STOCKPORT
METROPOLITAN BOROUGH COUNCIL

23rd Annual Public Health Report for Stockport 2016/17

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

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

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

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

Contents

The report is broken down in to levels and sections.

There are six sections:

- **Section A** describes and considers an overview of the health of the people of Stockport.
- **Section B** covers the diseases which cause death and disability in Stockport.
- **Section C** explores the major risk factors for disease, death and disability so we understand how we can address the issues described in section B
- **Section D** looks at these issues as part of the life-cycle, considering the health of children through to healthier aging.
- **Section E** summarises our response; how we are addressing the causes of ill-health and reducing health inequalities for the people of Stockport.
- **Section F** contains recommendations

This report presents section C of the report

Within each section there are five levels:

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

A full content list follows, and you can access any level of the report by clicking the chapter name in the content list. Each page contains a “return to contents” button to enable you to return to this list and navigate to other levels and sections of the report easily.

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

LEVEL 1

Tweets

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

C1.1 HYPERTENSION

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

C1.2 SMOKING

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

C1.3 DIET

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

C1.4 PHYSICAL ACTIVITY

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

C1.5 ALCOHOL

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

C1.6 WELLBEING

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

C1.7 SAFETY AND HEALTH PROTECTION.

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

C1.8 SMOKING IN PREGNANCY

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

C1.9 TYPE 2 DIABETES

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

  overview

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

LEVEL 2

Overview

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

C2.1 HYPERTENSION

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

Go to key messages or go to full analysis

C2.2 SMOKING

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

Go to key messages or go to full analysis

C2.3 DIET

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

Go to key messages or go to full analysis

C2.4 PHYSICAL ACTIVITY

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

Go to key messages or go to full analysis

C2.5 ALCOHOL

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

Go to key messages or go to full analysis

C2.6 WELLBEING

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

Go to key messages or go to full analysis

C2.7 SAFETY AND HEALTH PROTECTION

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

Go to key messages or go to full analysis

C2.8 SMOKING IN PREGNANCY

The case for supporting women who are pregnant to give up smoking is very strong; smoking is the single most modifiable risk factor for adverse outcomes in pregnancy and our ambition should always be to support all women to have a smoke free pregnancy. Reducing rates of smoking in pregnancy is a key priority for the Public Health Department of Stockport Council, Stockport Family, and Stockport Foundation Trust and Primary Care services. There are a wide range of programmes that are in place that are contributing to this reduction with some excellent good practice amongst our midwives and community staff. However young women living in the most disadvantaged areas of Stockport are far more likely to smoke during pregnancy than older women and all women who live in more affluent areas. For instance, during 2013/14 37.9% of mothers in Brinnington were smoking at time of delivery compared to 5.4% in Bramhall. We need serious consideration about different ways to engage with young women and ensure that all Stockport babies have the very best start in life.

Go to key messages or go to full analysis

C2.9 TYPE 2 DIABETES

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

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

Go to key messages or go to full analysis

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LEVEL 3

Key messages

LEVEL 3 (KEY MESSAGES) SECTION C: THE MAJOR RISK FACTORS FOR DISEASE, DEATH AND DISABILITY

C3.1 HYPERTENSION

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

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

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

Go to overview or go to full analysis

C3.2 SMOKING

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

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

Smoking in Stockport

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

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

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

How to tackle smoking

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

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

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

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

Go to overview or go to full analysis

C3.3 DIET

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

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

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

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

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

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

Most people know what a healthy diet is, although some confusion is caused by food fads and food scares. There are a number of reasons why people do not eat a healthy diet despite this. The evolutionary instinct to build up stores of energy in preparation for scarcity; skilful marketing; the inertia of eating patterns; lack of cooking and shopping skills; healthy food is more expensive to obtain easily. To address these cultural and commercial pressures we need:

- Action from Government to counter food industry unhealthy marketing
- Action in local communities to address local cultural determinants
- Social enterprises to make it easier to obtain healthy food
- Wider understanding of the commercial pressures and willingness to confront them and make genuine personal choices.

