Appendix 2

HEALTH INEQUALITIES STRATEGY

Public Health Partnership Board

Final draft - August 2007

CONTENTS

1.0 Background and Policy Context

1.1 Introduction

There are a range of national, regional, sub-regional and local influences on the development of a Health Inequalities Strategy for Stockport, which have helped to shape the development and implementation of this strategy.

This section will explore some of the most important issues that have been considered, covering new and emerging perspectives as well as those of a more long-standing / historical nature. It also provides a basic overview of public health practice, health improvement and health inequalities.

1.2 Overview

During the current Labour Government's period in office, public health has undergone a renaissance. The profile of public health is now higher than it has ever been in the post-war period; there is a Minister for Public Health; the national policy emphasis on health improvement and the active prevention of health problems is now equal to that of treating and managing ill-health; and the main growth sector within the NHS is primary care (GP and community services) rather than secondary care (hospital services). If the same level of interest in public health issues is sustained, it is conceivable that within the next 10 years the structure and nature of health and social care services, as most of us know them now, could have been reinvented.

1.2.1 Why focus on public health?

Public health is essentially the practice of preventing ill-health within the population:

- By protecting people's health, for instance, limiting the spread of infectious diseases such as childhood illnesses and those that cause serious, sometimes fatal side-effects e.g. tuberculosis, polio, meningitis;
- by ensuring safe clinical practices e.g. the prescribing of only locally approved medicines by GPs and hospital doctors; and
- by promoting good health and health improvement, including trying to understand and address why some groups within the local population are typically unhealthier or die sooner than others.

There are some very convincing reasons why we should focus on public health and health improvement in particular:

- The profile of the population in the UK is changing. We are generally having fewer children and more people are living longer, which means that the population will have an increasingly ageing profile, however, there are concerns that the levels of treatment and care required by an ever-growing older population may become unsustainable;
- Being broadly healthy during your lifetime and living into older age has obvious benefits for individuals, but also for the UK and local economies;
- Whilst average life expectancy in England has consistently risen since the 1940s, there are clear differences between groups and areas, for instance, women still live on average 4.3 years longer than men and men living in the south-east of

England live on average 2.6 years longer than men in the north-west, while women live on average 2.1 years longer;

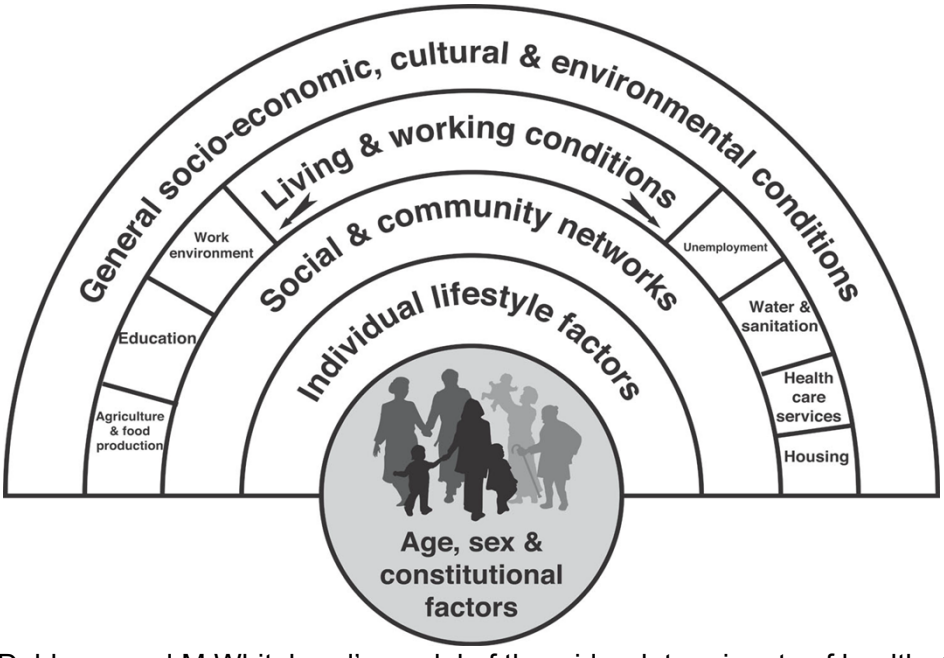
- For the first time ever, it is predicted that levels of obesity in the current generation of children and young people will lead to the premature death of children before their parents;
- Adult obesity has also risen by 40% in the past 9-10 years;
- The nature of alcohol consumption in the UK is changing, with the particularly damaging practice of binge drinking on the increase and the apparent rise in digestive disorders thought to be due to excessive alcohol use; and
- A recent national neighbourhood renewal evaluation showed that while progress has been made to reduce many of the differences between the most and least well-off in our communities, the health gap is widening, bucking this otherwise positive trend.

1.2.2 What are health inequalities?

Inequalities are differences between people and places that, in theory, would not exist under different conditions. Work to tackle inequalities, whether in housing conditions, employment status, wage levels, educational attainment, or age, disability, ethnicity, gender etc is based on the idea that inequality is ultimately unnecessary but comes about as a result of often complex social, environmental and economic factors.

A major part of tackling inequalities is the process of unlocking the causes of the differences and then planning and delivering services that help to address those causes, resulting in improvement.

Health inequalities, like other inequalities, are theoretically preventable, but as our health status is often a product of the various factors affecting our lives, inequalities in health can be especially difficult to reduce, as they rely on positive and sustained changes in other areas of our lives, as the model below helps to represent.



G Dahlgren and M Whitehead's model of the wider determinants of health, 1991

This is also why approaches to reducing health inequalities have to be holistic to ensure long-term gains in people's health. However, the factors that most directly influence an individual's health are lifestyle factors such as whether they smoke, nutrition and weight, alcohol use, sexual behaviours, frequency of exercise and whether they have access to high quality healthcare.

For this reason, the focus of this strategy is largely on the lifestyle factors that most negatively impact on health, the diseases that result, and the communities that have the greatest prevalence of health problems, as this is where significant health gains are most likely to be made, thereby reducing the local gap between the most and least healthy.

