



STOCKPORT
METROPOLITAN BOROUGH COUNCIL

25th Annual Public Health Report for Stockport

2019 PRESENTATION VERSION



Introduction

The Annual Public Health Report is an independent professional report on the health of the people of Stockport which the Council is statutorily required to commission from its Director of Public Health. At the time this report was commissioned in August 2018 Dr Steve Watkins was Stockport Director of Public Health and then Dr Donna Sager was appointed in September 2018. We have therefore written this report jointly.

A comprehensive account of the health of the people of Stockport was written in 2014 which has been updated and can be found on the Council website. Each chapter is written at different levels so that readers can select the amount of detail they want to read. As in the past three years this presentation version of the report includes the new material we have added this year which focuses on some specific topics that we feel are important at the moment, namely:-

1. Transport and health
2. Loneliness and social isolation in older people
3. Self-care
4. Health Protection update
5. Have improvements in mortality slowed down?

We both hope this report has a wide readership, particularly from members, partners and local community organisations and front line practitioners working regularly with local people and that it stimulates thought about how we can tackle the issues we have raised.

As always we would like to thank the other contributors for their excellent work –

Jennifer Connolly, David Baxter and Eleanor Banister have each contributed the first draft of an entire chapter. Simon Armour, Samantha Williams, Amy Beasley, The Transport & Health Science Group, Arteth Gray, Vicci Owen Smith, Sarah Turner, Katrina Marsden, and Denise Hibbert have also made important contributions.

We hope this report stimulates thought and discussion and that the recommendations we present are considered and actioned. Stockport residents deserve the best and we are determined that progress on all our current initiatives and new developments will secure this.

DONNA SAGER

STEPHEN WATKINS

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1. Transport and Health

1.1. Summary

A healthy transport system is one where people walk or cycle short journeys (up to a mile or two), cycle medium-length journeys (up to 5-10 miles) and use the train/cycle combination for longer journeys. To promote active travel we need to develop attractive walking and cycling routes, including the protection of aesthetically attractive walking routes, the development of safe cycle routes, the creation of residential cells, better cycle parking and the conveyance of cycles on trains. To promote public transport we need to fully support bus reform, but also we need to ensure a high quality frequent train/tram/bus rapid transit system with demand responsive feeders providing both orbital and radial routes across the whole conurbation.

The following are key principles that should be kept in mind:

- The major negative impacts of transport on health are traffic injuries, community severance and the effect of traffic on air quality. Other negative effects include stress, noise, loss of land use opportunities, climate change and constraints resulting from perception of danger.
- The major positive impacts are the health benefits of active travel and the access provided to facilities that benefit health, ranging from leisure facilities, social opportunities and countryside to hospitals and other health facilities.
- Active travel offers considerable benefit in the prevention of heart disease and the promotion of mental wellbeing. An hour a week of cycle commuting, or 25 miles a week of cycling, halves the risk of heart disease. Cycling for 30-40 minutes a day adds 2.15 years to life.
- Public transport and rail are substantially safer than self-driven road transport. Trains are 9 times safer per mile than cars.
- A universal 20mph speed limit for residential and shopping streets would be effective in saving lives, diminishing community severance and enhancing opportunities for walking and cycling.
- We should commence contingency planning for new technologies like driverless cars and the Hyperloop.
- It is important that people with disabilities are able to access public transport and this requires;
 - Disabled accessible transport, dementia friendly transport, demand-responsive door to door transport and a special mechanism for public transport for people who need help getting to the front or who need care in transit

1.2. Why is it a Public Health issue?

The major negative impacts of transport on health are traffic injuries, community severance and the effect of traffic on air quality. Other negative effects include stress, noise, loss of land use opportunities, climate change and constraints resulting from perception of danger.

The major positive impacts are the health benefits of active travel and the access provided to facilities that benefit health, ranging from leisure facilities, social opportunities and countryside to hospitals and other health facilities.

In “Country City”, a long term strategy for a greener Stockport written as part of the 11th Annual Public Health Report for Stockport, a programme for developing active travel in Stockport was outlined. This included:

- promoting walking as the preferred mode of transport for journeys under a mile by;
 - creating residential cells (areas without through traffic) so that use of cars for short journeys becomes less convenient, the community severance effect of traffic is reduced, and through safe routes are opened up for cyclists and walkers. The whole of Stockport could be turned into residential cells by 150 street closures.
 - developing aesthetically attractive pedestrian routes so that walking is pleasant. Country City mapped aesthetically attractive routes, suggested they should be protected from development which would erode the network and suggested link routes which could be aesthetically enhanced to complete the network. A programme “Ginnels, Snickets and Leafy Lanes” was put forward to show how this could be developed.
 - addressing the fear of crime
 - ensuring that facilities are more locally based
- promoting cycling as the preferred mode of transport for journeys of one to five miles by
 - creating residential cells so that use of cars for short journeys becomes less convenient and new cycle routes can be opened up
 - developing safe cycle routes segregated from large volumes of other traffic
 - developing cycle parking facilities
 - conveying cycles on public transport
- ensuring that facilities are more locally based.

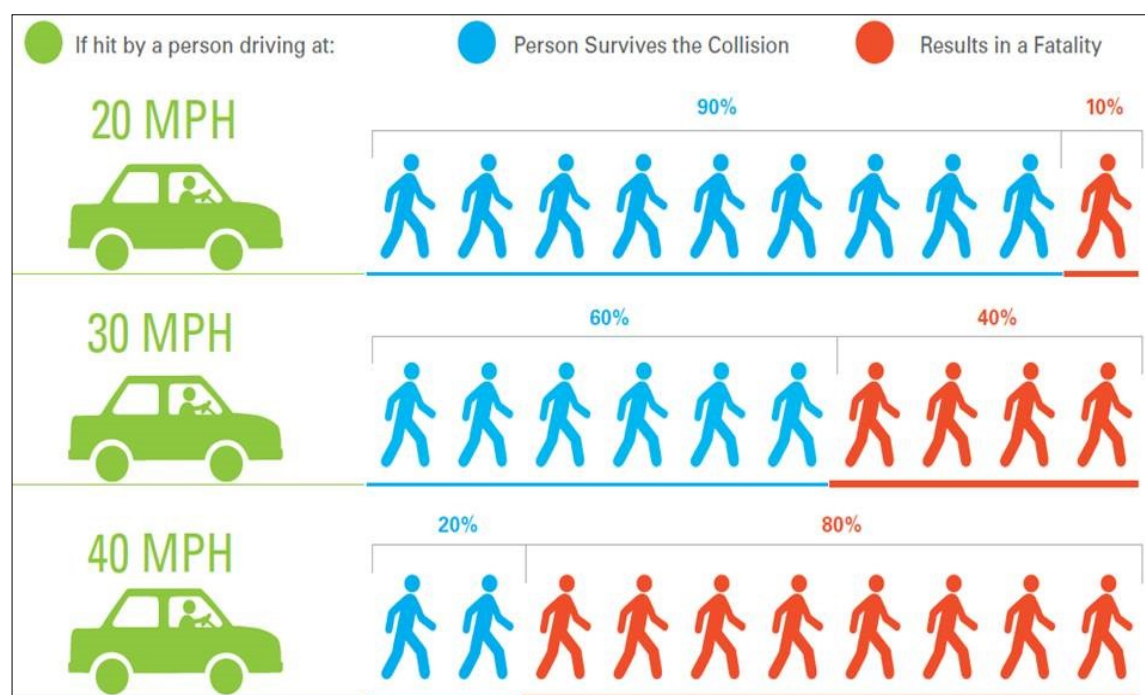
The strategy in “Country City”¹ is still relevant and may be referred to as additional information to this report. It is important that these areas are considered in as part of the Stockport MBC Walking and Cycling Strategy.

Active travel offers considerable benefit in the prevention of heart disease and the promotion of mental wellbeing. An hour a week of cycle commuting, or 25 miles a week of cycling, halves the risk of heart disease. Cycling for 30-40 minutes a day adds 2.15 years to life. Public transport and rail are substantially safer than self-driven road transport. Trains are 9 times safer per mile than cars. Congestion is produced by unmet demand for relocation and it is impossible to remove it by road development.

A 20mph speed limit on urban roads would save most pedestrian deaths with relatively little prolongation of journey time.

¹ Watkins (2000) ‘A Country City - Towards a Greener Stockport’. 11th Public Health Annual Report.

Figure 1²

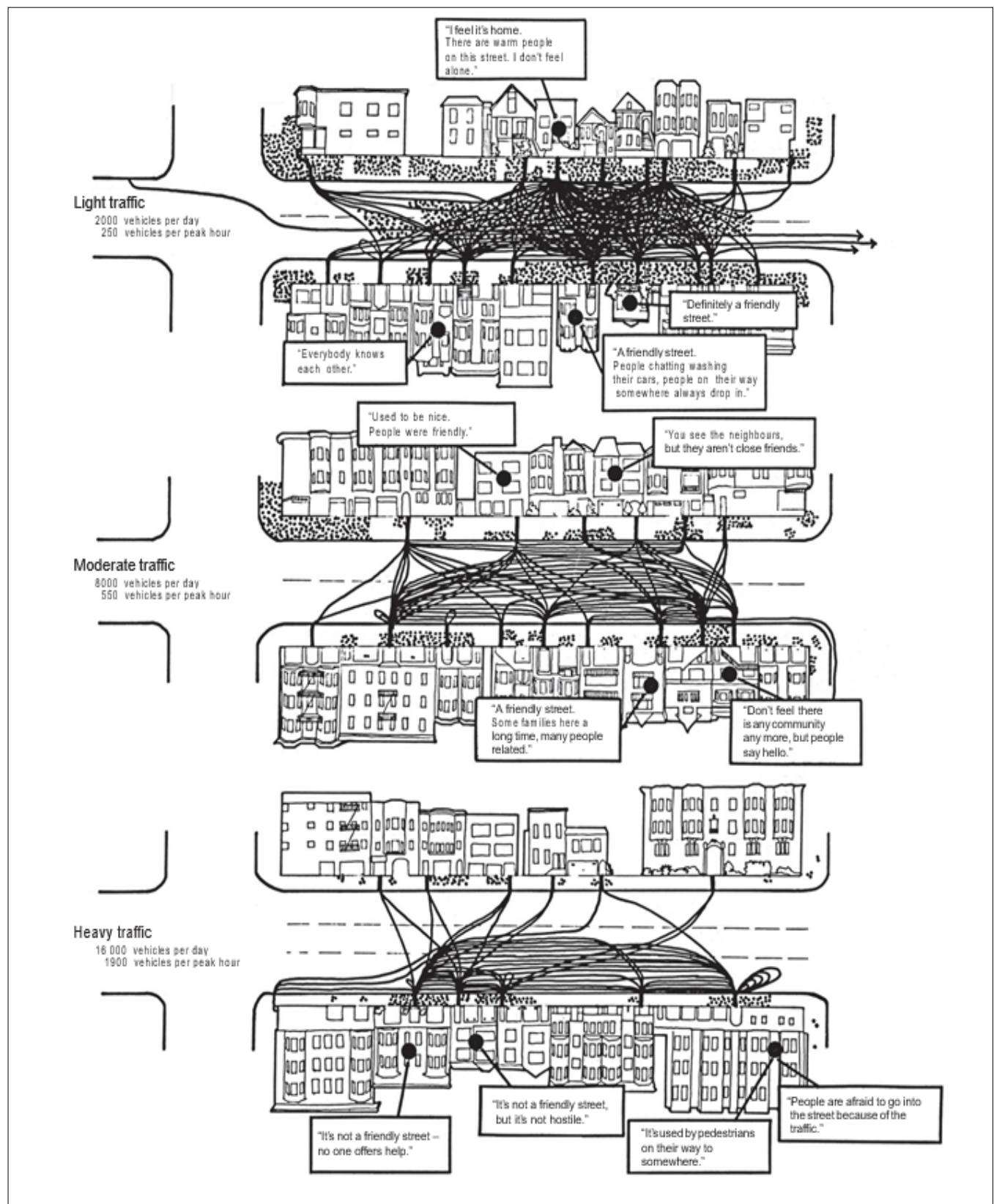


Few places are more than a mile from a main road. So few journeys will involve more than 2 miles through residential streets. To travel 2 miles at 40mph takes 3 minutes. To travel it at 20mph takes 6 minutes. The difference is 3 minutes. We are killing our children to save less than 3 minutes on our journey times. These issues are linked as being the consequences of rising traffic levels. Traffic congestion causes stress for drivers, diminishes walkability and worsens air quality.

² <http://betterstreets.co.uk/why-20mph-really-is-plenty/>

In residential streets traffic diminishes the strength of social support networks (see Figure 2 from Appleyard & Lintell)³

Figure 2



³ Appleyard & Lintell (1972) The environmental Quality of city streets; the resident's viewpoint. Journal of the American Institute of Planners. 38(2) 84- 101

1.3. What's the national picture?

1.3.1. Active Travel

Although there has been a considerable percentage increase in cycling rates over recent years this starts from a very low base. Cycle safety has improved – the number of casualties has not increased substantially despite the considerable increase in the number of cyclists. This suggests a “safety in number” effect.

It is difficult to obtain clear pictures of walking journeys because of problems of definition (a walk to and from the station will count as part of a rail journey rather than as a walking journey). Pedestrian safety remains a problem.

Cycle safety is an issue of some controversy. On crude figures, cycling is less safe per mile than driving, but this is because the figures for driving are improved by the many miles travelled on motorways which are much safer than other roads, whilst the figures for cycling include a disproportionate number of younger riders. For young males cycling is safer than driving. For older riders it is unclear whether cycling is or is not safer than driving on all purpose roads. If there is a difference in either direction it is a small one.

The Government has developed a Cycling and Walking Investment Strategy. It has been generally well received but funding levels are seriously inadequate. The Highway Code is being reviewed to offer more protection to pedestrians and cyclists. Stockport MBC have likewise prepared a Cycling and Walking Strategy.

Key facts about cycle safety are;

- For young males cycling is safer than driving
- For older riders it is unclear whether cycling is or is not safer than driving on all purpose roads
- If there is a difference in either direction it is a small one outweighed by a large margin, for society at large by the much lower levels of harm to other road users, and for the individual by health benefits
- Perceptions that cycling is dangerous are a major obstacle to cycling
- A higher standard of cycle safety should be pursued than just being no more dangerous than the car

1.3.2. Public Transport

Bus usage in London and rail usage everywhere has continued to grow. However the bus network outside London has continued to shrink.