Go to overview or go to full analysis

C3.4 PHYSICAL ACTIVITY

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

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

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

Health benefits of regular physical activity

Regular physical activity will help to:

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

UK recommended minimum levels of physical activity

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

Pre-exercise screening

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

Helping people take physical activity

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

Go to overview or go to full analysis

C3.5 ALCOHOL

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

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

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

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

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

Alcohol harm in Stockport

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

If current trends were to continue, we should anticipate an increasing financial and human cost affecting all our communities and all sectors of the economy. Alcohol related ill-health and deaths disproportionately affect the more deprived communities, and are key factors in maintaining health inequalities in the borough. Stockport Lifestyle Survey (2012) found:

- 3% of the respondents reported drinking at high risk levels in the previous week, (men more than 50 units and women more than 35 units in a week), with a further 17% drinking at increasing risk levels.
- 19% of the survey respondents reporting drinking twice the daily guidelines ('binge drinking') at least once in the last week.
- Young adults and people in their 40s are most likely to 'binge' drink, while middle aged adults aged 45-64 are the most likely to drink at increasing risk levels and people aged 45-49 are the most likely to drink high risk amounts.

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

Go to overview or go to full analysis

C3.6 WELLBEING

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

Evidence is particularly strong for the following:

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

There is also evidence for:

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

The biologically plausible explanation for this relationship is the stress reaction

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

The psychological literature contains some detailed theoretical analyses of well being

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

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

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

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

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

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

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

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

Protective factors that policies and organisations can help create include

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

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

Go to overview or go to full analysis

C3.7 SAFETY AND HEALTH PROTECTION

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

Preventing injuries and crashes

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

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

The difference between safe and risk adverse systems

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

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

C3.8 SMOKING IN PREGNANCY

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

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

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

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

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

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

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

Go to overview or go to full analysis

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

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

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

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

What increases risk?

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

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

How can we reduce the complications from diabetes?

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

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

Go to overview or go to full analysis

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

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

LEVEL 4

Full Analyses

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

C4.1 HYPERTENSION

Hypertension is a persistently raised blood pressure.

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

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

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

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

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

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

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

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

Hypertension is common in the UK population.

Prevalence is influenced by age and lifestyle factors.

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

50% of those over 60 years have hypertension.

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

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

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

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

How big is the problem?

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

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

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

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

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

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

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

How cost effective is treatment?

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

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

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

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

1 death for every 11 patients treated.

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

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

What can people do to help themselves?

Table C1: lifestyle Modifications

Lifestyle Modifications to Manage Hypertension*†

Modification	Recommendation	Approximate SBP Reduction (Range)
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m²).	5–20 mm Hg/10 kg weight loss[1,2]
Adopt DASH eating plan	Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat.	8–14 mm Hg[3,4]
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).	2–8 mm Hg[3,5]
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week).	4–9 mm Hg[6,7]
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks (1 oz or 30 mL ethanol; e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men and to no more than 1 drink per day in women and lighter weight persons.	2–4 mm Hg[8]

DASH, Dietary Approaches to Stop Hypertension.

* For overall cardiovascular risk reduction, stop smoking.

† The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.

What can Government do?

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

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

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

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

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

What can health professionals do?

Promote healthy food and alcohol consumption and physical activity

Consistent messages - working with public health and communities

Systematically identify and effectively treat people with hypertension

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

C4.2 SMOKING

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

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

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

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

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

Smoking prevalence data

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

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

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

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

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

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

Smoking Demographic

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

Smoking prevalence is higher in certain groups:

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

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

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

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

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

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

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

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

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

The Economic Downturn and Quitting Smoking

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

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

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

Tobacco control

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

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

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

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

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

The strategy has 3 main ambitions

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

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

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

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

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

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

What is the Evidence for what works?

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

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

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

Public Health GuidanceNo.10: Smoking Cessation Services

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

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

Public Health Guidance No 23 School based Interventions to prevent smoking

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

Public Health Guidance No 39 Smokeless Tobacco Cessation

Public Health Guidance No 45 Tobacco Harm Reduction

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

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

Smoking Cessation and Harm reduction

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

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

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

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

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

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

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

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

E cigarettes do carry a risk of lipoid pneumonia.

Young people

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

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

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

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

Prevention of uptake of smoking in Children and Young People

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

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

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

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

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

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

Smoking in Pregnancy

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

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

Strategy

We have had our tobacco control strategy reviewed by CLEAR.

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

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

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

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

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

The Council has adopted the Local Government Declaration on Tobacco Control

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

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

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

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

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

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

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

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

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

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

C4.3 DIET

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C4.4 PHYSICAL ACTIVITY

Benefits of Physical Activity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UK Physical Activity Guidelines

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

EARLY YEARS (under 5s)

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

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

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

CHILDREN AND YOUNG PEOPLE (5-18 years)

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

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

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

ADULTS (19-64 years)

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

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

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

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

OLDER ADULTS (65+ years)

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

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

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

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

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

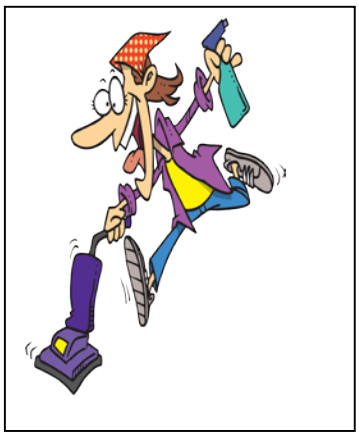
Should minimise the amount of time spent being sedentary (sitting) for extended periods.

