they face, many faith groups have been developing a philosophy which runs along similar lines – essentially, neither health nor spiritual matters can be viewed in isolation.

Political moves towards healthier communities and developing the social inclusion agenda mean that local government, health services and faith groups have many goals, which can be better achieved by joint working.

The intensity of links between neighbourhood health strategies and local faith groups varies across a spectrum from active collaboration to a more passive, but very valuable, cooperation, such as the subsidised provision of accommodation for a range of activities involving local residents. The activities described in this audit reflect that range.

It must be emphasised that this is a report of faith involvement in neighbourhood health strategies not a comprehensive report of faith contributions to local public health.

BRINNINGTON

Brinnington IMPACT group has regular contact with several faith groups. They are listed below, with the initiatives in which they have been involved.

Asian Women's Group – APPNA

This is based in Lower Brinnington and meets at the Crescent Road Day Centre. The main initiative this year has been the setting up, initial and subsequent funding of the local Islamic studies group. The studies for the children were held in Manchester and the travelling on a daily basis was a huge pressure on the parents. Brinnington IMPACT Group supported an application to the Community Grant Scheme to apply for funding for room hire.

The IMPACT group also supplied funding for prizes for the recently set up Islamic Cultural Studies Group.

The co-ordinator attended the Eid party in December 2001 in Lower Brinnington, which was also funded by the IMPACT group.

The women who are active in APPNA are, at present, working with local residents to explore options to set up a women's only exercise class.

Evangelical Church

Brinnington IMPACT group is invited to hold its meetings here free of charge. The church provides refreshments. The IMPACT group provides support to the youth group and workers and has supported funding for a volunteer to undertake training in a Children's behaviour course provided by the NCH for Stockport workers (set up by the Youth Offending Team).

St Luke's

The co-ordinators were invited to the inauguration of the new vicar, Father Ron.

The IMPACT group also holds its meetings there but is charged a nominal fee for room hire of £10 per meeting. This also applies to the sub group meetings. The church does publicise, free of charge, the Over 60's Health Group which is held alternate Tuesdays.

The now annual Over 65's Health Day (publicising and administering the flu vaccine) has been held very successfully at St Luke's for the last two years and is booked for this year also. Funding for the refreshments comes from the IMPACT group, matched by funding for room hire by the Communicable Disease Control Unit.

Stepping Stone

Stepping Stone is a drop-in for people with drug and/or alcohol problems. It is run by Stockport Centre Charismatic Church volunteers, many of whom have related personal or family experiences. The drop-in is open three days a week and the quality of care offered by the volunteers is a significant factor in gaining the trust of the clients. The drop-in offers friendship and a sympathetic ear as well as financial advice, privacy and a mailing address., It also arrange for

medial attention when required and the volunteers work in close conjunction with the nurse advisor to the Wellspring.

ADSWOOD

Many of the churches in the area are actively involved in the SRB partnership board. There are three Christian churches in the area. They are St. Gabriel's Church of England Church, Garners Lane Methodist Church and St Ambrose Roman Catholic church.

St Gabriel's Church

The IMPACT group has supported a number of initiatives that community workers from the church have developed. These include:

Healthy snacks for the Toddler group and carers
Creche facilities for people attending courses
Equipment for courses e.g. parenting course
Funding for group holidays
Funding for transport
Toys for play group

Garners Lane Methodist Church

Trinity Methodist Church and Garners Lane Church share the same minister. The work that the church does with the SRB Partnership board has been the key focus of community work.

St Ambrose Church

The work that the church does with the SRB Partnership board has been the key focus of community work.

DAVENPORT

There are several Christian churches in this community. Two of them have been involved with the IMPACT groups; Trinity Methodist Church and St George's, Church of England church.

One of the ongoing themes at Davenport IMPACT group has been the development of a coffee shop/community drop-in. The scheme has now been abandoned but its feasibility studies have been the source of a substantial amount of joint working.

Trinity Methodist Church

The minister has been keen for the premises to be used by the community and sought funding to help support activities that are run from the building: Information was provided on the source of local funds from both the IMPACT group and the local council as well as from other local charities

An EXTEND group (exercise for older people) that uses the building has been put in touch with Age Concern who are looking to provide a specialist information service.

The church are also interested in providing a luncheon club and have been encouraged to contact the IMPACT group should this go ahead.

Contact has also been made with a Parent and Tots group that were keen to find out more about local activities.

St George's Church

In the past, the ministers have been keen to support the Coffee Shop and attended meetings. Contact has been made with the Church about developing existing projects with the support of Age Concern.

Tai Chi has been popular and the church has reduced its rent to support the group. This group is also supported by a rent grant from the Council and additional funding from the IMPACT group.

Margaret Kelly (a community worker for the church) has been involved with the IMPACT group for many years.

The Bishop of Stockport, when he first arrived in Stockport, lent his support to the opening of the Men's Group at Parkview in Hardman Street.

Healthy snacks have been provided for a toddler group which runs in the church hall.

Shalom Centre, Roman Catholic Convent

The nuns and staff regularly attend the IMPACT meetings and were involved in the Coffee Shop.

Whilst they have never requested funds the premises are used for the IMPACT group meetings.

The Shalom Centre provides a quiet meeting place for many community groups and, in particular, supports carers.

OFFERTON

For the period April 2001 – March 2002 United Reform Church, Maitland Street, has offered premises to the strategy for:

**Women's fellowship
Over 60's widows group**

Women's Fellowship

This initiative was set up to help sustain a group who meet weekly. Different speakers attend and trips out are arranged. The women offer each other friendship and encouragement. It alleviates loneliness and promotes social contact.

The group donate money to the church for the use of its room and facilities.

Over 60's Widow's Group

The group was set up to provide support to women who have been bereaved. It has been supported by the IMPACT group so that these women can continue to meet and support one another. It donates to the church for use of its room and facilities. The church has also offered its premises for use of adult education courses and exercise classes for 2002.

Two members who attend Offerton IMPACT group are representatives of United Reform, St Albans and St John's Church. There are also links with St Andrew's Church, Hall Street from previous years. St Philip's Church has recently offered use of its facilities for 2002 for either a minimal fee or free of charge.

CHEADLE HULME

Cheadle Hulme IMPACT Group has well-established links with Christian churches in the neighbourhood. Joint initiatives from the year 2001-2002 are described below.

Grove Lane Baptist Church ran a parenting Group for local mothers and fathers. The IMPACT group purchased a Parenting Package, books for parents and leaders, videos etc., to facilitate the group activities.

Cheadle Hulme Methodist Church co-ordinates a wide range of activities for vulnerable local people of all ages. The IMPACT Group has supported them by funding the publication of an Information leaflet listing these activities.

Churches Together and the IMPACT Group have worked together to provide a comprehensive community Information Booklet for the neighbourhood.

BRAMHALL

Bramhall Youth Project is run by the Methodist and Anglican Churches. The leader of this activity has worked with the IMPACT Group to provide education programmes around drug awareness for local young people. Drug misuse is a particular problem in this neighbourhood.

The churches also make a major contribution to the local counselling services.

THE HEATONS

Heaton Mersey Congregational Church Hall has been the venue for Baby Massage teaching sessions run by local Health visitors.

GREAT MOOR

Dialstone Lane Methodist Church provides accommodation for Autumn Years, a drop-in for people over 55.

It is also the venue for a playschool. Affordable accommodation for such activities is difficult to find and church halls fulfill a vital community role in so doing.

St Saviours' church accommodates another drop-in for older people.

The United Reform Church, Lake St. provides accommodation for an Infant and Toddler Group.

MARPLE

The United Reformed Church provides a lunch each Christmas for local people who are isolated and alone. The IMPACT Group helps to publicise and fund this. Local health and social services staff often identify people who may like to attend.

There are twelve Christian churches in Marple, forming a strong 'Churches Together' organisation. A representative usually attends IMPACT group meetings and extended ways of working together are currently being explored.

WERNETH

The IMPACT Group has had links with St Marks' church for several years, although there have been no specific joint working in 2001/01.

Representatives of St. Chad's church regularly attend IMPACT Group meetings.

A11.5 HEALTH IMPROVEMENT : A MORAL IMPERATIVE

Is there a moral duty to help improve the health of the people? And if not is there at least a moral duty not to damage it?

These are philosophical and religious questions. If you damage the health of the people then you damage individuals. They may be anonymous individuals – they may even be unidentifiable individuals – but they are people nonetheless. A summary statistic of people's experiences is not just a number – it is a thousand personal stories. If I didn't believe that, I couldn't practise public health with all the passion of a doctor fighting for a patient. Yet it seems that many people find it hard to accept. They would neglect in the experiences of a thousand people recorded in a statistic what they would not accept in the individual person before them. Does the Good Samaritan have a duty to follow up the incident by writing to demand better crime prevention measures on the road where the thieves operated? What if the Good Samaritan has previously voted for reductions in those measures in order to save taxes and it is out of those savings that he has paid the innkeeper?

I believe there is a moral duty not to damage the health of the people. There is probably also a moral duty to improve it where you can do so by measures which it is not unreasonable to think you can take. So what does this require of us?

GLOBALISATION Each of us benefits from the oppressive way that the developed world treats the less developed countries.

What we are able to do about this is a matter that depends on our position.

Some of us may be in a position to influence the behaviour of a major corporate player. It is interesting how many people in such positions believe that the moral principles that govern them in personal life do not apply in their corporate role.

I remember once speaking to a director of a company that was one of the parties to a legal case in South Africa aimed at preventing its patents being infringed in the production of cheap HIV/AIDS remedies.

I pointed out that his company did not benefit from the action since the patented remedy was unaffordable and poor people could not buy it.

He asked why his company should be expropriated in order to meet a social need. Why should his shareholders bear a burden that belonged to everybody?

I suggested that it should act because it was in a position to do so. Permission to exploit that patent cost it very little but helped a large number of people.

He again asked why his company should have a duty. I said that it was morally wrong to act to ensure that poor people should be deprived of access to life saving treatment and especially so when there was no great cost to permitting such access.

He said that that was a moral statement, and that such statements could no doubt be made but were not really relevant to the debate.

I found that chilling.

A moral view that defended the company's action I might have accepted, even if I disagreed with it. A simple denial of moral obligations was much worse. Where individuals act without any restraint of morality we call them psychopaths.

Where corporations act without any restraint of morality do we call them corporate psychopaths?

Where such attitudes are accepted as normal features of corporate life across a whole economy do we live in a psychopathic economy?

In fact many psychopaths act perfectly normally most of the time because of the adverse consequences to themselves of incurring social disapproval.

And so the companies bringing the action in South Africa abandoned it because they could not face the consequences of international public disapproval.

Few of us have the power to change corporate policies on such matters. All of us have the power to contribute to a force of disapproval that compels such change.

Governments devote low priority to international development because they believe their electorates are not interested. They do not increase overseas aid because their electorates do not want them to.

But how informed are their electorates?

20,000,000 people have died because of third world debts which could be eradicated for a tax of 0.01% - a penny in every hundred pounds – on foreign exchange transactions.

Do we not care?

An opinion poll in the United States revealed that the majority of the electorate wanted overseas aid reduced by two thirds. They believed it was 15% of their economy and they thought it should only be 5%. It is in fact less than 1%.

A vote for a reduction or a vote for a 5-fold increase? Is the British electorate better informed? Shouldn't faith communities help spread understanding of this issue?

20 IS PLENTY If we reduce our speed to 20 mph when we leave the main road and enter side streets we will add less than 3 minutes to most journeys. Few places are more than a mile from the main road. Few journeys therefore are more than two miles (a mile at each end) on side roads. 3 minutes is the difference between travelling two miles at 40 mph and at 20 mph.

Britain has one of the lowest road accident rates in Europe but one of the highest child pedestrian road accident death rates. Most of these deaths occur away from main roads.

At 20 mph the chance of killing a pedestrian in a collision is about 1 in 20. 95% of pedestrians survive.

At 30 mph the chance becomes 1 in 2. At 40 mph it becomes 19 in 20 – only a 5% chance of survival.

We are killing our children for the sake of three minutes on our journeys.

Is this an area of legitimate personal choice? Can we choose to risk the death of children for so little benefit? Or is it a moral imperative?

The 20 is Plenty campaign seeks to persuade people to commit themselves to drive only at 20 mph in side streets. Stockport Council, the NHS in Stockport and the Stockport Police already ask their employees to support it. Churches too should ask their congregations to support it as a moral imperative.

UNHEALTHY ADVERTISING – Around the world rages a debate about tobacco advertising. The tobacco industry claim free speech (a claim upheld by the Canadian Supreme Court, whose judgements, deriving as they do from a similar cultural and legal background, may well influence British judges applying the new human rights laws). It claims commercial freedom to promote a lawful product. But tobacco is as addictive as any illegal drug. It is the only lawful product which kills a quarter of those who use it as it is intended to be used. The majority of its users wish to give up its use but can't. It is only lawful because so

many people are entrapped by it that it would be oppressive to criminalise them. Is there a right to persuade people to harm themselves when your own motive for doing so is commercial gain?

If there is so much of a struggle over tobacco advertising what of less clear cut cases? Such as advertising unhealthy foods as if they were good quality.

What are the responsibilities of advertisers for the behaviours they induce?

SOCIAL SUPPORT – Research has shown that the strength of social support networks is one of the strongest protectors against the adverse health consequences of stress. This translates into a situation where the difference in mortality between the least supported and most supported group in society is comparable to the difference between the poorest group and the richest groups.

Yet we live in an increasingly isolated society.

Churches and voluntary organisations play a major part in the creation of social support networks. They must continue to support their members and reach out to their communities.

But it is not just in their organisational behaviour that churches help fight the battle against lack of social support. They fight it also in the guidance they give to their members.

The Christian concept of love and the Islamic concept of hospitality, community and good works all require people to support and help others. They demand that we do not behave as if we were alone and we do not leave others alone either.

This is a divine message, a moral message and a public health message.

POLLUTION – So much of the pollution that threatens the health of the people is generated by all of us. Traffic is the total of all our transport behaviours. The waste that will be incinerated in the incinerators that will pollute our atmosphere with dioxins is produced by families who resent the suggestion they should recycle.

These issues are dealt with in the section on eco-congregations.

Do people have a right to choose lifestyles that pollute? Or is the Quran right in Chapter 6 verse 165 when it says that human beings are the custodians of the earth?

The economic concept of externalities confirm that a free market will only function properly if people pay for the damage their choices inflict on others. Only then will all the costs appear on the profit and loss account.

A useful example of this is the Tragedy of the Commons.

Imagine a common on which each commoner has the right to graze cows. Imagine it can support one cow for each commoner. Imagine that each commoner already grazes one cow. Imagine you are a commoner who is considering whether to graze an extra cow. You will get all the benefit of the extra cow but the consequences of the overgrazing will be spread across everybody. And surely the amount of overgrazing caused by just your one extra cow will be insignificant. So you add the extra cow. And so does everybody else.

This goes on till the cows die. Or the commoners get together and agree byelaws for the common.

The Tragedy of the Commons is with us in much of our daily lives. The decision that one bit of litter won't matter. The decision to use our cars all the time rather than only when public transport is unavailable. The decision not to take plastic bags with us to the shops because the shops will always give us new ones. The decision not to be bothered with recycling rubbish. All of these decisions are rational, harmless in isolation, and seriously destructive when everybody does them.

There are some choices that can only be exercised by all of us acting together. We can only create that freedom to choose together if we give up the lesser freedom to act alone.

SEXUALITY

The healthiest sexual behaviour would:-

not start sex too early (this increases the risk of cervical cancer)
not leave childbearing too late (this increases the risk of various other cancers)
not have multiple sexual partners (this increases the risk of sexually transmitted diseases and cervical cancer)

This message does fit quite well into most religious teaching about sexuality.

There are broadly two different philosophical approaches to sexual morality.

One believes that sexual behaviour is a central element of a society's means of reproduction and social structure so it is appropriate to have an accepted standard of behaviour. Another belief is that sexual behaviour is a matter of personal choice and that all that matters is that people accept the consequences of their choice and are open, honest and non-exploitative with each other as they should be in any relationship.

These two philosophies draw different interpretations from Christ's insistence that only those without sin should be permitted to stone the woman taken in adultery – a requirement that prevented her being stoned. Those who believe that there is a “Christian morality” about sexual behaviour interpret this event as being about forgiveness and understanding of human frailty, but still focus on Christ's parting words to the woman “Go away and sin no more”. Those who believe in a more libertarian sexual philosophy see the event rather as an indication that Christ was opposed to the punishment of unconventional sexual behaviour and probably attached little importance to it in the total frame of human behaviour. Mohammed's instruction that adultery should only be punished by stoning if there are four eye witnesses could perhaps be subject to the similar two alternative explanations, although as a Christian I hesitate to comment on interpretation of Islamic scripture.

Whilst the philosophy of conventional sexual morality can see Christ and Mohammed as disapproving of unconventional sexual behaviour libertarian philosophy might see them both as trying to move away from past harshness by making the punishment of sexual behaviour virtually impossible. Certainly if there need to be four eye witnesses to adultery and it can then only be punished by people who are without sin, it is hard to see that a programme of eradicating it by fear of punishment would be likely to progress very far.

On a personal level my view of Christianity as focussed on the Two Commandments – Love God and Love Thy Neighbour – and my generally libertarian approach to life both lead me to favour the libertarian interpretation. But to those who disagree with

me and who subscribe to the contrary interpretation of the scriptures – which probably includes most practising Christians and Moslems – I am professionally obliged to present them with a very important argument in support of their position.