Experiments in bus reform are now being permitted. Since 2010 investment in the railways has been at its highest for half a century. However that isn't difficult. There are still concerns at the balance between London and the rest of the country.

1.3.3. Transport for Older and Disabled Passengers

Transport for older people and disabled people is important to life opportunities for these groups. The Transport and Health Science Group (THSG) recognises four levels of transport impairment:

Level 1
Consists of people who can make their own way to the bus stop but cannot use a bus unless it is disabled-accessible. A wheelchair user would be a good example. The solution is disabled-accessible transport. Nationally a greater proportion of the transport network is now accessible but in the case of the bus system outside London this is offset by a shrinking network and in the case of the rail system there is still a long way to go.
Level 2A
Consists of people who can make their own way to the bus stop and use a bus but who cannot find their way about. A dementia sufferer would be an example. The solution is some system of supporting such passengers. There is little development of such systems nationally.
Level 2B
Consists of people who cannot make their own way to the bus stop but can make their own way to their own front door and can use a disabled accessible bus. The solution is a system of demand-responsive door to door transport. There have been some trials of MaaS (Mobility as a Service). The Government continues to believe that this is a good thing and to support experiments. There has also been some loss of ground due to many parts of the country finding it necessary to reduce funding of community transport.
Level 3
Consists of people who need help getting to the front door or who need care in transit. The solution is an ambulance service which doesn't just take people to hospital but is also available for other journeys as part of the public transport system. Over most, possibly all, of the country this is wholly undeveloped, unless people can afford private ambulances.

THSG always refers to “impairments and encumbrances” to point out that these states can be brought about for all of us. A pram can reduce any parent to level 1, we can all be at level 2A in a strange city, heavy luggage can reduce us all to level 2B, and inebriation can reduce us to level 3.

There has been much discussion recently of the older people's bus pass. This discussion has often focused on the cost and equity of the pass, but has neglected the considerable benefits that it provides by allowing older people to fulfil caring and volunteer roles and by avoiding the isolation which can create expensive health and social care needs. The pass serves as a subsidy to the bus system and helps sustain it. The cost to the state of providing the pass is less than the cost to the individual would be if it were withdrawn.

1.3.4. Traffic Nuisance: - Congestion & Community Severance

Community severance plays an important part in limiting the use made of local facilities. It must be realised that moving traffic, especially fast moving traffic, causes more community severance than stationary traffic so the link between the two forms of traffic nuisance are not perfect.

A community severance toolkit has been commissioned by Department for Transport and developed by a project led from University College London.

More roads or other measures to increase available road space are often recommended as the solution to congestion but increasingly it has been shown that these merely attract more users to the road until it becomes as congested as ever. Indeed in a study of traffic speeds in London from 19th century to the late 20th century, Mogridge showed that traffic speeds in London were virtually unaffected by anything that happened on the roads, even the replacement of horses with motor vehicles. What actually influenced traffic speeds on the road was the speed and convenience of the rail system. When the Metrolink line to Bury opened there was considerable modal shift from car to tram but congestion on parallel roads only fell off peak - in peak hours it was unaffected.



The explanation for this is the concept of a road system saturated by unmet demand for relocation. On an uncongested motorway a car can travel at 75mph quite safely -although outside the speed limit it is within police tolerance thresholds. Many people are happy to travel for an hour and a half on their commute. On an uncongested road system therefore the outer suburbs of Manchester can be located in Nuneaton.

When the point is reached at which the potential travel to work areas of different cities engulf each other in this way a demand for relocation comes into being which is impossible to meet. Congestion is what slows the traffic, shrinks the travel to work area and thereby switches off the pressure.

If congestion is reduced by additional road space then this is only temporary. What happens next is that some of the suppressed demand for relocation is met. This continues until congestion increases again and switches it back off.

Better alternatives to the car like walking, cycling and public transport improve the situation if created on the basis of a comprehensive network because they raise the point at which a trade-off is made which judges the congestion unacceptable. This is sometimes called the Downs-Thompson Effect. However it only works on a system wide basis; if related only to a single route the space created will be taken up by suppressed demand from other routes which share the same road.

The Government continues to use cost/benefit methodologies which assume that new roads will reduce congestion when, in fact, that is very unlikely, except temporarily.

1.4. What's the local picture?

1.4.1. Active Travel



The Greater Manchester Cycling and Walking Commissioner published the 'GM Made to Move' report in December 2017 which set out an ambitious vision to make GM a world class region for cycling and walking. In June 2018 this was accompanied by an initial map of Beelines, the proposed network for cycling and walking across the city region. In order to deliver the vision, an initial funding pot of £160m of Mayoral Challenge Funding has been made available to the 10 boroughs. The availability of funding presents the Council with an opportunity to deliver a step change in cycling and walking provision in Stockport. It is recommended that in developing proposals and finalising the Walking and Cycling Strategy, the following points are considered:

- Opportunities to encourage cycling and walking for leisure should be considered as well as just for commuting
- There should be a balance of delivering long distance commuting routes with delivering tangible local improvements to crossings etc.
- Improvements to physical infrastructure should be accompanied by efforts to encourage more people to walk and cycle in practice, through for example, education and training and promotional activities.
- Opportunities to deliver new green infrastructure with the associated benefits to local air quality should be considered as part of the provision of any new physical infrastructure.

1.4.2. Public Transport



“Country City” contained an analysis showing how to ensure that all of Stockport was within 1km of a railway station. It suggested the bringing of Metrolink to Stockport, the development of tram/train services to Marple and Manchester Airport, the opening of 12 new stations and the development of various people mover links.

Rail planning for Stockport has moved on to focus on the Orbit Tram proposal (a circular line round the conurbation which enters Stockport on the Reddish South line, runs through the town centre on a street tramway

and leaves via the Edgeley line on its way to Manchester Airport), tram/train links to Manchester via Belle Vue and to Marple via Reddish, and a Metrolink route through Heaton Mersey to Bridge Hall and then dividing into a route to Stockport and a route to Hazel Grove along the existing freight line.

European experience has shown that trains are more effective than buses at competing with the car and that therefore rail-based public transport systems have higher bus usage than bus-based ones. BRT consists of express buses running along reserved bus lanes, dedicated busways, or on existing highway subject to bus priority works. It is capable of filling the gaps in the rail and tram system and we ought to think of a rail/tram/BRT network.

As identified in the SEMMM Strategy Refresh, a BRT route is being planned in Stockport between Hazel Grove and Manchester Airport, with a longer term vision to deliver a new network of BRT in southern Stockport, including potentially along the A34. We could also think of a motorway coach service along the M60 and the M56 and BRT routes to fill in other gaps in the rail system such as to Woodford and Offerton.

A new Transport Interchange is planned which has a town centre park on its roof and a much improved walking route from the bus station to the railway station. This will bring to fruition a proposal originally advanced in “Country City”.

Buses are the mainstay of transport for those who cannot afford a car and they also help make the public transport system more comprehensive. Under the leadership of the elected GM mayor, Greater Manchester is committed to a programme of bus reform which presents an opportunity to ensure a better quality bus service to all areas in GM. Whilst still at the early stages, the Council continues to analyse current bus provision in Stockport to identify both the strengths and weaknesses, and subsequent priorities for bus reform.

In particular, bus reform provides the following potential opportunities which could be of benefit:

- Greater roll out of low emission buses, with subsequent benefits for local air quality
- Integrated and consistent ticketing
- More variety of routes and timetables
- Integration of timetables with other modes
- Improved quality of buses and stop facilities for passengers.

On the railways overcrowding remains a problem. Transport for the North is developing strategies for rail development across the North but there is a need to secure funding if these plans are to come to fruition.

1.4.3. Transport for Elderly and Disabled Passengers

Progress made to date and future directions are as follows:-

Level 1
There has been considerable recent development of disabled-accessible buses. There are however continuing problems in access to the rail system although a programme of investment is being undertaken across GM to deliver step-free access to stations.
Level 2A
There is currently little attention to dementia-friendly public transport and this is a matter which needs to be thought about. Demand responsive transport would meet the need but it may be possible to find other solutions.
Level 2B
Door to door demand-responsive transport remains an issue. Mobility as a Service (MaaS) is a relatively new concept and is evolving rapidly. A number of pilots of door to door demand responsive transport services are being undertaken in a number of urban areas across the world. It is recommended that the Council continues to work with TfGM to monitor the roll out of these services and consider opportunities to test them in the borough
Level 3
In principle it ought to be quite easy to improve public transport to hospitals so as to free the patient transport services to play a wider role, or to arrange a network of semi-scheduled services running to hospitals as hubs and between hospitals to create a network which could not only fulfil the needs of patient transport but could also provide the network of accessible door to door demand-responsive transport, with care in transit and care at the hub, which would meet the needs of level 2 and 3 passengers, whatever journey they were making. However it has been difficult to inspire the necessary vision. More recently, work has been undertaken with TfGM and the CCG to look at opportunities to improve provision to hospitals. It is suggested that the potential to build level 3 public transport into this should be explored.

1.4.4. Traffic Nuisance: - Congestion & Community Severance

Rat running' in Stockport affects many streets that could otherwise be pleasant communities and good walking and cycling routes, and congestion in Stockport remains a problem.

The SEMMS Refresh has identified a road based scenario and an active travel/public transport scenario for addressing the problem of congestion in Eastern Stockport. The latter performs better but the existence of funding dedicated to roadbuilding could lead to the funding of the former instead. The Council accepted the recommendation in last year's Annual Public Health Report:

In the context of the SEMMM Strategy Refresh and further development of the business case for the A6 to M60 Relief Road, there should also be examination of a public transport/ active travel-led solution based on the principles set out above, as well as a highways-led approach. If it is demonstrated that it would be more cost-beneficial to adopt the public transport/ active travel-led approach, priority should be given to it due to the wider societal and health benefits it would likely deliver. In order to deliver this, and if direct funding opportunities are not available under existing funding programmes, the Council, Stockport political parties and MPs should present a case that financial silos should not preclude the transfer of funds from highways-focused funding streams.

A broad range of options needs to be considered and reviewed as part of the public transport/ active travel-led option, including those consulted upon as part of the recent Stockport Transport Issues and Options consultation. Without in any way wishing to constrain the range of options being considered in the alternative business case we recommend that options considered should also include those recommended in the 2006 Annual Public Health Report, those suggested in previous reports and any other proposals likely to benefit the traffic flows in question.

1.4.5. Links to the Planning System

Integration of public transport and active travel infrastructure is delivered most easily when it is done as part of new developments rather than retrospectively. The Council is currently involved in drafting a new Local Plan, it is recommended that planning policy is utilised effectively to ensure that all new developments in Stockport are:

- Designed to be permeable to cycling, walking and public transport movements
- Fully integrated with existing cycling and walking routes in the neighbouring area
- Providing the highest quality infrastructure for cycling, walking and public transport, including cycle parking, bus waiting facilities and crossing points.
- Designed to encourage residents to utilise public transport and more active modes from the beginning, either through complimentary public transport season tickets or active travel equipment.

1.5. Recommendations – What more can be done?

- Stockport MBC and its partners should pursue their transport strategies fully conscious of the facts set out in the summary to this chapter.
- Stockport MBC should regard it as highly desirable to avoid community severance and make use of the Toolkit developed for Department for Transport by University College London.
- Stockport MBC needs to recognise that heavy traffic in residential streets disrupts social networks and aim to minimise traffic in residential streets including by creating residential cells, where residents wish them to be located.
- Stockport MBC are currently consulting on their Walking and Cycling Strategy, within this consideration should be given to protecting attractive walking routes. There needs to be development of safe cycle routes, the creation of residential cells, better cycle parking and the conveyance of cycles on trains.
- SMBC and TfGM should support plans for the Orbit Tram.
- The SMBC planning system need to ensure active travel and public transport are promoted in new developments so that all new developments in Stockport are:
 - Designed to be permeable to cycling, walking and public transport movements
 - Fully integrated with existing cycling and walking routes in the neighbouring area
 - Providing the highest quality infrastructure for cycling, walking and public transport, including cycle parking, bus waiting facilities and crossing points.
 - Designed to encourage residents to utilise public transport and more active modes from the beginning, either through complimentary public transport season tickets or active travel equipment.
- SMBC should pursue in the SEMMS review process the recommendations accepted from the 24th Public Health Annual Report relating to the SEMMS process and road building.

2. Loneliness and social isolation in older people

1.6. Summary

The emphasis of this chapter focuses on older people who are particularly vulnerable to loneliness and social isolation after the loss of friends, family, loved ones, and as a consequence of reduced mobility or limited income. This emphasis is in line with the ambitions of Stockport Together and with a recognition of our growing older population.

However, it is important to note that loneliness affects all ages. New mothers can feel socially isolated, as can vulnerable people in our communities who are unemployed, people with mental health issues and those who are vulnerable due to drug and alcohol problems, and homelessness. People who suffer from domestic abuse are very likely to be socially isolated. Experiencing bereavement or a breakdown in a relationship at any age can lead to loneliness and social isolation without a support network to enable the person to re-engage with their local community.

We know that some young people become lonely or socially isolated, at risk of bullying which has a considerable impact on their self-image, confidence and ability to do well at school. Young people from LGBT communities, young carers and those young people with a physical or learning disability are more at risk of becoming lonely and socially isolated because they may not have the support to connect or engage with others in their community. For some ethnic minorities, increased risk of social isolation is associated with social and economic disadvantage, housing problems and language barriers.

IT IS ESTIMATED THAT AMONG THOSE AGED OVER 65, BETWEEN 5 AND 16 PER CENT REPORT LONELINESS AND 12 PER CENT FEEL ISOLATED. THESE FIGURES ARE LIKELY TO INCREASE DUE TO DEMOGRAPHIC DEVELOPMENTS INCLUDING FAMILY DISPERSAL AND THE AGEING OF THE POPULATION. FOR EXAMPLE, BY 2025, THE NUMBER OF PEOPLE AGED 75 AND ABOVE IN STOCKPORT IS EXPECTED TO GROW TO 34, 591, WHILE THOSE AGED OVER 90 WILL GROW TO 3,864.

In the older age group, men are more likely to become socially isolated than women. Research has also found that many carers experience social isolation and loneliness as a result of caring. Especially those people who are caring for loved ones with dementia where they have less time and opportunities to socialise due to their caring role and often unable to afford social activities. This effect can be greater the longer someone has a caring role, due to the increasing amount of care they may have to provide.

