Written evidence submitted by the Director of Public Health, Deputy Directors of Public Health and Chair of the Health and Wellbeing Board for Stockport (PHP0058)

1. This is the evidence of the Director of Public Health and Deputy Directors of Public Health for Stockport and the Chair of the Stockport Health & Well Being Board. We use the words “for Stockport” rather than “of Stockport MBC” as our offices serve a population not an agency.
2. The evidence itself is about 3,000 words but we wish to support parts of it by providing documents for members to look over. We would normally have embedded such documents but given the style guidance we have added them as appendices.
3. Stockport is at the leading edge of healthcare public health and of the health implications of the shaping of place (including transport and spatial planning). We suggest these as case studies for your enquiry.
4. Stockport is professionally widely admired for vigorously recognising public health specialists as health professionals treating a population.
5. Stockport has a long history of working together between NHS bodies and the Council.
6. For many years prevention and the reduction of health inequalities have been the central tenets of Stockport MBCs approach to improving health of the local community. In September 1980 the Council considered the implications of the Black report and has worked closely with the NHS over the past 40 years.
7. The Council and NHS bodies see these two aspects as absolutely essential to the achievement of the objectives of the NHS Five year Forward View to which we understood the government was firmly committed. In February 2015 our understanding appeared to be confirmed at the launch of the Memorandum of Understanding between Greater Manchester and Government. The Chancellor, Secretary of State and Head of NHS England were all present and committed publicly to improving health and increasing healthy life expectancy.
8. Public health delivers many vital services. We have reviewed and recommissioned those for sexual health and drug and alcohol services to be more focused and cost effective. This process is continuing with other services we deliver. However we have considerable ambition to develop further preventive work and had expected to reinvest the savings made. If ministers are serious about reducing demands on the hospital part of the NHS, we need adequate resources to develop population based approaches to tackling key contributors to poor health such as obesity.
9. Following the 1974 reorganisation which separated the NHS from local government people would refer to the NHS as the National Sickness Service. There is a great risk of the same label being applied again if the focus of the NHS is entirely on treatment and curative services.
10. In Stockport, as across Greater Manchester, prevention is strategically key to containment of demand within the healthcare system, operating across our coordinated health system, Stockport Together.

11. Since 1948 the term “the NHS” meant the comprehensive health service established under the NHS Acts. From 1948 to 74 the local authority Health Departments were a wing of the tripartite NHS. Nye Bevan believed the NHS by improving health would contain its own demand. This wasn’t a naïve faith in the power of medical treatment. His NHS included the Health Depts. of local authorities. He was not let down. In the first quarter century of the NHS, its local government wing cleaned the air, cleared the slums, closed the TB hospitals and eliminated polio and diphtheria.

12. Public Health England and local government public health are part of the comprehensive health service but a new terminology describes them as “part of the health service but not part of the NHS”

13. This has implications for finance – see later section on public health grant.

14. We are currently denied access to data that we need to do our job because we are not seen as part of the NHS. For example we cannot access fully postcoded patient data as this is identifiable data, but without this it is impossible to construct analyses for geographical areas such as school catchments or roads aggregated by traffic level. We would only use such data for aggregation and we have strict rules on security and avoiding publication in identifiable form, but because we are part of local government not part of the NHS it is assumed we cannot be trusted to handle this data safely and professionally.

15. The terminology affects public branding depriving preventive services of the public confidence in the NHS.

16. It has implications for working relationships and recognition of public health within the healthcare system – see later section on healthcare public health.

17. This terminology is historically inaccurate –“the NHS” has always meant the same as “the comprehensive health service” and between 1948-74 embraced the local authority wing of the NHS.

18. This terminology contradicts everyday usage. The public see sexual health, health visiting, drug and alcohol services and NHS health checks as part of the NHS.

19. This new terminology should be abandoned. “The NHS” should mean what it has always meant – the comprehensive health service established under the NHS Acts. To distinguish NHS England and CCGs from Public Health England and local authorities we could refer to NHS Healthcare and NHS Public Health.

PUBLIC HEALTH GRANT

20. Because the public health grant is seen as an unprotected non-NHS budget it will be cut during the course of the current Parliament by an amount which more than eliminates the increases made as a deliberate act of policy in the last Parliament.

21. These cuts are described as non-NHS but they aren’t. They are NHS cuts.
Public health cuts are cuts in the NHS because public health is part of the comprehensive health service, the legal term for the NHS since 1948.

Public health cuts are cuts in the NHS because most of the money goes to NHS bodies who will suffer cuts in consequence.

Public health cuts are cuts in the NHS because prevention is core to financial plans of the NHS – the Five Year Forward View.

Public health cuts are cuts in the NHS because the only other way to fund prevention for the 5YFV is to move money from other NHS services.

Public health cuts are cuts in the NHS because the money came from the NHS in the first place.

Public health cuts are cuts in the NHS because public health services in local authorities operate under the NHS Constitution.

Public health cuts are cuts in the NHS because the Conservative Party manifesto rightly took credit for increasing them. They did this in the NHS section.

Public health cuts are cuts in the NHS because the Prime Minister said we need more funding of public health in a debate on NHS finance.

Public health cuts are cuts in the NHS because the public sees health visiting, GUM services, drug/alcohol services, family planning and school health as part of the NHS.

Public health cuts are cuts in the NHS because the public sees NHS health checks as part of the NHS (the clue is in the name).

Public health cuts are cuts in the NHS because public sector reform should focus on outcomes.

22. The growth in public health grant which we received in 2013/14 and 2014/15 was used to fund a range of new services that we had identified as likely to contribute early to reduction in health and social care demand. These included an inequalities project spending resources in local deprived communities in accordance with priorities identified by those working with the communities themselves, an innovative project to support mentally ill people in returning to work or other forms of meaningful life activity, measures to promote walking and cycling, an enhanced drive to ensure people had blood pressure measurements and a range of outcomes secured by activity across the whole of the Council.

23. We thought that the increases in the grant should only be used to achieve new outcomes. There were ways in which the Council budget legitimately benefitted from that, e.g. absorbing overheads or achieving outcomes through existing staff, but we rejected completely and as a matter of principle creative accountancy which would misuse the grant.

24. Some local authorities have not taken that approach. However the BMA survey of the extent of abuse showed this to be a minority. Nonetheless everybody is being tarred with the same brush even though the BMA has suggested ways to avoid abuse.
25. The consequences of the cut, if Stockport Together passes it on to its public health budget, will be cuts in drug and alcohol services, health visiting and sexual health. They are too much of the spend to be protected. We would also have to retender these services avoiding corporate overheads attached by NHS bodies to the inherited contracts; this will worsen the NHS financial position.

26. If however Stockport Together maintains the preventive strategy on which the future financial viability of the local NHS depends then it will have to make the cut good from funding of NHS healthcare.

27. We attach at Appendix 1 a description of the Prevention and Empowerment Strategy of Stockport Together.

THE WIDER ROLE OF THE LOCAL AUTHORITY IN IMPROVING HEALTH

28. The prime statutory duty of local authorities under the NHS Acts is to take such steps as they consider appropriate to improve the health of the people.

29. This is more than commissioning public health services.

30. Local authorities influence health through housing, transport, spatial planning, greenspace, cultural and leisure services and promotion of resilient communities and healthy ageing.

31. Each department of Stockport MBC commits to promote the health of the people through the Stockport Health Promise - attached (Appendix 2).

32. It should be explicit that health is a material consideration in all local authority decisions.

33. It is not a licensing objective but it should be. Licensing conditions ought to be one of the actions Councils can consider as appropriate to improve the health of the people.

34. Developers still argue that health is not a material consideration in planning applications. This is wrong given the explicit reference to health in the National Planning Policy Guidance (the only addition to guidance in what was a generally deregulatory document) and given various High Court decisions. Nonetheless planners worry whether planning inspectors would view it as a high priority.

35. There is a need to protect local authorities against the risk of costs being awarded against them in appeals against planning decisions based on health considerations. Costs are legally only awarded against a party to a planning appeal where they have acted unreasonably. The NPPG should say that it can never be unreasonable for a local authority to attach priority to health considerations in a planning decision and to accept the advice of its DPH as to what those considerations are. The prioritisation of health should not be seen as unreasonable even if the appeal is allowed on the basis of balancing considerations.

36. Increasingly planning decisions turn on viability or balance rather than mere policy enforcement. Where this is claimed to justify non-compliance with a health-relevant policy a health impact assessment should form part of the viability or balance assessment. Generally viability tests should take into account costs of policy non-compliance to the public purse and social costs.

37. To avoid adding to the burden on applicants we are working on guidance to facilitate identifying and taking account of health implications. This approach has worked well on other issues.
THE INDEPENDENT ADVOCACY ROLE OF PUBLIC HEALTH

38. Health specialists are health professionals treating a population. Their job includes envisaging a different future and advocating for the health of the people. It is the job of a Director of Public Health to be dissatisfied.

39. Sewers, safe pregnancies, clean air and smoke-free pubs were all ridiculed when first proposed.

40. Some local authorities do not think public health staff should influence public opinion. Some even say it is contrary to local government traditions although public health traditions were shaped in local government.