Integrating Physical Activity into Daily Life

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

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

Physical activity in and around the home

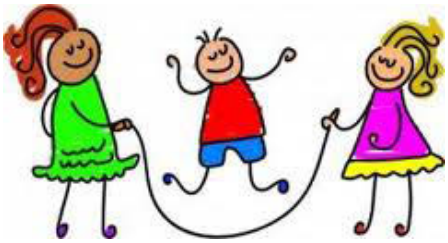


- cleaning the house
- washing the car
- gardening
- sweeping/mopping the floor

Physical activity at work and on the go

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

Physical activity with friends or family



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

Physical activity while watching TV

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

<u>Recreational Physical Activity</u>

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

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

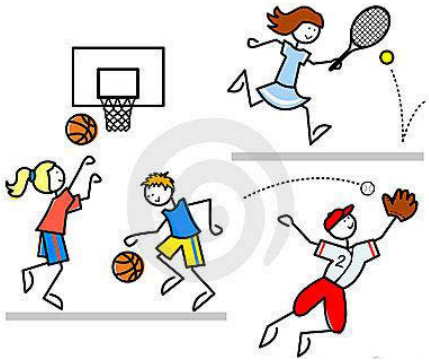
Physically active pastimes such as these are most beneficial if they are done routinely, and as well as promoting physical health, also play an important role in enhancing mental health and well-being by providing a buffer for stress and facilitating social interaction.

Recreational physical activity can be promoted by:

- ensuring opportunities for recreational exercise, through recreational footpaths, playing fields and open space, encouragement of sports clubs (especially community groups that may be attractive to the novice), promotion of walking, swimming, cycling and running
- specially organised activities to overcome barriers to recreational exercise e.g. women only swimming sessions
- encouraging mass participation events such as ‘fun runs’ or community bike rides
- building outdoor gyms in parks and open spaces
- the development of “green gyms” which provide opportunities for people to contribute to the environment through physically active voluntary work

Currently, 71% of women (16+), 61% of men (16+), 76% of girls (2-15) and 68% of boys (2-15) in England do not meet the age relevant minimum physical activity recommendations. Opportunities to engage in high quality recreational physical activity can play an important role in increasing current levels of participation.

Physical Activity in Schools



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

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

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

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

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

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

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

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

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

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

Active Travel

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

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

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

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

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

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

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

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

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

The benefits of active transport include:

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

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

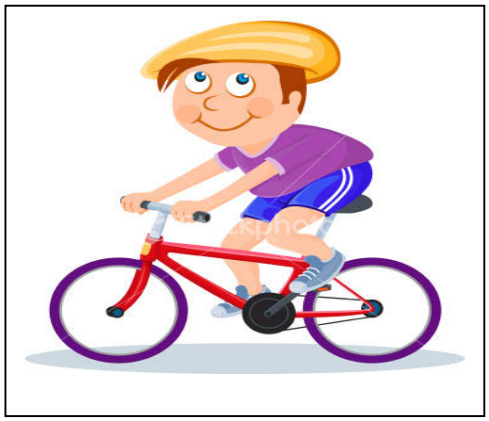
Helping local businesses – people using active transport are more likely to shop locally;

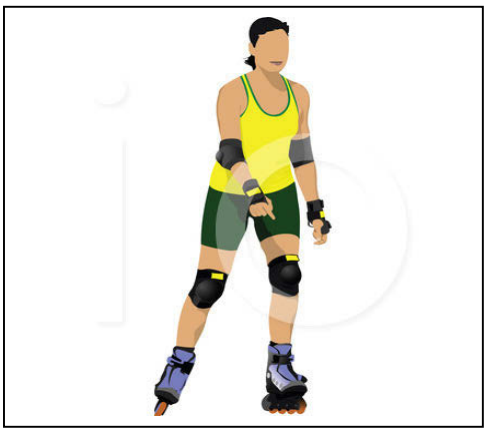
Access for all – walking and cycling are low cost activities that are available to the whole community;

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

Reduction in local congestion;