We, therefore, need to focus on how we can support older people to be socially active - having and maintaining good social relationships, feeling part of a network of family, friends and community, being involved in social activities that are meaningful, productive, stimulating, and having people they can rely on to talk to about things that matter to them in life. All this can help promote self-worth, provide a sense of purpose and link individuals to each other, the community and the wider world.

Evidence shows that the main benefits of making a contribution to your community are improved social connections and an enhanced sense of meaning and purpose. People who make an active contribution to their community are happier as a result, and have stronger social connections.

1.7. Why is it a Public Health issue?

There is growing evidence that loneliness can have serious consequences for the mental and physical health of people. It is linked to obesity, smoking, substance abuse, depression, and poor immunity.⁴ The effect of loneliness and isolation on death is greater than the impact of well-known risk factors such as obesity, and recent research suggests that it can have a similar effect as cigarette smoking.⁵

In 2010 Michael Marmot, in his Fair Society, Healthy Lives review observed that “Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely.”

Studies show that acute loneliness and social isolation can impact gravely on wellbeing and quality of life, with demonstrable negative health effects⁶. Being lonely has a significant and lasting negative effect on blood pressure. It is also associated with depression (either as a cause or as a consequence) and higher rates of mortality⁷. Loneliness puts individuals at greater risk of cognitive decline, and one study concluded that lonely people have a 64 per cent increased chance of developing clinical dementia.⁸

It is also a public health issue that is pertinent to our drive to reduce health inequalities as older people who are less well off, have fewer social connections and less activity in their lives at the moment would benefit most from contributing to their community.

Identifying risk factors

As we get older the following risk factors that might lead to loneliness begin to increase and converge.

Intrapersonal Factors (e.g. personality and cognitive variables, identity)			
Interpersonal engagement (e.g. quality of relationships with family, friends, neighbours)	Life stage events (e.g. retirement, widowhood, sensory impairments, physical health)	Wider social structures (e.g. poverty, quality of health and social care, ageism, transport, fear of crime, high population turnover, demographics)	Social environment (e.g. living arrangements, community connectedness, hobbies/interests, pets, housing, car, holidays/seasons, technology)

⁴ Mushtaq, R., Shoib, S., Shah, T., & Mushtaq, S. (2014). Relationship Between Loneliness, Psychiatric Disorders and Physical Health? A Review on the Psychological Aspects of Loneliness. *Journal of Clinical and Diagnostic Research : JCDR*, 8(9), WE01–WE04. <http://doi.org/10.7860/JCDR/2014/10077.4828>

⁵ Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS Med*, 7(7), e1000316.

⁶ Pitkala, K.H., Routasalo, P., Kautiainen, H. and Tilvis, R.S. (2009) ‘Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomised, controlled trial’, *Journal of Gerontology: Medical Sciences*, vol 64A, no 7, pp 792–800.

⁷ . Mead, N., Lester, H., Chew-Graham, C., Gask, L. and Bower, P. (2010) ‘Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis’, *British Journal of Psychiatry*, vol 196, no 2, pp 96–100.

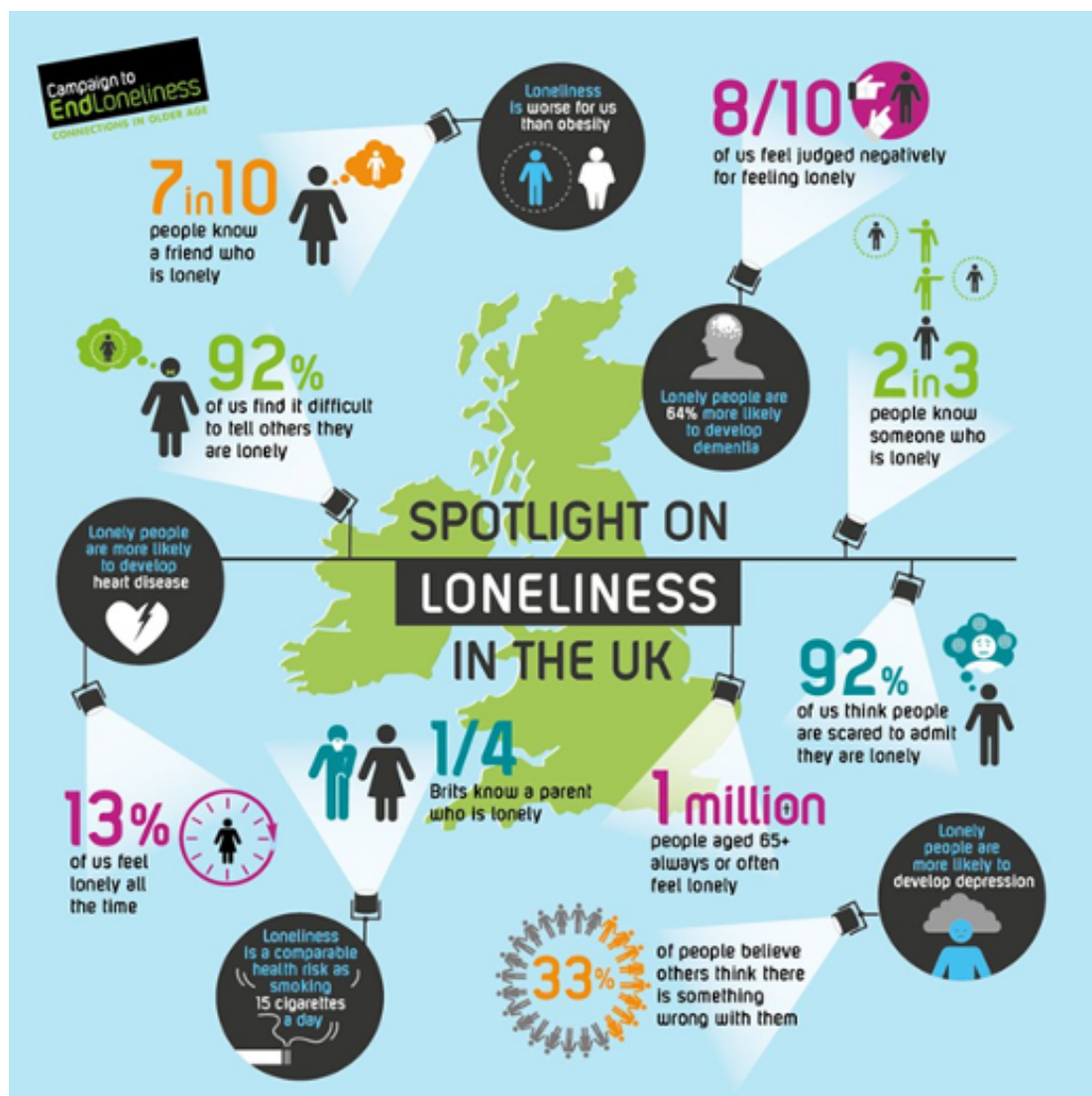
⁸ www.campaigntoendloneliness.org/threat-to-health Campaign to End Loneliness. Age UK Oxfordshire.

1.8. What's the national picture?

Nationally the impact of social isolation and loneliness is becoming well recognised. Public Health England Research reveals that;

- More than 9 million people always or often feel lonely
- Around 200,000 older people have not had a conversation with a friend or relative in more than a month
- 23 per cent of people aged 75+ who live alone do not see or speak with someone every day
- Three quarters of GPs (76%) report that between one and five patients a day attend their surgery primarily because they are lonely.

Figure 1⁹



⁹ <https://www.campaigntoendloneliness.org/spotlight-on-loneliness/>

This year a Ministerial lead on loneliness, Tracey Crouch was appointed to lead a cross-government group for driving action on loneliness across all parts of government. Her work programme will include:

Developing a cross-government strategy on loneliness in England to be published later this year. This will bring together government, local government, public services, the voluntary and community sector and businesses to identify opportunities to tackle loneliness, and build more integrated and resilient communities

Developing the evidence-base around the impact of different initiatives in tackling loneliness, across all ages and within all communities, led by the government's What Works centres

Providing seed funding for communities to come together to develop activities which enable people to connect

A dedicated fund which will see government working with charitable trusts, foundations, and others to: •stimulate innovative solutions to loneliness across all ages, backgrounds and communities

Establishing appropriate indicators of loneliness across all ages with the Office for National Statistics so these figures can be included in major research studies

Scale-up and spread existing work offering practical and emotional support to help lonely individuals reconnect with their communities

1.9. What's the picture locally? Approaches and activity in Stockport



Only **39.9%** of people who use adult social care services reported that they have as much social contact as they would like.



Only **46.7%** of carers reported that they have as much social contact as they would like.

1.10. So what more can we do in Stockport?

What does the evidence suggest? Research in this area is still incomplete and there is no 'one-size-fits-all' response; but indicates;

Community Navigators are usually volunteers who provide people with emotional, practical and social support. They essentially act as an interface between the community and public services and help individuals to find appropriate means of support. Community Navigators offer home-based visits, enabling often frail older people to discuss concerns and helping them to look into which service or community provision may be beneficial

There are many different group services available, which aim to help older people widen their social circles. The range of these services is broad, incorporating self-help and self-support groups covering friendship, creative and social activities and health promotion. Research evidence is particularly supportive of social group activities with a creative, therapeutic or discussion-based focus.

One-to-one befriending has been shown to reduce loneliness and has a modest but significant effect on depressive symptoms. Such regular one-to-one contact is particularly welcomed by people who are frail and housebound.

Developing approaches which avoid stigma or reinforce isolation
Tailoring interventions to the needs of people for whom they are designed
Supporting meaningful relationships

Access to transport and technology play an important role in addressing loneliness. Both were felt to be vital to enabling social connection, not only in supporting older people to maintain their existing relationships, but also in enabling services that support the development of new connections



There is a great deal of work underway across Stockport, taking action at all of the levels outlined in the above framework. Some of this work is outlined below.

- Our Ageing Well Strategy highlights the need to address many of the features, particularly around the structural enablers. An early draft of the strategy was taken to Health and Wellbeing Board and was accepted by members of that board as the agreed approach. Since, work has been ongoing to develop supporting action plans to deliver on this strategy and a revised version with more detailed action plans will be published shortly.
- Stockport Together's approach has included a focus on developing a neighbourhood delivery model for health and social care services, and a strong theme of 'Healthy Communities' (This approach addresses the structural enablers through neighbourhood approaches and asset based community development, and has resulted in development services that increase the offer of foundation services and direct interventions (as defined above) available in Stockport.
- Stockport Local is the online directory that connects people, communities and local services in Stockport. To support this, the Stockport Local Fund offers a £1m fund to support great ideas that make a difference in communities. It will invest in local activities and projects that help people to join together and make our neighbourhoods even better places to live in and to grow up and older in.
- Heatons Together. In the Heatons neighbourhood, through a place-based integration approach, local organisations such as U3A, Rotary and Sustainable Living in the Heatons have improved their relationship with each other and with public services, voluntary organisations and local businesses with the aim of supporting an improved offer for older people. As a result: many local businesses are in tune with the needs of older people, many now offering a seat and a drink for customers or a table which is marked as a place to chat and natter, there has also been a menopause café opened.
- New groups have established such as an additional Dementia Drop in and a Men in Sheds group linked to the local GP practice so that referrals can be made.
- The commissioned services and voluntary organisations such as Signpost for Carers and Red Cross are working together to align their offer and connect people into their local community where there are barriers to access.
- Practice community champions. Practice community champions are a group of volunteers who can provide and create connections to local groups, activities, the community and businesses. They will bring a wide range of skills together to create opportunities for the benefit of the practice, their patients and community. The aims of the programme are: Alvanley, Bracondale and Heaton Medical practice were in first phase, which was supported by Altogether Better and Public Health. Across these practices, there are at least 66 active practice champions. Activities developed range from singing groups, gardening groups, champions sitting in reception helping people find out what is going on locally, or how to log onto practice website to phoning isolated patients to check on wellbeing.

1.11. Recommendations

- SMBC, Stockport CCG, SNC and partners should ensure tackling loneliness and social isolation is considered in all their programmes areas and have systems in place to identify those who are, or who are at potential risk of becoming socially isolated.
- SMBC should continue its programme of support to for communities and individuals to support isolated people at a local level, and to build resilience and social capital in their communities and protect those most at risk of social isolation.
- Organisations, including the voluntary and community sector and should work towards creating an environment where people can connect with their neighbours, communities or people of the same interest.
- SMBC, Stockport CCG, SNC should ensure that frontline staff within their relevant organisations have the skills and knowledge to identify potentially lonely and socially isolated individuals and the confidence and tools to offer solutions, and signpost or support them to sources of help.

3. Self care

1.12. Summary

Almost everyone practices some form of self care as around 80% of all care in the UK is self care¹⁰. It really begins with an individual taking responsibility for making daily choices about their lifestyle, such as brushing their teeth, eating healthily or choosing to exercise. At the opposite end of the continuum is major trauma where responsibility for care is entirely in the hands of the healthcare professionals, until the start of recovery when self care can begin again. Public services can support people to self care at any point during the continuum.

Supporting people living with a long-term condition requires a partnership with patients over the longer term rather than providing single, unconnected “episodes” of care. Helping patients thrive in the presence of these diseases requires a paradigm shift in health care delivery models; moving from “What’s the matter” to “What matters to you?” This means moving to an approach that is empowering and increases patient knowledge, skills, confidence, self-efficacy and healthy behaviours, which are all needed to improve outcomes and reduce healthcare costs. As such it is part of an asset-based approach recognising what people and communities can do for themselves and each other rather than viewing people simply through the lens of ‘needs’. This is set out for Stockport in the ‘Stockport Way’.

IN STOCKPORT, 41% OF THE POPULATION (124,000) HAVE ONE OR MORE LONG TERM HEALTH CONDITION, AND THIS INCREASES WITH AGE, FROM 2% IN THE 0-4 AGE BAND, TO 90% IN THOSE AGED 85 AND OVER.

BY AGE 55, HALF OF THE PEOPLE HAVE ONE OR MORE OF THESE CONDITIONS AND 9% OF THE POPULATION HAVE TWO OR MORE OF 8 KEY LONG TERM CONDITIONS.

In Stockport, we have a range of services and activities working with people who have long-term conditions to make lifestyle changes that will support them in the management of their health. We are building on our existing services across the health, social and voluntary and community sectors, developing better connections with and between our communities and existing resources and assets, as well as developing new activities and new approaches.

We are particularly focussing on using Patient Activation (someone’s knowledge, skills and confidence of managing their own health) to tailor our services to individual levels. A key service development is the Wellbeing and Self Care team, which offers support patients with a long-term condition diagnosis or behaviours increasing the risk of developing a long-term condition, those with low mental wellbeing and people experiencing social isolation. We are also promoting the use of our newly developed [online resources](#) supporting people to help them live well with long-term conditions.