Conventional sexual morality is the simplest way of following the dictates of public health as set out at the start of this section. It is therefore entirely feasible to argue that society has over thousands of generations of evolution developed (or alternatively God has presented us with) a set of conventional sexual behaviours which promote our sexual health and which we depart from at our peril. And current biological theories of evolution which place great emphasis on the concept of a species having a reproductive strategy would also support this view, whether you regard this strategy as forged in natural selection or prefer to view it as given by God. Libertarians would join me in arguing that this is a matter of choices and consequences rather than morality, but the advocates of the contrary view have biological evidence to support them. Whether or not one regards sexual fidelity as morally obligated, it is certainly an advisable health behaviour.

Whatever one's view of the morality of sexual behaviour it is certainly the case that one could do far worse, from a health point of view, than follow the Church's traditional teachings on sexuality. The public health advice with which I started this action is not very different.

The problem comes when the idea of sexual morality is used to suppress debate about sexual behaviour. And when the social disapproval of certain sexual behaviours makes it difficult to cope with their consequences

I still remember a patient I had when I was a general practitioner – a young woman whose decision to keep her “illegitimate” baby had led to her total abandonment by her highly religious family. I could see little that I would call Christian in the behaviour of the family, and much to admire in this woman's decision to carry through the consequences of her choice.

There are still problems in implementing sexual education in some religious schools and still religious objections to providing family planning advice to young people who are sexually active. Public health professionals find it hard to understand such resistance from faiths which are rooted in an understanding of human frailty.

PURITANISM

Religion and public health share an image problem – both of us are accused of wanting to stop people enjoying themselves.

The proposition that everything you enjoy is bad for your health is, of course, biological nonsense. No species could survive millions of years of evolution, many of them in circumstances of deep adversity and strong competition for survival, if it were equipped with deep rooted instinctual drives to harm itself.

I have always found equally absurd the proposition that fun is spiritually prohibited. I have never managed to accept a concept of a God that would create people with a strong desire to do wrong so that he could measure their worth by their capacity to resist.

Often our instincts point us towards healthy choices. The crunch and tang of healthy food, the pleasant relaxation of moderate alcohol use, the fun of social networking, the sense of tranquillity amongst peace and beauty, the glow that follows exercise, the sense of peace that comes to those who commit themselves to a purpose in life – all of these pleasant feelings point towards what is healthy.

But our senses can deceive us too. The alcohol that is good for us in moderation is very bad for us in excess, and even in moderation can kill us if we mix it with highly skilled tasks in dangerous settings. The feeding drives that served our ancestors in millennia of scarcity do not necessarily serve us after a century or so of plenty. Our sense of peace – probably an important detector of conditions free of harmful stress – is an underused and unrecognised sense. And those who confuse immediate comfort with pleasure will never know the pleasures that come only to those who work to achieve them – like the glow that follows exercise or the satisfaction that follows achievement.

So there is a health message, and a spiritual message, about reaching these deeper and truer states of wellbeing. But it is not a Puritanical message, or a penal message. It is a message about the joy of life. We underplay it if all that we say is “No” and we can never find the way to convey the huge declaration of “Yes”.

A11.6 ECO-CONGREGATION

INTRODUCTION TO ECO-CONGREGATION

Eco-congregation is a programme for Churches to help them take spiritual and practical steps to care for God's creation. It has been developed from a partnership between the environmental-awareness charity Encams (formerly Going for Green) established as part of the UK Government's response to the 1992 Earth Summit, and the Environmental Issues Network of Churches Together in Britain and Ireland.

The Eco-congregation programme, which is available free of charge to all Churches, has three core elements:

A set of inspiring resource modules designed to fit into Church life.
A process to help support the activities of Churches
An award scheme to act as a target for Churches and to affirm their positive environmental achievements.

Eco-congregation is a tried and tested programme developed from a Pilot Study involving 22 Churches from eight denominations and a variety of contexts across Britain and Ireland. The pilot study led to the development of the full programme.

It is endorsed by all national Churches and Church leaders.

BENEFITS OF ECO-CONGREGATION

The benefits of the Eco-congregation, as stated by those who took part in the Pilot Study include:

Helping Churches to care for the Earth
Realising caring for the Earth is a key missionary activity
Enhancing the life and fellowship of Churches
Seeing that implementing energy – saving measures can save money too
Encouraging supportive links with local authorities and other community groups
Promoting a lifestyle for today, that all may enjoy tomorrow

STAGES OF THE PROGRAMME

The Eco-congregation programme has four main stages:

Stage 1: Registration
Stage 2: Receiving the resources, seeking wider support and getting going
Stage 3: Applying for the Eco-congregation Award
Stage 4: Receiving the award and reapplying

STAGE ONE

Registration

What Churches can receive:

By registering for the Eco-congregation programme, Churches can request modules from the list below. It is recommended that Churches should order at least three modules to aid their work towards the Eco-congregation Award.

A guide to the Modules:

Grounding in Faith

Module 1: Churches environmental check-up

An aid to identify a Church's current environmental practice and developing priorities for action

Module 2: Celebrating creation

Ideas and resources for worship

Module 3: Creation and Christianity

Some green theological perspectives

Growing in Faith

Module 4: Acorns to oaks

Ideas and activities for children's work

Module 5: Tread gently go green

Ideas and activities for youth groups

Module 6: Exploring God's green word

An address and two sets of Bible Studies for house groups

Managing in Faith

Module 7: Greening the cornerstone

Guidelines on caring for Church premises

Module 8: Greening the purse strings

Management of financial, catering and purchasing matters

Module 9: Planning and conserving Eden

Practical ideas and advice to care for church grounds and land

Living in Faith

Module 10: Green Choices

Information and suggestions to green personal lifestyles

Module 11: Community Matters

Ideas to help churches work with, through and for their local community

Module 12: Global Neighbours

Sources and Resources to help churches think globally and act locally

What Churches do during Stage One

Eco-congregation has been designed to support and develop the existing work and mission of the Church, not to be an extra task or burden. It is probably helpful and is recommended to form a small 'Green team' to steer the programme. Initially this

team is encouraged to use the first module, the Churches' Environmental Check-up to:

Identify their current good environmental practice
Identify areas where they would like to develop further work

Each area of Church life outlined within the Check-up has a resource module associated with it, and through completion of the Check-up, it is hoped that priorities for action, or areas that fit into the current work of the Church will become more clear.

Once the areas that would like to be tackled have been identified, and modules have been chosen that will help achieve them, the Church registers with the programme, using the Registration Form that comes with the Check-up.

The Registration Form requires the following from a Church as a sign of its commitment to the programme:

1. That Churches nominate a person to be a link person and receives the modules
2. That a Church decision-making body agrees that the Church will have a go at the Eco-congregation programme
3. Churches affirm that they have worked through Module One

If Churches agree this, then Encams will:

Freely supply the resources requested

Assist the Church in identifying a person or organisation (such as a local authority environmental office) to support the work of the Church.

STAGE TWO

Getting Going

Once the resource modules have been received it is recommended to:

Review the resources, distribute them to the appropriate people within your Church and encourage their use to stimulate ideas for action in and through the Church.

Contact and seek advice from other bodies, for example the local authority Local Agenda 21 Officer.

Formulate an Action Plan, listing targets, work needed to be done to achieve the targets, dates marking stages in the project and responsible personnel.

Remember the following to ensure that the programme is a success:

Make it fun, yet informative

Involve the whole congregation in the programme, through continual feedback

Ensure the support of the Minister/Vicar/Priest

Create a Green Team to take the programme forward, made up of people who have an interest or commitment to environmental issues.

Involve young people in the programme where possible, it will be a lesson in good project skills as well as involving them more in the running of the Church.

STAGE THREE

Applying for the Award

The Eco-congregation award

Encams is running an Eco-congregation Award scheme. This will enable Churches who work towards and achieve their targets to have their creditable efforts independently assessed and recognised.

Award Criteria

To qualify for the Eco-congregation Award, Churches must be able to demonstrate that they have:

Completed module 1 : Churches Environmental Check-up, and identified both current good practice and areas for action.

Undertaken a project/activity in areas covered by at least three of the resource modules.

Whilst Churches may choose which areas of work/modules they should cover, to gain the Award churches should include:

At least one activity with a strong spiritual dimension

At least one activity with a strong practical dimension

At least one activity which has had a positive impact on, or involved, their local community

To demonstrate the above, churches need to provide an overview of activity undertaken, and compile a dossier that illustrates the activities that they have undertaken. To aid this, it is suggested that churches keep records of their activities, such as orders of worship. Newsletters, posters designed and any press coverage from local papers.

Applying for Award

Step 1: The church sends their application for Award and dossier to Encams.

Step 2: Encams will contact the church and make a visit. Visits will normally involve two independent assessors, one from a church community and one from an environmental body or local authority officer.

Step 3: Following the visit, churches will be informed of the outcome of the assessment. Arrangements will be made with successful churches for a presentation ceremony.

The eco-congregation award is valid for a three year period from the date of the Award. Successful churches will be encouraged to continue their care of God's creation by working towards renewing their Award. To achieve a further Award, churches will need to demonstrate that they have undertaken further work in three new areas, or extended work in the areas already covered.

THE ECO-CONGREGATION PROGRAMME IN STOCKPORT

Stockport MBC are keen to support churches throughout the Borough to participate in the Co-congregation programme. Support is available from the Sustainability Team (see contact details overleaf), as part of the Stockport Agenda 21 initiative.

Stockport's Agenda 21 aims to make 'green thinking' central to the Council and to help local businesses, organisations, families and individuals to 'do their bit' to help the environment.

Case Study: Stockport Baptist Church

As part of the Shaw Heath Renewal Area activity, environmental awareness work has been carried out in conjunction with the Stockport Baptist Church.

The Church undertook a project to become more environmentally aware by firstly looking at the amount of rubbish that was produced from the Church on a weekly basis.

The Junior Church group led the project and carried out waste audits, to ascertain the types of rubbish that were being produced. From carrying out the project, it was discovered that many items, that could have been re-used or recycled, were being thrown away each week. Collection points for certain recyclable materials have now been established, and the church have now gone on to look at what other things they can do to become more environmentally friendly.

Although this work was not officially a part of the Eco-congregation programme, it can be used as evidence of the continuing good environmental practice that the church already undertakes, if ever applying for the Programme and the Award.

For more information, or a Registration pack for the Eco-congregation programme, please contact:
Encams, Elizabeth House, The Pier, Wigan. WN3 4EX

For more information on Stockport's Agenda 21, or the support available to churches carrying out environmental projects or involved in the Eco-congregation programme, please contact:

Helen Pennington
Sustainable Communities and Health Advisor
Stockport Metropolitan Borough Council, Town Hall (Victoria House) Stockport, SK1 3XE
Or E-mail: h.pennington@stockport.gov.uk

RECOMMENDATIONS

To the Local Authority

I welcome the work that is being done to involve faith communities in the Local Strategic Partnership and I recommend that it continues and that health improvement be an element of its agenda.

To the NHS

I note that the audit of involvement of faith communities in the neighbourhood health strategies has included only one non-Christian item and I recommend that all IMPACT Groups with a significant non-Christian element in their population should endeavour to involve faith communities on a multi faith basis.

I recommend that all practices and services carefully consider the implications of this report for their links with faith communities and their members.

To all local Strategic Partners

Often there is a degree of incomprehension between faith communities and secular organisations. Indeed some who have read this report have queried whether its use of language directed at faith communities may not seem to exclude those who do not have a strong faith. The public expression of a strong faith is increasingly seen as unusual. I think this division is unfortunate. Dialogue and involvement have much to offer faith communities themselves and also the wider community. Spirituality and faith are perspectives far too important to exclude from secular dialogue.

To the Central Structures of The Churches and Other Faiths

I recommend that a multi faith network be established in the Borough, and that health improvement be one of its agenda items.

I recommend that the issues of globalisation, pollution and unhealthy cultural norms (including their promotion by advertising) be debated and addressed.

I recommend that the churches and other faiths contribute their understanding of human reality to the processes of partnership and debate.

To Local Faith Communities

I recommend that all local faith communities should

define their local and wider communities
involve themselves in their neighbourhood health strategies
consider whether they can become eco-congregations

urge their members to sign the 20 is Plenty pledge
recognise their role in sustaining social networks and maintain appropriate pastoral work and communal activity to that end
contribute to maintaining neighbourhood leadership and reach out to the wider community
develop their buildings as a functional contribution to the community and also as an oasis of tranquillity
consider the development of projects that will promote health amongst their members and the local community of which they are part.

APPENDIX and POSTSCRIPT

An excellent example of a church committing itself to a local community and to the improvement of health is the Bromley-by-Bow Healthy Living Centre.

This Centre includes primary care services, complementary therapy, exercise classes, arts for health, education, a base for environmental work, a community café, and a base for developing community enterprises. 1500 different individuals attend regularly including 23% of local households.

Although open to the entire community the Centre is based in a functioning church – the Bromley-by-Bow Church in the Community, a United Reformed Church.

An information pack can be obtained, price £5.00, from:

The Bromley-by-Bow Centre
St Leonard's Street
Bromley-by-Bow
London
E3 3BT

Tel: 0208 709 9700

Fax: 0208 880 6608

Email: connect@bbbc.org.uk

Web site: www.bbbc.org.uk

**A12: A COUNTY
CITY: TOWARDS A
GREENER
STOCKPORT
(written 1999)**

A COUNTRY CITY

TOWARDS A GREENER STOCKPORT

A section of the 11th
Annual Public Health Report
for **STOCKPORT**

1999/2000

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Introduction to ‘A Country City : Towards a Greener Stockport’

The Annual Public Health Report is a report on the health of the people of Stockport written, as a personal independent professional report, by the Director of Public Health.

Individual sections of the report are published separately for the attention of those who have a particular interest in the topic discussed within them. This section of the report is aimed at those involved in the debate about future land use in Stockport, and in particular about transport policy and planning policy.

Like most boroughs Stockport is now revising its Unitary Development Plan. This is the plan which forms the policy basis for decisions on planning applications. It will lay the basis of what kinds of development will be permitted and not permitted over the next ten years.

Stockport is also now required to develop its Community Transport Plans. These plans will determine how effectively we tackle the problem of traffic which is seriously damaging to health and well being in Stockport.

This report is addressed to the issues involved in these Plans.

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

In 1910, Herbert Corbin. The Medical Officer of Health for the County Borough of Stockport wrote this on page 92 of his Annual Report:

“It is only necessary in any thickly-populated community to see how relatively new areas, with their congested housing, cul-de-sac streets, and haphazard planning, with only one object in view in many cases, viz., to get the largest number of dwellings on the smallest possible area, without the essentials for healthy life, leads in a relatively few years to the degeneration of such areas into slums.

The most modern, and so-called model, by-laws have utterly failed to prevent overcrowding of areas with houses, and, indeed, inasmuch as they allow as many as fifty-six houses to be built on an acre of land, they may be said to encourage the land speculator to destroy the amenities and prevent the comprehensive planning of town suburbs

The disease and death rate within a given area may be said, other things being equal, to vary directly with the density of the population in the given area, and apart from the toll extracted from a densely populated area by a high death-rate, the development of land according to the present bye-law system must necessarily increase the price of land.

At the request of your Housing Committee, I visited in Birmingham an estate known as the Harborne Tenants, Limited, which is laid out according to the newest town planning principles. A large main road passes through the centre of the area, from which other roads radiate. These roads are constructed on a plan less expensive and more pleasant than the type which conforms with the bye-laws. In the smaller streets there is a 16ft. carriage-way which is quite wide enough for the existing traffic, and having on either side a broad band of tree-planted grass, and a gravel pathway between this and the gardens, instead of the usual large area of macadam and paving stones. By such an arrangement the width of the road may be at any time added to should the traffic require it. Such an arrangement, by reducing the cost of street making, considerably reduces the rents of the houses, and in the case of the Harborne Estate this reduction amounts to a shilling, and in some cases to eighteen pence a week.

The fact that decent houses on an average of ten per acre in the neighbourhood of a large city, and containing two, and in some cases three bedrooms can be let at a rent of from 4s. to 4s.6d. per week including rates, directly contradicts the view which is commonly held that good and cheap houses for the poorest classes can only be obtained by land sweating, and the financial reports in connection with certain estates laid out on well ordered town planning lines, show that a fair return for money invested is obtained."

I do not imagine that Dr Corbin had any illusions that the clearance of the slums would require merely the endorsement of his report. I imagine that he was fully aware of the debates and difficulties and problems that would accompany that endeavour. I imagine that he fully appreciated the time that it would take to achieve. Yet he was confident that it could and would be achieved. Just as 30 years later when a successor wrote of the need to remove the smoke from the air he was fully aware that many who read his report would feel deeply troubled by its implications for the economic well being of a town where industries had always been driven by burning something. But he also knew that one day the air would be clean.

The first step to creating something is the decision to create it. To solve a problem you must acknowledge that it must be solved. I have never said that the creation of the Country City will be easy. I say only that it must be done.

Our predecessors did clear the slums and they did take the smoke out of the air. It took them time but they succeeded. In the same way we can create the Country City.

I am grateful for the contributions made to this report by Alison Cotterill, Carolyn Anderson, Gill Holden and Simon Armour. All opinions expressed in this report are my personal professional opinion and are written on my responsibility alone.

To avoid disruption for the general reader the report does not contain scientific references but points which need reference have been identified with numbers and a list of references will appear in the full Annual Report of which this section will be part. In the meantime they can be obtained on request from my office. As this is only a section of the report the numbering of pages, maps, figures and tables, sections, references and recommendations are continuous with the main report.