1.3 National drivers

1.3.1 Early reports and policies

The concept of health inequalities was first given a national profile in the late 1980s in the Black Report. This report was prompted by a growing recognition during the 1970's that although the UK had benefited from a welfare state system for over 30 years, our rate of health improvement was beginning to fall behind other European countries. There was strong speculation that this was due to health inequalities.

However, it wasn't until the late 1990s that the then new Labour Government began to make explicit links between the wider determinants of health, specifically poverty & social exclusion, and poor health. This was largely due to a further report, commissioned by the new Government, called the Independent Inquiry into Inequalities in Health, which was published in 1998. Led by Donald Acheson, a former Chief Medical Officer, the report looked in detail at the causes and nature of health inequalities in Britain and made links between health and social & economic status. It made the following conclusions (as at the late 1990s):

- Death rates in England have been falling over the last century, from an approximate death rate of 18 per thousand people in 1896 to 11 per thousand in 1996. Over the last 25 years, there have been falls in death rates from a number of important causes of death, for example lung cancer (for men only), coronary heart disease and stroke;
- In the early 1970s, the mortality rate among men of working age was almost twice as high for 'unskilled' workers as for 'professionals' but by the early 1990s it had increased to almost three times higher;
- In professional groups, smoking cessation has doubled from 25% to 50% since 1973, however, the rise in the rate of people stopping smoking from unskilled groups was only around 4% over the same period. In addition, the number of people who smoked in the UK had fallen, but the number of people from unskilled groups who smoked remained about the same;
- People from unskilled groups are twice as likely to have drink problems as people from professional groups. 17% of unskilled men and 6% of unskilled women have an alcohol problem, compared with 8% of professional men and 3% of professional women; and
- Children living in poverty suffer disproportionately from health inequalities, before and after birth.

The NHS Plan, which followed in 2000, set some initial targets for health improvement generally but also made clear reference to some of the health improvement issues that remain relevant today including reducing smoking, improving diet & nutrition and tackling alcohol abuse, especially where these factors are combined with multiple deprivation.

To drive national work to improve health and reduce health inequality, the Government set some initial health inequalities targets in 2001 and the current floor targets, which all neighbourhood renewal funded (NRF) authorities (those that include neighbourhoods with substantial and persistent social, environmental and health problems) work to are:

DH PSA1 - Substantially reduce mortality rates by 2010

- From heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and

- From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole

DH PSA2 - Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth

DH PSA3 - Tackle the underlying determinants of ill health and health inequalities by

- Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less

- Reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health

1.3.2 National Service Frameworks

Closely following the publication of the NHS Plan was the development of the National Service Frameworks (NSFs) which now cover some of the highest priority conditions affecting UK population health as well as key vulnerable groups. They are:

- Cancer
- Children's
- Chronic Obstructive Pulmonary Disease
- Coronary Heart Disease
- Diabetes
- Long Term Conditions
- Mental Health
- Older People
- Renal Services

The main purpose of each NSF is to set out a long-term framework, usually in the form of a set of core standards which highlight the key issues to be addressed, in

which clear quality requirements for care are established based on the best available evidence of what treatments and services work most effectively for patients.

Many of the NSF topics are directly relevant to health inequalities as are some of the specific standards within them, for example:

- Children's NSF Standard 1 - Promoting health and well-being
- Older People's NSF Standard 8 - The promotion of health and active life in older age
- The Cancer Plan - Improving prevention and screening
- The Mental Health NSF Standard 1 – Mental health promotion

1.3.3 The Wanless reports

In January 2002 Sir Derek Wanless, commissioned by the Treasury, produced 'Securing our future health: taking a long-term view'. The purpose of this review was to assess the financial and other resources that were needed to ensure that the NHS could provide comprehensive, high quality services to all who needed them through public funding. The review concluded that the UK would have to devote a greater proportion of its national income to health care over the successive 20 year period (initially) to begin to match the best international examples and thereafter to keep pace.

In his second report, Wanless II, he was asked to explore one of the ideas in his first report. This suggested that the least expensive option for delivering a publicly funded and effective NHS was to secure the full engagement of the public in their own health and wider health issues, coupled with a financially efficient NHS, which would result in better health status and longer life-expectancy. A key focus of this report was preventative health measures and health inequalities.

Of particular relevance to this strategy is the emphasis in the report on the need for evidence-based public health practice and that measures to improve health - by tackling key risk factors such as lifestyle choices to smoke, drink excessively, engage in risky sexual behaviour etc - should be given equal weight in the performance management systems used by the NHS.

1.3.4 Choosing Health: Making healthy choices easier - 2004

The Choosing Health White paper was heavily influenced by Wanless II and was the first public health White Paper to be published for many years. It was also unusual as its main purpose was to influence the health of individuals, encouraging and enabling all of us to make healthy choices which prolong good health, increase life expectancy and reduce health inequalities.

It also highlighted the need for the NHS as a whole to be proactive in promoting good health and the potential contribution of workplaces across the country to health improvement and the mental health benefits of being in employment.

Progress against Choosing Health has been set out in a more recent report entitled Health Challenge England (October 2006) which looks at people's expectations for their own health, identifies progress and examples of good practice as well as recognising the ongoing challenges.

1.3.5 Health & public sector reform

In the past four to five years there have been a number of Green and White papers that have set a new direction for a wide range of public services. The most important are:

Independence, Wellbeing and Choice – adult social care services
Every Child Matters – children's services
Youth Matters – services for young people & families
Our health, Our care, Our say – health and social care services
Strong and Prosperous Communities – local government

All of these papers incorporate, in one form or another, the health aspirations expressed within Choosing Health and in many instances have an explicit emphasis on the development of preventative services in favour of those that react to need and empowering individuals. This policy shift is significant and is heavily influenced by the recognition, as within the public health agenda, that prevention – ideally coupled with greater independence & choice for service users and community-based, flexible services - ultimately leads to better outcomes for individuals.

These policy reforms are very significant for the health improvement and health inequality agenda for two main reasons:

- health improvement does not happen 'in a vacuum' but comes about as a result of changes in a range of life factors, including those that are covered by these five policies; and
- these reforms primarily target the most vulnerable or disadvantaged members of society, for whom the health gap is often the greatest.