¹⁰ Department of Health, 2006. Our health, our care, our say: a new direction for community services. London: The Stationery Office.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

1.13. Why is it a Public Health issue?

“Self-care is a deliberate action that individuals, family members and the community should engage in to maintain good health. Ability to perform self-care varies according to many social determinants and health conditions”

(Self care is)... “The actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness.”

Supporting people living with a long-term condition requires a partnership with patients over the longer term rather than providing single, unconnected “episodes” of care. Helping patients thrive in the presence of these diseases requires a paradigm shift in health care delivery models; moving from

“What’s the matter” to “What matters to you?” This means moving away from a paternalistic and dependent consultation model of ‘fixing’ to one that is empowering and increases patient knowledge, skills, confidence, self-efficacy and healthy behaviours, which are all needed to improve outcomes and reduce healthcare costs. As such it is part of an asset-based approach recognising what people and communities can do for themselves and each other rather than viewing people simply through the lens of ‘needs’.

Furthermore, care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes.

Reducing the onset of preventable, long-term conditions; living well with and reducing complications associated with long-term conditions; and an asset-based approach to growing community resource to promote wellbeing, are all key public health issues.

1.14. What’s the national picture?

Over a quarter of the population in England has a long-term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes “Long Term Conditions are now a central task of the NHS”. We know that people with long-term conditions currently use a significant proportion of health care services¹³;

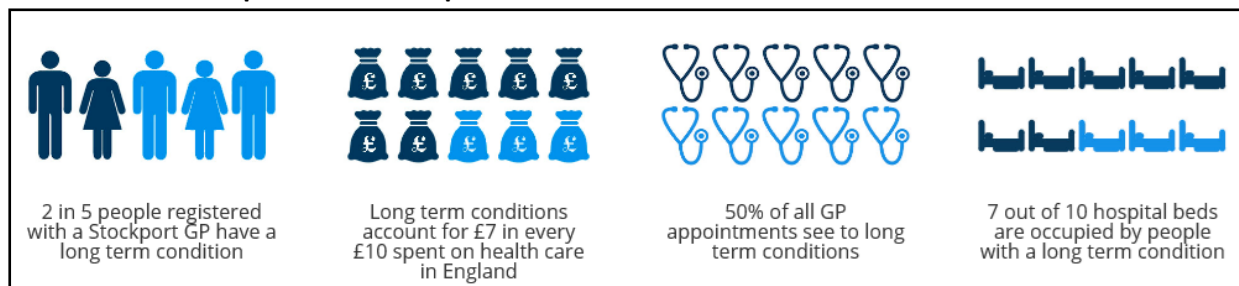
- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

¹¹ World Health Organisation, 2013. Self care for health. A Handbook for community health workers & volunteers. http://apps.searo.who.int/PDS_DOCS/B5084.pdf

¹² <http://www.selfcareforum.org/about-us/what-do-we-mean-by-self-care-and-why-is-good-for-people/>

There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and health and social care costs are significant. 15.4 million people in England are recorded as having have a long-term condition, and an increasing number of these have multiple conditions, the number with three or more is expected to increase by 1million from 2008-2018. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem.

1.15. What's the picture for Stockport?



In Stockport, 41% of the population (124,000) have one or more long term health condition, and this increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over. By age 55, half of the people have one or more of these conditions and 9% of the population have two or more of 8 key long term conditions. There are 26,000 people registered with a Stockport GP with a history of depression and there are 40,000 people registered with a history of anxiety. These are commonly associated with other long-term conditions and physical health problems, as well as social isolation (see chapter 2).

Rates of hospital admission increase with age and are higher at each age in areas with higher levels of deprivation. While the older population is lower in size in the more deprived areas in Stockport, the people living in these areas tend to have fewer social and economic assets to draw on and therefore may need more support from public and voluntary services. Additionally, people with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people.

As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly. In addition, the costs of providing care to this group of people are increased because of less effective self care and other complicating factors related to poor mental health.

When care is designed to empower self-management, people with long-term conditions and their carers play a more active role in managing their own health and reduce their need for help from the NHS and social care. NHS England, The Health Foundation and Nesta have recently published findings suggesting that effective self-management is the key to person centred care i.e. care that is personalised, coordinated and enabling.

National evidence is documented from the Realising the Value¹⁴ programme which addressed the NHS Five Year Forward View vision for a new relationship with people and communities. Based on a review of the evidence, the programme identifies five areas as showing significant potential to improve quality of life for people with long-term conditions and deliver benefits across the three

¹⁴ <https://www.england.nhs.uk/wp-content/uploads/2014/09/ltc-infographic.pdf>

¹⁴ <https://www.nesta.org.uk/project/realising-value/>

dimensions of value: Mental and Physical health and wellbeing, NHS sustainability and wider social outcomes. These are:

- Peer support
- Self-management education
- Health coaching
- Group activities to support health and wellbeing
- Asset-based approaches in a health and wellbeing context.

The programme recognises that person-centred and community-based support needs to be both holistic and tailored around the individual, and there are connections between these approaches and other key enablers such as care and support planning and social prescribing. Interventions linked to these approaches can help to increase people's activation. It is also important to note that efforts to increase levels of patient activation will be more successful when supported by a whole system approach including training of clinicians in these new ways of working. Nuffield Trust '*Shifting the balance of care: Great expectations*'¹⁵ states that programmes that aim to change patient behaviours are likely to be more successful than those that simply provide information. Evidence shows that self care initiatives, particularly those that rely on e-health or digital tools, are more successful when professionals support them.

1.16. What's the picture in Greater Manchester?

The Greater Manchester Health and Social Care Devolution Strategy 'Taking charge of our health and social care in Greater Manchester'¹⁶ includes a commitment to upgrade prevention and self care. The commitment to health and social care reform set out in this strategy sets out that by upgrading prevention and self care we are proposing to change the way people view and use public services, creating a new relationship between people and public services. This means more people managing their health, looking after themselves and each other. Some elements of the Greater Manchester strategy are:

- Large scale social marketing programmes, using behavioural insights, to support lifestyle change and engage the population to be more active in promoting their own and others' health
- Developing a GM framework for 'patient activation', motivating people to take control and supporting work to tackle health inequalities
- Increasing the range and profile of self care support programmes and train our workforce to deliver them
- Working with Health Education England (HEE) to upskill the public sector workforce in key areas of practice such as self-management education, shared decision making, health coaching and patient activation

¹⁵ Imison, C et al, 2017. Shifting the balance of care. Great Expectations. Nuffield Trust.

<https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

¹⁶ Taking charge of our health and social care in Greater Manchester, 2015. Greater Manchester Health and Social Care Partnership. <http://www.gmhsc.org.uk/wp-content/uploads/2018/04/2-Taking-Charge.pdf>

1.17. What are we doing locally?

1.17.1. Existing services

In Stockport, we have a range of services and activities working with people who have long-term conditions to make lifestyle changes that will support them in the management of their health. These include the Expert Patient programmes; [Healthy Stockport](#) family of services; Cancer Champions; voluntary sector alliances (The Prevention Alliance (TPA), Wellbeing and Independence Network (WIN) & Alliance for Positive Relationships (APR)); as well partner agencies such as Stockport Homes, and non-commissioned voluntary and community organisation activity. These services are complemented by workforce development such as Connect 5 and Health Chat training.

1.17.2. Healthy Communities

We are continuing to build on our Healthy Communities approaches, developing better connections with and between our communities and existing resources and assets, as well as developing new activities and new approaches. The ethos of this work is set out in the 'Stockport Way'.

Person and Centred Community approaches: The Stockport Way

One approach, working together for Stockport, on purpose, all of the time

- Making a conscious effort to think about how we can work together with people, communities and other organisations
- Considering how to achieve the best possible outcomes for individuals, families and wider communities.

Working *with* people, and building on their strengths

- Working *with* people, not 'doing for' or 'doing to'
- Enabling people to identify and access the strengths and resources available to them, as individuals and within family and community networks

Always connecting through conversations and building relationships

- Actively listening, seeking to understand, rather than assess
- Asking "what matters to you?" rather than "what's the matter with you?"
- Making connections and building relationships, to work collaboratively with each other across organisations
- Helping to connect people with supportive networks

Confident to make decisions, acting for the best outcomes for people

- Empowering staff within their organisations
- Enabling staff to be confident in their decisions, not asking permission but ready and able to explain them

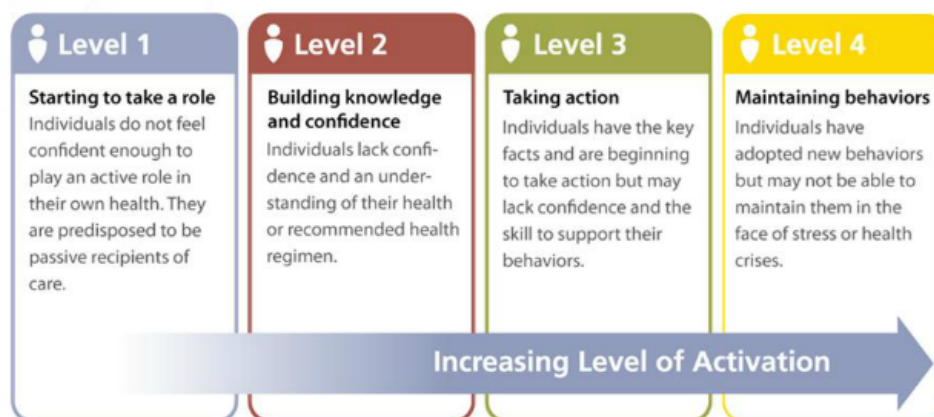
1.17.3. Patient Activation

People who have the knowledge, skills and confidence to manage their own health experience better health outcomes. Yet the ability of people to successfully manage their long-term conditions and to stay well at home can vary considerably from person to person. This is why understanding people's ability to manage their conditions is so important. The Patient Activation Measure (PAM) is a validated, commercially licenced tool¹⁷ that enables this and captures the extent to which people feel engaged and confident in taking care of their health. This can be described as their level of activation.

¹⁷ The PAM tool is licensed by the US company, Insignia Health LLC.

Evidence suggests that people at higher levels of activation tend to experience better health, have better health outcomes and fewer episodes of emergency care, and engage in healthier behaviours. On the other hand, patients with lower activation have low confidence in their ability to have an impact on their health and often feel overwhelmed with the task of managing their health and wellbeing.

Individuals are asked to complete a short survey (13 questions) and based on their responses, they receive a PAM score (between 0 and 100). The resulting score places the individual at one of four levels of activation, namely:



Our approach is to use PAM in a number of service settings to help tailor the service to the appropriate levels of activation of the service users. Two of our key services are now using PAM:

- Physical Activity Referral in Stockport ([PARiS service](#)) – this scheme delivered by Life Leisure, is designed to help inactive people with chronic mild to moderate medical conditions become and stay more physically active, whilst benefiting and improving their health. PARiS is our first service to go live with using the Patient Activation Measure.
- Wellbeing and Self-care Service – delivered by Viaduct Care CIC (details below).

1.17.4. Wellbeing and Self care Service

Clinicians and other front-line staff can often lack the time to invest in coaching people with long-term conditions to engage with and utilise the resources available in services and communities. This means can be a gap in the capacity to proactively identify, engage with and coach the people who could benefit from better self care and self-management that is required to bring about the scale of impact on demand that is needed to make the system sustainable.

As a result, Stockport Together has invested in a new Wellbeing and Self Care service, which offers social and psychological support to patients aged 18+ presenting to Primary Care with a non-clinical need. The service is suitable for patients with a long-term condition diagnosis or behaviours increasing the risk of developing a long-term condition, those with low mental wellbeing and people experiencing social isolation.

The service consists of 16 whole time equivalent practitioners who will look to provide in excess of 1,000 appointments each month across the borough. By the end of November the team will be fully recruited and be live in all eight neighbourhoods across Stockport.

1.17.5. Online Resources

We have developed a series of [online resources](#), designed to support people with a long-term condition to be able to access information about their condition, where to access local help and support. We have developed these pages for each of our top ten most prevalent long-term conditions, and we will continue to develop these resources further by:

- Testing and improving these resources with people who use the Wellbeing and Self Care service
- Adding podcasts from people giving their own stories and top tips about living well with chronic conditions
- Linking more directly with Stockport Local to help people find the full range of activities and events going on across Stockport
- Adding specific pages about more conditions

1.18. What more could be done? (Recommendations)

- Stockport MBC, Stockport CCG, and all Stockport Neighbourhood Care staff working individuals with long-term conditions should consider all opportunities for promoting the online self care resources.
- Stockport MBC and Viaduct Care CIC should further develop the online resources, with continued involvement from individuals using these resources and ensure they are widely available to our partners, community groups and the VCSE.
- Life Leisure and Viaduct Care CIC should continue to work with Stockport MBC to use the Patient Activation Measure to tailor their health coaching services offer to an individual's level of activation. Other Stockport Neighbourhood Care services should consider the potential use of Patient Activation Measure, accompanied with health coaching; to help support improved self-management for people with long-term conditions.
- Stockport MBC, Stockport CCG and all Stockport Neighbourhood Care partners should encourage their staff to be aware of their own self care, using the Healthy Stockport website resources, and the Five Ways to Wellbeing as a framework.

4. Health Protection update

1.19. Summary

Stockport Public Health Team provide Health Protection (HP) support to SMBC and partners around communicable diseases control, immunisation and environmental health issues (including chemical incident management) – the Team has a strong education and training function especially in immunisation.

The Health Protection team based at Stockport MBC (a specialist full time HP nurse, a senior full time nurse, a part-time nurse with lead responsibility for Care and Nursing Homes, three part-time administrative staff, a part-time Consultant in Public Health, all led by a Director of Public Health) are responsible for managing communicable disease outbreaks, working with various colleagues and provider organisations to deliver a comprehensive range of vaccine programmes, and providing the health input to the MBC in dealing with local environmental issues and hazards.

The team have consistently provided a high level of service to the Stockport population based on considerable individual expertise. This is readily seen from our vaccine uptake performance, with which we have been involved for more than 30 years.

A brief review of the activities for these three areas of HP is presented below with more detailed information about the immunisation component in the Appendix at the end.

1.20. Why is it a Public Health Issue?

Health Protection seeks to prevent or reduce the harm caused by communicable and non-communicable diseases, and minimise the health impact from environmental hazards.