STEPHEN J WATKINS
Director of Public Health

**A COUNTRY CITY
TOWARDS A GREENER STOCKPORT**

3.1.10 Country City/Civilised City

Both these concepts are directed towards making urban life more tranquil.

The two concepts are linked and complementary and their practical implications in the immediate future in Stockport may be interchangeable.

Table 3.1.10.1 The Concepts of a Country City and a Civilised City.

Civilised City	Country City
<p>Developed by the Royal Automobile Club Originates in the concept of traffic management</p> <p>A city where social interaction, opportunities to enjoy peace and beauty, community spirit and street life are prominent and the motor vehicle is controlled so it does not destroy them.</p> <p>Emphasises human relationships Short term, practical measures</p> <p>Promotes health through tranquility and social support</p> <p>Important to Stockport because our traffic problems create a major challenge to our quality of life</p>	<p>Developed in my 1995 Annual Report Originates in the concept of open space</p> <p>A city of village communities in natural surroundings with ready access both to urban facilities and to countryside</p> <p>Emphasises ecological balance, long term vision</p> <p>Promotes health through exercise and raising the human spirit</p> <p>Important to Stockport because generations of protection of tongues of countryside reaching deep into the borough, create opportunities</p>

Issues involved in these concepts are

Issue	Significance
TRANQUILLITY	Stress reduced by quiet, beautiful surroundings
BIOPHILIA	Health benefits from experience of nature ⁽⁴⁾
AESTHETICS	Beautiful surroundings raise the human spirit
EXERCISE	Prevents heart disease and osteoporosis and promotes mental health
TRANSPORT	Traffic destroys tranquillity and disrupts social interaction ⁽²⁴⁾ and community spirit. Walking and cycling are good exercises
OPENSACE	Tranquility, aesthetics, biophilia, exercise opportunities
CRIME	Creates stress. Disturbs enjoyment of local communities. Makes people afraid of walking, cycling, open space
COMMUNITY SPIRIT	Social support is beneficial to health ⁽²⁵⁾ . Empowered people can make healthy changes. Poor community spirit can contribute to crime, loneliness, and vandalism
NATURE & BIODIVERSITY	Contributes to tranquillity, biophilia and aesthetics. Biodiversity has ecological advantages

Table 3.1.10.2 Issues Involved in the Civilised City and Country City Concepts

3.1.18

TRANSPORT

3.1.11 Transport & Health

The Transport & Health Study Group has summarised the effects of transport on health as follows. Table 3.1.11.1 **Ways in which transport influences health**

Health Promoting	Health Damaging
Enables access to Employment Education Shops Recreation Social support networks Health services Countryside	Accidents Pollution Carbon monoxide Nitrogen oxides Hydrocarbons Ozone Carbon dioxide Lead *
Recreation	Noise
Exercise	Stress and anxiety
	Danger
	Loss of land and planning blight
	Severance of communities by road

On journeys of comparable length the risk of fatality in an accident is seven times as high in a car as in a bus or coach and nineteen times as high in a car as on a train.

Traffic causes about three quarters of the nitrogen oxides pollution in Stockport and is a major contribution to the greenhouse effect.

Table 3.1.11.2 **Health Hazards of Pollutants from Motor Vehicle**

Pollutant	Health Hazards
Carbon monoxide	Deprives body of oxygen by reacting with haemoglobin. Slows thought and reflexes. Causes drowsiness and headaches. Long term exposure may aggravate arteriosclerosis causing cardiovascular disease. May retard foetal development in pregnant women. A "greenhouse gas".
Nitrogen oxides	Irritate lung tissue increasing susceptibility to viral infection, bronchitis and pneumonia. Responsible for one-third of the acidity of rainfall. "Greenhouse gases".
Hydrocarbons and airborne particulates	Heavy metals and polyaromatic hydrocarbons carried deep into lungs on fine particulates are potentially carcinogenic. Irritate respiratory system.
Ozone	Irritates eyes, nose, throat and lungs causing coughing, headaches and reducing resistance to respiratory infections. Aggravates asthma and bronchitis. Implicated in damage to trees from acid rain. A "greenhouse gas".
Carbon dioxide	No direct health effects, but it is the most important "greenhouse gas" contributing to global warming.
Lead *	Impairs mental development in children.
Benzene	Associated with cancer, leukaemia and impotence.

Sources: Holman, 1989; Department of the Environment, 1974.

* Since these tables first appeared lead free petrol has produced a rapid decline in the levels of this pollutant.

3.1.19

Almost one in seven of the households in the UK who want to move house mention traffic noise as a reason.

Heavy traffic significantly diminishes the extent to which people can enjoy their local community. Traffic is a major contributor to the increasing restrictions on the independence of children, with a growing proportion of children spending more of their time indoors and being taken to and from school by car rather than being allowed to make their own way there. The effect on health of raising an entire generation of children in such restricted surroundings remains to be seen. It is likely that there will be long term impacts on psychological development and that diminished exercise may have long term effects on cardiovascular health. Heavy traffic levels in Britain in the 1980s and 1990s may therefore have effects on the health of the people well into the twenty-first century.

Research has shown that heavy traffic significantly diminishes people's sense of community. In lightly-trafficked streets people perceive "neighbours" as being people up to several houses in each direction. In heavily-trafficked streets this shrinks to the house next door, if that. The most likely explanation for this is the impact that traffic has on diminishing activities which lead to the casual contact that feeds good neighbourliness. On this basis traffic contributes substantially to the deteriorating quality of life and to the declining sense of community.

However transport also has benefits. Access to shops selling healthy food at affordable prices is necessary in order to have a healthy diet. Access to leisure facilities and the countryside is important for exercise. Transport contributes to the maintenance of social support networks and research has shown that psychiatric conditions, physical conditions and death are all increased in frequency in people who have inadequate social support networks.

Walking and cycling are very healthy forms of transport. Fox and Goldblatt,⁽²⁶⁾ in a longitudinal study of factors affecting mortality conducted by the Office of National Statistics have shown that men who walk or cycle to work have a lower rate of death from heart disease than men who travel by car. Public transport users have in between rates.

The British Medical Association⁽²⁷⁾ has calculated that if one third of car journeys under five miles were replaced by bicycle journeys this alone would achieve the Government's "Our Healthier Nation" target for coronary heart disease.

These benefits outweigh the higher accident rates of cyclists and pedestrians, but it would obviously be better if cycling and walking were made safer so that the benefits of greater exercise were no longer offset by the deaths of cyclists and pedestrians killed by cars.

The health effects of transport are distributed in a socially inequitable way, with the health damage of transport falling disproportionately on the lower social classes who also

3.1.20

have the least access to the benefits of transport. For example in 1991-3 65% of unskilled manual workers' households were without a car as opposed to 6% of the households of professional people. However the standardised mortality ratio for road accidents in unskilled manual workers was 185, as opposed to 66 for professional people. Similar differences affect the children of these groups.

Car ownership is determined by income rather than need.

Table 3.1.11.3 Household car ownership by real household income equivalent quintile, UK:

	No Car	One Car	Two Cars	Three or More cars
	%	%	%	%
Lowest	73.7	23.5	2.6	0.2
Second	47.6	44.0	7.6	0.8
Third	24.4	55.4	17.5	2.6
Fourth	12.0	52.9	28.7	6.4
Highest	7.0	46.2	38.5	8.3
All	33.0	44.4	19.0	3.7

Source: National Travel Survey

Public transport does not compensate for this differential.

Table 3.1.11.4	No. of Public Transport Journeys per Person per Year			
Income Quintile	Bus as Main Mode	Rail as Main Mode	Taxi Stages	Total
Lowest	115	7	14	136
Second	97	9	13	119
Third	76	13	12	101
Fourth	56	20	12	88
Highest	37	41	13	91

Source: National Travel Survey

Some people believe that the problem of the motor car can be dealt with by expanding car ownership to remove social inequities, building new roads to reduce congestion, and adopting cleaner engines to reduce pollution.

However this is viewing the world through a rose-tinted windscreen.

3.1.21

Greater car ownership would worsen the impact of cars in streets. Research by the Open University⁽²⁸⁾ has shown that new technology can reduce the growth of traffic pollution but that traffic is projected to grow to a greater extent than the benefit so pollution will still get worse. We need to reduce the use of the car.

New roads simply create the traffic to fill them.

The reason that traffic has such a limitless capacity to grow is so called “suppressed demand”.

People arrange their lives so that their shopping, travel to work, and social lives can be accommodated within the time that they are willing to spend on travel. The ultimate technical capacity of a road system is probably reflected by a journey at a continuous 80 mph, and since some people are prepared to commute for 1½ hours and many for one hour, this makes it technically possible to locate the outer suburbs of Manchester in Nuneaton or Middlesbrough, with the centre of the suburbs located in York or Stafford.

Limitations on traffic flow draw in the boundaries of this sphere of potential travel. As new roads are opened the sphere widens. As people adjust their lives to the wider sphere the roads fill up. As the roads fill up a new equilibrium is reached but the people who moved early in anticipation that the roads would remain open and uncongested are now campaigners for new roads to restore the freedom they sought, temporarily enjoyed and then lost. And so the process repeats itself.

In this situation the position is best summarised as follows:

1. New roads do not alter the level of congestion (except temporarily). In the long term all they do is increase the number of people who suffer from the same equilibrium level of congestion.
2. The equilibrium level of congestion is not determined by the amount of road space but solely by the level of congestion that will be tolerated before people decide not to travel.
3. Market theory would predict that this equilibrium can only be altered by increasing the attractiveness of alternatives, thus increasing the number of options that are perceived as better than not travelling, and therefore leading to a congested road journey being rejected as a choice before failure to travel becomes the trade off. This implies that bus priority measures on main roads should eventually reduce congestion despite the road space lost.
4. Road traffic will therefore only flow freely when walking, cycling, public transport and living in the inner city become more attractive. However building new roads damages all these alternatives.

3.1.22

- CONCLUSION: In conclusion we need to move towards a transport strategy which
- promotes walking as the preferred mode of transport for journeys under a mile by
 - creating residential cells (areas without through traffic) so that use of cars for short journeys becomes less convenient
 - developing aesthetically attractive pedestrian routes so that walking is pleasant
 - addressing the fear of crime
 - ensuring that facilities are more locally based

 - promotes cycling as the preferred mode of transport for journeys of one to five miles by
 - creating residential cells so that use of cars for short journeys becomes less convenient
 - developing safe cycle routes segregated from large volumes of other traffic
 - developing cycle parking facilities
 - conveying cycles on public transport
 - ensuring that facilities are more locally based

 - promotes public transport as the preferred mode of transport for longer journeys on major demand lines by
 - ensuring good public transport facilities
 - using segregated track forms of public transport (railway, tram, guided bus, busway) so as to gain the benefits of speed
 - bus priority measures on highway
 - orbital routes and interchange facilities recognising that almost half of all car journeys are non-radial journeys over five miles
 - ensuring that facilities are accessible by public transport
 - establishing delivery systems for shopping to make shopping by public transport less inconvenient

 - recognises that the car will continue to have a place but seeks (as in most of Europe, where car ownership is higher than in the UK but car use is much less) to avoid its misuse by
 - creating residential cells within which vehicle use will be controlled
 - recognising that congestion can only be solved by creating alternatives not by building roads
 - planning for access by other means of transport instead of assuming access by car
 - controlling the proliferation of car parks.
 - taking through traffic away from centres of population but ensuring that the bypass roads that achieve this are no greater in capacity than the roads they replace and are not permitted to generate new development. There may be a place for a single carriageway two lane bypass of Hazel Grove but there is no place for the A6(M).
 - developing Park and Ride facilities

3.1.12 Residential Cells

One way to reduce the impact of traffic on local residents is to create residential cells. These are areas from which through traffic is excluded so that only local traffic is present.

This can be done either by slowing traffic down over a large area by traffic calming, so that through traffic avoids the area out of impatience, or by closing roads so that through traffic is impossible.

The former approach has the advantage of slowing traffic down as well as reducing it and allows residents to use all the exits from the cells. However it can be hazardous to cyclists, is expensive if carried out over large areas in an aesthetically attractive way, and may fail to deter through traffic so that it inconveniences drivers to no effect.

Street closure creates lengths of safe cycle routes, is totally effective in altering traffic flows and is cheap. But it can disrupt bus routes and flows of emergency vehicles and limits the exit from the cells available to residents.

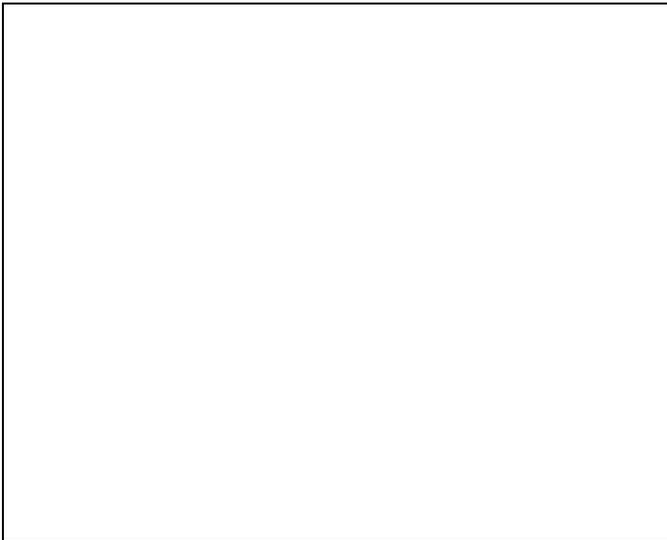
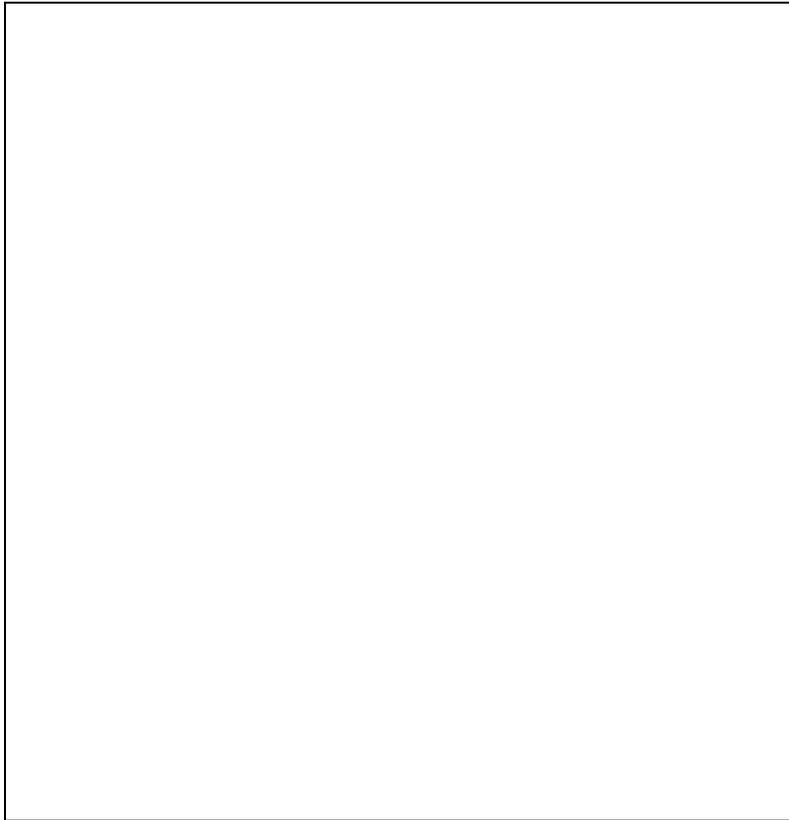


Photo 3.1.12.1

Example of a street closure

Map 3.1.12.2

Bramhall – showing routes used by through traffic



Map 3.1.12.3

Bramhall – showing street closures which could confine traffic to main roads
(Illustrative only – not a proposal)



3.1.25

Street closures can be simple or sophisticated.

Fig 3.1.12.4 A very simple way to close a street - achieved by putting two large rocks in the road

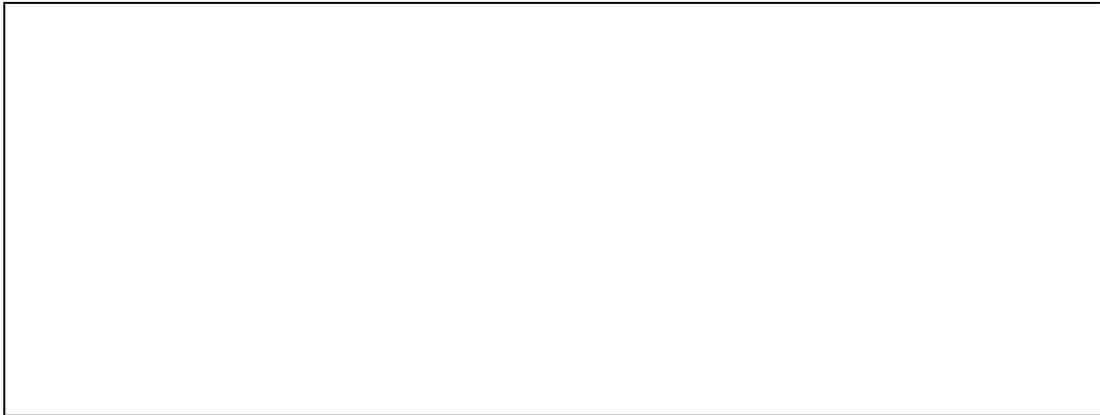


Fig 3.1.12.5 A more sophisticated way to close a street – rising bollards, cardholder to allow emergency vehicles, buses and residents to lower the bollards, turning circle, dropped kerb, cycle lane created in advance of the blockage by islands



Traffic engineers would prefer to build the second of these two options. It allows vehicles to turn in the turning circle, carefully controls the conflict between cycles crossing to the cycle gate and other traffic, and it allows buses, emergency vehicles and local residents to open the barrier. However it would cost £20,000 rather than £500, and is also more intrusive on the aesthetics of the road.