1.4 Regional influences

The new North West Strategic Health Authority was established on 1 July 2006 and adopted the following service priorities, which are derived from national priorities:

- **Health inequalities**: To increase life expectancy at birth and reduce health inequalities by 10% by 2010 with an initial focus on smoking cessation.
- **Cancer**: Sustain a 31-day maximum wait from decision to treat to treatment and maximum 62-day wait from urgent GP referral to treatment.
- **18 week maximum wait** from GP referral to hospital treatment by December 2008.
- **MRSA**: To achieve year-on-year reductions in MRSA levels using 2003/04 as the baseline year.
- **Patient choice and booking:** To continue to ensure every hospital appointment is booked for the convenience of the patient (by implementing Choose & Book) and that every patient is offered a choice of at least four providers with 90% of referrals through CAB by December 2006.
- **Sexual health and access to Genito-Urinary Medicine**: Everyone referred to GUM clinic should have an appointment within 48 hours by March 2008.

Health inequalities sits prominently at the top of these priority areas and picks out smoking cessation as the initial focus. The reason for this is that despite significant

investment in smoking cessation nationally, smoking and exposure to smoke remains the single greatest cause of preventable illness and premature death in the UK and it is thought that smoking is the main risk factor for cancer and coronary heart disease, increasing the likelihood of these diseases by around 25% in both cases. Smoking is also strongly linked to the rise in prevalence of lung diseases known as COPD (chronic obstructive pulmonary disease) typically amongst middle-aged and older people.

Given that smoking prevalence is generally greater amongst manual groups, the effects of smoking disproportionately impinge on the health of these groups and more deprived neighbourhoods. The impact of smoking also has a harmful effect on some of the most vulnerable groups within the population including pregnant women, pre-natal infants, babies & young children and older people.

1.5 The GM picture

The Greater Manchester conurbation has one of the lowest life expectancies in the country and the city of Manchester has the lowest life expectancy for men and the second lowest for women in England. (Health Profile for Manchester 2006). It is anticipated that Greater Manchester is unlikely to meet the 2010 health targets set by the Department of Health, in particular, the desired 10% reduction in health inequalities as measured by infant mortality and life expectancy.

Although there is a mixed health picture across Greater Manchester, with some boroughs performing well against national averages, there are persistent health issues in some boroughs and a broadly consistent pattern of health inequality.

GM Boroughs Ratio between the directly standardised morality rate for those aged under 75 years in the most deprived fifth areas and the borough average

	2002-02 (%)	**2003-05 (%)**
***Stockport**	63.8	73.5
Bolton	59.3	60.1
Trafford	46.8	58.9
Rochdale	44.0	58.0
Bury	39.1	53.8
Salford	53.1	48.7
Oldham	50.2	46.3
Wigan	41.0	42.4
Tameside	42.4	39.8
Manchester	29.9	29.8

*The table shows that Stockport has the greatest difference in the under 75s death rate for those living in the fifth most deprived areas compared with the borough average (for both measurement periods above) and that this difference is increasing, significantly so between the dates shown above.

In response to these issues, during 2006 the Audit Commission undertook a review of health inequalities in Greater Manchester and on completion of the review process in February 2007 made a number of recommendations which included:

- Create strong health leadership at senior officer, Elected Member and non-executive director level;
- Ensure policy decisions are made in light of their impact on health inequalities;

- Develop robust public health data to inform decisions and commissioning; and
- Ensure that health inequalities commissioning works effectively in the target communities by working with local residents and grass-roots / voluntary and community sector organisations to develop imaginative and innovative services.

The Association of Greater Manchester Primary Care Trusts has also jointly established 16 projects forming a programme of work which is dedicated to improving life expectancy and reducing health inequalities within the sub-region. The projects include a focus on Coronary Heart Disease (CHD), cancer, smoking, mental health, alcohol and obesity.

It is widely recognised that success or failure in improving health in Greater Manchester will have the most direct impact on the ability of the north-west region to meet Government targets.

1.6 The local perspective

1.6.1 Stockport's borough profile

There are a small number of neighbourhoods within Stockport which are recognised as experiencing high levels of deprivation (under the Index of Multiple Deprivation [IMD]) but these are juxtaposed against some of the most affluent neighbourhoods in Greater Manchester leading to Stockport often being quoted as the most polarised borough in Greater Manchester. However, when set within a background of otherwise *relatively* typical neighbourhoods, these extremes are hidden statistically.

In the context of reducing inequalities, especially health inequalities, these two different ends of the socio-economic spectrum are very important as they are the barometer by which the reduction of inequalities is judged in Stockport. For example, the Brinnington Health Scrutiny review in 2006 identified the average difference in male life expectancy for a Brinnington resident and a Bramhall resident to be 12 years.

Analysis of public health data for the Stockport borough shows that the strongest contributory factor in poor health and premature death is socio-economic disadvantage. The health needs of all groups within the communities that the Strategy targets will be considered e.g. men, women, people from different ethnic groups and people with disabilities, where the evidence base suggests that there are different impacts for these groups, such as lower life expectancy in men, higher prevalence of some conditions / problems in ethnic minority communities. However, the scope of the strategy will primarily be directed towards the most influential factor in creating health inequalities which is the link between poor health / premature death and the geographical pattern of socio-economic deprivation in the Borough.

1.6.2 A Local Area Agreement for Stockport

Stockport's first Local Area Agreement (LAA) began in March 2006 and it will run for three years. The overall theme of the LAA is inequalities and there are a number of measures across the 4 themed blocks of the LAA that address public health issues and health inequalities specifically.

The only health related 'reward target', for which local partners receive funding to support achievement of the stretch target, is around smoking cessation. Much of the

work undertaken to achieve this target has been in neighbourhoods where there is high smoking prevalence, most notably in Brinnington.

1.6.3 Neighbourhood renewal & health inequalities

The purpose of neighbourhood renewal is to reduce inequalities within the community, and in doing so, narrow the differences between the least and most well-off communities across a wide range of issues including worklessness, educational attainment and access to high quality services, facilities and support. Given the polarity within Stockport described above, this could be argued to be an even greater challenge than in boroughs where the intra-borough differences are less extreme.

An important issue that is increasingly being recognised locally, through more sophisticated data analysis and work directly with communities, is that health problems in our most deprived communities often differ in both order and nature to the health issues that are seen in the wider community. Atypical patterns of behaviour, which are likely to be a product of the complex needs and challenges facing these individuals, can appear to be at the root of the severe and persistent poor health seen in these communities.