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





Stockport Walking Strategy

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

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

Draft Cycling Strategy

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

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

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

Personal ability to cycle and fitness

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

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

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

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

C4.3 ALCOHOL

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

Four major factors in this epidemic were

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

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

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

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

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

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

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

Table C4 Alcohol related hospital admissions

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

Broad definition

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

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

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

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

Narrow definition

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

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

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

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

Harmful drinking

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

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

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

Three key priorities have been identified for 2013-14:

Review of treatment system

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

Health & Well-being Capacity Development

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

Domestic abuse and alcohol

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

(d) The Contribution of Local Cultures

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

C4.4 WELL BEING

The Science - Key Messages

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

Evidence is particularly strong for the following:

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

There is also evidence for:

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

The biologically plausible explanation for this relationship is the stress reaction

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

Stress may also impact on cancer via gene transcription factors

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

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

The psychological literature contains some detailed theoretical analyses of well being

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

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

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

Key Messages for People and Organisations

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

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

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

Protective factors that policies and organisations can help create include

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

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

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

Starting Well – early years with parents and young children:

- Universal and targeted parenting support
- Focus on 'school-readiness' via the home-learning environment and pre-school programmes
- Whole-school approach to mental wellbeing support

- Enhancing the physical environment (green-space/nature; access routes/mobility)

Working Well – working age adults:

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

Ageing Well – older adults:

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

Neighbourhoods and Communities.

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

Key Messages – Cultural determinants

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

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

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

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

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

The strategy for tackling the challenge of creating opportunities for individuals and communities to

live healthier lives is broadly described as addressing the cultural determinants in Stockport. It comprises two strands of community development- primary community development and purposive community development.

C4.5. THE SCIENCE

The Scientific Evidence

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

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

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

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

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

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

The Stress Reaction

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

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

The Psychological Perspective

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

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

The four level hierarchy with ego status and belongingness as one tier fits Galbraith's four modes of motivation – compulsion (dig the ditch or be shot), compensation (dig the ditch and we'll pay you), identification (the ditch needs to be dug) and adaptation (diggers decide where the ditch goes). Maslow's additional tiers suggest additions to Galbraith's theory – sensualisation (digging ditches is

great fun) or spiritualisation (gain one-ness with the earth/build character through hard labour/ counter pride from high status occupation/ make an opportunity for meditation).

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

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

EMPATHIC COMMUNICATION RELATIONSHIP - someone wants to understand our meaning

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

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

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

SELF-DETERMINATION understanding and influence over ourselves and our environment

RESILIENCE & HAPPINESS capacity to tolerate frustration and fully experience pleasure

RESPECT & RESPONSIBILITY reciprocal respect, regard and responsibility towards others

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

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

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

The Measurement of Well Being

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

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

The Role of Empowerment

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

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

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

C4.6. THE IMPLICATIONS FOR PEOPLE AND ORGANISATIONS

FIVE WAYS TO WELL BEING

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

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

your life, the way you react to what happens around you, focus on 'now' and take pleasure in the moment and give your time, your energy, your attention to those around you in small ways or big ones

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

How Organisations Can Help

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

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

Strategic Principles

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

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

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

- reduced risk of mental illness and suicide

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

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

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

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

Local action focused on mental wellbeing in Stockport

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

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

We will do this through:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C4.7. THE CULTURAL DETERMINANTS OF WELL-BEING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local action focused on cultural determinants in Stockport

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Aligning with Investing in Stockport and Stockport Together developments
- Obtaining more real time information about characteristics of people who don't attend screening to enable us to target them more effectively.

- Identifying mental wellbeing priorities and developing an offer.
- Developing effective community based interventions to address alcohol misuse.
- Building on initial GP engagement and developing further partnership initiatives.
- Connecting with our target groups - “never screened “ and “yet to reach” “men”, and ensuring engage people not already active in existing local groups or activities
- Maximising opportunities for the community to develop its own priorities; initiatives work best when they come from them, not ‘well-intended’ ideas from services.
- Increased use of social media which will sign up more people for ongoing contact.
- Recruiting and supporting more local champions for health.
- Community coaching and small funds to stimulate interest and responsibility
- Stimulating programmes that more naturally bring the community together such as pop up gardens and food activity rather than discrete health activity.

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

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

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

C4.8. SAFETY AND HEALTH PROTECTION

Control of Infection

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

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

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

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

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

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

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

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

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

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

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

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

Food Hygiene and Standards.