1.21. What has happened locally?

The most significant incident that happened during the previous twelve months occurred in a Primary School. The School was affected by an outbreak of co-circulating scarlet fever and chickenpox, which lasted 67 days, until the Easter Holidays. The school had initially notified the Health Protection Team about a scarlet fever outbreak, and had been issued with the PHE guidance for management of scarlet fever in schools.

Scarlet fever can occur as a result of an infection with group A streptococcus (GAS), and usually occurs after a throat or skin infection. Some strains of GAS produce a pyrogenic exotoxin, which then causes scarlet fever. Symptoms include sore throat, fever, swollen glands and a rash. The rash gives the skin a characteristic sandpaper texture, and gives rise to strawberry tongue, another characteristic sign of the disease. This usually occurs 1-2 days after the onset of the sore throat and fever.

Chicken pox is a common childhood disease caused by infection with the Varicella zoster virus. The disease is characterised by the appearance of a rash of small itchy blisters, which eventually crust over. It usually starts on the chest and back, and then spreads to the rest of the body. The rash is usually accompanied by a fever, and feeling generally unwell.

Scarlet fever is a notifiable disease, and schools are advised to contact their local health protection team for advice in the event of an outbreak. Chickenpox is a very common infection in younger children, and is not normally notifiable. However, if chickenpox and scarlet fever are circulating in a school at the same time there is a risk of co-infection. Co-infection with scarlet fever and chickenpox increases the risk of complications such as invasive GAS infection, due to

the presence of open lesions caused by chickenpox, which gives a possible portal of entry to GAS.

When both infections are co-circulating, an early response (less than 3 days) is required if a chickenpox immunisation programme is required. The Health Protection Team in conjunction with the School Nursing Team had the necessary expertise and following discussion with Public Health England, provided immunisation sessions within the Nursery to protect vulnerable children who had no previous history of chickenpox infection. These sessions required significant collaboration between partners to ensure all aspects of the sessions were managed as appropriately and as safely as possible.

This incident occurred at a time when there was a national increased incidence of Scarlet Fever circulating in the community, therefore information was provided to all schools regarding the preventative measures that they needed to put into place to prevent the spread of the infection.

1.21.1. Immunisation



Vaccines have had a huge impact on human health and may, justifiably, be regarded as the medical intervention second only to safe drinking water in reducing deaths and disease. Vaccines utilise the body's natural defence systems to protect against a number of specific pathogenic bacteria and viruses that have the potential to cause serious disease.

Using non-disease-causing components of microbes, vaccines activate the immune system to provide protection before natural exposure to the pathogens can occur.

1.21.2. Infants and children



The infant and child immunisation programme delivers a number of vaccines that provide universal protection currently against diphtheria, tetanus, whooping cough, Haemophilus influenza b, Neisseria meningitides types B and C, Streptococcus pneumonia 13 serotypes, Hepatitis B, Measles, Mumps, Rubella, Rotavirus and Influenza (4 serotypes). There are targeted programmes that protect against Tuberculosis and Chickenpox.

See Appendix 1 for uptake figures for all the different programmes, and an in-depth discussion of the results.

There are known data quality issues with these reported rates, and we anticipate that the true vaccination rates are 1 or 2 percentage points higher than reported. Stockport is currently implementing a new data transfer system which should improve reporting levels, and we anticipate will show that 3 or 4 of these vaccines rates are above 95%. However rates for DTaP-IPV booster and MMR2 boosters at 5 years are concerning, and work is underway to improve uptake.



Our **adolescent programme** is largely delivered by an excellent, highly experienced group of school nurses. The programme delivers three different vaccines – Revaxis (Tetanus, Diphtheria and Polio), Gardasil (Human Papilloma vaccine) and MenACWY (meningococcal vaccine 4 serotypes). The Stockport Schools' nurse team have delivered a high uptake programme for a number of years – 2017 to 2018 was no different. See Appendix 1 for uptake figures for the individual vaccines.

- In 2017/18 there were approximately 1545 females eligible for the year 9 HPV programme – the uptake was 95% for dose one, with 93% completing dose two: the highest performing school was 100%, with the lowest at 88%.
- The overall refusal rate was 3.9%. The team are still trying to catch up girls who have missed their second vaccination so this figure will increase over the next few months.
- There were approximately 3280 children eligible for the MenACWY vaccine in 2017/18– uptake rates were 97% with the highest performing school being 99% and the lowest 94%.
- There were approximately 3280 children eligible for the TdIPV school leaving booster vaccine programme – average uptake rates were 97% with the highest performing school being 99% and the lowest 95%.

Variation in vaccine uptake by individual provider is a feature of all our programme, with the school programme being no different – we will continue to work with our school nurse team to see how this can be reduced over the coming years with our objective being to ensure that all schools achieve the uptake of the highest performing school – likely sources of variation include the following:

Parental factors - eg lack of knowledge about the disease and vaccine

Service factors - services that are not readily accessible deter a number of parents

Professional factors lack of knowledge among health care workers that immunisation can be an important problem

Disease specific factors eg influenza vaccine and the view that it caused flu and has serious adverse events

1.21.3. Pregnant women

Pregnant women vaccination protects against Whooping Cough and Influenza. The Consultant in Public Health has worked with the midwifery team for more than 25 years on influenza vaccine and with their lead and support our midwives have achieved the best influenza vaccine uptake rates in England and Wales for the last 4 years consecutively.



In 2017/ 18 Stockport achieved over 72% uptake overall with 82% for those women in an at-risk group and was again **top in the country**.



In 2017/ 18 more than

97,000 people were vaccinated.

A tremendous achievement by hugely dedicated staff.



Adults

The main focus of activity in adults is protecting at-risk individuals against influenza, and ensuring that they are protected against the vaccines that infants, children and adolescents receive during their programme, particularly for communicable diseases of current concern – for example Measles.



Older People

Vaccination for people aged 65 years and older largely focuses on protection against Shingles including Post Herpetic Neuralgia together with influenza both of which are offered universally

1.21.4. Influenza

Vaccination to protect against influenza is a key programme for the Stockport Community because of the associated morbidity and mortality.

In 2017/ 18 the programme was delivered by three different sets of providers – GPs vaccinated 2, 3 and 4 year olds and those aged 6 months to 64 years in an at risk group.

The private provider “IntraHealth” vaccinated 5 to 8 year olds at junior school. Those aged 65 years and above were vaccinated by GPs, Community Pharmacists and the Stockport Public Health Immunisation Team.

4.3.5 Chemical Incident Management

Part of the remit of the Public Protection Team is to deal with potentially contaminated land within the borough of Stockport.

During 2016 / 17 the team became involved in the investigation of a brownfield site in Bramhall. Historically, the site was a clay extraction pit (1930s-1950s), which was then filled with domestic waste between the 1950s and 1970s, therefore a pre-licensed landfill. The site is currently vacant with no structures and is privately owned: work on the site to determine its suitability for housing continued into 2017/ 2018.

A number of investigations were undertaken to ascertain whether the site was posing, or would pose any risk to human health. The Public Health Team were involved providing medical advice relating to the residential areas surrounding the site

Public Health provided an overview of morbidity and mortality data for the period 1995 – 2015. The study included a defined area that had been provided by the Public Protection Team.

The analysis on this statistical data was that there were no difference in health outcomes between the study area and the borough average.

1.22. Recommendations

- Stockport MBC, Stockport CCG, Stockport Neighbourhood Care, Stockport NHS Trust and Stockport Family staff should continue to prioritise immunisation programmes to ensure that we have maximum coverage to protect all our local residents.
- Stockport MBC, Stockport CCG, Stockport Neighbourhood Care should increase efforts to ensure that the variability in GP practice uptake in immunisation rates is addressed.
- Stockport MBC should ensure that the excellent working relationships with the Directorates in the Council to protect the public's health are maintained.
- Stockport MBC should continue to recognise the importance of a strong local health protection function being available to improve health protection outcomes for our residents.

5. Have improvements in mortality slowed down?

1.23. Summary

The long term trend for mortality rates in England has been a steady fall over time; however since 2011 the rate of decline (the improvement) has significantly slowed and life expectancy improvements have therefore stalled. The Office for National Statistics (ONS) have concluded that a “statistically significant slowdown in the long-term improvement in age-standardised mortality rates for England and Wales took place around early 2010s¹⁸”.

Local mortality rates in Stockport have followed this pattern, until 2010/12 the rate of decline for both males and females was consistent and followed a linear trend, since then rates have stopped falling and have instead held steady. This paper summarises these trends and explores some of the issues that may be causing the change.

These trends are being driven particularly by deaths for older people, and especially for those over 90, although mortality improvements are slowing down for younger age groups too. The changes are also being felt most significantly in the deprived areas, particularly for female under 75 years, reinforcing existing inequalities. These patterns are seen both locally and nationally.

There are many suggestions about the possible causes of this change, including flu infections, cold weather, the impact of austerity and cohort effects; and it is possible that a number of these factors are contributing to the trend. As yet there is no national consensus and reasons are being debated hotly¹⁹.

We cannot yet say what will happen to the trend in the mortality rate in the future, as there is not enough evidence to help predict whether it will return to its earlier trends or continue with current worsening patterns, although early data for 2018 suggest that the deterioration is continuing²⁰.

Stockport decision makers are asked to note this analysis and to intensify efforts to improve mortality (particularly for older people), reduce inequalities (particularly for younger females), protect vulnerable communities and to improve outcomes for stroke, COPD, dementia and pneumonia. The Public Health Team will continue to monitor trends and provide updates as evidence develops.

1.24. Why is it a Public Health issue?

The prime aim of Public Health is to improve the health of the population, enabling them to live longer healthier lives. Mortality rates are the way in which we quantify and measure whether we are achieving this. Any deterioration in the long term improvement of mortality is a cause for concern and requires investigation and action.

¹⁸<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/changingtrends inmortality in england and wales 1990 to 2017/experimental statistics>

¹⁹<https://www.kingsfund.org.uk/blog/2017/11/improvements-mortality-slowed-down>

²⁰<https://theconversation.com/rapid-rise-in-mortality-in-england-and-wales-in-early-2018-an-investigation-is-needed-93311>

1.25. What's the national picture?

The Office for National Statistics (ONS) have undertaken a robust statistical analysis of the changing trends in mortality²¹ and stated that a “statistically significant slowdown in the long-term improvement in age-standardised mortality rates for England and Wales took place around the early 2010s. This was true for England and Wales, for both sexes, and for older and younger people suggesting that this change – whatever its cause – is not restricted to certain demographic groups but is more widespread”. These trends match those being experienced in Stockport.

ONS also stated that “No definite inference can be made at this point on how the trends will develop in the future”, they have committed to further analysis to explore the change in mortality trends in more detail looking at age groups, geographical and socioeconomic differences and examining trends for causes of death, analysis which is yet to be completed.

Public Health England and the Kings Fund have both published commentary about these trends, and are continuing work to understand the underlying causes of the change^{22 23}.

1.26. What's the picture for Stockport

1.26.1. Overall trends for Stockport

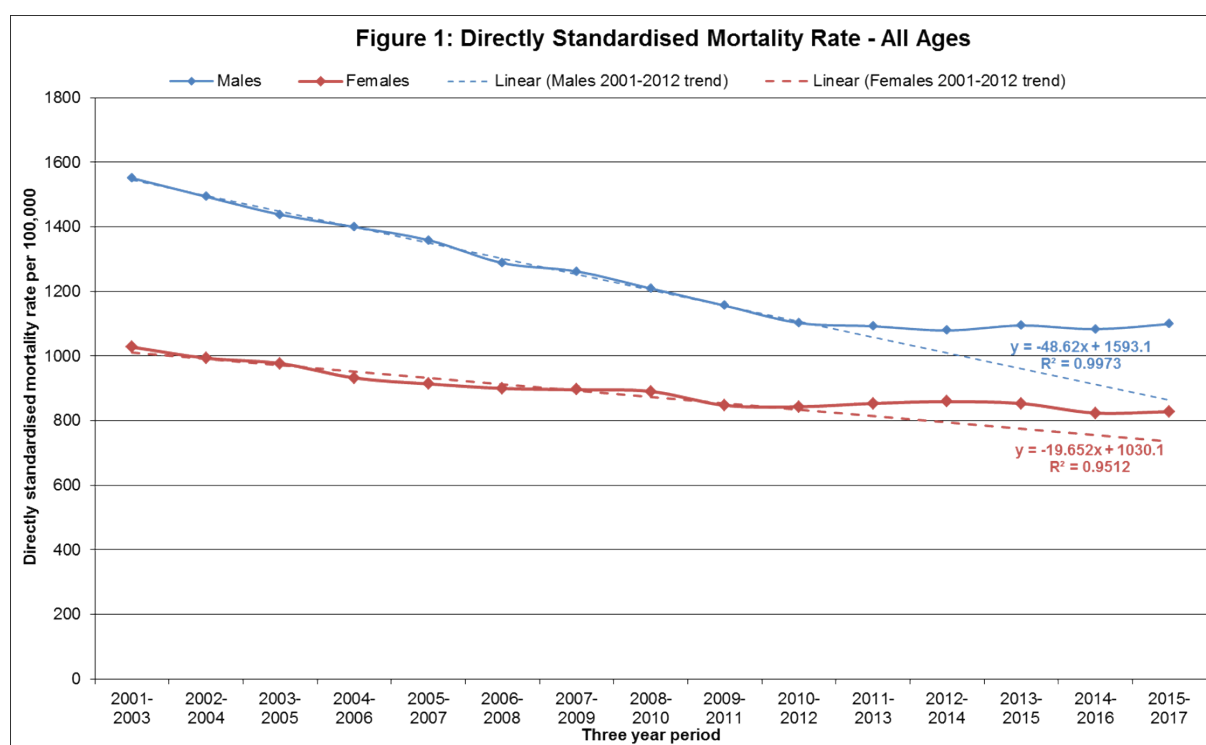


Figure 1 shows the overall mortality rates for Stockport since 2001. Until 2010/12 the rate of decline for both males and females was consistent and followed a linear trend, with the rate for males

²¹<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/changingtrends inmortalityinenglandandwales1990to2017/experimentalstatistics>

²²<https://publichealthmatters.blog.gov.uk/2017/07/20/whats-happening-with-mortality-rates-in-england/>

²³<https://www.kingsfund.org.uk/projects/mortality-rates-uk-why-are-improvements-life-expectancy-slowing-down>

falling more rapidly than for females, narrowing the gender inequality; this trend is long standing and likely goes back to the beginning of the last century.