To convert Stockport entirely into residential cells would require 150 street closures.

3.1.26

Using simple closures it would cost £75,000 plus cost of consultation and legal costs. Using more sophisticated closures it would cost £3,000,000 plus legal costs and costs of consultation.

There is a balance between cost and benefit.

To close a road like Lisburne Lane, Chester Road or Cherry Tree Lane without permitting passage for buses, emergency vehicles and local residents would clearly be absurd. A sophisticated closure is clearly called for. However there are many other settings where the use of much simpler methods may be possible. Striking this balance is the art of making the creation of residential cells cheap enough to be economically viable without making them so cheap and nasty that they are simply seen as an imposition.

MAKING USE OF RESIDENTIAL CELLS

Residential cells

- reduce the disruptive effect of rat running on residential areas
- create lines of quiet streets for use in a cycle network
- open up streets for community use for purposes other than just the passage of traffic.

Home Zones

Traffic calming in Stockport has mainly consisted of obstacles to the free flow of traffic – usually humps, sometimes chicanes.

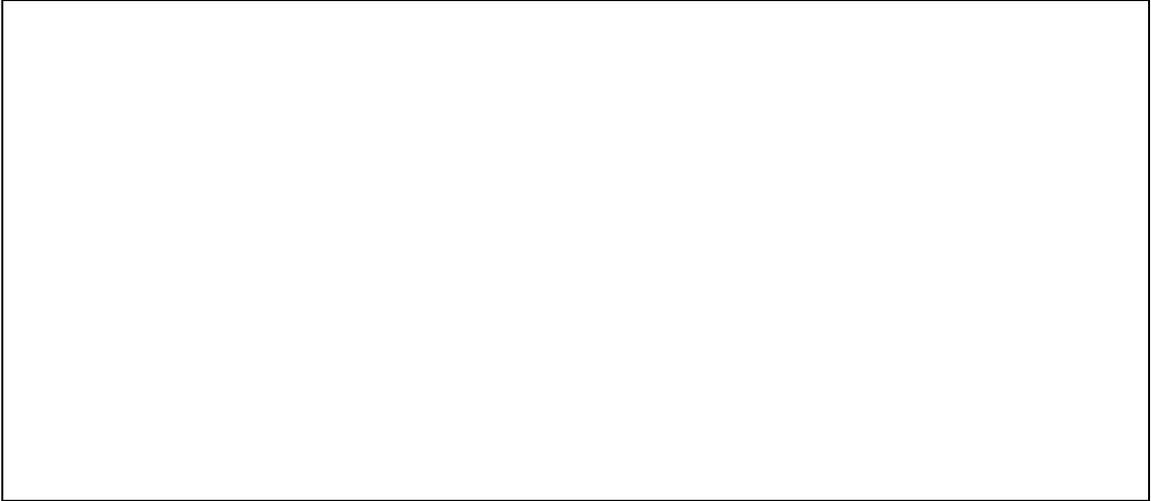
Humps have been a cheap form of traffic calming but they create problems for bus services, cyclists, and disabled drivers. Chicanes would have been preferable, but there are forms of traffic calming which go well beyond either of these.

If roads are for cars and streets are for people then streets can be used to develop local communities.

In Holland such streets are called “woonerfen” (living streets). The street is planted with trees and laid out with street furniture, tranquil sitting areas and play areas.

Traffic is still allowed to use the street – indeed parking areas are marked out. But it must pick its way between the trees, the picnic tables, and the playgrounds which are placed on the carriageway as well as the pavement (indeed the distinction between carriageway and pavement disappears).

Photo 3.1.12.6 Woonerf



I believe that we should seriously consider the development of such living streets in Stockport where local residents wish to see them. It is good to see that Home Zones will form part of the Adswold SRB bid and there are other areas where it should be possible to use public money to develop them.

Dutch experience is that house prices in a woonerf increase, so in more affluent areas the Council could lay down criteria, lay down a process for testing resident's views, and be prepared to carry out the necessary legal measures (essentially resolutions to "deconstruct" part of the carriageway), whilst the residents should develop the scheme and pay for the necessary road markings and street furniture to implement it.

20 mph Campaigns

Britain has one of the lowest road accident rates in Europe but one of the highest child pedestrian accident rates. This is because we do not clearly distinguish between a road and a street.

Roads are for cars and streets are for people.

At 40 mph a pedestrian hit by a car has a 95% chance of being killed. At 30 mph this falls to 50%. At 20 mph it falls to 5%. Most child pedestrian accidents occur in side streets, so if we slowed down to 20 mph when we leave the main road and enter the street network we would save most child pedestrian deaths.

Few places are more than a mile from the main road. Therefore few journeys involve more than two miles in the street network – a mile at each end. To travel two miles at 40 mph takes 3 minutes. To travel it at 20 mph takes 6 minutes. So hardly ever would it add more than 3 minutes to a journey if we limited the speed in the street network to 20 mph.

3.1.28

Formal 20 mph speed limits, traffic calming (not necessarily by road humps – chicanes can be created by changing the side of the road on which parking is permitted every 25 yards), and home zones all contribute. But it is also important to run campaigns which create a culture of slowing down in streets.

One advantage residential cells would bring to such a campaign would be the clear distinction that they would create between the road network and the street network.

3.1.13 Promoting Cycling

Recreational cycling, including mountain biking, is an important means of exercise and must continue to be promoted as part of our exercise and open space strategy. Cycling can also be regarded as a means of serious transport. Indeed cycling combined with trains can be an alternative to the car.

Cycling is currently perceived as a dangerous mode of transport. Cycling in heavy traffic is unpleasant and potentially unhealthy because of the inhalation of exhaust fumes, and dangerous because of the risk of being run down. Cycle lanes make it safer but do not remove the fumes although it should be noted that exhaust fumes are actually present in a greater concentration within the cars themselves. Nor do they completely remove the danger, as junctions remain problematic.

Whilst cycle lanes undoubtedly play their part in creating a safe cycle network they are not completely satisfactory and they can be quite expensive to create.

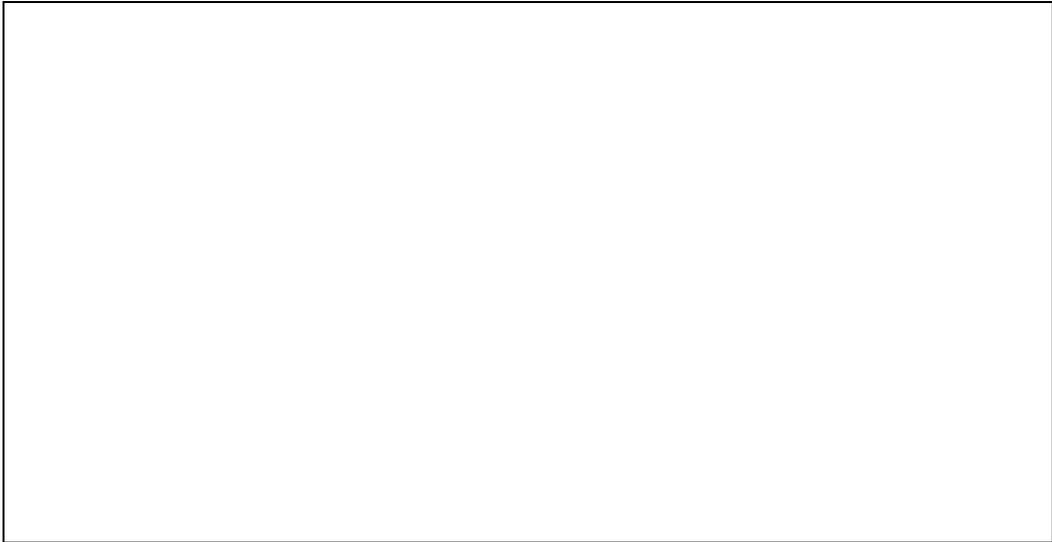
Other ways of creating a safe cycle network include:

- use of off road cycle routes
- use of lines of quiet street linked by special cycle paths
- use of cycle gates between residential cells.

One example of the possible use of off road cycle routes is the projected Marple Cycleway. The construction of the Marple Cycleway would immediately create a new opportunity for people in Marple to make the journey to Stockport – a journey that currently can be severely delayed by congestion.

3.1.29

Map 3.1.13.1 The Marple Cycleway: an example of a possible mainly off road cycle route



Opening up cycle routes is a valuable additional benefit to the creation of residential cells. The removal of through traffic from roads opens them up to cyclists.

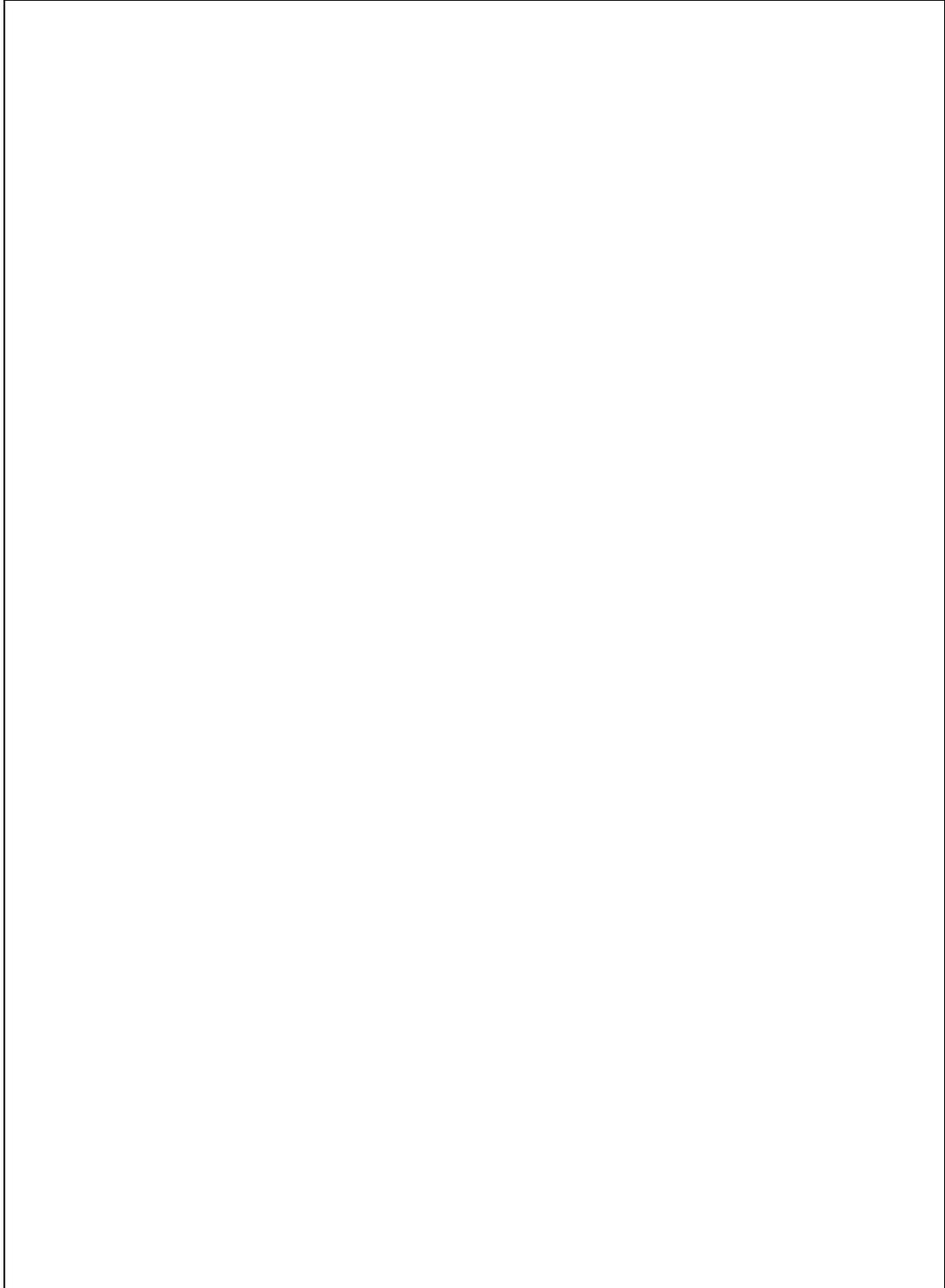
Map 3.1.13.2 How creating residential cells could open up safe cycle routes



Sometimes a line of streets parallel to a main road forms an alternative to a main road. For example it would be extremely difficult to put a cycle lane along the A6 south of the Town Centre but an alternative route involves comparatively little work, mainly at junctions or on publicly owned sites such as Stepping Hill Hospital, Heathfield Mental Health Centre and Stockport Grammar School.

3.1.30

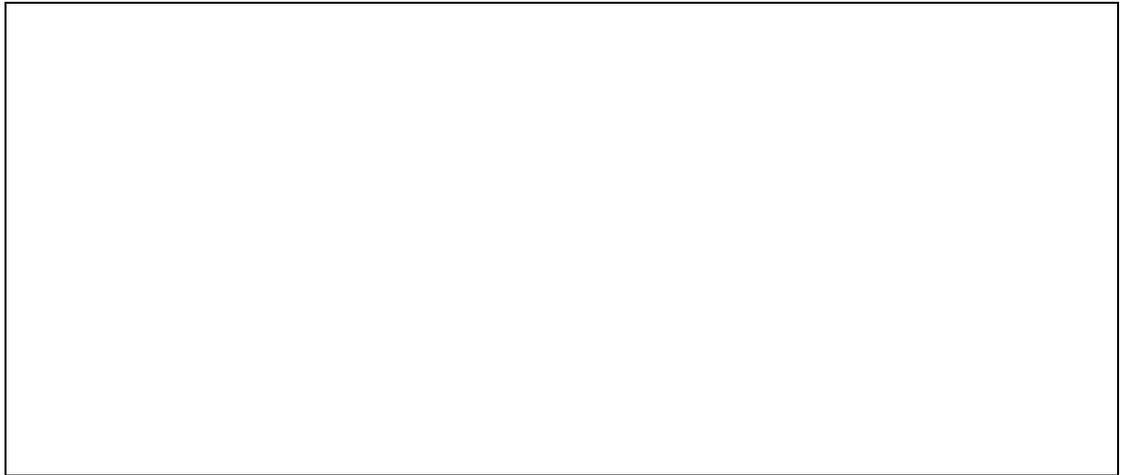
Map 3.1.13.3 The A6 in Great Moor and Hazel Grove: an example of a route where a parallel cycle route could be created.



3.1.31

Cycle lanes can sometimes be provided on wide pavements:-

Photo 3.1.13.4 Dialstone Lane: a pavement that could accommodate dual use.



It would be important that the cycle lane should at the very least be marked out and ideally separated from the pedestrian part of the pavement by a kerb. Dropped kerbs would be needed at junctions and stop lines would need to be set back to emphasise that the cycle lane is part of the major road.