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

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

Some examples of recent work include:

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

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

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

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

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

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

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

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

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

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

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

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

Healthcare Associated Infections

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

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

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

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

Performance management of the target on a biweekly basis

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

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

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

Antibiotic stewardship ward rounds for patients in acute care

Review of both community and acute antibiotic policies

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

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

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

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

MSSA Bacteraemia

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

This has increased from 59 in 2012/13

EColi Bacteraemia

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

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

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

Infection Prevention and Control Assessments in General Practice

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

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

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

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

Infection Control and Inspection in Care Homes

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

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

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

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

Infection Control in Stepping Hill Hospital

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

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

- Three MRSA Bacteraemia cases in 2014-15.

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

Table C8

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

Zoonoses

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

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

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

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

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

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

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

Immunisation report 2014/5

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

24 month cohort

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

5 year cohort

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

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

HPV

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

Season Influenza uptake 2014/15

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

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

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

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

Measles and Mumps

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

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

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

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

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

Mass Immunisation Plan**:**

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

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

Sexually Transmitted Diseases

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

Sexually transmitted diseases can be addressed by:

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

Sexual Health - Nationally

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

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

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

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

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

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

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

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

Stockport Context re Sexually Transmitted Infections

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

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

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

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

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

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

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

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

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

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

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

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

Meningitis

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

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

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

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

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

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

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

Some Significant Risks

<u>Infection and Travel</u>

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

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

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

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

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

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

The Risks of a Flu Pandemic

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

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

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

The Risks of Losing Antibiotics

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

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

The misuse of antibiotics is fundamentally irresponsible.

Chemical Hazards

Hazardous Substances

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

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

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

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

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

Land Contamination

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

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

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

Air Quality

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

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

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

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

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

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

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

Noise and Nuisance

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

Health and Safety

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

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

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

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

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

Unsafe products

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

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

Some examples of recent work include;

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

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

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

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

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

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

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

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

Health and Safety at Work

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

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

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

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

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

Recent activity:

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

Housing Standards

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

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

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

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

The Housing Standards Team deal with a range of housing related duties. The team investigate requests for service relating to:

- Conditions in privately rented homes

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

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

Emergency Planning

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

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

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

C4.9. ADRESSING THE CHALLENGES OF SMOKING IN PREGNANCY

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

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

Health effects of smoking in pregnancy

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

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

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

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

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

Smoking in pregnancy data in Stockport.

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

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

The cost of smoking in pregnancy

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

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

Good Practice in Stockport

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

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

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

Why do women continue to smoke during pregnancy?

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

E cigarettes and Pregnancy

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

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

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

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

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

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

Key messages include:

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

Incentives

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

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

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

Greater Manchester work.

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

Recommendations Arising from the chapter on smoking in pregnancy

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

C4.10. TYPE 2 DIABETES – TIME TO DIFFUSE THE TIMEBOMB

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

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

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

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

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

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

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

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

What increases risk?

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

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

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

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

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

How can we reduce the complications from diabetes?

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

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

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

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

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

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

Move more

Snack less

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

Recommendations Arising from the chapter on Type 2 diabetes

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

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

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

LEVEL 5

Additional Analysis

LEVEL 5 (ADDITIONAL ANALYSIS) SECTION C: THE MAJOR RISK FACTORS CAUSING DISEASE, DEATH AND DISABILITY

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

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

C5.1 HYPERTENSION

- JSNA briefing - Long term conditions

C5.2 SMOKING

For help to stop smoking go to http://www.healthystockport.co.uk/

- JSNA briefing - Adult Lifestyles

C5.3 DIET

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

- Chapter 12 of the 17th report – Foresight Report
- Chapter 18 of the 18th report – Fluoridation
- JSNA briefing - Adult Lifestyles

C5.4 PHYSICAL ACTIVITY

For help taking more exercise try walking more and go to http://www.healthystockport.co.uk/ or http://www.lifeleisure.net/ or http://www.stockport.gov.uk/services/leisureculture/walkinginstockport/ or http://www.stockport.gov.uk/services/leisureculture/cyclinginstockport/

- JSNA briefing - Adult Lifestyles

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

- Chapter 6 of the 15th report – The Western Stockport Cycle Trunk Road
- Section 4.6 of the 16th report – Protecting Walking Routes : Effect of Pedestrian Impermeable Street Designs
- Chapter 12 of the 17th report– Foresight Report

C5.5 ALCOHOL

- JSNA briefing - Adult Lifestyles

For help with alcohol problems go to http://www.healthystockport.co.uk/

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

- Section 4.1 of the 16th report – Units of Alcohol

C5.6 WELLBEING

- JSNA briefing - Mental health and well-being

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

- Chapter 10 of the 16th report – Empowerment

C5.7 SAFETY AND HEALTH PROTECTION.

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

- Chapter 8 of the 15th report – Housing and Health