Since 2010/12 the pattern has changed, for males mortality rates have stopped falling and have instead held steady, for females rates have levelled out fluctuating slightly around a plateau point.

In terms of total volumes of deaths, 2011 saw the lowest number of deaths in Stockport at 2,524 registrations in year. By 2017 this volume had risen to 2,821 (a 12% increase).

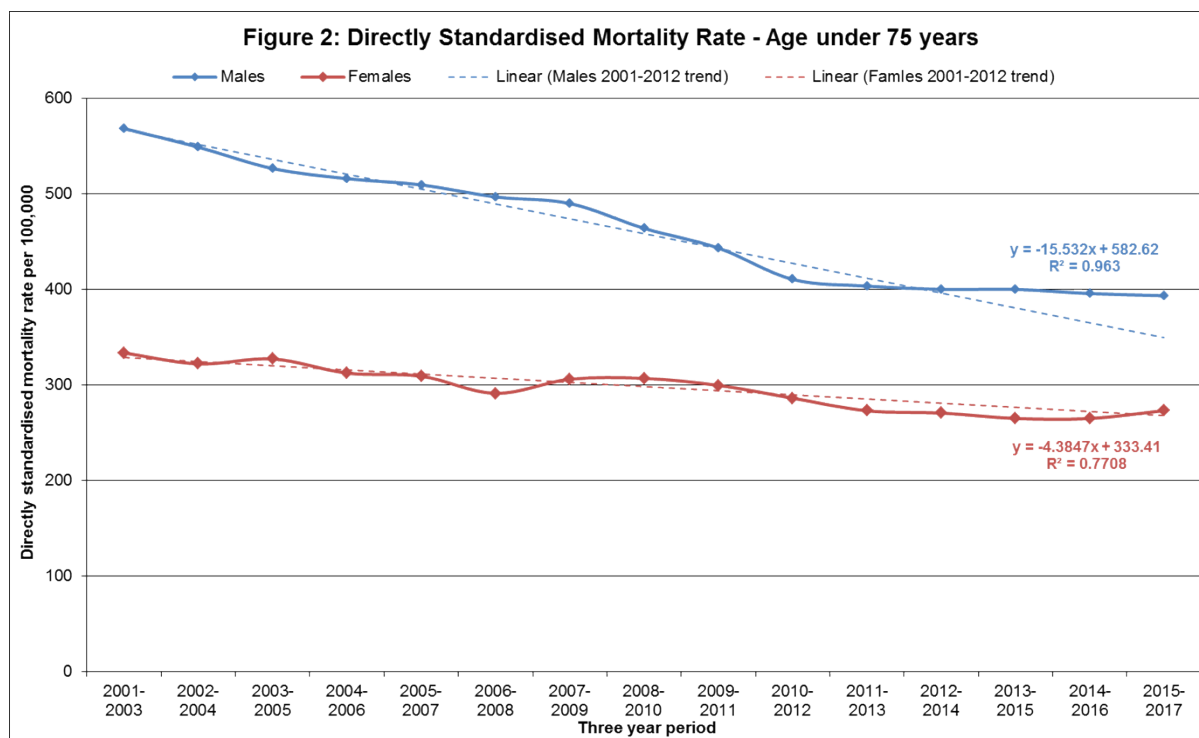
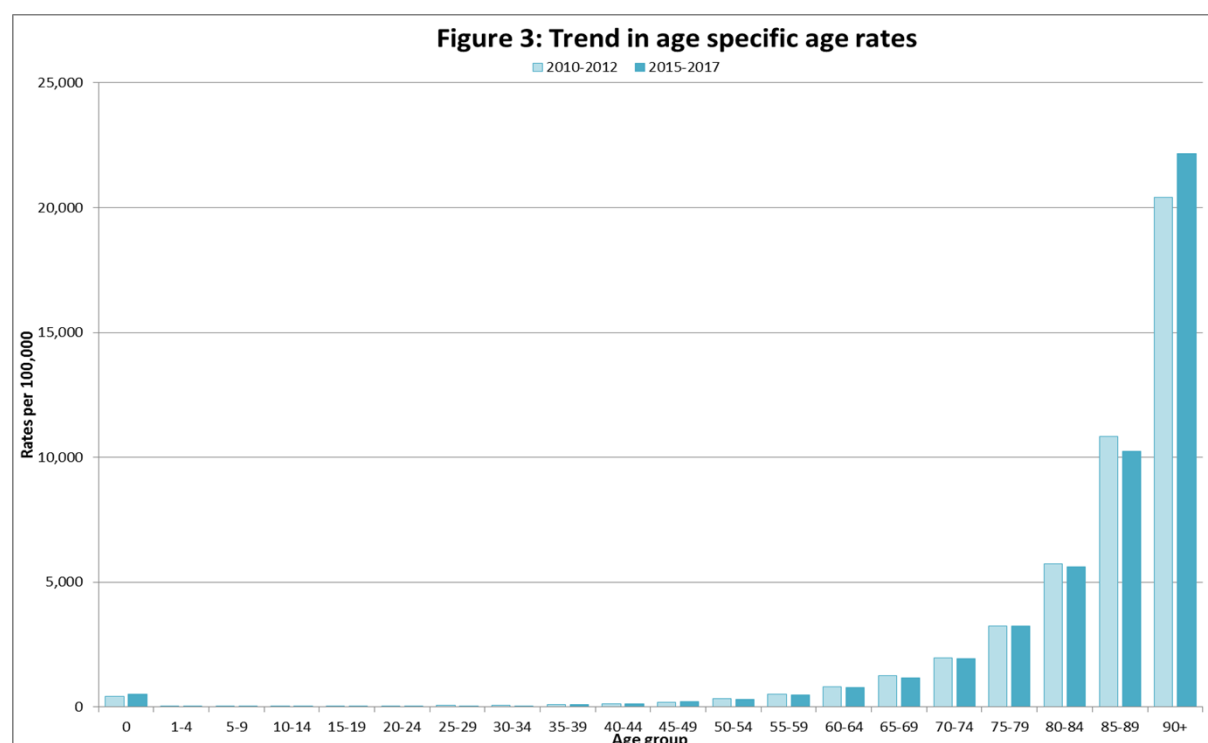


Figure 2 shows the trends in premature (under 75) mortality rates for Stockport since 2001, the male rate shows similar patterns to the all age rate, although with a smaller impact, with a decline until 2010/12 and then a significant slowdown in the decrease. For females the trend is slightly different as rates have fluctuated and the long term decline has been slower than for males, but on average rates declined until 2013/15, but in the last two years have increased.

Life expectancy trends show similar patterns, with a consistent increase for both males and females up until 2010/12 and then a flatter trend up to 2015/17.

1.26.2. Trends by age for Stockport



The majority of the increase in the volume of deaths in Stockport between 2011 and 2017 has been for those aged 90 years and older, numbers of deaths in this age group increased by around 165 (37%).

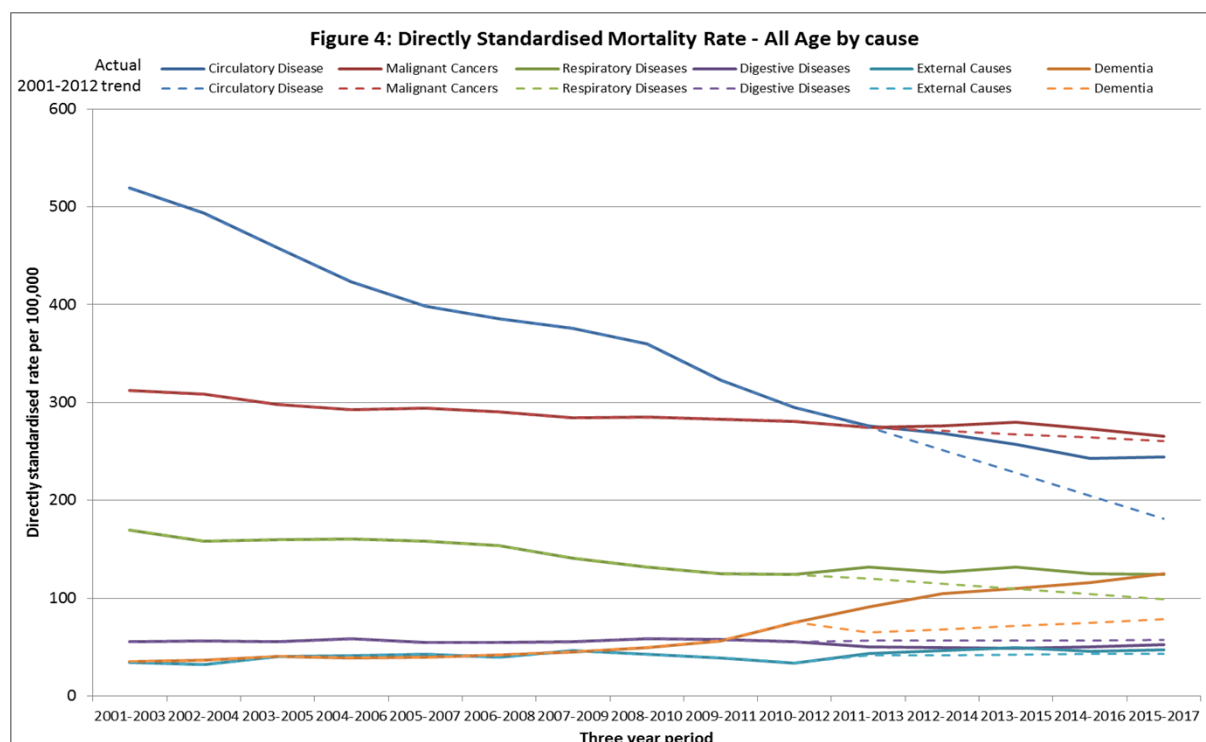
Patterns for rates of mortality show that for most age groups there was a slight decrease in rates between 2010/12 and 2015/17, however rates of mortality for those aged 90 and above actually increased over the period – these two trends combining to give an overall steady state (see figure 3).

There has been a long term trend of mortality rates in the older ages decreasing (even as the number of deaths rose, as the population also grew), as the average age at which people die increases, however since 2010/12 this rate of decrease has slowed for all ages over 70 years.

The overall trends are therefore being driven by deaths for older people, and particularly for those over 90.

1.26.3. Trends by cause for Stockport

Definitions of the underlying cause of death changed in both 2011 and 2014 which makes it difficult to draw firm conclusions about trends in the cause of death. The following section described patterns, but analysis should be treated with caution (see figure 4).



Long term trends have led to a rapid decline in deaths from circulatory disease, so that cancer is now the single most common cause of death. In the period since 2010/12, while mortality rates from circulatory disease have continued to fall, the rate of decline has reduced. In 2017 the volume of deaths from circulatory disease was the highest since 2013. In particular rates of mortality from cerebrovascular disease (stroke) have virtually levelled since 2010, following a rapid decline in the preceding decade. It is likely that coding changes since 2011 have led to a lower number of deaths being identified as circulatory disease than were previously, so it is possible that trends seem more positive than they otherwise would have been

The long term decline in cancer mortality has been less significant than for circulatory disease but rate have none the less reduced, since 2010/12 the rate of decline has remained similar to that in the previous 10 years, in other words as yet there does not seem to have been a change in the rate of mortality falls from cancer; coding changes have also not particularly impacted cancer.

Respiratory disease mortality has followed a similar trend to heart disease. The decline in mortality rates from pneumonia in particular has halted and are now beginning to rise. Deaths from pneumonia are linked to many factors including old age, cold weather and infectious diseases. It is likely that coding changes have led to fewer deaths being attributed to overall respiratory disease.

Mortality rates from dementia have increase significantly since 2011, due partly to coding changes which have made it more common cause of death but also in part due to rising prevalence and diagnosis, and the ageing population.

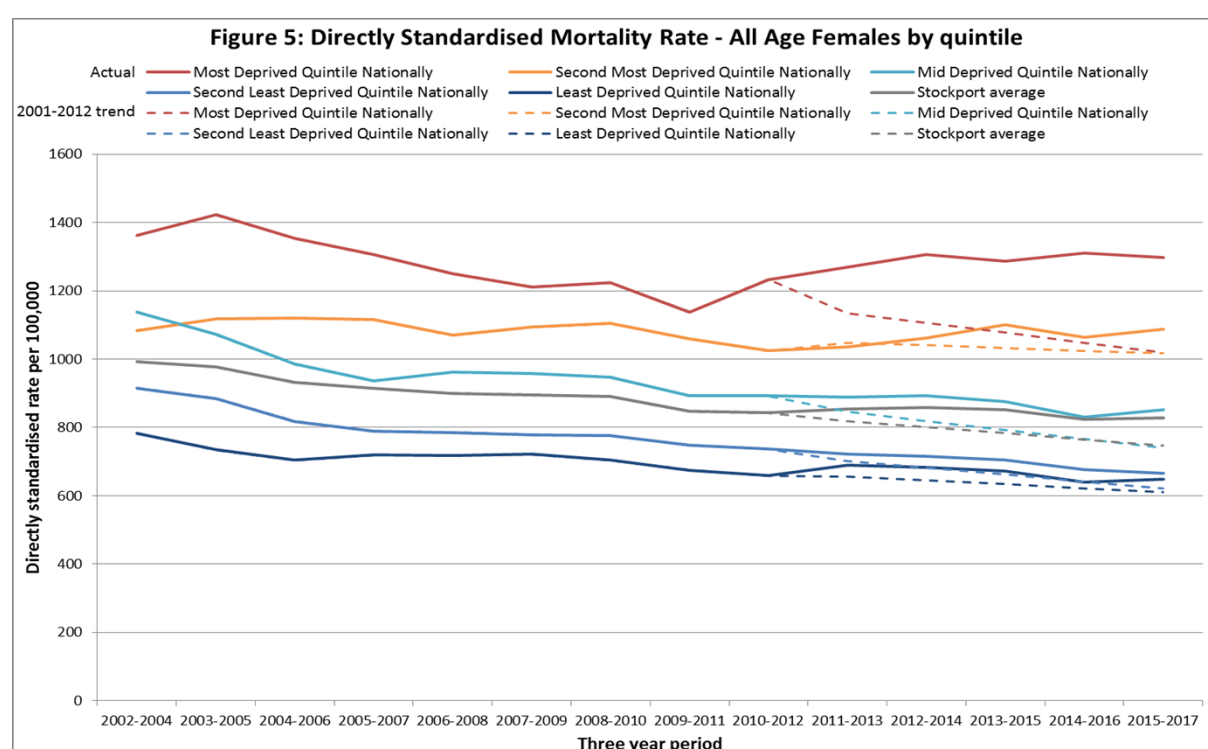
Over the analysis period there have been no particular trends in excess winter deaths (EWD), rates have continued to vary year to year with no correlating pattern of peaks in EWD with the general rise in mortality.