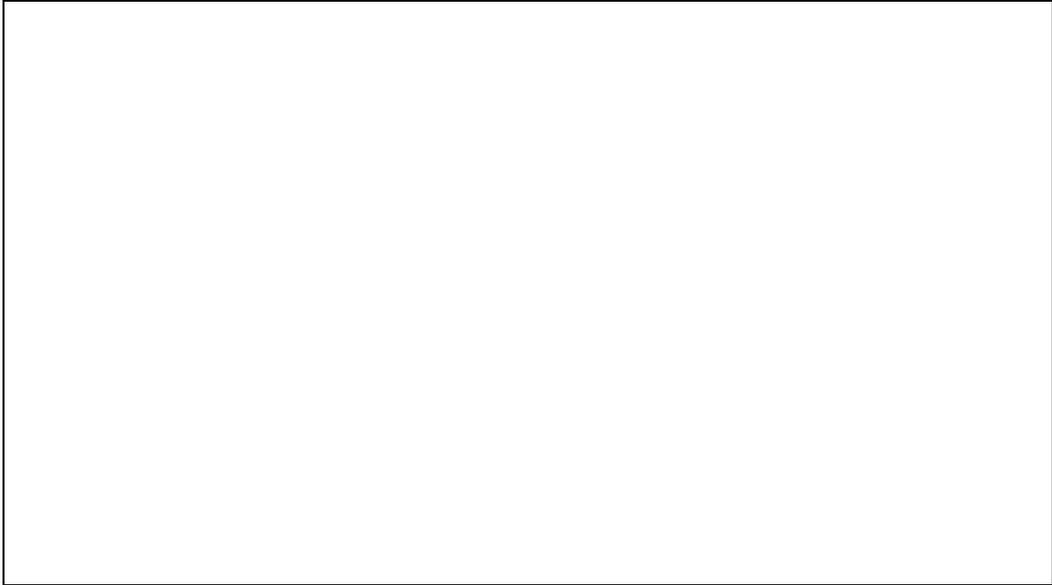
Photo 3.1.13.5. Example of a cycle lane on a pavement



3.1.32

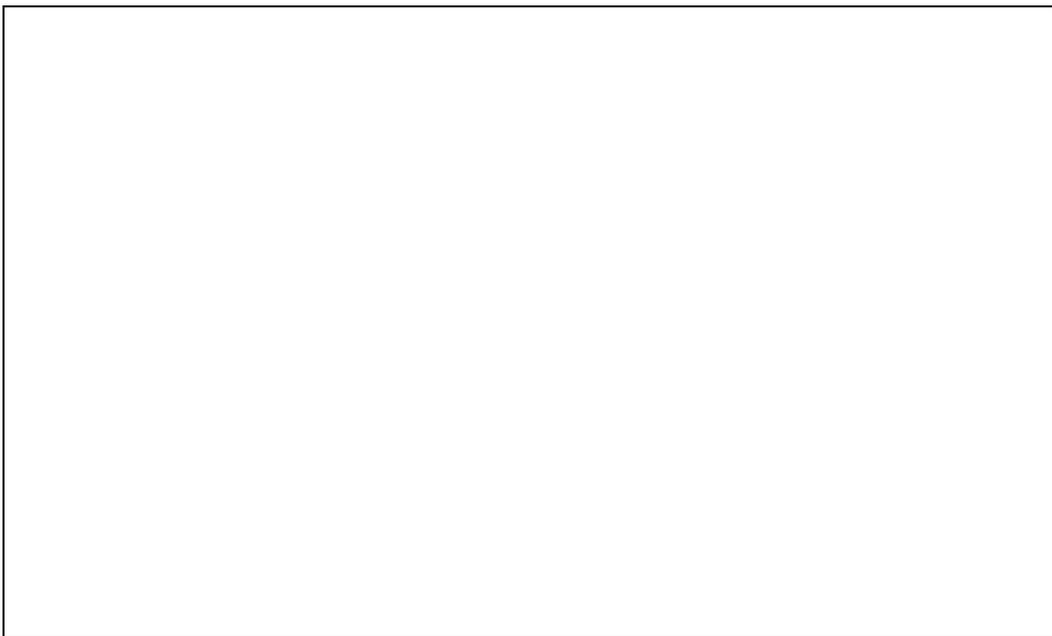
Sometimes pavements which do not access premises can be entirely given over to cycles if a parallel pedestrian route exists. On the following photograph of King Street the pavement on the right could easily be given over to cycles.

Photo 3.1.13.6 King Street



In Offerton between Offerton House and Offerton Green diversion of pedestrians to a parallel footpath would allow an existing pavement to become a cycle lane. It may not be wide enough for bidirectional use but could be used uphill where the speed differences, and hence danger, is greatest.

Map 3.1.13.7. Design for Offerton Road, between Offerton House and Offerton Green



3.1.33

3.1.14 Promoting Public Transport

Three years ago I advanced the view that most of Stockport could be brought within 1km of a railway station by relatively minor changes to the rail system (a Marple to Manchester Airport rail service via new chords in Reddish and Gatley, twelve new stations on existing lines, and a town centre funicular from the station to the bus station).

Map 3.1.14.1 Areas Within one kilometre of Actual and Possible Railway Stations

Built up area within 1km of railway station with direct rail service to Stockport

Shows areas that would be served if new stations were built

Does not currently have rail service to Stockport:- would have direct service with proposed new services

Would have indirect service with proposed new services

Areas within 1km of station on the proposed Metrolink to Stockport via South Manchester

3.1.34

I pointed out that only a few parts of the borough lay more than one kilometre from the actual and potential stations shown on this map. One of these was the Mersey Valley and Heaton Mersey and this area will now be served by the Metrolink extension to Stockport when it is built. This could later be extended to Offerton, the other major area without a rail service.

Very light rail systems such as the Parry people movers, could link Compstall to Marple, Bruntwood Park to Gatley (along the centre of the A34), Mellor, Wybersley and Marple Ridge to Strines, Hawk Green to Rose Hill, Windlehurst to Middlewood, Woodford to Poynton, Bramhall Park to the proposed station at Adswood, and Dairyground to Bramhall. If all these schemes were implemented the Borough would be entirely within 1km of a rail service.

Currently the rail system is predominantly radial in running into and out of the centre of Manchester. However over 50% of car journeys in Greater Manchester are non radial journeys over five miles.

It is therefore important that the rail system be developed to make non-radial journeys easier. The Directors of Public Health for Greater Manchester have proposed a Greater Manchester Orbital Railway linking the various outer Greater Manchester boroughs with an Inner and Outer Circle service. Both these services would enter Stockport along the old railway line through Reddish with Outer Circle trains leaving along the line to Altrincham and Inner Circle trains leaving along the new Metrolink line.

Trains are more effective at competing with cars and evidence based on comparing cities across Europe has shown that only cities with a good rail network have been successful in developing the use of public transport. Such cities have also been better at developing use of buses.

Trains are also important because the combination of frequent trains and cycling can be as flexible a means of transport as the car. The core high frequency rail network needs to be cycle friendly.

Bus services are however an important part of the public transport network.

Bus priority measures and the creation of stable networks would considerably enhance the use of buses. One of the main drawbacks buses currently face is that they are stuck in the same traffic as the cars they compete with. Another is that routes change with little notice and people feel unable to base their lives around a changing pattern of services.

<p>The open space section of the report follows. However the transport section has not yet ended. Section 3.1.15 is relevant to both transport and open space.</p>

OPEN SPACE

3.1.15 Promoting Walking: Ginnels, Snickets and Leafy Lanes

Several years have passed since I wrote “Ginnels, Snickets and Leafy Lanes”, a design for a pedestrian network in Stockport. Nonetheless the argument remains valid and that document is the basis of this section.

INTRODUCTION

Stockport is a beautiful town to walk around.

Each of the communities of the town has its own distinctive relationship to countryside and to large parks that act as surrogate for countryside.

Some communities encircle pieces of country so that walking around the community consists of crossing and recrossing it – Gatley and the Goyt Valley Estate are the two best examples of this.

Other communities are set amidst countryside – Marple and Reddish for example. And often these communities have linked the surrounding countryside across the village by lines of aesthetically pleasant routes, whether these be the tree lined roads of Heaton Moor, the succession of tiny green patches that characterise a walk across Brinnington, Dairyground’s system of walkways linking public gardens hidden amongst the houses, the pleasant landscaping of the new estate between Adswold and Davenport or the green swathes that run through Offerton Green.

Other communities are even more closely interlaced with countryside. Bramhall is a patchwork of countryside and housing, arranged in layers to give a lasagne-shaped village.

As you walk the network that this produces a succession of delights unfold. Apart from those who live there, only the walker will see the village green at Sydall Green, the pleasant group of cottages at Offerton Fold, or the farmyard which straddles the northern approach to Shopping Giant in Hazel Grove. Only the walker realises how close to the town centre the countryside comes –that a riverside garden adjoins Sainsbury’s, that horses graze in a field behind Culver’s, and that the King Street bridge is the start of continuous riverside path that stretches to Cheadle and on into South Manchester, with branches over the fields to Gatley, and over Heaton Mersey Common to Heaton Moor.

3.1.36

Every community of this town, except for a few areas immediately south of the town centre, can be reached from the town centre by a walking route that lies predominantly through countryside or park. As we drive around the town it seems to be a succession of built-up areas clogged with traffic jams. As we walk around it we realise it is a patchwork of pretty country villages.

Exercise reduces the risk of heart disease and eases stress. So why don't we walk the footpaths of the town – for serious journeys every day as well as for leisure at weekends.

Time is often mentioned as a reason. But we think nothing of a 20 mile journey by car so why should a two mile journey on foot be any more offputting? If car users would switch to public transport for inter city journeys and for journeys into city centres, to cycling for journeys of three to five miles, and to walking for journeys of under three miles, we would dramatically reduce traffic, dramatically improve health and still have our cars for the journeys that they are uniquely useful for.

There are of course other problems. Many of our footpaths become very muddy in wet weather. Others are lonely and could be quite scary at night.

We need to invest in them as part of our highway network. And we need to use them, so they are thronged with people and no longer lonely and frightening.

The exercise of walking contributes to the reduction of heart disease, osteoporosis and stress and improves mental health.

Enjoy your town, raise your spirits and live longer. Walk!

WHY A PEDESTRIAN NETWORK?

People are more likely to walk when they can do so safely and pleasantly.

They will not make serious journeys on foot, except over very short distances, unless there is something that attracts them to do so. Walking already suffers from the disadvantage of being a slow means of transport. The fact that it is healthy is not a sufficient counterbalance. It also needs to be positively pleasant.

If people were asked why they do not make serious journeys on foot they will often answer "time". But somebody who would regard as "short", and barely notice, a 45 minute road journey to the other side of Greater Manchester would draw back from a walk between, say, Bramhall and Hazel Grove, which would take about the same time and be much more pleasant. Why?

The main problems are probably

- lack of knowledge of the network
- gaps in the network
- the poor quality of much of the network
- security
- habit.

3.1.37

A programme of promoting walking must therefore include

- COMPLETING a network, so that existing gaps are filled
- PROTECTING the network, so that new gaps do not appear
- IMPROVING the network, to overcome problems of security and poor quality paths
- PROMOTING the network, to overcome entrenched habits and lack of knowledge.

THE STARTING POINTS OF A NETWORK

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.
- 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
- 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.

COMPLETING A NETWORK

There needs to be an aesthetically attractive strategic network linking the various parts of the borough. It is important that there are local links and particularly links between housing and workplaces, local facilities, public transport etc.

Map 3.1.15.1 shows the pedestrian network that was drawn up in Ginnels, Snickets and Leafy Lanes and subsequently endorsed by the Planning Inspector as a valuable reference document supporting a strategy in Stockport’s Unitary Development Plan.

3.1.38

Existing pleasant routes are shown as follows:

DARK BLUE	-	waterside routes.
GREEN	-	rural footpaths, paths in parks, quiet country lanes etc. These are the parts of the network where you feel you are in the country.
YELLOW	-	pleasant urban routes with a green feel to them, including the walkways in Radford estates, the linked closes, streets that adjoin fields or recreation grounds, and some heavily tree lined routes.
ORANGE	-	other attractive urban routes such as pedestrianised shopping centres or conservation areas.
BROWN	-	roads that fall into the yellow or orange category but whose role as a through motor route does create some threat of their attractiveness being destroyed by traffic.
PINK	-	heavily trafficked routes where the footways alongside them are nonetheless sufficiently attractive to be pleasant.

It can be seen that these routes already represent a significant network. Gatley, Cheadle, Heaton Moor, Bramhall, Cheadle Hulme, Marple, Romiley and Offerton already have comprehensive networks. An almost continuous spinal path leads the length of Reddish. All parts of the town have continuous, or almost continuous pleasant pedestrian routes to the town centre. The Ladybrook Valley forms a non radial route across the south of the borough. Bruntwood Lane forms a similar route to the south west, and Nelstrop Lane to the north west.

To complete the network we need:-

- (a) a programme of footpath development to put in place 31 new footpaths establishing links where open land lies across gaps in the network.
- (b) a number of roads, 43 miles in total, have been marked LIGHT BLUE on the map to indicate roads that are already quiet and safe to walk along and therefore potentially part of a pedestrian route, but which require aesthetic enhancement if they are to be pleasant.

Aesthetic enhancement can take a number of forms.

In terraced streets hanging baskets and window boxes are probably the simplest form of aesthetic enhancement. Street art is another option. In other cases the creation of chicanes, with the planting of trees, gardens or grass where the road has been narrowed, can give an aesthetically improving effect.

Insert Map 3.1.15.1

3.1.39

3.1.40

Avenues of trees can be planted along the edges of long straight roads.

These developments may be carried out by the Council but it is also possible that residents or commercial frontagers could be persuaded to assist.

The ultimate form of aesthetic enhancement would be the “gardenway” that I have described in previous reports, essentially a woonerf in which the street space is largely given over to garden, although there are considerable resource implications to this.

- (c) Certain stretches of main road, marked GREY on the map, also need aesthetic enhancement as they are unavoidably part of pedestrian routes.

PROTECTING THE NETWORK

Had I drawn the map a few months before I did Heathbank Road, Cheadle Hulme, would have been shown as yellow, as are Egerton Road North and South and Tatton Road North and South in Heaton Moor. It is the heavy overhang of trees from the railway that in each case is the factor that makes (or made) these roads pleasant to walk down. The cutting down of the Heathbank Road trees by Railtrack made it necessary to show this road, a critical link in an important north/south route, as light blue, with the consequential recommendation for expensive aesthetic enhancement. Since I drew this map the trees in Heathbank Road have grown somewhat but Railtrack has now repeated this thoughtlessness in Heaton Moor.

The network is threatened by

- developments which remove the attractive features that have led to some roads being labelled yellow or orange
- developments which increase traffic on roads that are part of the network
- developments which destroy the “green” characteristics of particular paths or routes
- the closure of through passages
- unsightly development visible from the network

Planning policies to protect the network have been put in place in the last few years, but are still not as rigorous or as effective as they could be.

In much of the town rights of way have not been mapped. It is important to do this to protect routes, including those on the pedestrian network but also others of more local significance. Steps are now being taken to do this.

IMPROVING THE NETWORK

Ginnels, Snickets and Leafy Lanes recommended a rolling programme for improvements of the network. There have been improvements in the river valleys and along the Houldsworth Way and at some specific points but much of the improvement that was called for remains to be achieved.

3.1.41

Opportunities to improve the network occur in connection with

- workplace Green Transport Plans
- new developments
- highways work
- countryside work

Surfacing

82 miles of the paths in the network are badly surfaced and poorly drained making them a quagmire except in dry weather. This is of no importance to a rambler in walking boots, but it significantly detracts from the prospects of the path being used for serious journeys. There needs to be a rolling programme for surfacing all unsurfaced paths included in the network. The method of surfacing chosen should be sensitive to rural characteristics – a path across a field for example may be better surfaced by use of paved “stepping stones” rather than be converted into a tarmac strip. Nonetheless the network needs to be surfaced.

Lighting

An unlit path is useless at night. Although it will undoubtedly be many years before the Council can light every path in the network it should at least affirm this intention and build it into resource plans for the network. Again on rural paths conventional street lighting is inappropriate. Low level lights that look like way marks during the day, or lights concealed in trees may be more appropriate, and lights with sensors that only turn on when somebody is on the path may cut down light pollution.

Given that lighting of all paths is undoubtedly a long term ambition, phosphorescent way marking may be a low cost interim measure.

Road Crossings

Ideally there would be a safe crossing – bridge, underpass, pelican crossing or zebra crossing – at every point where the pedestrian network crosses a main road. It will be important to recognise that where a road serves as an uncrossable barrier there may currently be few pedestrians and therefore conventional criteria for crossings will not be met. Since “Ginnels, Snickets and Leafy Lanes” was produced the Council has installed a number of pedestrian crossings on the network. This must continue.

Security

Security is a major problem. The perception of passages and paths as points where hazards lurk, and even of streets as sources of danger, dissuades many people from walking. Moreover the idea has arisen that in this dangerous world safety consists of withdrawing into small isolated groupings of houses, so that passages and paths become seen not as part of the flow of people about a large community but as a dangerous escape route down which burglars can make their way back to the parts of the town where “they” live.

3.1.42

Lighting will help, but only to a limited extent and is in any case an expensive solution.

A steady flow of people about the network would help dramatically but this is a chicken and egg situation as this flow cannot be created until the network is secure.

It may be that people can be persuaded to walk in groups, perhaps even as a conscious “reclaim the night” movement. On some paths traffic flow, and hence security, is diminished by a quite unnecessary prohibition of cycling.

It may be that people could be persuaded to volunteer as special constables to patrol the paths, or that regular path users could establish a Pathwatch scheme. Perhaps police on patrol could also spend more time on foot and less in cars.

Hygiene

The fouling of footways by dogs is a problem. Ginnels and snickets are particularly badly affected as owners often see them as unowned waste territory rather than public territory, or feel that they are less likely to be observed there. Any strategy adopted to address fouling must include snickets and ginnels.

SIGNPOSTING

Promoting the network

Some paths are marked by the “public footpath” sign. Even more can be picked out by a widespread brand marking – the “no cycling” sign. Many are completely unmarked. Very few are marked by signs that indicate their destination – hardly any by medium distance destination signs such as a sign in Offerton “Footpath to Marple” or in Bramhall “Footpath to Hazel Grove”.

In Ginnels, Snickets and Leafy Lanes I suggested that

- the “named” river valley paths such as the Valley Way or the Ladybrook Way should all start in Mersey Square.
- new named paths should be established for other long lengths of continuous pleasant path. The Council has made one response to this suggestion in designating the Houldsworth Way.
- each township in the Borough should be allocated a colour and the network should be waymarked with coloured arrows pointing to their destinations.
- maps of the network, descriptions of the waymarking system and indications of mileage should be displayed in Mersey Square, the Railway Station and the major urban centres, and published in a future edition of Civic Review.
- cul de sacs which include through routes for pedestrians should have the words “(except pedestrians)” or “(except pedestrians and cyclists)” added to their cul de sac or no through road signs.

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- particularly prominent signs, emphasising the long distance nature of the path, are called for where the network crosses major roads. This publicises the network to people in cars.

Apart from the Houldsworth Way, none of these suggestions have been implemented.

Other Promotions

In "Ginnels, Snickets and Leafy Lanes" I suggested the organisation of guided country walks through the town and other promotional events. The Council has responded very positively to this.