41. This attitude, especially if duplicated in Public Health England as part of the civil service, will mean the monopoly employers of public health specialists smothering scientific advance in public health, depriving the public of information essential to proper debate and depriving the health of the people of informed advocates.

42. In Stockport we reject this. We acknowledge in their job description the role of public health consultants as health professionals treating a population and include the courageous advocacy of the health of the people amongst their duties. We use the following guidelines on politically controversial topics

Guidelines on Public Health Advocacy on Politically Contentious Issues for Public Health Professionals

<table>
<thead>
<tr>
<th>LEGITIMATE</th>
<th>ILLEGITIMATE</th>
<th>GUIDELINE</th>
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<tbody>
<tr>
<td>1. Stating public health facts, even if they embarrass the powerful</td>
<td>1. Manipulating public health data in order to embarrass the powerful</td>
<td>1a. Have scientific justification for statements 1b. Do not suppress facts</td>
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<tr>
<td>2. Making recommendations that will clearly benefit the health of the people</td>
<td>2. Putting public health support behind political positions unrelated to promoting health</td>
<td>2a. Be clear of the health objectives 2b. Be open minded about alternative ways of achieving it</td>
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<td>3. Ensuring that advice is made public and reiterating it if necessary</td>
<td>3. Using public resources to campaign for political causes or oppose government policy</td>
<td>3. In highly contentious issues if there is a danger of over stepping this line use official mechanisms to place issues in the public domain where others can make what use of it they wish</td>
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<td>4. Advocating changes of policy</td>
<td>4. Implementing unauthorised use of resources contrary to policy</td>
<td>4. Distinguish advocacy of a position from its implement-action and recognise that authorities are entitled to reject your advice</td>
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<td>5. Offering scientific and professional support to those working for health promoting causes</td>
<td>5. Using public resources selectively for the benefit of a particular political group</td>
<td>5a. Always be prepared to work with all political parties if working with any 5b. Offer scientific and professional support directly but be careful about offering political parties any other resources 5c. If working with any party see that it is open and that the others are free to use the same facility</td>
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<tr>
<td>6. Facilitating a community identifying its own needs and expressing them</td>
<td>6. Stirring up a community to do what you want</td>
<td>When acting as a community developer – 6a. Don’t dominate 6b. Don’t lead 6c. Provided you don’t dominate or lead stand by the community you are working with</td>
</tr>
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43. In Stockport the Director of Public Health is empowered to escalate a failure to follow formal public health advice to the Chief Executive (in the case of a managerial decision) or the Leader (in the case of an executive decision). The advice and the outcome of the escalation will be placed in the public domain.

44. The commitment of the medical profession to treating populations as well as individuals is an important feature of British medicine and an important contribution to discourse. It is not in the interests of local authorities to undermine it, especially if they aspire (as we do) to play an increasingly prominent role in the planning and direction of the healthcare system.

45. Public health remains a medical specialty albeit one which has established a non-medical route of entry so as to draw upon a wider knowledge base. All public health specialists from whatever route of entry have undergone a
postgraduate medical training under the direction of a medical Royal College and they deserve the standing which goes with that.

PUBLIC HEALTH AND HEALTH CARE

46. Healthcare Public Health (HCPH) ensures healthcare provides high quality services at the best value and benefit for the whole population’s needs and tackles underlying causes of poor health. See FPH definition in Appendix 3

47. HCPH focuses on evidence-based healthcare, assessing and planning health need, prevention, quality (safety, outcomes and patient experience), efficiency (good outcomes per £ spent), value (to patient or population), variation, and equity in healthcare pathways.

48. In Stockport a consultant (Dr. Owen-Smith) acts as Deputy Director of Public Health for the Council, Clinical Director of Public Health for the CCG and Associate Medical Director for Public Health at the local Foundation Trust. Working across the system, she focuses on prevention and early detection. For example:

- training front line staff in conversations about health behaviours
- designing a shared record where professionals record health behaviours, screening and advice
- making the hospital a healthy setting, focusing on corridors, retail offer and restricting sugary drinks sales on site.

49. She interprets data on health needs and outcomes to prioritise improvements and design pathways with clinicians. The current focus is pre-operative smoking cessation, diabetes prevention and clinical pathways, atrial fibrillation treatment pathways and ensuring universal recent blood pressure measurement. Through this strategic approach, we investigated issues such as low rates of early stage breast cancer and high incidence of melanoma. We developed and refined a set of public health standards for hospitals (see appendix 4)

50. Reorganisation and now grant cuts are losing trained HCPH expertise. Stockport is unusual in prioritising this resource. HCPH experts are vital to commissioning organisations and to integrated care or accountable care organisations as they develop. Many hospital providers and some CCGs employ HCPH consultants but these work in isolation from the wider public health system. We are still training HCPH experts but opportunities are diminishing for their employment in Local Authority teams.

THE ROLE OF ELECTED MEMBERS IN PUBLIC HEALTH

51. Elected members have the following roles in public health

- They can debate public health policy. It has for some years been the practice to include in Stockport’s Annual Public Health Report advice to local MPs and political parties on issues it would be worth debating
- Through the Health & Well Being Board they can be a source of democratic accountability for the health and social care system
- They are important advocates for change in their local community, often taking an inductive approach which mirrors that of GPs
They can be important role models
They have many contacts with the public so we have included them in the health chat training which is part of our Making Every Contact Count initiative
They are powerful opinion formers
The Chair of the Health and Well Being Board is an important part of the public health leadership process providing valuable wisdom and understanding of public attitudes
The Chair of the Health and Well Being Board is an important part of the public health advocacy process adding a political voice to the professional views of the DPH and Deputy DPHs.

HEALTHY AGEING

52. Healthy ageing is the key to long term affordability of social care.
53. A dependency ratio defined as people over age 65 divided by people of working age is at an all-time high and rising. Defined as people within 15 years of life expectancy divided by people actually in the workforce, it is at an all-time low and stable. This is due to the dual effect of rising life expectancy in the numerator and increasing workforce participation of women and older people in the denominator.
54. Appendix 4 sets out theoretical calculations of different ageing scenarios on health expenditure.
55. A healthy ageing strategy must encourage people to remain active into old age, to maintain friendships and a purpose to life, and to continue with healthy lifestyles, such as healthy diets. It must ensure that people are not encouraged to accept that they suffer from old age when in fact they suffer from treatable illness. We must make it easier for old people to remain active and involved, and support people in staying independent when old age does begin to affect them. Physical activity in old age has been shown to ward off frailty.

Dr. STEPHEN J. WATKINS
Director of Public Health

Dr. VICCI OWEN-SMITH
Dr. DONNA SAGER
Deputy Directors of Public Health

Cllr. JOHN PANTALL
Chair of the Health & Well Being Board
APPENDIX 1 THE PREVENTION AND EMPOWERMENT STRATEGY OF STOCKPORT TOGETHER.

Overall Prevention and Empowerment Vision for 2020
• Our purpose is to reduce health inequalities and enable more people to live healthy lives for longer
• Our approach will build and strengthen individual and community assets and resilience through:
  – Increasing the availability and take up of support for adopting healthier ways of living, addressing both mental and physical aspects of health
  – Working with communities and organisations to develop social, economic and physical environments that are more conducive to health and well-being.
• This will lead to reduction in both the overall prevalence and the inequalities in illness, disability and premature mortality

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

Prevention and Empowerment

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

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

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

The model includes five service components:

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

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

Behaviour change support

This includes the following service components and developments

• Healthier living hub providing information, advice and referral, (face to face, by phone or online) on lifestyles and wellbeing issues
• Simple integrated electronic referral system to connect people to the healthier living and self-care hubs
• Healthy Living Pharmacies to provide enhanced support for prevention and self-care
• Renewed Healthy Stockport service, providing one to one and group support to help people address their lifestyle and behaviour issues. This will include new neighbourhood-based health trainer roles in all neighbourhoods, with provision weighted to more deprived areas
• Increased capacity for social prescribing, including Arts on Prescription, Walking for Health
• Promotion of cancer screening take up and early symptom checking
• Specialist support for people with entrenched behaviour issues including drug or alcohol dependency, low mental well-being, physical inactivity and eating disorders
• Increasing capacity of the Targeted Prevention Alliance of voluntary sector providers to enable prevention activity particularly for vulnerable people to be tailored to and delivered at a local level
Early identification and prevention
Key to the P&E model is the identification of need and motivation of people to access preventive support and services and this will be delivered by means of:
• Prevention embedded in every pathway, facilitated by integrated IT, to facilitate the capture of opportunities for preventive advice and support. All health and social care services will be commissioned to include this as core business. This will require a holistic approach to the person which takes account of wider needs, circumstances and assets, to enable them to achieve better health.
• Find & Treat: Development and testing of risk modelling tools which utilise GP, health, and social care records to extend risk stratification approaches to proactively target those at risk such as people with no recorded blood pressure (BP) readings, those at risk of diabetes and those with mental health concerns
• Increasing the reach of the older people’s health check questionnaire, which will help identify needs and opportunities for prevention
• Building the capacity and reach of the Know Your Numbers project, to deliver health checks, BP testing and brief advice in non-medical settings in the community.
• Targeted social marketing to engage identified segments of the population whose lifestyles are more likely to be risking their health, Promoting take up of appropriate screening programmes.
• We will also work in partnership with other public service providers such as housing providers, Benefits Agency, GMFRS and Police to engage people in health promotion and support.