In Stockport, Brinnington has been a renewal area since the late 1970s but a number of other neighbourhoods within the Borough have benefited from Government and European funding programmes during the late 1990s / 2000s, such as Single Regeneration Budget (SRB) and European Regional Development Fund (ERDF), due to their IMD profile.

The 40% most deprived neighbourhoods in Stockport have been mapped out and feature 4 levels of priority where priority 1 represents the top most 20% deprived neighbourhoods nationally. Priority 1 neighbourhoods are Brinnington, Adswood and Bridgehall and Lancashire Hill & Heaton Norris and these neighbourhoods typically feature the greatest health inequalities within Stockport.

While these neighbourhoods feature some of the most entrenched and notable examples of local health inequality, they represent a relatively small proportion of the local population that has the *potential* to suffer from heath inequalities. Public health research and practice shows that to make the greatest health gains, health improvement work must focus on the groups and communities that are most at risk of health inequalities, and this typically equates to the 40% most deprived communities nationally. For this reason, health inequalities work in Stockport will extend to the 40% most deprived communities (the 4 Priority Areas), but in the first instance will rightly focus on those neighbourhoods where there is the most deep-seated and concentrated incidence of poor health.

Bridging the health inequalities gap in Stockport will be extremely challenging, requiring focused and sustained effort over many years, especially when improvements in the health of more affluent communities are likely to continue. A reduction in health inequalities within Stockport will therefore only be seen if sustained improvements in health are made at a *higher rate of health gain* than in affluent boroughs.

Reducing health inequalities in Stockport is a robust challenge which has to be regarded as a multi-agency issue. Intervention activity must be evidence-based and targeted at the most vulnerable or ‘at risk’ groups. Above all, while the services developed in response to the health issues in each neighbourhood will be delivered

by a range of professional staff, how those services evolve and where and how they are delivered must be community-led.

2.0 Health Inequalities Needs Assessment

2.1 Introduction

The following chapter collates key indicators that provide a picture of health inequalities in Stockport in 2005. It outlines key targets and our performance against them. It demonstrates both the scale of the problem we confront and highlights the areas for action where we are likely to have the greatest impact on narrowing the inequality gap.

2.2 Overview

In summary, the data analysis on life expectancy identifies that:

- Inequalities exist even though Stockport is perceived to be relatively affluent compared with other boroughs in the North West.
- Stockport has pockets of deprivation which show stark differences in health outcomes compared to both the national average and the most affluent areas of Stockport.
- The top three drivers of the life expectancy gap are deaths from circulatory, cancer and digestive conditions which in turn are largely smoking or alcohol related.
- Health inequalities are complex and difficult to change, and efforts to sustain improvements have to be regularly reviewed and refocused to take into account changes in contributory causes. As evidenced by the fact that despite successes in reducing the gap related to circulatory and respiratory disease which are largely smoking related, progress made has been offset by the increase in deaths attributable to alcohol.

It follows from the in depth analysis of trends for life expectancy outlined overleaf that the immediate priorities to address intra Stockport inequalities are:

- **A focus on our major killers** i.e. circulatory and cancer, preventing early death for those with existing disease or at high risk of developing it (i.e. primary and secondary prevention)
- **A redoubling of efforts around tobacco**. Smoking remains the single biggest preventable cause of the social economic gradient in life expectancy.
- **Tackling alcohol misuse**. Alcohol related deaths have increased by 90% in the last 10 years and it is now a major influence on increasing the life expectancy gap in Stockport.
- **Halting the rise in obesity prevalence**. It is estimated that by 2020 one third of adults will be obese. Obesity is a key risk factor for both circulatory disease and diabetes which are strongly associated with deprivation and therefore it is forecast to have a major impact on the life expectancy gap. Significant efforts need to be made now to put in place funding and services to ensure achievements in life expectancy are sustainable.
- As highlighted in the previous chapter work is also required on the **wider determinants** to ensure impact is achieved beyond 2010. In Stockport the main strategic driver for this will be the Local Area Agreement, which has reducing inequalities as its overall goal.

In addition, the role of **mental wellbeing** in addressing health inequalities has been acknowledged as essential. The skills and attributes associated with positive mental

health lead to improved physical health, better quality of life, reduced crime, higher educational attainments, economic wellbeing and personal dignity. The strategy will focus on assessing need and developing a coherent approach to promoting positive mental health across 3 levels, individual, community and structural.

2.3 Strategic objectives for priority work programmes

Section 5 provides further analysis on the various contributory causes of the life expectancy gap i.e. CHD, cancer, tobacco, alcohol, obesity and mental wellbeing. This needs assessment highlights the necessity for a step change in the way we approach health inequalities and our strategic intentions to deliver this are detailed below. 30% of Stockport's population is defined as deprived so achieving our targets is about large scale change. This is therefore not about short-term initiatives but about mainstreaming action.

- To incentivise GPs in deprived areas to improve access to effective treatments and lifestyle behaviour change services for those with existing circulatory disease or at high risk of developing it.

- To develop innovative ways to engage and reach high risk individuals in deprived populations, using social marketing approaches to tailor messages and services.

- To improve cancer detection in deprived communities, with a particular focus on public education and screening programmes.

- To create a "quitting culture" within our 4 most deprived neighbourhoods that have the highest smoking rates, through the development of community programmes tackling all aspects of tobacco control, smoking cessation and prevention.

- To maximise the impact of the ban on smoking in public places through targeting additional support to workplaces with high numbers of manual workers and launching a Smoke Free Homes initiative.

- To double capacity in the smoking cessation service in order to systematise referral to services for pre operative patients and other key target groups.

- To develop and deliver screening and brief intervention services for alcohol misuse, targeted at key settings and deprived communities.

- To develop new weight management services for children and adults and intensify primary prevention programmes re food and physical activity in deprived communities.

- To recognise the importance of mental wellbeing in addressing health inequalities and gather baseline information to assess need, set targets for improvements where appropriate and develop a coherent strategy to drive forward change.

2.4 The two national priority targets for inequalities – life expectancy and infant mortality

2.4.1 Life Expectancy

Life expectancy is a summary measure of mortality which calculates the average age to which babies born at the current time would live if there was no change throughout their life in the age-specific mortality rates currently being experienced by the present population.