BEYOND THE NETWORK

The fact that a footpath, snicket or ginnel has not been included in the network does not mean it is unimportant. It may not be strategically important for serious journeys, but rural paths that do not lead to major centres are still pleasant to walk on and important as leisure paths, whilst many urban snickets or ginnels are important for local use. The promotion of the network is not an excuse for neglecting these other paths and they should also be protected by the Council's existing policies.

In indicating certain priority footpath developments I in no way wish to downplay the importance of other opportunities for opening up pedestrian access, for example as part of S.106 agreements. The designation of the network is intended to heighten awareness of pedestrians not to justify their neglect elsewhere.

It was most frustrating in preparing Ginnels, Snickets and Leafy Lanes to see how often a development which backs onto open land has been allowed to close off any possibility of creating future footways across the land. I suggest that this should not be permitted in future and that any development adjoining open land should be required to have snickets through to open land, even if there is no current intention to establish a right of way. This will keep future options open. Such snickets need not be security hazards as they can be walled off until needed.

In the same way I believe that where two developments adjoin, snickets should be established between them. If there is a strong resistance to them currently being used they can be walled off but remain available to open up if a future change of mind should occur.

In short, whilst developers should be free to close off new developments provided they obstruct no existing passage in doing so, they should not under any circumstances be permitted to close off the development irreversibly. Those who today cry out for privacy should have the opportunity tomorrow to change their mind and ask to be linked to the free flow of humanity.

3.1.44

The network includes two routes – Spath Lane and the path from the Ladybrook Valley to Middlewood – that pass out of and then back into Stockport's borders. Discussions will need to take place with neighbouring authorities about these paths and also about the more general issue of whether they would wish to develop similar networks in adjoining communities and if so how they should be linked.

3.1.16 Open Spaces

I propose largely to restate the analysis of open space which I presented three years ago.

By "open space" I mean land which is not built upon and which contributes to public enjoyment either by being available for public use or by contributing to the public visual environment.

Included in this definition would be a number of different kinds of land

- open countryside
- small areas of countryside trapped within the town
- parks and recreation grounds
- public gardens
- private gardens visible to the public
- small patches of land available for public use
- small patches of greenery

It is increasingly being recognised that such land has an important contribution to make to public health. It also contributes to the maintenance of wild life within the town and therefore contributes to the social goal of maintaining biodiversity. In this section I have concentrated on its role of maintaining human health, as biodiversity is dealt with in a later section. Both goals are important. They may sometimes be in conflict - small patches of land which are enclosed away from public access provide a better nature reserve than similar small patches of land available for people to play games on. Equally they do reinforce each other - the kinds of land which create wildlife habitats are also aesthetically attractive, the large country parks which are so important to exercise opportunities also provide a home for animals and plants, and the sight of a rabbit or fox within the town has the same kind of uplifting effect on the human spirit as greenery.

There are particular opportunities to create wildlife sanctuaries on land to which the public cannot be given access because of safety, security, or privacy, such as railway cuttings and embankments, the grounds of factories and schools, and private gardens.

THE HEALTH ROLE OF OPEN SPACE

Exercise

Open space provides important opportunities for exercise. Small patches of land, even relatively unattractive land, can be used for ball games. Larger areas can be used for

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walking, running, or cycling. Other relevant types of exercise include allotments, formal sports (such as soccer, rugby and hockey) and countryside recreation.

Raising the human spirit

The human body is a good instrument for measuring stress - we know when we feel uptight and when we feel relaxed. If the body is to recover from the raised blood pressure, and raised blood cholesterol which occurs in the former state, it needs to have substantial periods of the latter.

Most of us instinctively know that a green rural environment helps create a situation of relaxation. This may well be one of the factors that contributes to the longstanding epidemiological recognition that death rates are higher in urban areas than in rural areas (although other factors such as pollution, social conditions, and the tendency for more affluent people to choose rural lifestyles, also contribute).

There is scientific evidence to support the contention that green environments raise the human spirit – the concept of biophilia.

Some studies have shown that people recovering in hospitals may do so more effectively if they have a view of nature, as opposed to the built environment. This finding (if substantiated by further research) has obvious and important implications for the health benefits that could arise from providing nature areas in hospital grounds and around health centres in the town.

Exposure to nature may enhance a person's sense of coherence and thereby positively influence that person's position on the health continuum, maintaining them in a better state of health.

Nature has been shown to positively influence emotions, contributing to human well-being by enhancing pleasurable feelings and by reducing negative feelings.

A 'green' site may be used passively as well as actively, people may obtain pleasure (or improved well-being) from simply looking at the area when passing by. A view of the surrounding hills from within the town can also provide an uplifting experience for many people.

For some people, green environments are relaxing and restorative, whilst for others they are places which can generate excitement and exhilaration. For example, children involved in nature projects may find 'wildlife is fun' and that this activity generates a 'sense of adventure'.

Contact with nature can provide rewarding experiences with full sensory stimulation (from sound, sight, smell and touch) and positive psychological support to the elderly, enhancing their self-esteem and accordingly their well-being. Setting homes for the elderly amongst natural greenspace might, therefore, be tremendously beneficial to this community group.

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Contact with nature may encourage improved social interactions within our society, easing tensions and at the same time giving people the confidence to take constructive actions - of value both to themselves and to the local community.

Nature evidently stimulates childrens' sensory feelings, actions and imaginations. Involvement in school 'greening' activities (e.g. introducing wildlife into school grounds) and in community conservation projects has been shown to lead to changes in social behaviour and to engender an increased sense of belonging and collective ownership.

A research team in London recently concluded that "one of the most powerful factors in reducing crime and vandalism on problem housing estates was the presence of a garden".

A number of surveys have shown that many people in different towns and cities in the UK would like to see more public gardens, flowers and green space.

We should recall that public parks were originally provided to improve the health of the urban community.

Our parks today have considerable potential for improving and developing healthy lifestyles across the community, whilst also providing for nature conservation and other forms of public enjoyment. Health promotion through parks, integrated and co-ordinated with other health strategies in Stockport, could make a substantial contribution to the Our Healthier Nation targets, especially CHD and stress relief.

The existence of different types of natural green space within the town increases diversity and variety and helps uplift the human spirit.

Promoting walking and cycling

People are more likely to walk and cycle on serious journeys if it is pleasant to do so. The river valleys make important contributions to a possible pedestrian and cycle network by providing long lengths of off road footpath/cycle track. However, to create a network of such routes it is necessary to link these valleys. Small patches of open space, even something as simple as a patch of shrubbery by a road junction, or a tree-lined street, can help create the continuity of a pleasant journey.

Exercise opportunities in Stockport

In a previous report I said that 80% of Stockport lies within a quarter of a mile of an opportunity for a long walk in pleasant surroundings, such as countryside, a linear green route, or a large park.

In that analysis I had neglected some opportunities that exist and I now believe that the figure is even higher: in excess of 90%. Map 3.1.16.1 shows the current situation.

Recreation grounds and local open space make an important contribution to exercise.

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Equally there are other exercise opportunities within the Borough as well as open space. Map 3.1.16.2 shows the exercise opportunities created by recreation grounds and protected open space, Map 3.1.16.3 the SWIMBUS routes and Map 3.1.16.4 the leisure centres.

Map 3.1.16.1

Insert above page number Map 13.1

3.1.48

map 3.1.16.2

Insert above page number on Map 13.2

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Map 3.1.16.3

Insert above page number Map 13.3

Map 3.1.16.4

LEISURE CENTRES IN STOCKPORT

Insert Map 13.4

1. Reddish
2. Brinnington Estate
3. City Villages
4. The Heatons
5. Gatley/West Cheadle
6. Cheadle Heath/Councillor Lane
7. Adswood/Shaw Heath
8. Davenport
9. Heavily/Great Moor
10. Offerton
11. Bredbury/Romiley
12. Marple
13. Hazel Grove
14. Bramhall
15. Cheadle Hulme
16. Heald Green

Promoting Green Gyms in Stockport

Green Gyms is a new concept which brings together health, community empowerment and open space. It is an outdoor alternative to the traditional “gym” – through practical conservation activities such as tree planting or footpath improvements participants are able to improve their physical health and mental well being whilst also learning about and enhancing their local environment.

Developing Green Gyms would significantly contribute to the greening of the borough – “Gardenways” could be created and maintained, local footpaths could be resurfaced, areas of wasteland could be reclaimed – all by local residents determined to improve their surroundings.

Promoting gardening

Promoting gardening through Community Garden projects would also contribute to the overall vision of Country Cities. Community Gardens make more effective use of domestic gardens and allotments. Local people are involved in developing the gardens with the aim of producing their own produce.

Pleasant green views

No data is available on the proportion of houses, schools, workplaces and public places within Stockport which have a soothing aesthetically attractive aspect.

Public open space would be only one of the factors to take into account in analysing that issue.

For houses without gardens it would be important to know whether they have a view of public space, but for houses with gardens a more critical question would be whether the house is so designed that the garden was visible from the kitchen or living areas.

For enclosed spaces, including many workplaces, internal design would be as important as the surrounding area. There is much lack of imagination in such design. Few workplaces are aesthetically attractive yet plants can be purchased for a few pounds and the pump necessary to build a waterfall for about £60.

Impossible as it may be to produce hard data, most people's daily experiences would tell them that aesthetically attractive surroundings are an intermittent experience in their life, not a constant experience. Few people would claim to be in aesthetically attractive surroundings for most of the time. Yet it is quite feasible to change that.

A PROGRAMME FOR OPEN SPACE

Objectives. I would suggest the following as being appropriate objectives to be included in a strategy for open space in the Borough.

a) to maintain an aesthetically attractive green appearance to as much as possible of the public space of the town so that if parallel programmes of public art and aesthetic enhancement of workplaces were also put into effect, most people would have the opportunity to spend most of their time in aesthetically attractive surroundings.

b) to provide a network of continuous aesthetically attractive routes for walkers, equestrians, and cyclists both for serious transport and for recreational use

c) to provide all parts of the town with pleasant walk opportunities, ideally offering

a choice between wild natural surroundings and more formal or urbanised laid out areas, as people differ in their preferences between these two types of greenspace.

d) to provide safe opportunities for play, both for children and adults.

e) to maintain wildlife habitats and enhance biodiversity so as to ensure that people encounter nature on a regular basis and see wildlife within the town.

Role of different kinds of open space.

The Green Belt helps limit the distance from the centre of the town to open countryside and, by preserving countryside, maintains country walk opportunities and wildlife habitats. It also preserves the rural character of existing villages instead of allowing them to be engulfed in the town. Strategic open space such as the Mirrlees Open Space and the river valleys bring these benefits deeper into the town and give the opportunity for a rural feel to be given to suburbs like Bramhall or the Goyt Valley Estate. Patches of open space, even rough ground, help provide exercise opportunities throughout the town as well as contributing to aesthetic quality. Railway embankments and cuttings and other enclosed patches of land can make a significant contribution to biodiversity. Very small patches of land, even as small as the centre of a roundabout, or a patch of grass verge, can contribute to the maintenance of a green environment and it may be that local residents could “adopt” these and personalise them as if they were their own garden. It is important that the role of buildings should not be neglected. Hanging baskets on a building can have the same aesthetic effect as a small patch of land and there is no reason why factories and warehouses cannot have horticultural features, such as roof gardens, that fulfil the same roles as small patches of open space. Development can be designed to promote the green appearance of the borough and provide opportunities for nature.

Countryside Management in Urban Area.

In National Parks and in the river valleys country rangers fulfil such roles as developing footpath networks, organising guided walks, identifying problems in land management,

3.1.53

conserving wildlife and maintaining diversity of plant life, regulating use so that public access is combined with effective regeneration of vegetation and maintenance of nature sanctuaries. These techniques can equally be applied in urban areas. Indeed where land is more limited, and therefore more precious, these techniques may be even more important.

Urban nature conservation is closely linked with the well-being of people living in towns and cities. Urban nature conservation also makes a considerable contribution to economic regeneration, sustainability and to anti-poverty and equal opportunities policies by improving the quality of life and the attractiveness of local areas.

Countryside Management has to be skilled in managing the different habitat types found within the Borough. These consist of woodland; grassland; tall herbs and ferns; heathland, water course, swamp and other wet habitats; open water; industrial habitats and other smaller types (arable, bare ground, hedgerows and walls). Some existing degraded habitats such as woodland may need to be enhanced and new habitats created in areas that are currently deficient in wildlife.

Ecological landscaping, using native plant species, suitable to the local environment, is often preferable to conventional landscaping. However, this should not be used as a substitute for protecting existing established habitats from adverse developments, such as road building. Creative conservation or ecological landscaping must not be used to mitigate habitat destruction unless the total biodiversity gain is greater than the loss! Ecological landscaping can also be used to increase habitats that are poorly represented in the Borough and to fill gaps in potential wildlife corridors. Extreme care should be taken to ensure that non native wild plants are not introduced, as this may damage existing habitats.

It is important to realise that, as in much of Britain, there are no absolute natural habitats remaining in Stockport. Our wildlife sites are semi-natural in that they have been influenced in some way, over time, by human intervention. Habitats, if left alone, will change over time due to natural processes and management is necessary, therefore, in order to maintain diversity and to provide for a wide range of wildlife.

A significant proportion (22%) of Stockport's Open Space consists of closely mown amenity grassland which has very low wildlife value although it does, of course, have recreational value. This includes public parks, playing fields, golf course, landscaped schemes and grass verges. The wildlife value of selected sites could be increased by reducing mowing frequencies and by planting or seeding with native wildflowers. Monotonous areas of grass would be replaced by swards of beautiful spring and summer wildflowers. However in immediate proximity to houses there is a demand for short grass due to hay fever. Countryside management needs to effectively involve the community in the development and on-going maintenance of wildlife areas. This partnership with the local community and specialist wildlife groups helps to reduce site management problems and enhances public pride and ownership in the area. Wildlife sites need to be accessible to local people if the benefits from contact with nature are to be received.

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The local authority plays a key role in urban nature conservation, in particular by ensuring that this is given proper consideration and treatment in the planning process. The effort and concern given to urban nature is encapsulated in the presentation of the UDP. The council is addressing the imbalance in the distribution of habitats in the Borough, ensuring that new wildlife areas are easily accessible to all and that these areas are linked to form connected areas of wildlife across the Borough and into the surrounding countryside. Much more needs to be done to ensure adequate funding to carry out the Action Plan for Nature.

In protecting the town wildlife habitats, the local authority needs also to protect the wider environment which affects these habitats, for example by acting to reduce pollution and to improve air and water quality.

Wildlife sites in towns are subject to more conflicting demands than sites in the countryside; in particular for recreation needs (walking; cycling; riding; water sports) and also from anti-social behaviour (fly-tipping; car dumping). An effective Ranger service, operating across these sites, can be of tremendous value in resolving conflicts and in promoting public understanding and enjoyment.

3.1.17 Development in a Country City

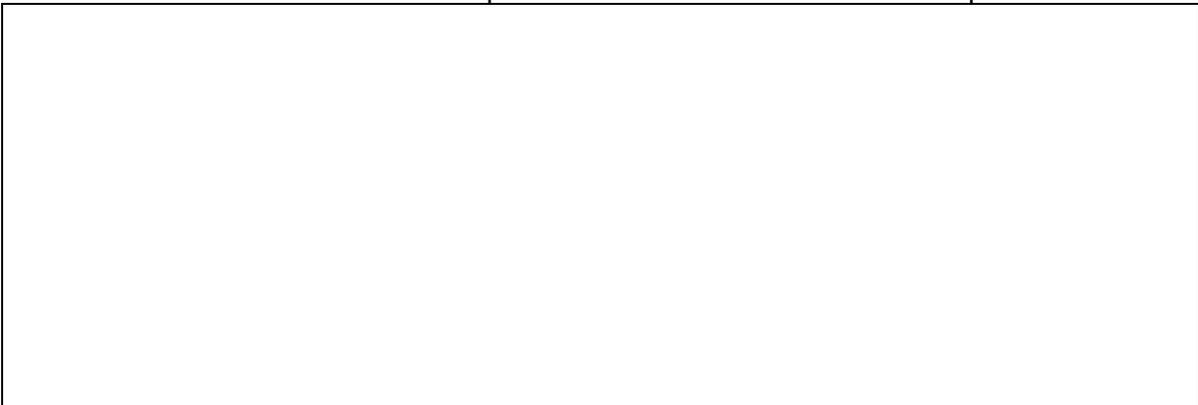
Traditionally development control has operated on the basis that open space and development are in conflict – the one can only be established at the expense of the other.

I believe that this is simply not true.

Development can take place in a way which enhances the perspective of open space.

Landscaping can play a key role as in the excellent development between Adswold and Davenport.