In summary, causes associated with older ages of death have experienced the most significant slow-down in mortality improvement.

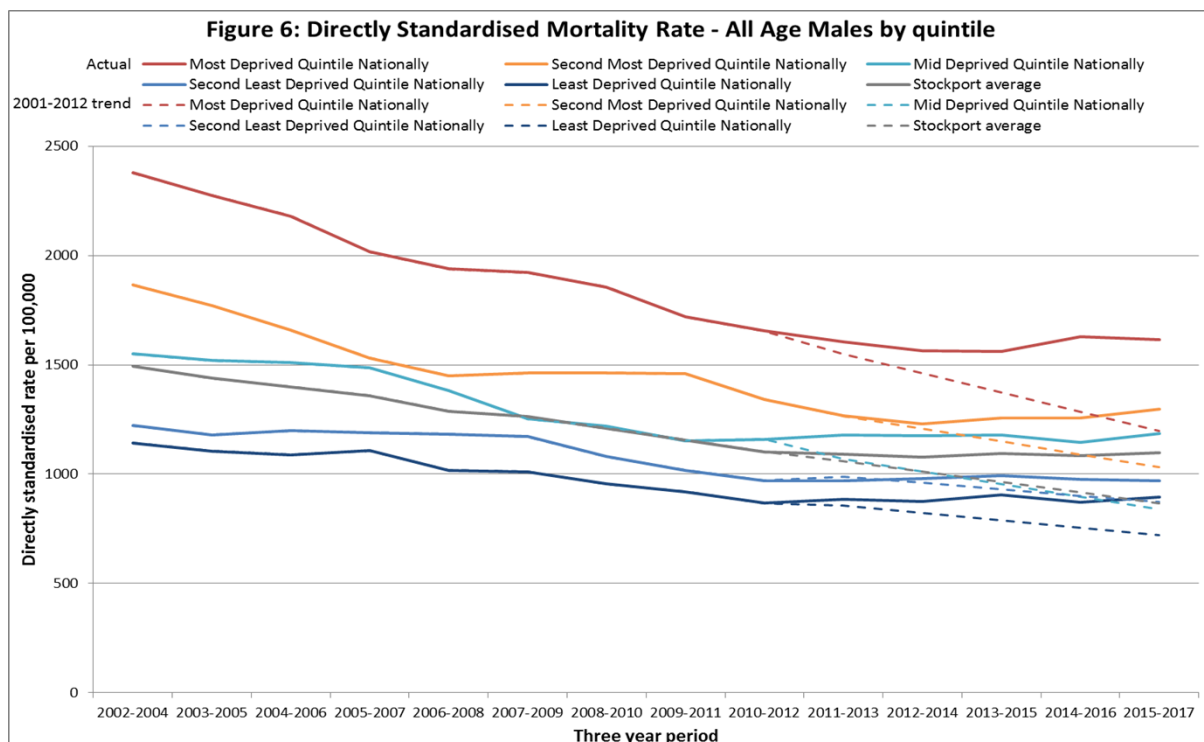
1.26.4. Trends by deprivation for Stockport

Analysis by quintile of deprivation within Stockport shows that this slowdown in the in the long term decline in mortality rates is being experienced in all areas, but most acutely in areas of highest deprivation (see figures 5 and 6). For males between 2001/03 and 2010/12 mortality rates had fallen most rapidly in areas of deprivation, since this point the levelling out has been experienced reasonably evenly across the quintiles. For females previous differences in the mortality rates were less marked, and since 2010/12 mortality rates in the most and second most deprived quintiles have actually increased (by 5%).

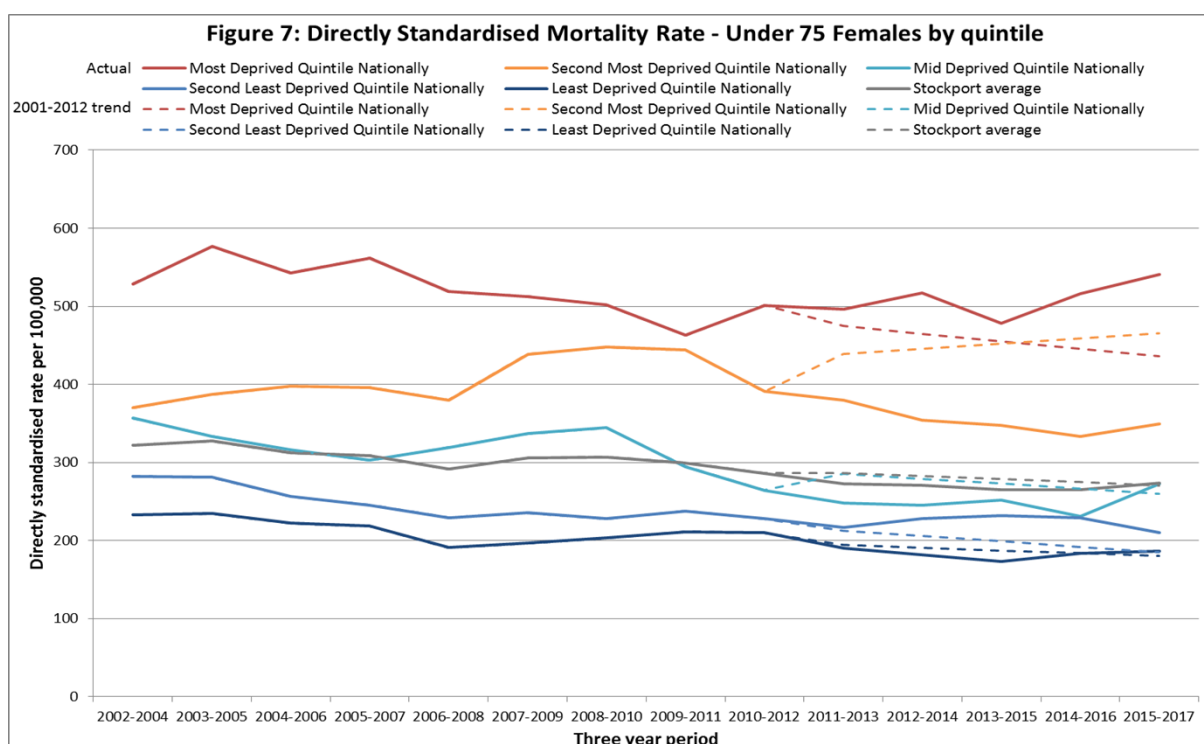
Trends in life expectancy (a slightly less sensitive measure) show that for the last two periods the life expectancy of females in the most deprived areas has fallen from 78.1 to 77.3, back to the 2005/07 level. A trend also noted nationally by ONS²⁴ “there were noticeable falls in female life expectancy at birth in the 20% most deprived populations in England”.



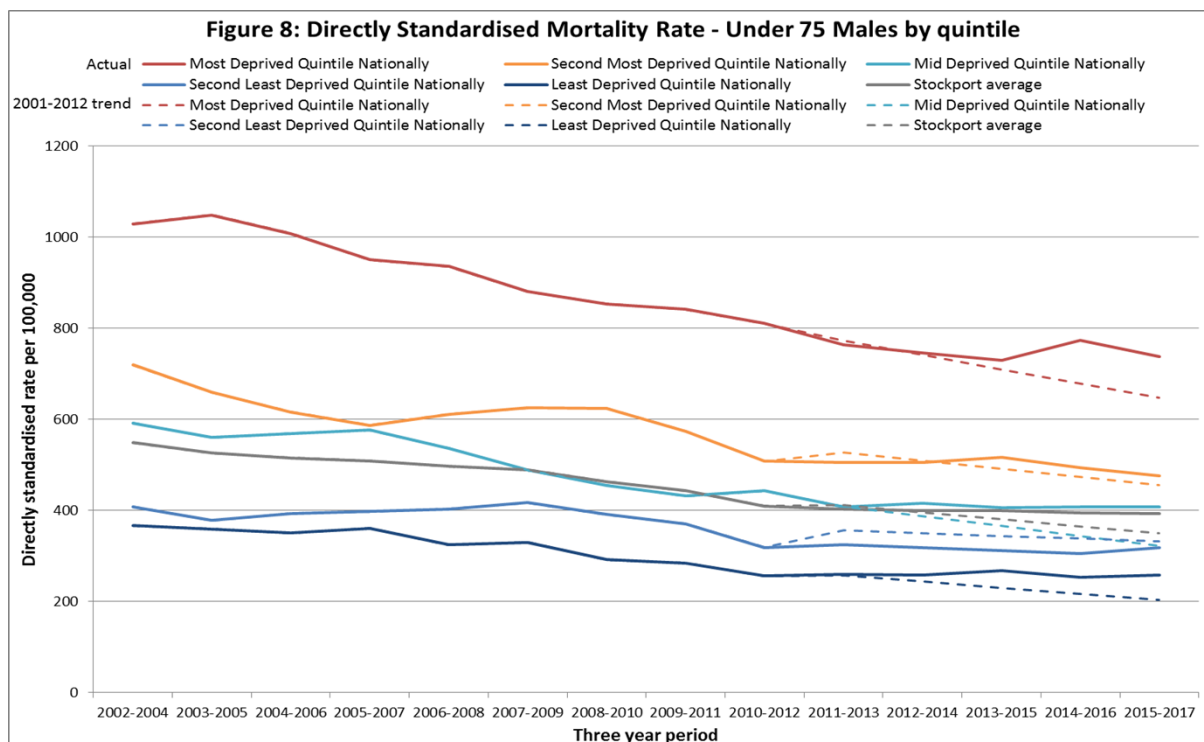
²⁴<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/englandandwales2014to2016>



Patterns for trends in under 75 mortality by deprivation quintile are shown in figures 7 and 8. For males the trend of a steady state since 2010-12 can be seen in most quintiles, with the largest gap between 2015/17 actual and previously predicted in the most deprived quintile (90 per 100,000 or 14%), despite the fact that the under 75 mortality rates in the most deprived quintile have continued to fall since 2010/12 (by 9%), as previous decreases had been more rapid.



For females the trend is somewhat different, again a levelling out since 2010/12 can be seen in most quintiles, however the most deprived quintile mortality rates rose by 8% over the period. It is likely that mortality patterns in the most deprived areas are driving the overall Stockport trends noted in figure 2.



Analysis by cause of death in the most deprived quintile suggests that there has been a marked increase in deaths from respiratory disease across both genders, particularly for COPD - although again results need to be treated with caution.

In summary the slow-down in improvement in mortality has been felt most significantly in the deprived areas for both genders for older people, and also for female under 75 years.

1.27. Possible causes of the change

The causes of the changes in the long-term trend for mortality are being hotly debated nationally, with different views about whether correlation equates to causation²⁵. Many organisations and academics proposing possible factors including:

-
- Winter impacts, with particular flu strains and cold weather being major factors.
 - The ‘cohort effect’ with previous gains from lifestyle and health care improvement such as reducing smoking and increasing statins nearing realisation and therefore no longer contributing as much to reductions in mortality .
 - The ‘cohort effect’ hypothesises that the cohort born the in decade before 1919, and who survived the 1918-1919 flu pandemic, were contributing significantly to the continuing decrease in mortality, and now that this cohort are 100+ years their impact on overall mortality trends has lessened considerably.
 - Austerity and national policy, particularly the pressure on NHS budgets, reductions in social care provision and reductions in benefits – all of which impact vulnerable older people and people in deprived areas disproportionately.
 - Ageing population effects that as people may be succumbing to more complex and multiple long-term conditions as a result of living longer.
 - Statistical artefact, errors in the population estimates or methods leading to an incorrect analysis.
 - Improvements will slow down as we come closer to maximum achievable longevity - however if this were the explanation it would have occurred to a greater extent in the least deprived groups, not the most deprived, and international comparators.
-

It is possible that a number of these factors are contributing to the trend, but as yet there is no consensus and no official explanation; PHE and ONS are continuing to examine the trends and commentators are calling for further and urgent investigation²⁶.

Although the slowdown in mortality improvement is not unique to England the effects here are worse than in other European countries^{27,28}, which is also causing concern with many commentators.

²⁵ <https://www.kingsfund.org.uk/blog/2017/11/improvements-mortality-slowed-down>

²⁶ <https://theconversation.com/rapid-rise-in-mortality-in-england-and-wales-in-early-2018-an-investigation-is-needed-93311>

²⁷ <https://www.kingsfund.org.uk/blog/2017/11/improvements-mortality-slowed-down>

²⁸ <https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-uk>

1.28. What's the plan nationally for the future?

ONS have committed to further analysis to explore the change in mortality trends in more detail looking at age groups, geographical and socioeconomic differences and examining trends for causes of death, analysis which is yet to be completed.

Public Health England, the Kings Fund and the Health Foundation are also continuing work to understand the underlying causes of the changes, and more publications are expected later this year.

At the moment there is no national consensus about the causes of the change nor anticipated future trends, therefore there are as yet no recommendations for action relating specifically to the slowdown in improvement.

1.29. What are we doing locally?

Stockport Council's Public Health team will continue to monitor trends locally and review national evidence as it develops. The findings of this work will be shared regularly and any resulting recommendations will be assessed and actioned locally.

Stockport's Health and Wellbeing Board will receive this data and actively consider the contributions the Health and Wellbeing Board partners can make in addressing the new local trends.

Until national recommendations are agreed, local strategies and programmes to improve health and reduce inequalities will continue to deliver.

1.30. What more could be done? (Recommendations)

- Stockport MBC and Stockport CCG should note this analysis and ensure plans and programmes are in place to intensify efforts to improve mortality – particularly for older people.
- Stockport MBC and Stockport CCG should note this analysis and ensure plans and programmes are in place to intensify efforts to reduce inequalities – particularly for females.
- Stockport MBC and Stockport CCG should note this analysis and ensure plans and programmes are in place to intensify efforts to protect vulnerable communities.
- Stockport MBC and Stockport CCG should note this analysis and ensure plans are in place to intensify efforts to improve outcomes for stroke, COPD, dementia and pneumonia.
- Stockport MBC and Stockport CCG should continue to monitor such analysis, assess national recommendations, as these emerge, and ensure refocused local action.