As there may be future changes in mortality during the lifetimes of those babies, as there have been past changes in mortality during the lifetime of those now alive, and as the people now alive are those who have survived the earlier years of their generation, it does not correspond to any actual average age of death. It is a summary predictor if the current situation were to continue. There are a range of national targets for health improvement and reduction in health inequalities which are described in the below, however these are all brought together under summary targets which state:

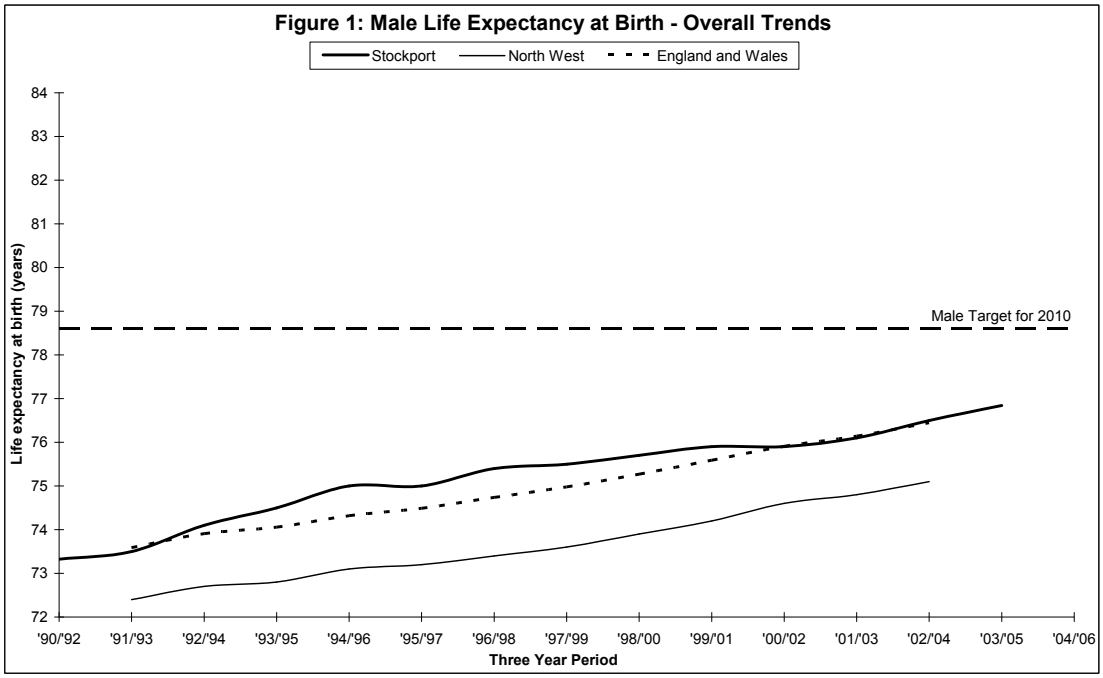
- *To increase the life expectancy at birth in England to 78.6 years for males by the year 2010.*
- *To increase the life expectancy at birth in England to 82.5 years for females by the year 2010.*
- *To reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole by 2010.*

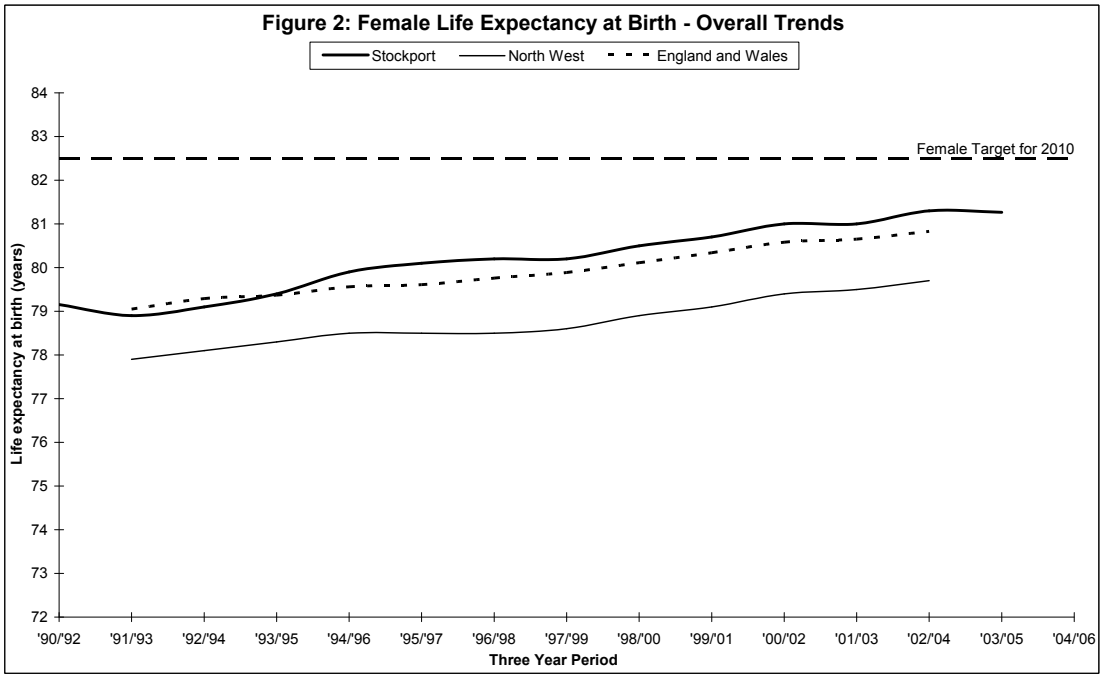
Nationally the inequalities element of this target is monitored by measuring the gap between the fifth of PCTs with the lowest life expectancy, the 'spearhead' PCTs, and the national average; for many years this has been the sole measure of progress and as Stockport was not identified as a spearhead PCT there was no formal target to work towards. Recently, however, guidance has been issued requiring non-spearhead PCTs to begin monitoring and reporting their contribution towards the health inequalities target by setting local targets within their Local Area Agreement (LAA) which focus on narrowing the gaps in life expectancy between small areas within their local area.