Photo 3.1.17.1 Photo of the development between Adswold and Davenport



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Roof gardens or subterranean buildings can preserve open space on land that has been built on

Photo 3.1.17.2 Roof garden building

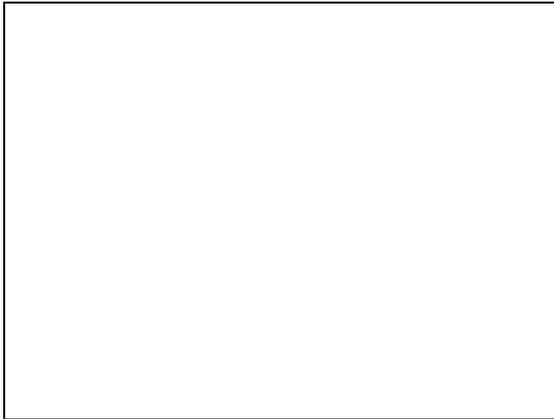
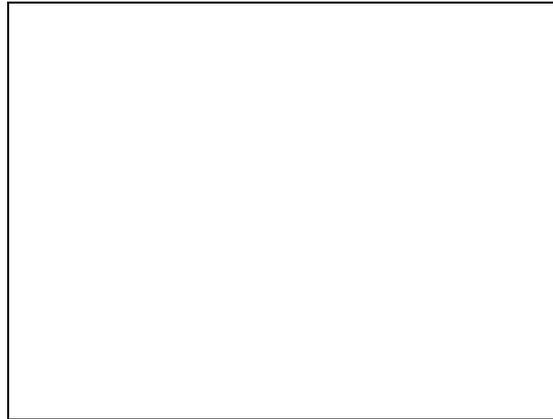


Photo 3.1.17.3 Earth sheltered building



Virginia creeper is commonly associated with old mansion houses but climbing plants (including native climbers like honeysuckle) can give a green appearance to modern buildings such as factories or multi-storey car parks. Climbing plants chosen with care for each site can enhance buildings and fencing.

Photo 31.17.4



Courtyards in new developments could be useful, the space between buildings needs more attention and the use of balcony gardens can redefine the appearance of a building and provide opportunities for enjoyment for those without a garden.

Trees and hedges can give a green appearance to areas Hedges can be a very effective security barrier – a thick thorny hedge is even more impenetrable than a fence or wall.

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Photo 3.1.17.5 Courtyards

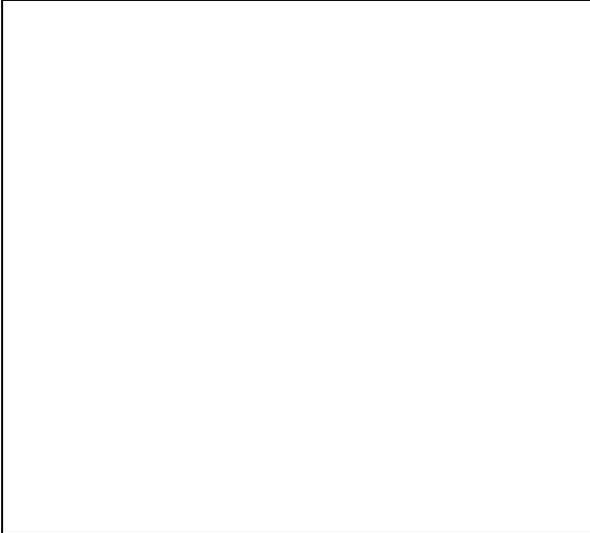


Photo 3.1.17.6 Balcony Gardens

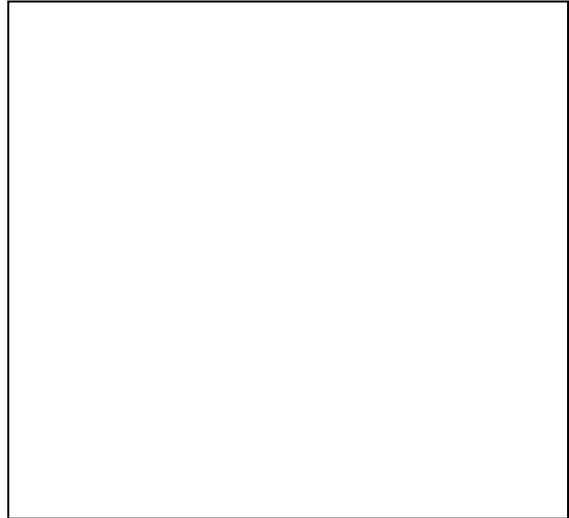


Photo 3.1.17.7 Trees and Hedges



Building can take place in clearings in forests. There are areas of Stockport where a combination of afforestation with building in clearings could improve an area of rather drab countryside. At first glance it seemed to me that the fields between Bramhall and Woodford where tranquillity has already been lost by the traffic noise from the Manchester Airport Eastern Link Road would be a good example, but whilst I was circulating an early draft of this report for comment an officer of the council challenged the idea of sacrificing natural habitats for trees and a councillor protested “Oh! And we don’t think its drab or that it has lost its tranquillity – last weekend I heard, at different times, traffic noise from the MAELR, sheep bleating, the bells ringing in Poynton, footballers playing on the rec and the splendid sounds of the toddler next door”. These are powerful and considered views and are a demonstration of how grand designs can sometimes conflict with local perception. We will obviously have to look elsewhere for space for the forest.

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Pleasant green passages can be created through buildings.

Sustainable urban draining schemes can help create wildlife habitats.

The Good and the Bad Way to Preserve a Right of Way

Photo 3.1.17.8. Dreary passage alongside

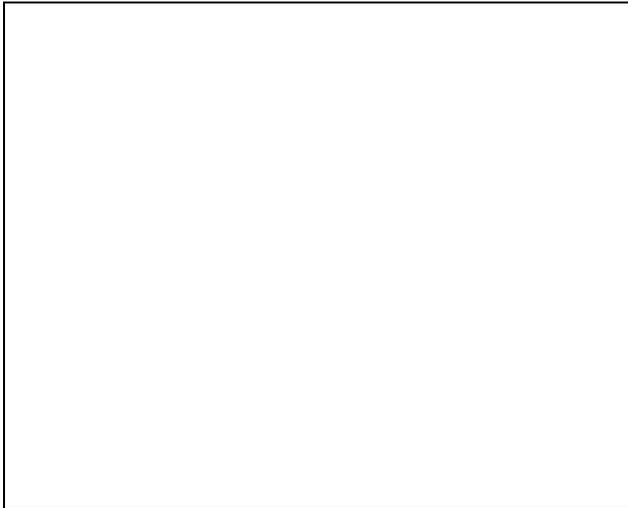
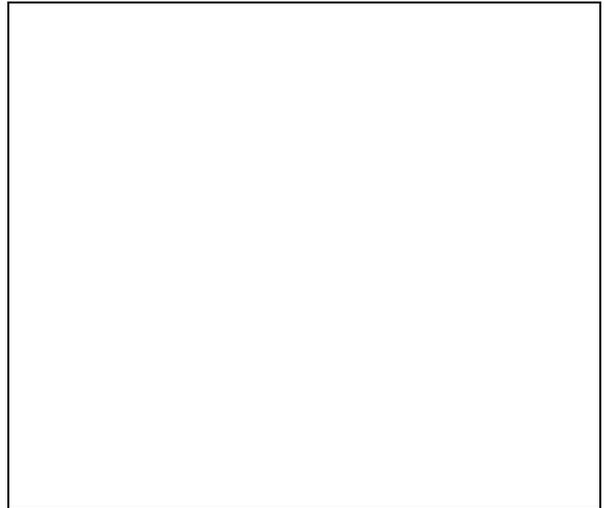


Photo 3.1.17.9. Tree-lined stream

Hexham Walk



A large attractive central building can add to a park and also help make the park less lonely by creating a regular flow of people through it.

A building on the top of a hill can crown the hill rather than detract from it.

Photo 3.1.17.10. Bramall Hall Andalusian Castle



Photo 3.1.17.11.



3.1.58

There may well be scope to create in the Green Belt some new hamlets, provided that this is done sensitively and carefully and in a way that retains a rural feel. If it were necessary to release land for housing development a new village would be better than piecemeal erosion

Photo 3.1.17.12 Hamlet

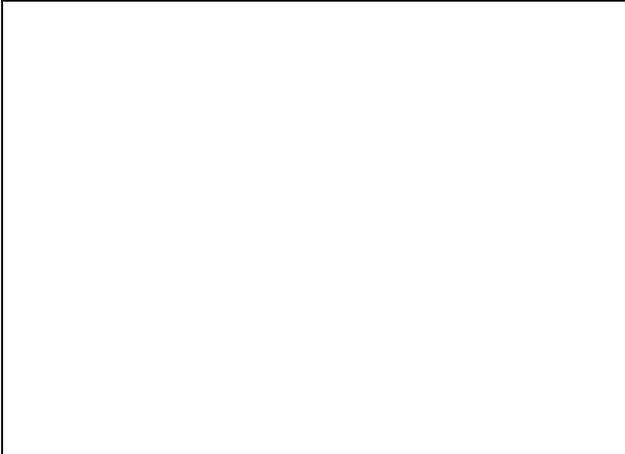
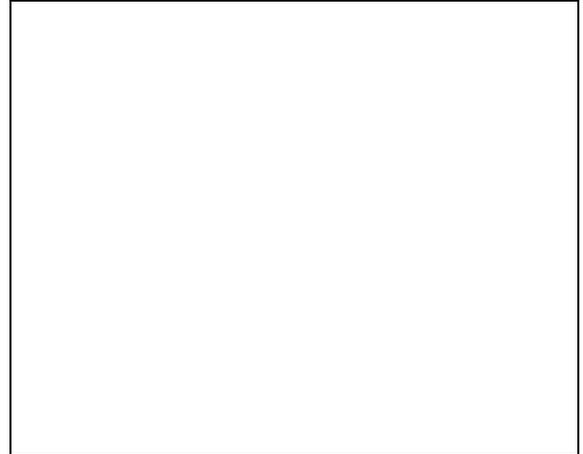


Photo 3.1.17.13 Hamlet



I believe we need to shift our planning approach from asking “How important is this piece of open space compared with this development?” to “What is the role of this piece of open space and what development is compatible with that role?”

For example, where open space mainly has an exercise role roof gardens may replace it. Where its main role is aesthetic, subterranean development or afforestation with buildings in the clearings are entirely compatible with this role. Where open space has the nature of a formal park then an architecturally attractive building could enhance it.

The Green Belt needs to be protected along its edges but in the middle of it new hamlets and new villages may not detract from its role of keeping countryside in close proximity to town. It may be that a derelict and run down disused farm in the middle of the Green Belt is a less damaging place to build than a patch of derelict land in the middle of the town which has become a home for wildlife, a source of green aspects to areas otherwise bereft of them, and a place for wildflowers. It would be important however that the transport implications be considered. Ideally the opportunity could be taken to generate improved rural public transport rather than to generate more cars. Opportunities could also be taken to develop housing especially suited for working from home.

Often a building could be an attractive addition to an area of open space but the car parks, access roads, and traffic that would serve it would be highly destructive. We need therefore to start to think about traffic free developments. There is now experience from elsewhere that such developments in the housing field are attractive and that houses in them sell at a premium not at a discount. This is not because they are the most popular kind of house – most people have no wish to live separated from their car. The reason they are viable is because there is a significant market which is currently virtually completely unprovided for.

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Table 3.1.17.14 Opportunities to create traffic free or traffic reduced estates

Market Niche	Discussion	Action
Cyclists	An increasing number of people want to cycle to work or to the station.	<ol style="list-style-type: none"> 1. Cycle paths with a traffic free area of the estate. 2. Spend money under a s.106 agreement on contributing to a Cycleway instead of on traffic schemes. 3. Establish a private cycle park in the Town Centre and sell space in the cycle park along with the houses.
People who want to walk to work		Establish links to river valley paths or other pleasant routes and actively promote the houses as having this opportunity.
Blind People	Blind people often hold well paid jobs but experience special obstacles in ordinary urban environments.	Textured pavements in a traffic free area of the estate. Scented gardens.
People who prefer to use public transport.	Many people prefer public transport but on the whole public transport is infrequent and unreliable in the kinds of area where affluent people like to live.	Develop the site in conjunction with a public transport operator who will introduce a frequent non-stop rail link coach from Stockport Station to the estate. The service will help to sell the houses and the people to whom the house/coach combination is sold will make the service viable. (This is the technique that was used to build the Metropolitan Line and the North West London suburbs).
Retired people.	Retired people may well be affluent but are unlikely to use cars in peak hours. They often find it hard to find houses tailored to their needs.	Include some single bedroom bungalows in the estate.
People who want their children to walk to school	Even if people drive to work, not making a school journey would be a significant traffic saving.	Establish safe routes to school from traffic free areas of the estate.
People who want to live in traffic free areas, either for aesthetic reasons or for reasons of child development.	This group probably strongly overlaps with the preceding groups (although there will be some people who want to live in a traffic free area <u>and</u> use their car). The action plan for several of the above niches has included a traffic free area.	Develop a traffic free area with separate vehicular access either to a separate garage block or via separate rear accesses.
People who do not want to use cars at all.	Probably a minority even of the above minorities, but it does exist.	Include in the estate a proportion of houses that have an extra room in place of a garage.

3.1.18 Nature and Biodiversity

WHAT IS BIODIVERSITY?

“Biodiversity: the variety of life. Biodiversity is all living things, from the tiny garden ant to the giant redwood tree. You will find biodiversity everywhere, in window boxes and wild woods, roadsides and rainforests, snowfields and seashore.”

Biodiversity is a new word, short for biological diversity, which represents between 5 and 30 million known species on Earth. The term also encompasses the genetic variation within species and variation between the habitats and ecosystems in which these species live.

Why should we care about biodiversity?

The need to protect our biodiversity is more important now than it has ever been. This is because human activities are affecting the environment more and more, often reducing the range of wild plants and animals that can survive. It is not just large scale human activities such as urban development, intensive agriculture and road building that can have an adverse impact on our wildlife. Even small things like cutting down a tree or neglecting a pond can make a difference to our local biodiversity.

There are many reasons why we should take action to protect and enhance biodiversity:

- *Survival*

Without plants and animals we would not be able to survive on this planet. Each and every form of life contributes to the delicate balance of nature. If we upset that balance, we are putting our own existence in danger.

- *Quality of life*

Our physical, mental and spiritual wellbeing are enriched by contact with nature

- *Moral*

We have a duty to hand on to future generations an environment no less rich than the one we inherited. Species that have evolved over many thousands of years may be lost very quickly and cannot be recreated. Already this century, we have lost over one hundred species in the UK alone.

- *Economic*

Biodiversity creates a pleasant and healthy environment which for many people is an important factor when choosing where to live and work. It is also a focus for recreation and tourism that benefits both the local and national economies. Many plants, animals and micro-organisms are essential for modern agriculture and medicine, providing a vital reservoir of natural stock and genetic variability. As we know so little about many species, it makes sense to conserve as many as possible for the future.

The Stockport Response

In 1998 Stockport Council embarked on the development of the Action Plan for Nature. This was a direct response to the UK Biodiversity Action Plan and a key theme of Stockport's Agenda 21 programme. Initially, a strong partnership was developed involving all sectors of the community, organisations and agencies across the north west region. Through this partnership approach, action will be taken to protect and enhance nature throughout the Borough. This will be achieved by implementing an all-encompassing approach to nature conservation through:

- Community involvement
- Awareness raising, education and interpretation
- Habitat, species and site protection
- Best practice advice and fact sheets
- Resource procurement

Stockport's Action Plan for Nature

The detailed development and implementation of this approach will be guided and promoted by the Action Plan for Nature which includes:

- A Framework for Action
- A Local Biodiversity Action Plan for Stockport
- Fact Sheet series
- Best Practice Guidance Note series

Stockport's Action Plan for Nature will be available in a number of different formats including loose-leaf ring binder, Stockport MBC website and on CD-Rom at public libraries and information centres.

An important element of the Action Plan is the promotion of gardening, including wildlife gardens. Gardening represents an important source of exercise and gardens can improve the aesthetic green appearance of the biodiversity.

SUMMARY

- Urbanisation, industrialisation and modern agriculture has substantially altered and degraded the nature of the land, and the resources to counterbalance this degradation on the remaining greenspace have been minimal
- The natural landscape and the wildlife within it are fundamental to the 'sense of place' of an area – its topography, natural features and inherent ecology
- Research has shown clearly that the benefits of tranquillity, biophilia and aesthetics to local people are dependent on a range of factors including colour, texture, sound, smell, sense of enclosure or open horizons, sense of scale, landscape, visible wildlife, topography, natural features etc. These are closely linked to the biodiversity, ecology, habitats and wildlife of an area and collectively give rise to the 'sense of place'.

3.1.62

- The management of land to encourage diversity of habitats and species is highly skilled and there are many good practice examples in urban fringe areas of Britain. Each site must be considered on its own potential – simplistic and fatuous proposals must be avoided and careful consideration given to the possibilities for habitat and species management and/or development. Any attempt to increase biodiversity on a habitat or species basis should be integrated within a sustainable management regime.

LIVING AS A COMMUNITY

3.1.19 Community Spirit

Community spirit is important both as an end in itself (lack of social support is a powerful risk factor for death and ill health) and as a means to an end (working together to make things better).

Stockport has a powerful cultural tradition of working together for the good of the borough which is underlined by its success in moving from being one of the most deprived boroughs in Greater Manchester to one of the most affluent in about a century.

But how can we ensure that community spirit is strengthened and protected instead of being allowed to fade away.

Several programmes of work can help:-

Community development

Community development is a process of helping local communities address their own problems. It starts with people's own perceptions and builds on them. Skill sharing and empowerment are its key methods. Group working and articulate communities are the signs of its success. Stockport Health Authority has one of the largest mainstream-funded community development programmes in the NHS. Stockport Borough Council has several longstanding community development processes which it is now linking together in a coherent strategy. Together we can take pride in outcomes of these processes, such as the credit unions, the food co-operative and the safety equipment cheap purchase schemes. Most spectacular of all the successes has been the successful regeneration bid for Brinnington.

Community streets

A process of reclaiming streets for people will enhance community spirit. This is true simply by removing the negative feature of traffic interrupting social interaction. It is even more true if street furniture and community areas turn the street into a community resource.