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

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

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

Healthy Cultures and Environments
• This element will focus on creating healthier environments, including homes, workplaces, schools and communities so that people can live longer, healthier and more productive lives and ultimately reduce the reliance on health and social care services. The Stockport Health Promise is a vehicle for securing potential health promoting/protecting impacts of a range of council services. This work area will
  – Identify system wide factors that are currently contributing to poor health outcomes in Stockport and use our local knowledge and (inter)national evidence base to achieve sustainable change.
  – Ensure a public health contribution to policy decisions relating to employment, the local economy, infrastructure, education and housing to facilitate healthier ways of living and healthier social, economic and physical environments. Pay specific attention to addressing wider determinants in our deprived communities using the intelligence and experiences of local residents.

Workforce development
• Delivery of the prevention agenda depends on cultural change, including engagement of the Stockport Together agencies and other partners’ workforces to develop the
attitudes, skills and processes required to deliver an empowering, prevention-focussed approach to health and social care. This and will include:

–Making Every Contact Count (Patient Activation): Train and empower the workforce to deliver positive and consistent health promoting messages, primary prevention interventions and motivational support proactively and holistically wrapped around the person’s needs.

–Building on Stockport Health Chat, Patient Activation model and Connect 5 and develop more advanced behaviour change techniques incorporating motivational interviewing and patient activation approaches that can be used in clinical and non-clinical settings, by appropriately trained staff, professionals or volunteers in health, social care and related fields such as housing or Police.

• This will be interdependent with the wider cultural change objectives of Stockport Together, as well as the workplace health initiatives, to create rewarding and engaging workplace cultures in which staff are empowered, skilled and motivated to actively capture opportunities for prevention and it is recognised as a core part of their roles

• This will be supported with the identification of and support for a prevention and empowerment lead in every setting: neighbourhood/ practice/ team

• Taking a population approach means seeking to deliver wider social change which creates new norms of healthier ways of living. This involves addressing the wider determinants of health, such as:

–Planning and environmental work to make active travel easier and more attractive

–Housing conditions including heating and insulation and shared spaces

–Promoting attitude and cultural changes including in our workplaces, in our relationships with food, alcohol and tobacco, attitudes to exercise, and looking after our own emotional health and well-being

–Addressing the availability of goods and services that are health promoting (e.g. healthy food) and health harming (e.g. alcohol)
APPENDIX 2 THE STOCKPORT HEALTH PROMISE

STOCKPORT HEALTH PROMISE 2015/16

Introduction.
As part of the comprehensive health service established under the National Health Services Acts, Stockport Council has responsibility for ensuring measures to improve the health of the people. Whilst in part this is discharged by commissioning certain specific services, it is also a function which requires the commitment of the whole of the Council and the collaboration of its partners. The following Health Promise reflects this breadth of commitment given by the Council and partners to improving health. It is expected that this will be added to year on year as the commitment of other partners to achieving Public Health outcomes increases.

Children and Young People: The best start in life.

1. As part of the Health Promise Stockport Council’s staff who work with vulnerable children and families have started new ways of working to increase integrated working for the most effective use of resources and improve outcomes for children, young people and families. Under the ‘Stockport Family’ approach workers will use restorative approaches that support relationships to be built, maintained and repaired when differences arise, and work with families to support their solutions for children’s well-being.

2. Front line workers will be trained in ‘Health Chat’ in order to maximise the benefits of this strength based approach. Stockport Homes is also committed to continuing to offer this training to staff and will include it within its annual training programme.

3. Stockport Council staff in Children’s Centres and Children and Family Centres work closely with Health Visitors jointly providing skilled and effective targeted support to parents of babies and young children.

4. Stockport Council’s staff working with vulnerable children and families will continue
   - Promotion of breastfeeding, working with local communities, especially in parts of the borough where this is low, following close joint analysis of data and evidence.
   - Support to reduce ante natal and post natal smoking
Support for maternal mental well-being via targeted delivery of group based interventions including ‘Living Life To The Full’

Support for early years social, emotional, behavioural cognitive and physical development

Integrated work towards a reduction in teenage conceptions and increase in positive personal relationships

Supporting work to reduce childhood accidents including the promotion of home safety with parents of early years

Actively work to promote strong parenting for secure and healthy parent/child relationships, including the delivery of the Family Nurse Partnership programme

Actively work with substance misusing parents to promote healthy development of their children

Promotion of healthy eating with parents of early years

Actively work with parents to promote healthy weight in children and families

Actively work with children and parents to reduce obesity levels through promoting increased physical activity and encouraging healthy eating choice

Actively work to reduce alcohol and substance misuse by young people.

Actively work with children affected by parental substance misuse, including promoting improving health and emotional wellbeing and promoting healthy lifestyle (healthy eating, exercise, hygiene, prevention of substance misuse, developing positive coping strategies)

Actively work with parents and grandparents of substance misusing children, to improve mental wellbeing, and reduce further ill health by developing positive coping strategies and reducing negative coping strategies to stress.

5. Stockport Council’s children’s social care staff will work with colleagues across Stockport Council and partnerships to develop our health provision to our Care Leaving population to ensure that they have timely access to mainstream and specialist health services, which meet their physical and mental health needs.

6. Stockport Council’s children’s social care staff will work with our partners to develop the extended offer to meet our corporate parenting responsibilities to our children up to 25-28.

7. As part of the Stockport Health Promise Stockport Council’s children’s social care staff have already started to develop links with health prevention and
promotion services to improve the health of Stockport’s most vulnerable children. In particular Stockport Council part funds the Health Visiting post within the front-door into social care recognising the significant impact that an integrated approach to assessment and risk analysis has.

8. Stockport Council’s children’s social care staff will continue to

- Promote good physical health through involvement of LAC specialist nurse and safeguarding HV
- Promote emotional health and mental well-being and services such as KITE and Child and Adolescent Mental Health Services, (CAMHS).
- Promote a healthy diet and lifestyle in team around the child, child protections and Looked After Children plans and reviews
- Reduce drug, substance and alcohol misuse through links with MOSAIC
- Reduce smoking through links with MOSAIC
- Promote sexual health awareness and education
- Improve awareness and education about risk and healthy relationships
- Reduce teenage pregnancy and reduce unplanned pregnancies
- Improve access to local community services and self-help groups/support.

9. Stockport Council’s youth offending service will promote healthy lifestyles/choices visual and promotional materials displayed throughout the service.

10. Stockport Council’s youth offending service will involve children and young people in physical activities through reparation: eg sports, horticultural activities.

11. Stockport Council’s youth offending service will

- Help young people make positive choices e.g.: sexual health (including distribution of condoms) diet, mental wellbeing and keeping safe incorporated into supervision and intervention plans.
- Ensure young offenders can access speech and language services.
- Provide direct input from youth offending service health practitioner to all young people on the caseload re. GPs and dentistry.
12. Stockport Council’s youth offending service will deliver the Respect DA programme working with children and young people in order to reduce potential for domestic abuse towards parents/carers.

13. Stockport Council’s youth offending service will deliver one-to-one and group work programmes around alcohol and substance misuse in partnership with MOSAIC.

14. Stockport Council will:
   - Commission activities for children and young people with a disability that promote physical exercise and well being
   - Promote healthy lifestyles for children and young people with a disability via our frontline staff
   - Provide and promote short breaks for parents and carers to increase mental health and wellbeing and to enable them to continue to care effectively for their son/daughter
   - Support children and young people with a disability to access appropriate services to meet their health needs
   - Promote healthy eating options for children with autism
   - Personalise services that better meet health and care needs of children and young people with a disability/additional needs

15. As part of the Health promise Stockport Council has already started
   - Development of the local offer to enable young people with a disability and their parent/carers to understand what is available and how they can access it
   - Have more of an emphasis on healthy eating in faddy food groups for children with autism and sensory issues
   - Work more effectively with CAMHS and other services to ensure services for children and young people are accessible, timely and meet identified need

16. Stockport Council will continue
☐ A variety of short break programmes that introduce and encourage children with disabilities to engage in sporting activities

☐ Work with partners to develop the new mental health service for children

☐ Work to implement the new 0-25 agenda for children and young people with disabilities that will better coordinate planning, assessment, resource and transition.

☐ Introducing personalisation for children which will put families more in control of provision and how this can meet need. This will be done via the introduction of personal budgets.

17. Stockport Council will promote improvements in the dental care of vulnerable children by

• Working with partners to encourage families to register with a dentist
• Providing toothbrushes and toothpaste to buy at cost in Children’s Centres
• Raising information about dental care in multi-agency meetings, e.g. Neighbourhood Boards
• Making every contact count and think about positive dental care with the children we work with
• Promoting awareness of dental advice and support with early education providers.