The following sections summarise an in-depth analysis of trends for life expectancy and inequalities that has recently been conducted by Stockport PCT before setting out the local targets for life expectancy inequalities that Stockport has agreed to within the LAA.

2.4.1.1 Overall Trends

Life expectancy in Stockport, as in the rest of the country, has increased over the last 15 years. In the early and mid 1990s it improved faster than the national average and Stockport moved from having slightly worse life expectancy than the England and Wales average to having slightly better life expectancy. Since then however the rate of improvement has slowed (see figures 1 and 2).





Looking at the data for the different genders, we can see that for males, prior to 2000, the average life expectancy in Stockport was higher than the national average. Between 1999-2001 life expectancy plateaued allowing the national average to catch up and since 2001 has been rising at the same rate as the national average.

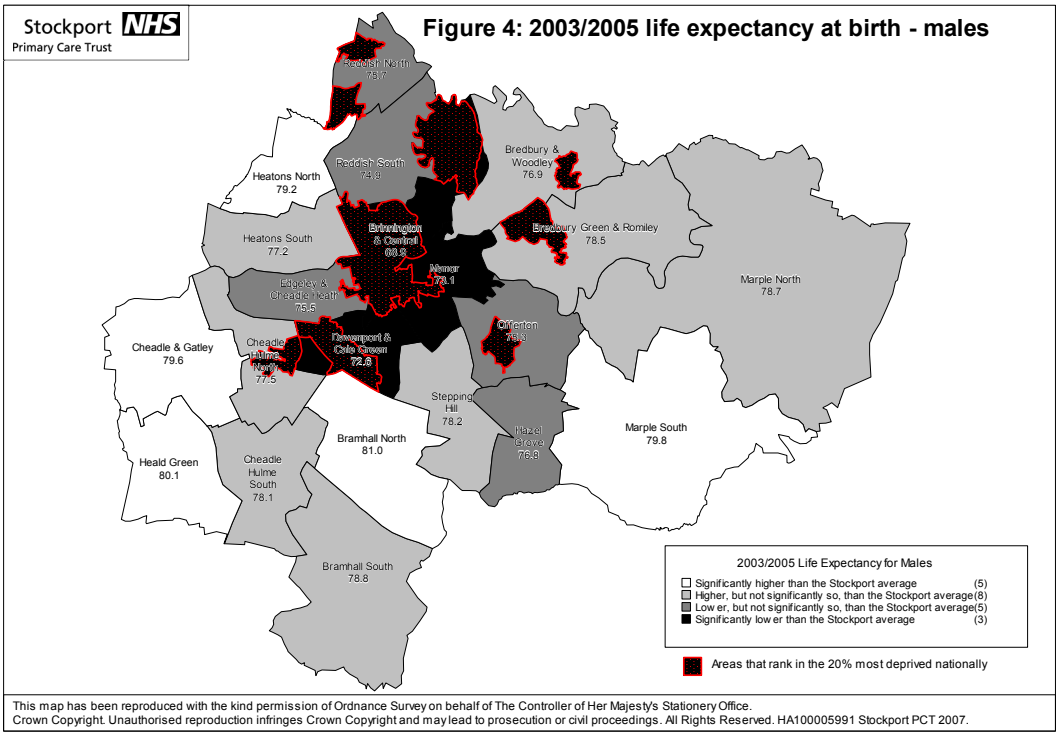
Since then the male life expectancy has been approximately the same as the national average, i.e. despite an overall increase in life expectancy for men the rate of improvement has slowed down and the gap between Stockport and England and Wales has closed. Currently males born in Stockport can expect to live an average of 76.8 years. Close performance monitoring allowed timely action and this seems to have brought Stockport's trend back in line with the national average.

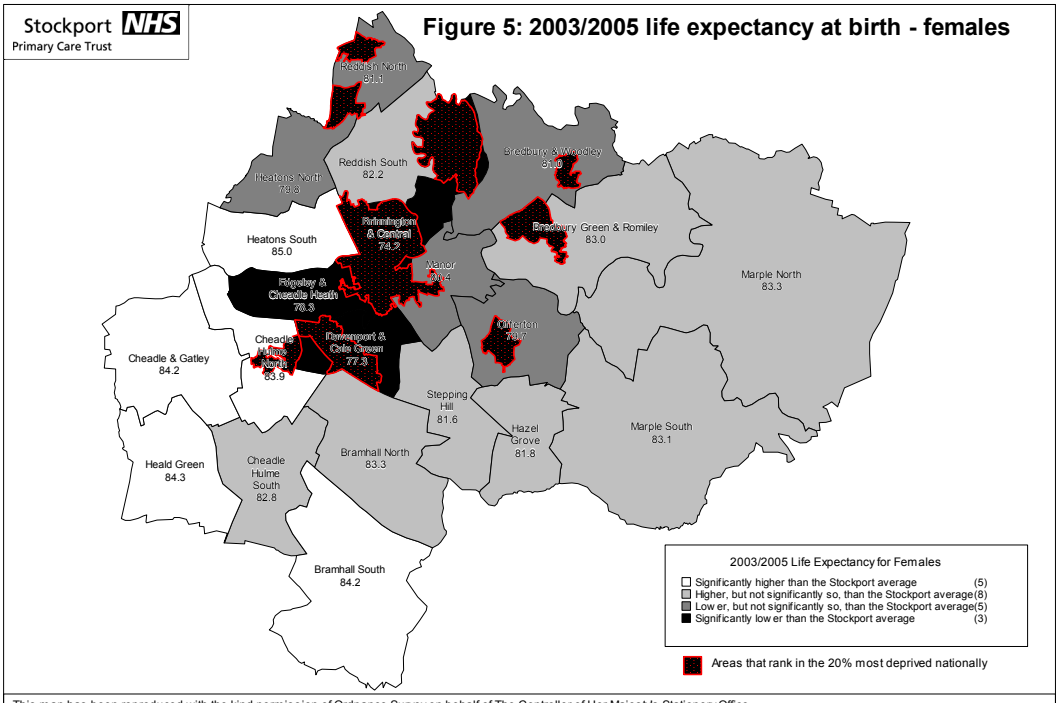
In females, the average life expectancy in Stockport has been consistently higher than the national average and females born in the area can currently expect to live for an average of 81.3 years. Despite some year-on-year fluctuation female life expectancy in Stockport is broadly following the national trend.