6. Recommendations

1.31. Transport and Health

- Stockport MBC and its partners should pursue their transport strategies fully conscious of the facts set out in the summary to this chapter.
- Stockport MBC should regard it as highly desirable to avoid community severance and make use of the Toolkit developed for DfT by UCL.
- Stockport MBC needs to recognise that heavy traffic in residential streets disrupts social networks and aim to minimise traffic in residential streets including by creating residential cells where residents wish them
- Stockport MBC are currently consulting on their Walking and Cycling Strategy, within this consideration should be given to protecting attractive walking routes. There needs to be development of safe cycle routes, the creation of residential cells, better cycle parking and the conveyance of cycles on trains.
- Stockport MBC and TfGM should support plans for the Orbit Tram
- The Stockport MBC planning system need to ensure active travel and public transport are promoted in new developments so that all new developments in Stockport are:
 - Designed to be permeable to cycling, walking and public transport movements
 - Fully integrated with existing cycling and walking routes in the neighbouring area
 - Providing the highest quality infrastructure for cycling, walking and public transport, including cycle parking, bus waiting facilities and crossing points.
 - Designed to encourage residents to utilise public transport and more active modes from the beginning, either through complimentary public transport season tickets or active travel equipment.
- Stockport MBC should pursue in the SEMMS review process the recommendations accepted from the 24th Public Health Annual Report relating to the SEMMS process and road building.

1.32. Loneliness and social isolation in older people

- Stockport MBC, Stockport CCG, SNC and partners should ensure tackling loneliness & social isolation is considered in all their programmes areas and have systems in place to identify those who are, or who are at potential risk of becoming socially isolated.
- Stockport MBC should continue its programme of support to for communities and individuals to support isolated people at a local level, and to build resilience and social capital in their communities and protect those most at risk of social isolation.
- Organisations, including the voluntary and community sector and should work towards creating an environment where people can connect with their neighbours, communities or people of the same interest.
- Stockport MBC, Stockport CCG, SNC should ensure that frontline staff within their relevant organisations have the skills and knowledge to identify potentially lonely and socially isolated individuals and the confidence and tools to offer solutions, and signpost or support them to sources of help.

1.33. Self care

- Stockport MBC, Stockport CCG, and all Stockport Neighbourhood Care staff working individuals with long-term conditions should consider all opportunities for promoting the online self-care resources.
- Stockport MBC and Viaduct Care CIC should further develop the online resources, with continued involvement from individuals using these resources and ensure they are widely available to our partners, community groups and the VCSE.
- Life Leisure and Viaduct Care CIC should continue to work with Stockport MBC to use the Patient Activation Measure to tailor their health coaching services offer to an individual's level of activation. Other Stockport Neighbourhood Care services should consider the potential use of Patient Activation Measure, accompanied with health coaching; to help support improved self-management for people with long-term conditions.
- Stockport MBC, Stockport CCG and all Stockport Neighbourhood Care partners should encourage their staff to be aware of their own self-care, using the Healthy Stockport website resources, and the five ways to wellbeing as a framework.

1.34. Health Protection update

- Stockport MBC, Stockport CCG, Stockport Neighbourhood Care, Stockport NHS Trust and Stockport Family staff should continue to prioritise immunisation programmes to ensure that we have maximum coverage to protect all our local residents.
- Stockport MBC, Stockport CCG, Stockport Neighbourhood Care should increase efforts to ensure that the variability in GP practice uptake in immunisation rates is addressed.
- Stockport MBC should continue to ensure that the excellent working relations with the Directorates in the Council to protect the public's health are maintained.
- Stockport MBC should continue to recognise the importance of a strong local health protection function being available to improve health protection outcomes for our residents.

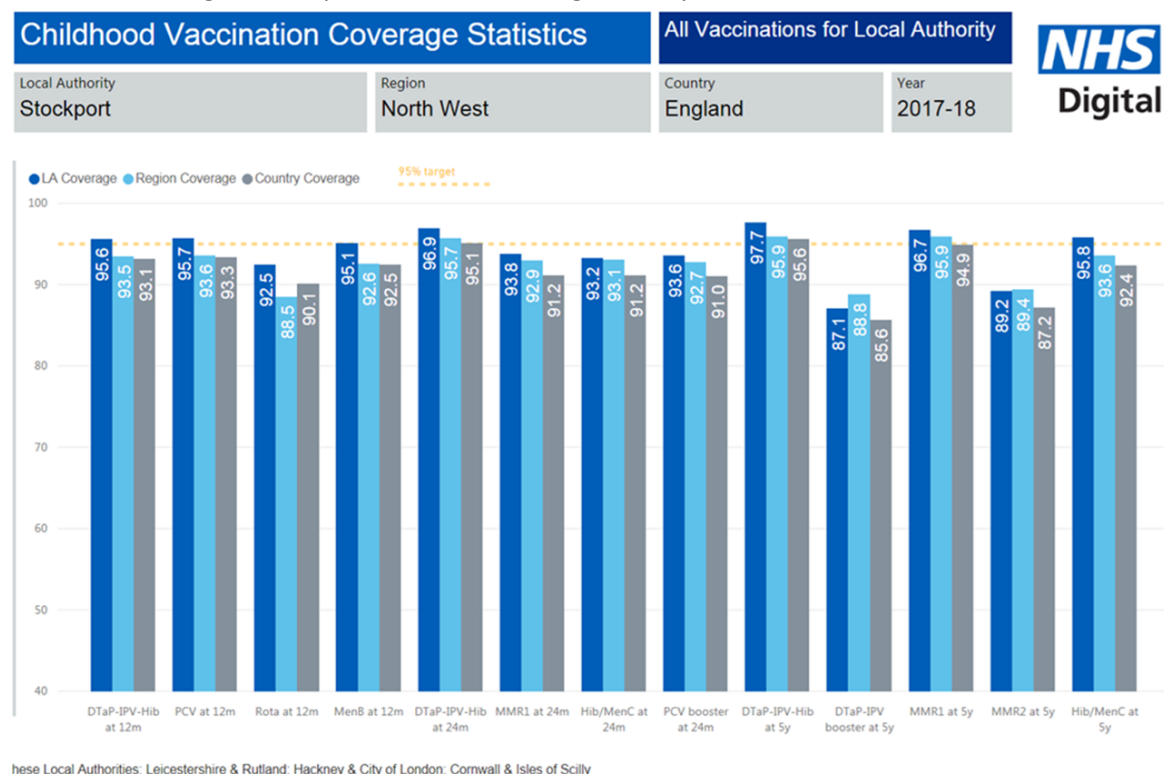
1.35. Have improvements in mortality slowed down?

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- Stockport MBC and Stockport CCG should note this analysis and ensure plans and programmes are in place to intensify efforts to protect vulnerable communities.
- Stockport MBC and Stockport CCG should note this analysis and ensure plans and programmes are in place to intensify efforts to improve outcomes for stroke, COPD, dementia and pneumonia.
- Stockport MBC and Stockport CCG should continue to monitor such analysis, assess national recommendations, as these emerge, and ensure refocused local action.

Appendix 1 for Health Protection update

Immunisation Uptake Data

2017/18 Coverage – Stockport, North West, England – by vaccine

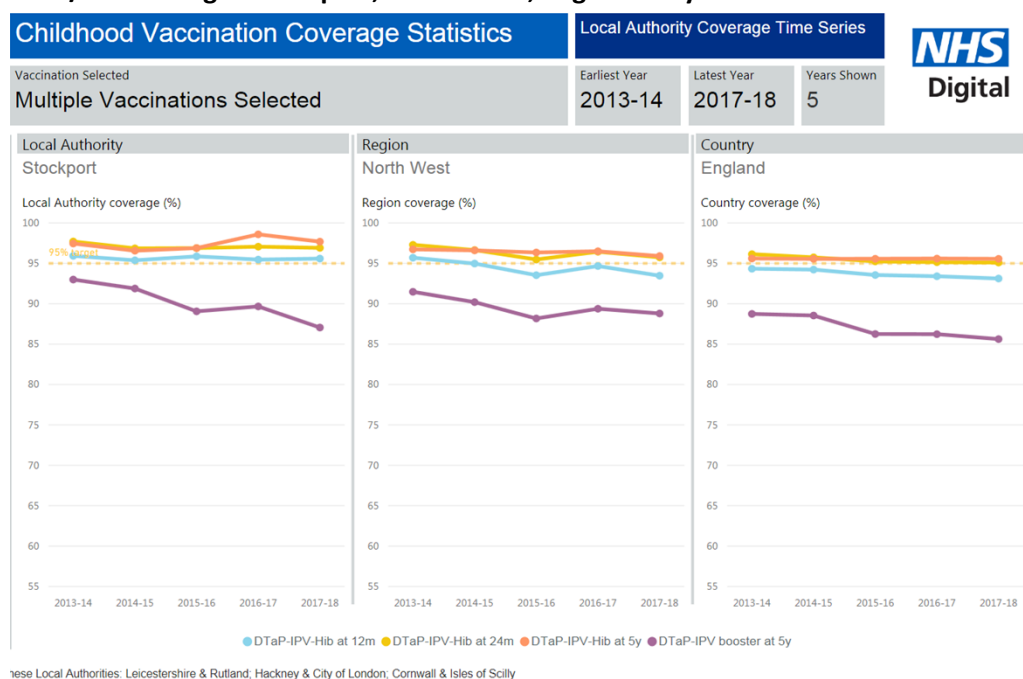


The chart above shows the 2017/18 uptake for the routine childhood vaccines at 1 year, 2 years and 5 years of age for Stockport (dark blue), North West (light blue) and England (grey).

- For all 13 vaccines measurement points rates in Stockport are above the national average
- For 11 of the 13 vaccine measurement points rates in Stockport are above regional average. They are lower for:
 - ❖ MMR 2 booster at 5 years
- For 7 of the 13 vaccine measurement points rates in Stockport are above the 95% target rate. They are lower for:
 - ❖ Rotavirus at 1 year
 - ❖ Hib/MenC at 2 years
 - ❖ DTap-IPV booster at 5 years
 - ❖ MMR1 at 2 years
 - ❖ PCV booster at 2 years
 - ❖ MMR 2 booster at 5 years

There are known data quality issues with these reported rates, and we anticipate that the true vaccination rates are 1 or 2 percentage points higher than reported.

2017/18 Coverage - Stockport, North West, England – by vaccine – 5in1 trends since 2013/14



The Figure above - Trends in Stockport for the 5 in 1 DTaP-IPV vaccine - shows that while rates for the vaccines given in early years are holding steady (against a regional and national decline) the rates for the 5 year booster have declined significantly and at a faster rate than the regional or national average.

2017/18 Coverage - Stockport, North West, England – by vaccine - MMR trends since 2013/14

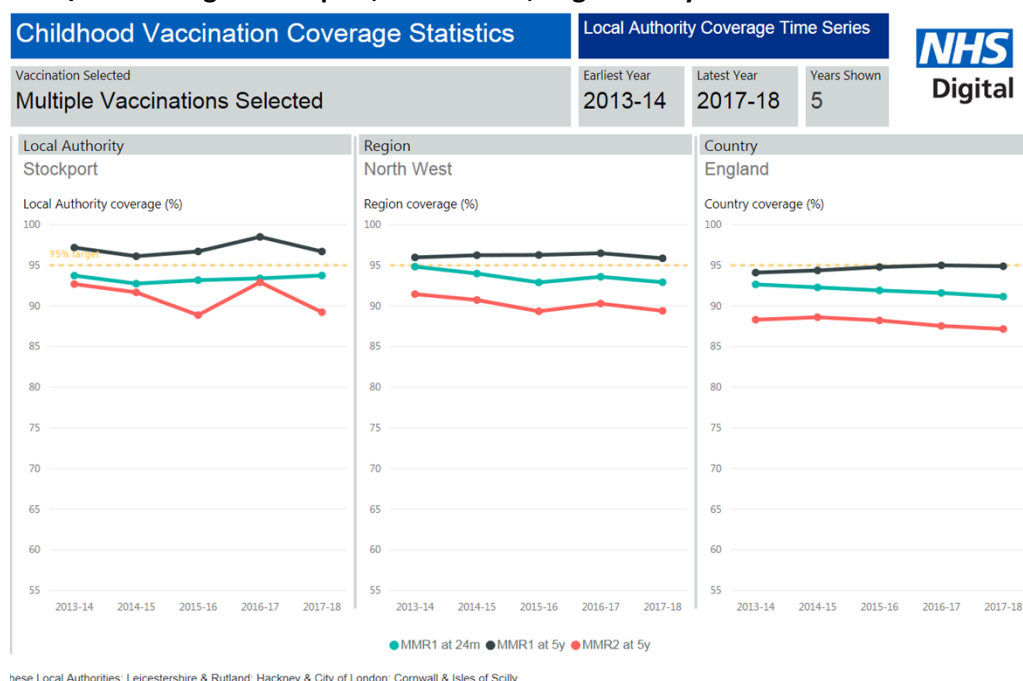
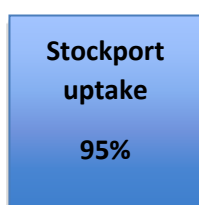
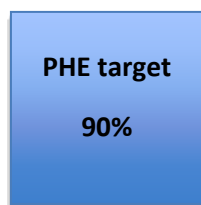


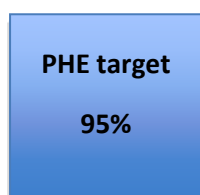
Figure 3- Trends in Stockport for the MMR vaccine - shows that while rates for the vaccines given in early years are holding steady or rising the rates for the 5 year booster has been more variable and overall has declined.

Quarterly trends for Infanrix hexa (diphtheria, tetanus, whooping cough, Haemophilus b, polio and hepatitis B) vaccine coverage for infants at 12 months of age:



This reflects good performance by the primary care teams who deliver the programme – a more realistic target should, however, be **97%**, which was the achieved figure when service governance was a more local responsibility.

Quarterly data for vaccine uptake in two year olds:



Locally we have always aspired to the more demanding **95%** target and we are very nearly meeting this. This is a programme delivered by primary care and variation in uptake by individual provider is a feature of the service, which we are trying to explore and determine how it can be addressed.

Quarterly vaccine coverage in 5 year

olds; the PHE target of 90% is not met by the “Repevax” programme (diphtheria, tetanus, whooping cough or polio), but was just met for the two dose MMR programme during the period 2017-2018. One issue being investigated is data accuracy, which we have recognised for a number of years as a potential source of error.