18. Stockport Homes will work with the Childhood Accident Co-ordinator to consider the best approach in promoting home safety and continue to install home safety equipment funded by Public Health.

19. Stockport Council will explore promoting and developing the Play Streets programme in targeted neighbourhoods

20. Stockport Homes will continue the provision of ‘Your Local Pantry’, linking with local groups to expand availability further, providing families with access to healthy and affordable food. The ‘Your Local Pantry’ scheme will also explore the viability of provision of items via ‘Healthy Start’ vouchers.

21. Stockport Homes will promote healthy lifestyles to residents through a range of media including via ‘Stockport at Home’ newsletter and online messages

**Schools Health and Well Being**
22. The Council will encourage and support schools to recognise the importance of healthy lifestyles including having a healthy diet, maintaining good oral health and maintaining a healthy weight.

23. The Council will continue to encourage and support schools to deliver better educational outcomes, promote healthy behaviours and reduce risky health behaviours such as smoking, behaviour likely to cause injury and alcohol and drug misuse among children and their families.

24. The Council will continue to support schools to develop life skills such as problem-solving, tolerance and confidence in order to build self-esteem and resilience to peer and media pressure and bullying.

25. The Council will ensure that schools are aware that physical activity improves educational attainment.

26. The Council will encourage and support schools to incorporate more physical activity within and beyond the curriculum, in order to increase children’s moderate and vigorous activity levels and reduce levels of sedentary behaviour.

27. The Council will encourage and support Stockport schools to implement a planned, age appropriate, progressive programme of Relationship and Sex Education.

28. The Council will support schools in continuing and developing dissemination of good practice and sharing intellectual resources in order to incorporate public health messages across the school curriculum.

29. The Council will establish a steering group to develop a cohesive approach to service provision to support all pupils but particularly those at risk which will enhance the Stockport Family approach. This will consider best practice in developing robust and well communicated pathways to support early intervention.

30. Stockport secondary schools will continue to develop and deliver a high quality relationships and sexual health education as part of their PSHE curriculum. This will continue to support young people in Stockport to keep themselves healthy and give them an age-appropriate understanding of healthy relationships, and how to stay safe from abuse and exploitation.

31. Stockport Schools’ Sport Partnership will support the increase of children and young people’s participation in high quality physical education, physical activity, competition and community links in schools and colleges.
32. Stockport Schools’ Sport Partnership will use Change4Life to increase participation for the least active in schools/colleges
33. Stockport Schools’ Sport Partnership will deliver targeted activities in schools/colleges
34. Stockport Council will provide delivery support for School Travel Plans
35. Stockport Schools’ Sport Partnership will support school staff to promote and model physical activity in a positive way
36. Feeding Stockport will develop growing groups in schools as an alternative to sports based activities and link into community based projects

**Active and Safe travel.**
37. The Council will continue to organise the Walk-a-day programme of rambles on our ROW network.

38. Through the Greenspace Forum the Council will foster links between Friends Groups (who need volunteers) and disadvantaged groups who need outlets.
39. The Council will provide walking routes on line for people to download and promote the ‘Green A-Z’.
40. The Council will offer Health Watch, FLAG, Stockport4Health and other health-based organisations the opportunity to promote health & fitness to the public by notices in our car parks.
41. The Council will set up/encourage more ‘social’ exercise groups for lunchtime including walking, swimming, dancing, climbing etc.

42. The Council will provide more cycle stands in car parks.

43. Stockport Homes will work with Transport for Greater Manchester and The Council to increase the number of public cycle storage opportunities in estates

44. The Council will support and encourage healthy and sustainable modes of transport.

45. The Council will continue to pursue the development of linked-up walking and cycling networks.

46. The Council will ensure that walking and cycling is built into any strategic development proposal on the borough’s highway network.
47. Stockport Homes will support this initiative by linking in with tenants and residents associations.

48. Stockport Council will utilise external grant opportunities to further develop the quality of existing walking and cycling routes, including Public Rights of Way

49. Stockport Council will develop an enhanced Guided Walk programme

50. Stockport Council will increase awareness of and access to active travel as an attractive and viable form of transport

51. Stockport Council will provide cycle and walk leader training

52. Stockport Council will establish evidence of the costs to public health and other Council budgets of developers not implementing existing sustainable transport (including active travel) related planning policies

53. Stockport Council will establish an active travel working group

54. Stockport Council will review the Stockport Council Travel Plan to ensure the promotion of physical activity is a priority

55. Stockport Council will support the continued development of active travel to and from school/college

56. Stockport Homes will support this initiative further by being an active member of the Physical Activity Strategy Steering Group.

Health and Spatial Planning.
57. The Council will further develop its new system for including public health advice in relation to planning applications

58. The Council and Stockport Homes will offer and promote healthy and sustainable food choices as part of the Sustainable Food Cities Programme. This will include the appointment of a co-ordinator in January 2014, employed by the Kindling Trust, the establishment of ‘Feeding Stockport’ Partnership in 2014 and the agreement of 3 year Sustainable Food Action Plan in 2014.

59. The Council will ensure wider understanding of the legal basis for considering health as a material factor in planning decisions and will seek to identify a group of councils prepared to share the costs of test cases.

60. Stockport Council will attach high priority to ensuring that all new major developments have walking and cycling designed into them

61. Stockport Council will review design guidelines to make them more appealing for active play and promote clear connectivity to greenspaces

62. Stockport Council will undertake an evidence based revision of supplementary planning documents with a focus on design to encourage physical activity and reduce sedentary behaviour
63. Stockport Council will consult on planning applications to continue to include Public Health and to include reference to physical activity and the promotion of non-obesogenic design (including new schools)

64. Stockport Council will ensure inclusion of the streetscape when looking at ways that planning can assist in promoting physical activity

65. Stockport Council will review indicators in the annual Authority’s Monitoring Report around the provision of new development that enables improvement to new sustainable transport, children’s play, open space, green infrastructure, indoor and outdoor sports and recreation facilities

66. Stockport Council will ensure greater focus on stair location and design in planning applications

67. Stockport Council will endorse sustainable design and construction approaches which support developments that result in enabling daily activity

68. Stockport Council will ensure policies result in development which contributes to integrated walking and cycling networks

69. Stockport Council will review local planning policy to support delivery of a Living Streets programme

70. Stockport Homes will continue to work with Stockport Council, communities and key stakeholder to raise awareness of the social, environmental and well-being benefits of greenspaces including parks, open spaces, allotments and play spaces.

Country City

71. The Council will review and refresh Country City and formally establish its status in the planning system.

72. By the summer of 2016 it will secure the basis for a recommendation to members to support the principle of greenspace-compatible development, revise the Council’s existing Sustainable Design & Construction Supplementary Planning Document (SDC SPD) to ensure it reflects the approaches outlined in Country City as well as containing an updated business case for sustainable design and construction methods that support good public health and re-launch revised SDC SPD with support for approaches from relevant Portfolio holders as well as Executive Council backing. It will hold a launch event for developers

73. By the summer of 2016 it will co-ordinate provision of low cost / no cost locally available training on sustainable design and construction to enable local developers to embrace the design approach and understand the benefits. This work should include local and/or national best practice examples of all the aspects of green space compatible development outlined in this section of the Action Plan. This work should tie in with planning work around raising the profile of Green Infrastructure.

74. By the summary of 2016 it will ensure that existing relevant planning policy and any revisions of such are robustly evidenced in terms of cost benefit and social benefit of greening the built environment, including public sector budget implications, in order to provide robust information in terms of viability discussions.
75. Over the next two years it will ensure that the JSNA and other Council strategies / policies and action / implementation plans reflect the need for green space compatible development acknowledging the public sector budget benefits as well as social / economic and environmental benefits to Stockport’s residents / businesses.

76. The Council will continue to encourage green roofs. Within the next two and a half years it will establish links to a building project that could incorporate a green roof into the design; engage relevant project’s lead officer to take forward green roof as part of development.

77. On the issue of Green Security the Council will engage Greater Manchester’s Directors of Public Health to approach GM Police regarding Secure by Design Standard and any health implications that this standard may engender.

78. On the issue of Green Security the Council will produce a promotional leaflet for developers.

79. The Council will seek low cost methods of making council buildings aesthetically attractive.

80. The Council will encourage staff to make their workplace more aesthetically attractive and run a competition for those doing the most in staff areas and those front line departments doing the most in public-facing areas.

81. The Council will encourage schools to make the school more aesthetically attractive and run a competition.

82. The Council will adopt procedures which will allow communities to improve public realm.

83. Stockport for Health and Well Being will encourage other organisations to take part.

84. The Council will promote JSNA work on supportive text for planning regarding Green Infrastructure, sustainable transport, sustainable urban drainage and measures to address urban heat effect.

85. The Council will review its approach to urban heat effect.

86. The Council will pursue the development of local guidance and provision of training for planners and developers on the process of HIA and the importance of green space compatible development.