Progress in Stockport towards the 2010 national targets for life expectancy for both males and females is slightly below the level necessary to achieve targets.

2.4.1.2 Intra Stockport variation in life expectancy

Table 3: 2003/2005 life expectancy at birth - 3-year average		
	Males	**Females**
2004 WARDS		
Bramhall North	81.0	83.3
Bramhall South	78.8	84.2
Bredbury & Woodley	76.9	81.0
Bredbury Green & Romiley	78.5	83.0
Brinnington & Central	68.9	74.2
Cheadle & Gatley	79.6	84.2
Cheadle Hulme North	77.5	83.9
Cheadle Hulme South	78.1	82.8
Davenport & Cale Green	72.6	77.3
Edgeley & Cheadle Heath	75.5	78.3
Hazel Grove	76.8	81.8
Heald Green	80.1	84.3
Heatons North	79.2	79.8
Heatons South	77.2	85.0
Manor	73.1	80.4
Marple North	78.7	83.3
Marple South	79.8	83.1
Offerton	75.3	79.7
Reddish North	75.7	81.1
Reddish South	74.9	82.2
Stepping Hill	78.2	81.6
Most Deprived 5 wards	73.2	78.3
Mid deprived 11 wards	77.5	81.8
Least deprived 5 wards	79.2	83.2
DEPRIVED AREAS - *LSOAs in 20% most deprived nationally*		
Deprived areas	70.0	76.2
Non-deprived areas	77.9	82.0
STOCKPORT AVERAGE	**76.8**	**81.3**





Although life expectancy in Stockport has gradually increased in all areas, it has not done so at a uniform rate throughout the district and there are large differences in the average life expectancies for different communities within the borough. There is a powerful relationship between the gap in life expectancy and local measures of deprivation. The lowest life expectancies are to be found in the most deprived fifth of areas nationally, in Stockport the areas in the centre and north of the borough such as Brinnington, Adswood and South Reddish, and people living in these areas can expect to live on average 4 to 6 years less than the Stockport and England average.

At its most extreme this gap increases to 12 years (men), 11 years (women) if you compare the ward with the lowest life expectancy (Brinnington and Central) against the wards with the highest life expectancies (Bramhall North for males and Heaton South for females) (see table 3, figure 4 and figure 5).

Figure 6: Male Life Expectancy at Birth - Geographical Differences in Stockport

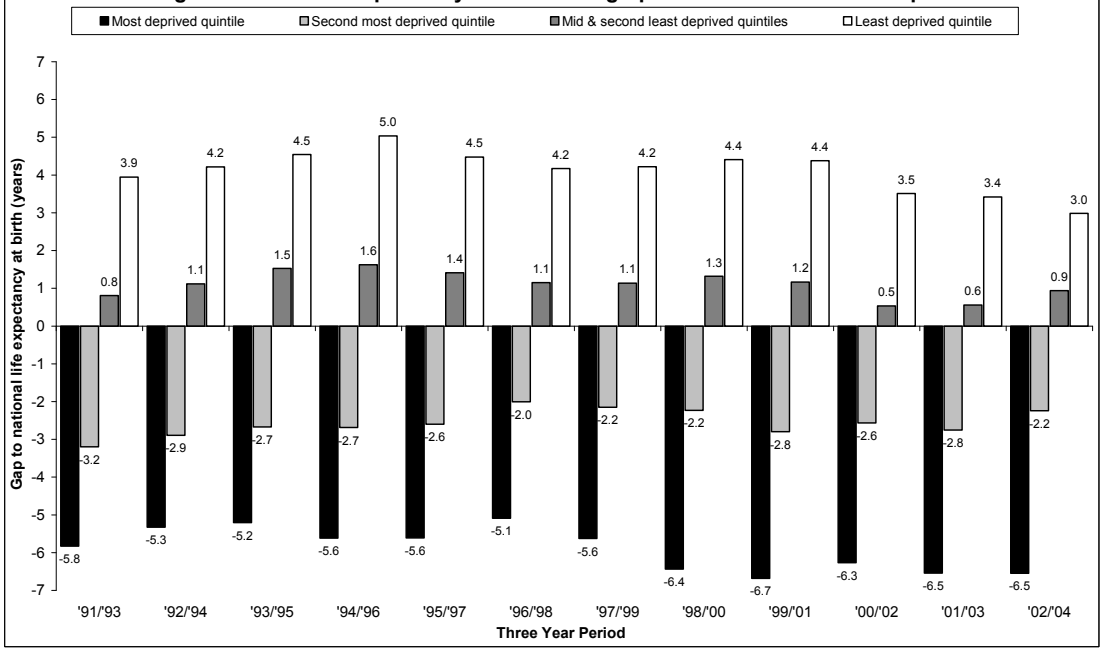
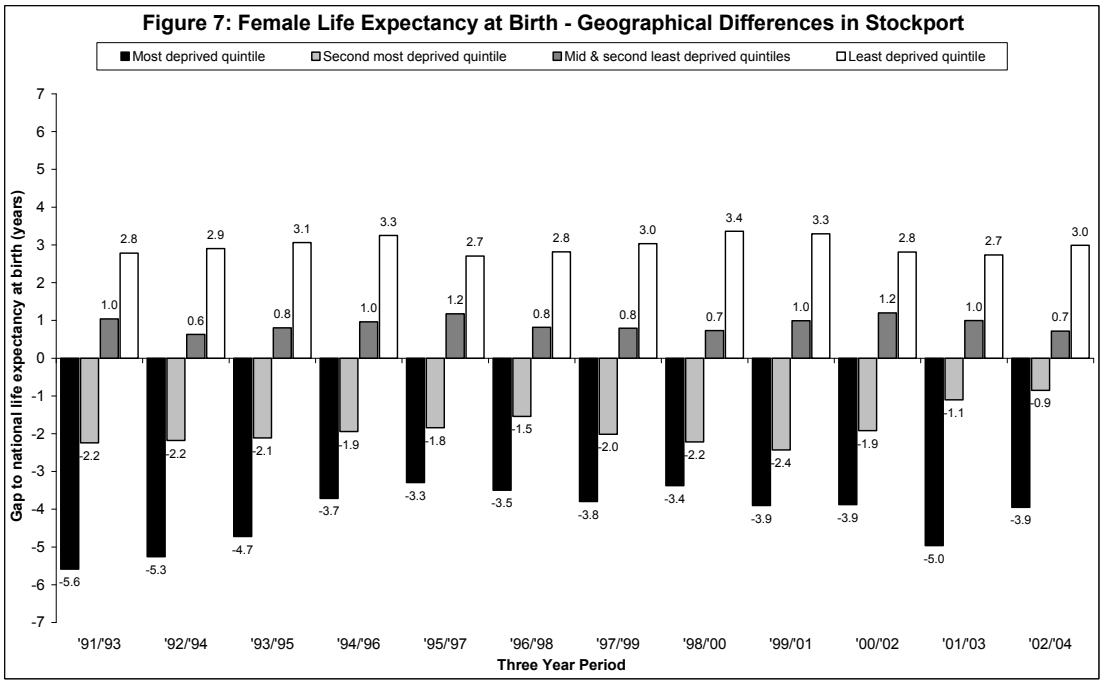