Healthy living centres

The concept of a healthy living centre was discussed in detail in my 1995 report (part 3, Chapter 26, pages 326-331). Since then the concept has been formally adopted as a central feature of the Government's public health strategy, Our Healthier Nation. Stockport's approach is to create a healthy living network which will link existing community facilities and neighbourhood strategies and will fill in the gaps neighbourhood by neighbourhood.

Public involvement

We see public involvement in the neighbourhood health strategies as extremely important. Our current focus is on securing public input into the IMPACT groups. The health authority is also seeking to develop public awareness of, and influence over, its approaches through the system of networking events.

Local public services can be a focus for local communities. It is unfortunate that a range of public policies from commercially-motivated retrenchment of the post office network through efficiency-motivated centralisation of health services to consumer-choice-motivated breakdown of catchments in education have all led public services to be less clearly rooted in local communities.

Voluntary sector

The role of the voluntary sector in health was discussed in my 1992 report (Chapter 16 pages 146-154). The chapter argued that the voluntary sector brought a number of specific contributions to health – including open debate, access to some specific funding streams, volunteer involvement, and freedom to innovate. It argued for the voluntary sector to be supported by mainstream contractual funding. Stockport's commitment of £760,000 to permanent voluntary sector contracts, £60,000 to neighbourhood budgets and £7,500 to the community small grants scheme is large in contrast with other authorities but still less than 1/2% of the total budget for the NHS in Stockport.

3.1.65

3.1.20 Sustainability

Many of the issues discussed in this report are now generally considered under the heading of “Sustainability”. The Local Government Association has produced a checklist for a sustainable community.

Table 3.1.20.1

<p>A sustainable community respects its local environment and does not cause damage to other places or communities – now or in the future. Quality of life and future generations are valued above short term thinking and material consumption.</p>	<p>An unsustainable community exploits its local environment and damages other places and communities – now and in the future. Material consumption and short term gains have priority over quality of life and the interest of future generations.</p>
<p>In a sustainable community</p> <ul style="list-style-type: none"> • Resources and energy are used efficiently. Waste is minimised. Land and buildings are recycled and reused. 	<p>In an unsustainable community</p> <ul style="list-style-type: none"> • Resources and energy are used inefficiently. Large amounts of waste are produced. Land and buildings lie derelict while greenspace is built on.
<ul style="list-style-type: none"> • Pollution is limited to levels which natural systems can cope with. 	<ul style="list-style-type: none"> • Pollution damages or destroys natural systems.
<ul style="list-style-type: none"> • The diversity of nature is valued and protected. 	<ul style="list-style-type: none"> • Natural diversity is neither valued nor protected.
<ul style="list-style-type: none"> • Where possible, local needs are met locally supporting local business and reducing traffic. 	<ul style="list-style-type: none"> • Needs are met from the cheapest source, however far away.
<ul style="list-style-type: none"> • Everyone has access to good quality food, water, shelter and fuel at reasonable cost. 	<ul style="list-style-type: none"> • Good quality food, water, shelter and fuel are available – but at a price. Many people are worried or affected by food safety, poverty, poor housing or homelessness.
<ul style="list-style-type: none"> • Everyone has the opportunity to undertake satisfying work in a diverse economy. The value of unpaid work is recognised, whilst payments for work are fair and fairly distributed. 	<ul style="list-style-type: none"> • Many people are unemployed or have boring, low-paid, insecure jobs. Local economies are vulnerable to the collapse of a few activities.
<ul style="list-style-type: none"> • Everyone’s health is protected by creating safe, clean, pleasant environments and health services which emphasise prevention of illness as well as proper care for the sick. 	<ul style="list-style-type: none"> • Many people’s health is damaged by living or working in dirty, noisy, unsafe places. Preventative medicine is badly resourced and only the rich have access to high quality healthcare.
<ul style="list-style-type: none"> • Access to facilities, services, goods and other people is not achieved at the expense of the environment or limited to those with cars. 	<ul style="list-style-type: none"> • Public transport is run down, expensive or non-existent. New developments allow only those with cars to reach them easily and safely.
<ul style="list-style-type: none"> • People live without fear of personal violence and crime, or persecution because of their personal beliefs, race, gender or sexuality. 	<ul style="list-style-type: none"> • Crime rates are high, with many people experiencing or fearing violence, or persecution which is racially, politically or sexually motivated.
<ul style="list-style-type: none"> • All sections of the community are free to participate in the decision making processes. 	<ul style="list-style-type: none"> • Power lies in the hands of private organisations or unelected groups.
<ul style="list-style-type: none"> • Everyone has access to the skills, knowledge and information needed to enable them to play a full part in society. 	<ul style="list-style-type: none"> • Education and training places and resources are in short supply. Much information is kept secret from the public.
<ul style="list-style-type: none"> • Opportunities for leisure and recreation are readily available to all. 	<ul style="list-style-type: none"> • Only the wealthy have access to a wide range of leisure and recreational opportunities.
<ul style="list-style-type: none"> • Places and spaces are attractive and valued. Settlements are “human” in scale and form. Local features and traditions are maintained. 	<ul style="list-style-type: none"> • Places and spaces are ugly and alienating. Settlements are designed for cars not people. Everywhere looks increasingly alike.

3.1.66

Currently those principles are being applied neighbourhood by neighbourhood through the borough.

The action needed to develop a sustainable neighbourhood will vary from one part of the borough to another. In some cases open space and traffic will be the key issues. In other cases it may be the absence of local facilities or the need to develop a stronger local culture.

Sustainable neighbourhoods became a key focus for delivery of the agenda discussed in this document.

Neighbourhood open space plans are being developed as part of our involvement in the Civilising Cities Project.

Neighbourhoods are the base of the proposed healthy living network.

Analysis of desire lines and traffic flows at a very local level is central to developing walking and cycling networks.

And neighbourhoods are the focus of community development.

The recent employment of two neighbourhood sustainability officers to develop sustainability plans neighbourhood by neighbourhood is therefore a central element of the pursuit of the civilised cities agenda.

3.1.21 Crime

Community safety affects most people's lives in some way, for example, poorly lit streets, noisy or threatening neighbours, through to experiencing crime directly or living in fear of crime. Some individuals suffer repeatedly from crime. British Crime Survey figures show that 20% of victims of domestic burglary were victimised more than once a year. Repeat victimisation is a common feature of under-reported crimes, such as racial attacks and domestic violence.

In public health terms crime affects quality of life, creates stress, and diminishes social networks, walking and cycling by making people afraid to go out as much as they otherwise would.

A large proportion of acquisitive crime is drug related. The NHS has a role in countering this through drug treatment. The question also arises of whether this important source of crime could be stemmed if those who are determined to use drugs had access to a legal avenue of supply, although this needs to be weighed against the hazard of allowing availability to increase use.

Violent crime not only causes health damage in its own right but is particularly serious in terms of creating fear.

Fear of crime can also lead people to advocate measures that are harmful to public health such as closure of footpaths. Vandalism can make it difficult to promote policies of aesthetic improvement.

Fear of crime is more prevalent than crime itself. Fear of crime can affect people's everyday confidence in going out of doors. Concern about personal safety can discourage many people, especially women, from using public transport.

Often an exaggerated fear of crime leads to action which is objectively irrational. An exaggerated perception of the danger of strangers to children may lead to children's independence being restricted or even to children being exposed to traffic danger in order to avoid "dangerous" parks.

Like crime, the effects of fear of crime are not evenly distributed – they tend to be concentrated within certain communities, and the most vulnerable groups in society are those who are most adversely affected.

Fear of crime is reduced by a visible police presence on streets and paths. Police patrols should not concentrate on response time (important though it is) to such an extent as to lose their function of deterrence and re-assurance.

Stockport's Crime and Disorder Strategy takes account of these issues and recognises the needs of those communities most at risk.

3.1.68

The main elements of the Strategy focus on Acquisitive Crime, Young People, Violence, Quality of Life Issues and addressing the Causes of Crime and Disorder.

Crime is the tip of an iceberg of the consequences of declining community spirit and increasing alienation. Other elements of this iceberg – deteriorating interpersonal behaviour, and deteriorating commitment to the quality of products and services, for example – may also be harmful to the quality of life.

The Crime and Disorder Act recognises that Crime as an issue is everyone's responsibility, and not just one agency. The focus is more on shared ownership and multi-agency problem-solving.

**UNREALISTIC DREAM OR PRACTICAL
NECESSITY?**

3.1.22 Sustainability and the Economy

Often sustainability is seen as being in conflict with economic growth. It is therefore argued that a balance must be struck.

However this overlooks the importance of pleasant living conditions to businesses choosing where to locate. Even in the current economy businesses describe the living conditions and cultures as amongst the main incentives of locating to Stockport and traffic congestion as amongst the main disincentives.

This position will intensify as we move into the technology-based culture of the future. Within the next decade or two the driving force of the economy will be Internet-based businesses. These will be extremely mobile – it will literally not matter where they are located. Homeworking will be an important mode of work. Creativity will be the principal asset.

This society can develop in very positive or very negative ways. Consider the following dream and nightmare scenarios of a technology-based economy.

A is an accountant holding a major position as a commercial negotiator with a large company. From the large purpose built study in A's house, on the Mull of Kintyre, deals running into millions – sometimes billions – are negotiated daily by e-mail. The study has a beautiful view across the sea and allows her to keep one eye on the children playing on the beach. At five past six she closes a major deal, drinks a glass of champagne, calls to the children and still has over an hour to get ready for her dinner party at 7.30.

B and C live in a two bedroom terraced house in a northern industrial town. Because of the high technology home-working adopted by their employer, they have had to fill the sitting room with computers, fax machines and other office equipment, and have only the kitchen to live in. As C struggles to complete a long list of telephone calls, B changes the baby's nappy. B's computer beeps insistently. The doorbell rings. The shopping that C ordered on the Internet late last night has arrived. As C opens the door to collect it, she realises that it is the first time the door has been opened in seven days. B notices that the order does not include any alcohol and shouts at C. B's computer beeps again. The baby starts crying and B sticks the safety pin in himself. B hits the baby. There is an ominous silence.

3.1.70

How can we ensure that Stockport is the locus for the better quality work of the new economy rather than a reservoir of cheap labour?

Internet based businesses will be attracted by two things. One is pleasant living conditions. The other is an environment that feeds creativity.

We cannot expect to beat the Mull of Kintyre for living conditions. But not everything that people want in their world is available in remote beautiful surroundings. Nightclubs, for example, seem unlikely to be totally eclipsed by the e-mail chat networks and music. Direct human interaction still provides a greater creative spark than the same discussion electronically. And some forms of shopping – fashion shopping for example – do not seem to be popular in electronic form.

The Country City poses a direct bid for the best of both worlds – for beautiful living conditions in proximity to the entertainment and shopping opportunities of a city and the creative energy of a vibrant community.

The simple fact of a technology-based economy is that to attract the most dynamic and successful businesses a borough will need to market itself as an attractive place to live and a source of creative stimulation.

To destroy attractive settings in the belief that they must be sacrificed to economic growth may be an own goal. It might be as foolish as it would have been in the 18th century to have diverted the streams that were to power the mills and use them in an irrigation project in the belief that wealth would always derive from agriculture.

To develop a vibrant community of creative empowered people living in beautiful surroundings may not simply be a dream, or a social ideal – it may be an economic necessity.

Unless the debate about our Unitary Development Plan asks what pattern of land use will be needed in a technology based economy we could delay for another critical ten years the measures necessary to position ourselves for that new world.

3.1.23 Timescale

The Country City cannot be created overnight. For example there is no way that we could remove the remaining Areas of Open Space Deficiency immediately except by demolishing buildings. But that does not mean that work to create it does not need to start immediately.

An example of one of our successes may illustrate this. Fifty years ago the area between Reddish and Brinnington was occupied by railway sidings, a waste dump, an industrial estate and a chemical dump. Today it is the Reddish Vale Country Park. Distinguished visitors are often taken to the bridge over the Tame by the Reddish Vale Visitor Centre and asked to admire the rural surroundings, to watch the kingfisher dive, to note the picnic areas. And then they are reminded that they are deep in the heart of inner city Greater Manchester, five miles from the limit of the urban envelope with Stockport Town Centre to the south and with the inner city communities of Reddish, Denton and Brinnington to the west, north and east.

If 50 years ago councillors had said that the creation of a country park in that area was an unrealistic dream then it would not exist today. A succession of short term decisions would have reshaped the area instead. Instead councillors ensured that every decision made about the Vale pointed in the same direction.

I hope that the borough is proud of that achievement.

I hope that it also still has the confidence to repeat it. Does this generation have the same visionary civic pride that allowed our parents and grandparents to bequeath us this treasure? Will we and our children create further similar treasures for our grandchildren?

3.1.24 Political and Legal Constraints

There are obviously limits on the extent to which a democratic authority can impose a vision on a community in which there will be conflicting values and conflicting interests.

Many of the ideas in this report, those relating to traffic calming for example, push clearly with the grain of established public opinion. In other cases however there is a need to create a consensus that does not yet exist – my proposals about earth sheltered buildings, about forest development, and about televillages fall clearly into that category.

But there is a widespread concern about traffic. Opinion surveys show that there is widespread support for the protection and development of open space.

I believe that the current consultation exercise on the Unitary Development Plan offers an opportunity to shape a consensus that we wish to live in a borough which will actively manage its traffic problem, which will steadily become greener as it moves, over time, towards the concept of a Country City, and which will devote a great deal of attention to creating communities.

3.1.72

If such a consensus can be created it will be much easier for councillors to commit to the long term programmes that are necessary to create this vision.

Some of my proposals, were they to be incorporated in a Unitary Development Plan, would run a risk of being struck out by the inspector as too radical a departure from the normal planning approach. But if that happened we would at least be no worse off than if we had never submitted them and would have demonstrated a problem from which pressure to change the law could arise. One thing is clear – if we do not include them in the draft they will not be in the final version whereas if we do include them there is the basis for fighting the battle.

A good example of a recent success is the Council's policy requiring open space (or a compensatory commuted payment) for planning in all new developments. That proposal had to be argued for before the inspector and then again in court upon a judicial review. But the Council won and thereby secured for itself, and for other councils, the freedom to establish such policies. I believe that there are areas where such battles are worth fighting.

I do not mean to suggest that all the Council needs to do is to endorse this document and implement it. On the contrary endorsing this vision would raise a host of political and legal questions that would need to be addressed. Nothing worthwhile was ever achieved in any other way.

3.1.73

3.1.25 Recommendations

26. I recommend that the Council makes all possible efforts to adopt a planning policy requiring any development to be earth sheltered, or otherwise greenspace compatible (eg forest developments) if

- a) it is large enough to make a significant self contained area of open space;
- or b) it lies in an area of open space deficiency;
- or c) it is established on land that has been released from protected open space.

27. I recommend that the Council adopts policies to protect, develop and promote a pedestrian network, similar to those recommended in Ginnels, Snickets and Leafy Lanes.

28. I recommend that the Council aims to establish an architecturally-significant building as a centrepiece of each park.

29. I recommend that in the Unitary Development Plan land should be designated for the creation of an urban forest with buildings in clearings.

30. I recommend that a cycle network be designated, protected and developed.

31. I recommend that rural hamlets designed and designated for technology-based homeworking be developed within the Green Belt, but that with this exception there be a vigorous refusal to release land from Green Belt.

32. I recommend that the Council resists the idea that land at the fringes of the Green Belt is less important than land deep within it. In many ways the reverse is true as eroding the fringes of the Green Belt puts the whole borough further from the countryside. For the same reason strategic open space within the urban envelope should be regarded as being as important as Green Belt.

33. I recommend that all employers take simple steps to render the workplace aesthetically attractive.

34. I recommend that people and organisations be encouraged to aesthetically enhance their environment through the use of hanging baskets, green roofs, green walls, public art, and open space. Everybody should be asked to aesthetically improve any territory for which they are responsible.

35. I recommend that the Council adopts a strategy for developing residential cells, Home Zones and living streets.

3.1.74

36. I recommend that the Council opens discussion with the PTE, and the railway industry to establish a Hayfield – Manchester Airport service including new Reddish and Gatley curves, the Greater Manchester Orbital Railway, the Metrolink to Stockport, twelve new stations on existing lines and a town centre funicular from the station to the bus station/Metrolink station.

37. I recommend that the Council should press for active promotion of the combination of rail and cycling and should ensure cycle access to all stations is well designed and linked to the cycle network.

38. I recommend that the Council explores the land use implications of a knowledge-based economy with a view to positioning Stockport to take full advantage of this, and that it urges the remainder of the region to do likewise so that the North West may become a centre for the new economy.

39. I recommend that the Council makes all possible efforts to adopt a planning policy requiring the use of hedges as security barriers rather than fences and walls.

40. I recommend that local political parties debate the issue of planning laws with a view to persuading their national parties to adopt a policy of expanding the powers of local authorities to promote coherent visions.

41. I recommend that the local political parties debate the various trends that are loosening the roots of public services in local communities.

42. I recommend that all agencies seriously debate the causes and consequences of deteriorating community spirit.

43. I recommend that, to overcome the problem that not all public health implications of planning applications fall within existing planning policies, the Council makes all possible efforts to adopt a planning policy that all health implications will be considered.

44. I recommend that the Council strengthens the mechanisms for ensuring that individual highways decisions accord with its overall transport and health strategy.

45. I recommend that all large organisations in the Borough adopt a Green Transport Plan.