87. The Council will articulate during the development of the GMSF and then implement in its own Local Plan measures to develop an evidence base that supports successful implementation of health relevant planning policies, develop an appropriate and deliverable HIA Policy for local plans, assess existing Planning Policy and local Guidance for robustness and capacity in terms of promoting green security and green infrastructure, promote greenspace-compatible development.

88. The Council will ensure that walking and cycling are prioritised in TCAP.

89. The Council will explore using using the new simplified powers for definitive map adjustments to pursue the lost ways project more actively and see if it is possible to complete the map for the former CB area.

90. The Council will empower volunteers to work on rights of way improvement.

91. The Council will carry out exploratory work for partial pedestrianisation of the A6 between Heaton Lane and Longshut Lane, subject to appropriate arrangements for buses, cyclists and access to Stockport Station and Stockport Exchange.
92. Stockport Homes and Feeding Stockport will increase opportunities for community gardening and growing spaces

93. Stockport Council, Stockport Homes and Life Leisure will provide a range of green space and leisure facility environments that are appealing and conducive for physical activity for all ages within the Borough

94. Stockport Council will work in partnership with stakeholders, such as Friends Groups to encourage active use of parks and greenspaces

95. Stockport Homes will continue to build new homes for both rent and shared ownership. All the new build properties will meet or exceed building regulation requirements in relation to insulation, heating and comfort levels.

96. Stockport Homes will continue to invest in existing stock in particular targeting properties with expensive to run inefficient heating systems and replacing them with new efficient heating systems. Stockport Homes will also continue with insulation programmes and the installation of renewable technology such as PV panels. These programmes are designed to address fuel poverty and the comfort levels of customers’ homes

Resilience and Inclusive communities

97. Council services and Stockport Homes will access and will support groups and organisations to access and manage funding that promotes health & wellbeing, most recent examples being the Big Lottery Wellbeing Fund (Stockport’s Food & Fitness for Families), Adult Social Care accessing various EU funds around sustainable living and NHS Homeless Discharge Fund.

98. The Council will continue to lead on input to Manchester MHealth Ecosystem and ECH Alliance.

99. Stockport 4 Peace in conjunction with Stockport 4 Health will organise a programme of work on awareness of international public health issues.

100. Stockport Homes will expand the provision of physical activity within community settings

101. Stockport Schools’ Sport Partnership will develop leadership and volunteering opportunities within schools and colleges

102. Life Leisure and Sport Stockport will support the development of the community voluntary sector to promote physical activity

103. Stockport Schools’ Sport Partnership and Life Leisure will develop improved school/community sports and activity partnerships

104. Stockport Council, Life Leisure and Stockport Schools’ Sport Partnership will support practitioners working with all age groups to develop their physical activity knowledge and expertise
105. Stockport Council will work with community development to support the growth of grass-roots community-led physical activity

106. Stockport Homes will continue to offer training via the successful Skills for Life programme aimed at improving healthy lifestyles.

**Workplace Health**
107. The Council will promote services to businesses (eg the “Good Work: Good Health Charter) that will improve the health and wellbeing of their workforce and promote the health and well-being of the Council staff.

108. Stockport Homes is committed to supporting and enhancing the social, physical and psychological well being of all its employees based on the national Investors in People, Health and Wellbeing good practice Award which was achieved and has been retained following review since 2012.

109. The Council will support the growth of the low carbon business sector in Stockport through our grant scheme and business support.

110. The Council will support the establishment of healthy food outlets in the town centre through our grant scheme and business support.

111. The Council will facilitate and encourage businesses to develop collaborative healthy offers and alternatives.

112. Stockport Council, Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust and Life Leisure will support workplaces to be active places including encouraging the use of stairs in buildings.

113. Stockport Council, Stockport Homes, Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust and Life Leisure will encourage regular active breaks during work time.

114. Stockport Council will offer cycling and walking incentive schemes.

115. Stockport Council and Stockport Homes will link with Cycle loan to develop ‘bike loan’ schemes.

116. Stockport Council and Life Leisure will promote the Workplace Challenge with major employers.
117. Stockport Council will provide opportunities for staff to be physically active through the Workforce Health and Wellbeing Group

118. Life Leisure will use Acti-life to promote an active lifestyle within the workforce

119. Stockport Council will promote physical activity as part of the Stockport Together Health and Wellbeing programme for all staff

120. Stockport Council will promote workplace building design to support active commuting

121. Stockport Council, Stockport Clinical Commissioning Group, Stockport Homes, Stockport NHS Foundation Trust and Life Leisure will promote 2x10 minute walk breaks per day for staff with sedentary occupations

122. Stockport Council, Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust and Life Leisure will promote the option of standing workstations and standing meeting rooms within the workplace

123. Following on from the success of the ‘Fitness 15’ initiative, Stockport Homes will widen the scope of what’s on offer for staff in 2016 under the rebranded ‘Wellbeing 16’.

124. Stockport Homes will develop it’s pool of Mental Health First Aiders under the ‘Active Listeners’ scheme, offering additional support to staff who may be experiencing emotional distress and poor mental wellbeing.

125. Stockport Homes will provide additional ad hoc health opportunities including free fruit, blood pressure checks and massages

Other
126. The Council’s Trading Standards and Licensing teams will continue to work with the Police and other partners to tackle the problems of illicit tobacco and the impact that is has on communities.

127. The Council will erect signs in selected areas within parks (such as children’s play areas) indicating that they are smoke free.

128. Life Leisure will develop an active and professional fitness and sports workforce through accredited providers

129. Stockport Council, Stockport Homes and Life Leisure will use both traditional and social media to promote the benefits of physical activity and the risks of being sedentary

130. Stockport Council will promote physical activity through the Health Chat programme with providers

131. Stockport Homes are committed to signing up to a set of Health and Wellbeing Pledges devised by all housing organisations across Greater Manchester.
Healthy Ageing

132. Build on the work to date to promote increased awareness of social isolation and loneliness of older people as a significant risk factor to health and wellbeing, by extending this approach more widely to people with physical and sensory disabilities, people with mental health problems and carers.

133. Continue to expand our knowledge of the factors which reduce independent living and the factors which promote resilience and wellbeing through insight gathered from the new preventative contracts and the early work through the multi-disciplinary teams. Capture this for wider use across providers, the Council and partners.

134. Improve the awareness of the benefits and promotion of appropriate physical activity across the domiciliary care sector and residential care settings, identifying appropriate partnerships through which to promote these messages, including promotion of the home exercise guide.

135. Continue to seek opportunities to apply the principles and content of the Health and Wellbeing Check (for older people) to other appropriate settings and contacts with older people, including Stability Services and hospital wards / clinics.

136. To ensure that a series of appropriate public health / lifestyle questions are incorporated into the initial conversation with service users who are being supported through the integrated health and social care hubs.

137. To improve the understanding and identification of falls risk amongst social care practitioners, in particular with a view to intervening early with aids and adaptations in the home environment.

138. Stockport Homes supports the healthy ageing strategy and will continue current events in sheltered schemes and seek to explore other opportunities to run specific programmes to the within the wider community through the continuation of an Older Person’s Activities Co-ordinator.

139. Stockport Council and Age UK Stockport will ensure access for older / vulnerable people to locality level activities.

140. Age UK Stockport, Step Out Stockport and Life Leisure will support activities for more vulnerable people for maintaining / improving balance and mobility.

141. Stockport Council will promote regular physical activity, as an effective means by which to support healthy ageing.

142. Stockport Homes will continue with the delivery of the Older Persons Strategy and Action Plan in collaboration with partners.

143. Stockport Homes will review support services delivered to Older People and seek to ensure services are delivered on a wider footing.

144. Stockport Homes will deliver roles within the Wellbeing and Independence Network focussing on older people, disabled people and carers, work will include the provision of practical advice and support to sustain independent living including adaptations, repairs and maintenance, income maximisation, wellbeing and independence in the community and additional activities.
145. Stockport Homes will provide an annual winter welfare check for vulnerable elderly tenants ensuring they are ready for the colder winter months.

146. Stockport Homes will promote dementia awareness in local communities

Prevention in Social Care

147. Substantially enhance the social model of self-care through the preventative commissioning work and the Proactive Care workstream by taking steps to grow social action and community capacity which will create informal but organised support for individuals, families and communities

148. To continue to work towards addressing the health inequalities of people with learning disabilities through an annual review of the Learning Disability Self-Assessment Framework

Lifestyle and Behaviour Change.

149. The Council will train front line staff in the public health skills necessary for making every contact count.

150. Stockport Homes will seek to make every contact count, for example, reviewing access points into services with a view to forming links to, and promoting, use of primary care services and/or other appropriate programmes.

151. The Council has recently submitted the CLEAR self-assessment on how we are locally progressing the tobacco control agenda. We will be assessed on this in March 2014 and following this will consider all of the recommendations alongside the Local Government Declaration on Tobacco Control.

152. Stockport Homes will continue to work with relevant agencies to promote and support customers and staff in knowing about and being able to access smoking cessation services, as well as linking in with the Family Nurse Partnership, to help reduce the number of younger mums smoking in pregnancy.

153. The Council’s Trading Standards and Licensing teams will continue to work with the Police and other partners to tackle the problems of illicit tobacco and the impact that it has on communities.

154. The Council will erect signs in selected areas within parks (such as children’s play areas) indicating that they are smoke free.
155. Life Leisure will encourage a more physically active Stockport across all ages, through the provision of high quality leisure facilities.

156. Life Leisure will work in partnership with external agencies to provide sport and physical activity opportunities which can impact positively upon criminal activity and anti-social behaviour.

157. Life Leisure will continue to develop innovative and forward-thinking initiatives such as the Health Hub, PARiS and All Together Active to support inactive children and adults with chronic illnesses to better manage their health through physical activity.

158. Life Leisure will focus on addressing health inequalities and develop partnerships with external organisations to reinforce positive health messages within the Neighbourhood Management priority areas.

159. Life Leisure will offer and promote family offers within leisure facilities across the borough.

160. Life Leisure will ensure that leisure facilities are accessible to all across the borough.

161. Life Leisure will develop large scale and targeted community interventions (including the big event series).

162. Life Leisure will provide support for voluntary sector sports club infrastructure development in priority areas.

163. Life Leisure will deliver events in green spaces where participation involves physical activity.

164. Stockport Council, Age UK Stockport, Stockport Homes and Life Leisure will engage with older people to provide and promote opportunities to reduce sedentary behaviour.

165. Stockport Council will work with parents/carers to limit the amount of time young children are restrained in highchairs, pushchairs or car seats.

166. Stockport Council and Stockport Homes will develop family and home-level interventions targeted at reducing screen-based sedentary behaviours in children and young people.

167. Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust, Life Leisure and Stockport Council will support sedentary people with moderate
medical conditions to increase their physical activity levels (including referral to Physical Activity Referral in Stockport [PARiS])

168. Life Leisure will deliver targeted sports opportunities within the community

169. Life Leisure and Stockport Homes will utilise grants and external funding opportunities to support doorstep activity

170. Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust, Life Leisure and Stockport Council will support overweight or obese children and young people aged 5 – 13 years to increase their physical activity levels (including referral to All Together Active [A2A])

171. Stockport Council and Stockport NHS Foundation Trust will ensure physical activity is addressed within all lifestyle intervention and support programmes

172. Stockport Council will use both regional and national physical activity initiatives to help address wider health determinants

173. Stockport Council, Stockport Homes, Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust and Life Leisure will promote and support the use of Apps, pedometers and accelerometers to change behaviour

174. Life Leisure will develop and expand the use of Acti-life to change behaviour within the wider population

**Stockport Clinical Commissioning Group.**

175. The Stockport Clinical Commissioning Group and the Council will continue the integration of health and social care through Locality Hubs and in that context will seek to put in place a pattern of care which optimises resources through prevention, early diagnosis and the more efficient harmonisation of services and clinical pathways.

176. The Stockport Clinical Commissioning Group will pursue a campaign to increase levels of early diagnosis of hypertension.

177. The Stockport Clinical Commissioning Group and NHS Greater Manchester will explore developing the role of community pharmacists in prevention.

178. The Stockport Clinical Commissioning Group, the Stockport NHS Foundation Trust the Council and Stockport Homes will pursue a “making every contact count” programme.

**Health Protection.**
179. The Council’s Neighbourhood Management Teams and Stockport Homes will encourage local people to make full use of immunisation and screening services.

180. The Council’s social care staff and Stockport Homes will promote the importance of the pre-winter flu immunisation amongst staff and service users.

181. The Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust, local GPs, NHS Greater Manchester, Stockport Homes and the Council will aim to further increase uptake levels of flu vaccination in Stockport in the 2014/15 programme, especially where it is lower than the generally excellent levels in the Borough as a whole.

Public Health resources.

182. The Council is currently engaged in a major exercise to ensure that its services achieve the best outcomes that are possible within increasingly limited resources. In that exercise it will ensure that the value of preventive approaches both to achieving outcomes and to reducing cost will be fully recognised.

183. The Council is currently engaged in a major exercise to ensure that its services achieve the best outcomes that are possible within increasingly limited resources. In that exercise it will ensure that the health of the people is seen as an important outcome wherever its services can assist.

184. The Council is currently engaged in a major exercise to ensure that its services achieve the best outcomes that are possible within increasingly limited resources. In that exercise it will recognise the value of empowered and resilient communities.

Drug and Alcohol Misuse.

185. Stockport Homes is committed to tackling anti-social and other related behaviour as a result of substance misuse and will join the Substance Misuse Group.

186. As part of this membership Stockport Homes will consider an improved offer to those affected by substance misuse issues (specifically alcohol related) where housing is ‘key’ to recovery.

187. Stockport Homes will also continue to work in close partnership with drug and alcohol services in Stockport and continue to provide home detoxes within temporary accommodation schemes.
188. Stockport Homes will contribute a package of training in schools around homelessness and anti-social behaviour.

189. Stockport Council, Stockport Homes and Life Leisure will work with other services to promote and engage hard to reach groups in physical activity

**Mental Health and Well Being.**

190. The Council will extend the pathways access and recovery model already used in mental health to people with long term conditions as part of the integrated care model.

191. Stockport Homes will promote the destigmatisation of mental health and the promotion of well-being through its staff: health and wellbeing events, training and wider staff support. Opportunities to access support will also be offered to customers.

192. Stockport Homes will play an active part in the Stockport Suicide Collaborative Group and support and promote Wellbeing Week.
APPENDIX 3 THE FACULTY OF PUBLIC HEALTH
DEFINITION OF HEALTHCARE PUBLIC HEALTH

Short headline definition of Healthcare Public Health
Healthcare public health is one of the three core domains of specialist public health practice, alongside health improvement and health protection. Healthcare public health (HCPH) is concerned with maximising the population benefits of healthcare while meeting the needs of individuals and groups, by prioritizing available resources, by preventing diseases and by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient healthcare interventions and pathways of care.
Health Services Committee
Faculty of Public Health
12.11.2015

Foreword
The longer narrative presented here is an attempt to encapsulate a complex and highly skilled function that harnesses public health sciences and applies them to healthcare services planning, commissioning and provision. It describes the core technical tasks required to produce intelligence that can then be used to assist understanding and subsequently leadership and decision-making. This may be carried out by public health specialists or by others, but here we describe what makes up the function of specialist Healthcare Public Health that at the very least allows the production of that intelligence. We completely acknowledge that these skills and approaches apply to health improvement and health protection equally, but the lens and definition here is about how they apply to healthcare (NHS, third sector or private) services. We also recognise that integrated health and social care systems require these approaches across social care as well as healthcare.
Chris Packham
Chair, Health Services Committee
What is the Public Health Function as it applies to health care service planning commissioning and delivery:

“A robust, adequately resourced healthcare system that can secure and sustain the public’s health, addressing health and associated policy issues at a population level and leading a co-ordinated effort to tackle underlying causes of poor health.”

HealthCare Public Health (HCPH)

Healthcare public health is one of the three domains of „public health“, alongside health improvement and health protection. Healthcare public health (HCPH) improves health at a population level, by preventing diseases or improving health-related outcomes through access and utilisation of effective healthcare interventions or treatments.

HCPH focuses on developing and improving evidence-based healthcare through the careful assessment and planning of health need, prevention, quality (safety, outcomes and good patient experience), efficiency (good outcomes per £ spent), value (that the patient or population derive), variation, and equity in healthcare pathways. This helps drive improvements in population outcomes and a reduction in health inequalities in a cost effective manner.

HCPH ensures pathways include balanced consideration of prevention and early diagnosis as well as treatment. HCPH practice also involves leading the practical delivery of population healthcare services such as screening and immunisation programmes and preventative work such as lifestyle and nutritional programmes across populations.

HCPH components include:

- Population Focus: Assess the health needs of the population in specific areas and more widely and identify the population that is able or likely to benefit from a service.
- Evidence: Provide an independent interpretation of published evidence, available data or other relevant and important knowledge sources, Inform and support „evidence-informed” and „value-based” decision making, with the aim of ensuring equitable access to effective, safe, person-centred and integrated care services.
- Evaluation and research: Provide advice and support for monitoring and evaluation of the observed impact following the implementation of service change. Develop and lead research where appropriate.
- Strategic View: Work with NHS and other service colleagues to ensure clarity on the strategic direction for services, to better meet the needs of the population, effectively, efficiently and in a balanced way.
- Service design: Ensuring all Health and Healthcare providers working with key partner organisations, develops and provides services (including treatments, therapies, models of care) that work well (effective), are good value (efficient) and are informed by a clear understanding of the needs of the population.
- Inter-professional and Partnership working: Experience and confidence to build effective working relationships, bring different professional groups, patients and
colleagues in other organisations together to help achieve real progress and beneficial change in service development.

- **Tackling inequalities:** To advise on the design and distribution of health services that are well regarded by their users, equitable, responsive, accessible according to need and accessible by those with the greatest need to minimise inequalities in health.

- **Prioritisation and Option Appraisal:** Advising on approaches to prioritisation to help ensure that our services focus on areas of greatest population need whilst also ensuring a balanced approach to maintain equitable access to more specialist or intensive services for groups of people who have high or particular needs. Ensuring that proposals for change are assessed for opportunity cost (foregone alternative use of resources) against existing services, service pressures or planned service developments.

- **Preventive services:** Advising on preventive healthcare service interventions including screening and immunisation.

- **Link across areas of PH practice:** Maintain effective working with other areas of the public health function (health improvement, health protection and health intelligence).

HCPH is collaborative, involving a range of stakeholders from across the NHS and other agencies to facilitate productive links between health professionals, health managers, policy-makers, academic researchers and public / patient representatives. The time-frame for HCPH activities may vary from short "turn-around" requests for advice on individual care applications, advice on service risks or in year service developments to longer term service redesign work. The impact of improvements to care and service developments will often last for decades leading to sustained improvement in population health and sustained delivery against organisational goals and priorities.

**Statutory functions for HCPH** (including Outcomes Frameworks, Local Authority functions, Public Health England roles and NHS Public Health Responsibilities (Section 7a 2006 Act)

**HCPH in NHS organisations**

Appropriate and equitable access to high quality services is a key determinant of population health, based on individual outcomes that maintain, restore or maximise health. A strong HCPH function helps ensure the delivery of better care and better value healthcare and joint health and care services. It will also help monitor the issues around equity, which include not only access but utilisation and equity of outcomes.

PH Professionals who contribute to or work within HCPH work across service boundaries to create collaborative networks at local, national and regional level as required. Public Health specialists and practitioners who undertake HCPH work can inform and support population needs assessment, translation into strategic direction, and approaches for prioritisation.

The key areas of operation for HCPH at local level cover roles in leadership, co-ordination, building good working relationships locally and more widely, and direct execution of skills and tasks.
Specialist public health advice works locally in the areas listed above to fit in with local priorities and strategic opportunities. The combination of skills often based on previous experience, along with a sound understanding of how the NHS and partner agencies work, gives specialist public health the ability and credibility to engage and lead clinical and NHS management staff in service design, improving service quality, patient outcomes, and the delivery of added value at a population level. Although non-statutory, many health and care services issues can benefit from a Public Health perspective – which can provide the function of an independent population advocate. Necessary decision-making across sectors or along care pathways is often complex due to uncertainty, multiple dimensions, competing objectives, unavoidable trade-offs and time constraints. If decisions are not actively taken and there has not been active public health involvement, then sub-optimal options may be chosen by default. Recent inquiries, such as the Francis Report on hospital care in Mid-Staffordshire, have focused on how a health system responds to the needs of a local population.

HCPH at regional and national level
The locus of decision-making for health care strategic planning and service developments varies, with some decisions or solutions needed at national or regional level. Successful implementation requires local engagement built on robust links and effective working relationships to ensure real service change on the ground. Public Health Professionals working in health services public health have a range of positions and responsibilities in each of the countries of the UK. These differ depending on the system but all involve important supporting and leadership roles (these include roles within national Public Health bodies, national-level and regional-level organisations, policy groups, working groups and decision forums as well as NICE and SIGN Scottish Intercollegiate Guidelines Network).

HCPH and Social Care
The skills and approaches described here apply to health improvement and health protection as well, but the lens and definition here is about how they apply to healthcare (NHS, third sector or private) services. As integrated health and social care systems develop, they will require these approaches across social care as well as healthcare.

This statement was developed by Professor Chris Packham, Chair of FPH’s Health Services Committee, with particular thanks to members of the Health Services Committee, Scottish colleagues who provided substantial background material, and colleagues in Public Health England and the Association of Directors of Public Health for helpful suggestions and comments.
APPENDIX 4 STANDARDS FOR A HEALTHY HOSPITAL

Developed at Stepping Hill Hospital, Stockport

Introduction

The current crisis in the NHS rests in part upon growing demand and this in turn rests upon not taking full advantage of opportunities for prevention. It is not sufficient to transform and rearrange services unless this is accompanied by a public health programme for preventing the illnesses that create these demands.

A public health programme includes a range of steps from social policy to specific public health services to public health within healthcare.

The purpose of this paper is to address the contribution that hospitals can make to public health within the areas in scope of Healthier Together.

It rests upon three basic themes

- Making Every Contact Count
- Recognising the Preventive Implications of Clinical Findings
- Ensuring Hospitals Are a Health Promoting Environment.

Purpose

To ensure that clinical contacts in hospitals are used fully for their preventive potential so as to reduce further demand by preventing its causes

Greater Manchester public health in hospitals standards

<table>
<thead>
<tr>
<th>Ref</th>
<th>Area</th>
<th>Standard</th>
</tr>
</thead>
</table>
1.1 The hospital should have baby-friendly status which would require the Trust to:
   • Have a written breastfeeding policy that is routinely communicated to all health care staff.
   • Train all health care staff in skills necessary to implement this policy.
   • Inform all pregnant women about the benefits and management of breastfeeding.
   • Help mothers initiate breastfeeding within one half-hour of birth.
   • Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.
   • Give new-born infants no food or drink other than breast milk, not even sips of water, unless medically indicated.
   • Practice rooming in - that is, allow mothers and infants to remain together 24 hours a day.
   • Encourage breastfeeding on demand.
   • Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
   • Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

1.2 If breastfeeding initiation rates are below 80% this should be regarded as grounds for investigating and enhancing work in this field.

1.3 Hospital should have places where women who are visiting the hospital can breast-feed.

1.4 There should be arrangements to screen and refer for tongue tie where it is likely to adversely affect breastfeeding.
2.1 All women should have their smoking recorded.
2.2 Women should be warned of the impact of smoking on their baby.
2.3 Women who smoke should receive an intervention to assist in changing their behaviour.
2.4 Midwives should:
   • Assess the woman's exposure to tobacco smoke through discussion and use of a CO test.
   • Explain that the CO test will allow her to see a physical measure of her smoking and her exposure to other people's smoking.
   • Ask her if her or anyone else in her household smokes.
   • To help interpret the CO reading, establish whether she is a light or infrequent smoker. Other factors to consider include the time since she last smoked and the number of cigarettes smoked (and when) on the test day.
   • Provide information (for example, a leaflet) about the risks to the unborn child of smoking when pregnant and the hazards of exposure to second hand smoke for both mother and baby. Information should be available in a variety of formats.
   • Explain about the health benefits of stopping for the woman and her baby. Advise her to stop – not just cut down.
   • Explain that it is normal practice to refer all women who smoke for help to quit and that a specialist midwife or adviser will phone and offer her support.
   • Where appropriate, for each of the stages above record smoking status, CO level, whether a referral is accepted or declined and any feedback given.
   • The above should be recorded both in the woman's hand-held and computer record.
2.5 If smoking rate at the time of delivery is above 10% or the proportion of women drinking more than 7 units a week during pregnancy exceeds 10% this should be regarded as grounds for investigating and enhancing work in this field.
| 2.6 | Almost all notes will contain a record of a conversation about the harms of smoking, alcohol and weight on the health of the mother and baby. |
| 2.7 | Women should be warned of the impact of alcohol on their baby. |
| 2.8 | Women should avoid alcohol altogether and receive an intervention to assist in changing their behaviour. |
| 2.9 | Trusts should comply with the CMACE/RCOG Joint Guideline on the Management of Women with Obesity in Pregnancy (March 2010) |
| ALCOHOL IN A&E AND OTHER ACUTE PRESENTATIONS | There should be arrangements to address alcohol problems which manifest themselves by A&E attendance as follows:-  

3.1 All persons who attend A&E having consumed alcohol should receive a warning about the risk.  
3.2 Patients presenting with alcohol related harm receive screening with an appropriate tool and a brief intervention or have one arranged.  
3.3 Clear pathways exist for providing help to those who repeatedly attend A&E with alcohol related harm and are used.  
3.4 There should be screening for domestic violence using an intimate partner violence routine enquiry protocol. |
<table>
<thead>
<tr>
<th>PH4</th>
<th>HEALTHY BEHAVIOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1</strong></td>
<td>90% of front line staff will have received training within 3 years on current recommendations for healthy behaviours and empowered/ supported to ask people if they are concerned about their behaviours and would like help to do something now.</td>
</tr>
<tr>
<td><strong>4.2</strong></td>
<td>General advice on behaviours will be readily available and visible in wards, clinics, reception areas etc. As a minimum this would include a) leaflet displays on every ward and outpatient area about smoking and alcohol and where to go for advice and b) public displays in corridors</td>
</tr>
<tr>
<td><strong>4.3</strong></td>
<td>A patient’s screening history for the population screening programmes for which the patient is eligible will be checked, unless this is inappropriate, and advice given.</td>
</tr>
<tr>
<td><strong>4.4</strong></td>
<td>The following further health screening tests will be carried out on patients, unless inappropriate: MRSA screen Water loss assessment VTE screen MUST nutritional screen Fracture risk assessment Moving and handling assessment Depression Patients over 65 years will be asked about and reminded that they can access free sight tests Patients will be asked whether they have any hearing problems</td>
</tr>
<tr>
<td><strong>4.5</strong></td>
<td>Clinical systems will ensure that blood pressure, pulse rhythm, cholesterol, HBA1C and creatinine readings will be included in the electronic discharge summary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PH5</th>
<th>PRE-OPERATIVE SMOKING AND WEIGHT LOSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The potential to use surgery to stimulate smoking cessation and weight loss should almost always be taken.</td>
<td></td>
</tr>
<tr>
<td>PH6</td>
<td>ENCOURAGEMENT OF ACTIVE TRAVEL TO HOSPITAL</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>6.1 Hospital information leaflets and websites should always include active travel information.</td>
</tr>
<tr>
<td></td>
<td>6.2 Stairs should always be clearly indicated and poster encouraging their use should be clearly displayed.</td>
</tr>
<tr>
<td></td>
<td>6.3 Cycle parking should be provided.</td>
</tr>
<tr>
<td></td>
<td>6.4 A cycling mileage rate should be paid.</td>
</tr>
<tr>
<td></td>
<td>6.5 Walking routes to the hospital within one mile will be identified, improved and signposted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PH7</th>
<th>CORPORATE CITIZENSHIP</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Hospitals will have strategies for acting as good corporate citizens.</td>
</tr>
<tr>
<td></td>
<td>7.1 Recycling</td>
</tr>
<tr>
<td></td>
<td>7.2 Reducing energy use</td>
</tr>
<tr>
<td></td>
<td>7.3 Reducing carbon emissions</td>
</tr>
<tr>
<td></td>
<td>7.4 Creating employment in deprived local areas</td>
</tr>
<tr>
<td></td>
<td>7.5 Acting as partners with local communities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PH8</th>
<th>PATIENT NUTRITION AND HYDRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nutrition and hydration will be seen as important elements of professional care with real impacts on outcomes and not just as peripheral aspects of quality.</td>
</tr>
<tr>
<td></td>
<td>8.1 The importance of adequate hydration and nutrition of patients will be ingrained into all ward staff.</td>
</tr>
<tr>
<td></td>
<td>8.2 Attractive and nutritious food will be provided. This should comply with the National Catering and Nutrition Specification for Food and Fluid Provision in Hospitals in Scotland.</td>
</tr>
<tr>
<td></td>
<td>8.3 Wastage rate above 10% will be regarded as evidence of a need to review this process as will poor satisfaction scores from patients.</td>
</tr>
<tr>
<td></td>
<td>8.4 Patients who cannot feed themselves will be properly fed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PH9</th>
<th>A HEALTHY AGEING STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.1 There will be a practice of early mobilisation of elderly patients in recognition of the risk of prolonged stay and permanent loss of function which can result if this is neglected.</td>
</tr>
<tr>
<td></td>
<td>9.2 Advice about appropriate physical activity and companionship will be shared with all older patients unless it is</td>
</tr>
<tr>
<td>PH10</td>
<td>NICE GUIDANCE</td>
</tr>
<tr>
<td>PH11</td>
<td>HYGIENE</td>
</tr>
<tr>
<td>PH12</td>
<td>FLU IMMUNISATION</td>
</tr>
</tbody>
</table>
| PH13 | AESTHETIC SETTINGS IN WARDS | In the light of the work of Ulrich (who showed that post-operative recovery was enhanced by a view of trees from a window)  
**13.1** Greenery will be planted in hospital grounds.  
**13.2** Wards will be aesthetically attractive.  
**13.3** If there are thought to be grounds to ban flower this will be weighed against these considerations. |
| PH14 | HEALTHY EATING | **14.1** Healthy snacks will be on sale in hospital shops and trolleys and more prominently on display than unhealthy (high fat and sugar) alternatives.  
**14.2** Sugary drinks will not be sold. If patients require isotonic drinks, these should be provided.  
**14.3** Salt content of all meals (to patients and staff) will be within healthy limits. |
| PH15 | PHYSICAL ACTIVITY | Staff will be able to give advice about the therapeutic benefits of physical activity |
APPENDIX 5 AGEING SCENARIOS AND HEALTH COSTS

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

In the 1970s and 1980s the UK experienced an ageing population because a cohort of increasing population had reached old age. In the 19th century people used to have a lot of children so some would survive the high infant mortality. In the 20th century reproductive behaviour adjusted to much lower infant mortality. However there was a gap of about a generation whilst this happened and as a result there was a generation of large families most of whose children survived (although a lot of the men were killed in World War I). This generation grew into old age in the 1970s and 1980s. This was the largest ageing of the population the country had ever experienced so it conditioned our expectations of what an ageing population would bring. Shortly after this the first generation of men to live their entire adult life in peacetime matured into old age. This also modified the gender ratio in old age so it became more common for old people to have a partner. The pressure of ageing then eased off for a few years but in 2016 the post war baby boom starts to reach the age of 70 and from that point on cyclical increases and decreases in numbers of old people will occur similar to those which have in the past affected the child population. However in parallel to this process life expectancy is increasing. Older people use more health and social care than younger people. Therefore it is often said that an ageing population must mean the cost of health and social care will rise. This was certainly true when the main factor ageing the population was demography. Does this change when increasing life expectancy is also a factor? Do older people use more health and social care resources because they are older or because they are closer to death. If it is the former then an ageing population will use more resources. If it is the latter they might not. Indeed a lengthening life expectancy might reduce the burden of an ageing population because a smaller proportion of the population will be in their last few years of life.

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

Fig 18.2A
The fear is that increasing life expectancy does not delay the onset of disability, it simply makes it last longer. For every extra year of life there is an extra year of woe. We live longer, but the extra time is spent taking longer to die.

Fig 18.2B
In this case there will be a huge increase in disease burden for the individual (and hence health and social costs for the population) as a result of an increased life expectancy. Another possibility however is that all that happens is that disability and death are both delayed. For every extra year of life woe is delayed by a year but there is no change in the amount of woe. We live longer and the extra time is spent living – we spend no extra time on dying.

Fig 18.2C
In this case there will be no increase in the disease burden incurred by the individual. At a population level the health and social care costs will be delayed and the proportion of the population incurring them at any one time may therefore be reduced.

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

Fig 18.2D
In this case there will be some increase in the disease burden incurred by the individual and some increase in the health and social care costs incurred by the population, but it will not be anything like as great as in the first scenario. The most optimistic scenario however is that we will live longer and we will spend less of that time ill. For each extra year of life there will be fewer years of woe. We will live longer and die quicker. My preferred mode of death is to be shot by a jealous lover at the age of 104.
If this scenario is correct then the lifetime disease burden on the individual becomes less as life expectancy increases – we have the double benefit of living longer and suffering less. Health and social care costs for the population are both diminished and delayed – again a double benefit.

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

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

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

An alternative theoretical perspective, without the concept of a maximum longevity, but still with the perspective of compressed morbidity, views ageing as a harmonious deterioration of organ systems which diminishes resilience and increases the probability of death. Old age brings “frailty” – a term used here with the particular meaning that people are fully healthy and fit but are less likely to recover from factors which disturb that health and fitness. Improving population health delays people experiencing the disease that will kill them. The older they are when they encounter that disease the less resilience they will have and the shorter their death will be. On this basis the compression of morbidity consists of somebody living on, fit and well, into old age until they die suddenly of a disease or injury which a younger person would have recovered from.
This third theoretical perspective is increasingly gaining support and the evidence for it is increasing. Indeed work is being developed on ways of both recognising and treating frailty. Particularly exciting is the discovery that physical activity is a powerful treatment for frailty. This carries the potential for intervening to prevent the pessimistic scenario and promote the optimistic scenario. It turns the frailty perspective from being an optimistic but nonetheless fatalist scenario into a perspective which, both for the population and the individual, carries the potential for action to prolong health and delay death.

**The Population Financial Implications of the Scenarios**

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

\[
\text{Life expectancy minus healthy life expectancy} \over \text{Life expectancy}
\]

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

For example:

<table>
<thead>
<tr>
<th>Life expectancy</th>
<th>Healthy life expectancy</th>
<th>Proportion needing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>65</td>
<td>7.1%</td>
</tr>
<tr>
<td>80</td>
<td>75</td>
<td>6.25%</td>
</tr>
<tr>
<td>90</td>
<td>85</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Table 18.3A

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

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

<table>
<thead>
<tr>
<th>Life expectancy</th>
<th>Healthy life expectancy</th>
<th>Proportion needing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>65</td>
<td>13.3%</td>
</tr>
<tr>
<td>75</td>
<td>68</td>
<td>9.3%</td>
</tr>
<tr>
<td>75</td>
<td>70</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

Table 18.3B

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

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

<table>
<thead>
<tr>
<th>Life expectancy</th>
<th>Healthy life expectancy</th>
<th>Proportion needing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>65</td>
<td>13.3%</td>
</tr>
<tr>
<td>80</td>
<td>75</td>
<td>6.25%</td>
</tr>
<tr>
<td>----</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>90</td>
<td>87</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Table 18.3C
Applying this theoretical calculation to the figures for Stockport wards gives the figures in Table 18.4:

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

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

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