Figure 7: Female Life Expectancy at Birth - Geographical Differences in Stockport



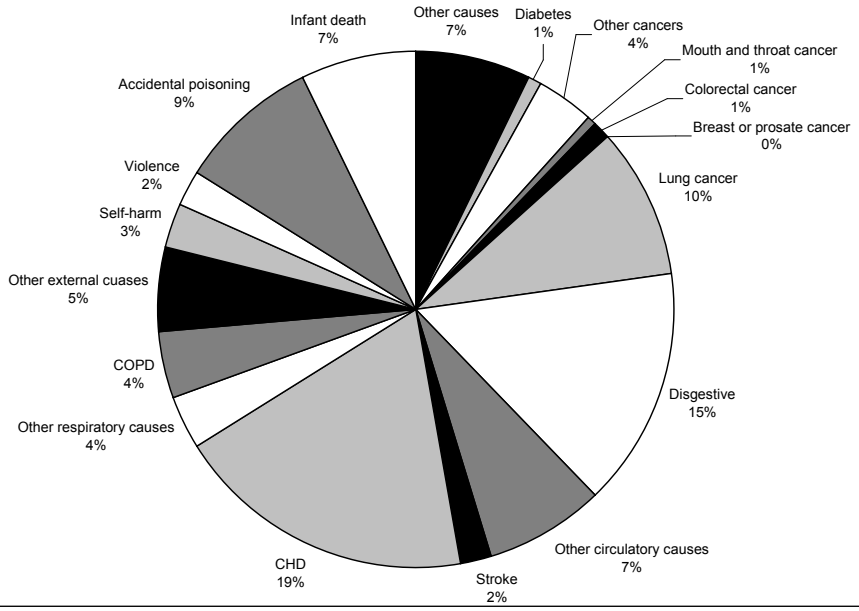
Looking at trends in geographical differences over time (figures 6 and 7), we can see that for males, there has been a decrease in the life expectancy of populations in more affluent areas relative to the national average, a trend that is being seen across the northwest. For the most deprived areas the gap with the Stockport average has actually widened.

For females there has not been any significant variation between the least deprived areas and the local average. The data does show a narrowing of the gap in both the worst and second worst quintiles in the early to mid 1990s but this has not been sustained and since 2000 the gap between non deprived and deprived areas has widened.

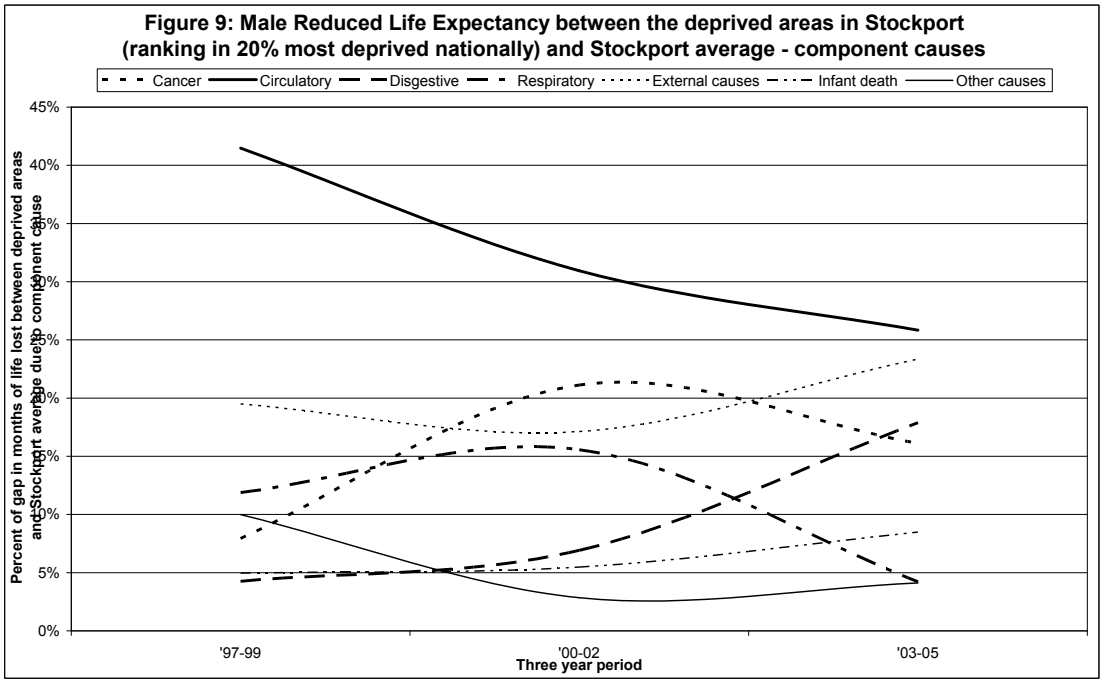
2.4.1.3 Causes of the difference in life expectancy

Life expectancy overall is made up of various contributions by different component causes of death. In order to be able to plan for and undertake effective interventions it is critical to understand and track these components. The major drivers in differences in life expectancy are currently, circulatory disease (28%), cancer (16%) digestive disease (15%) and with smaller contributions made by accidental poisoning (9%) and respiratory conditions (8%).

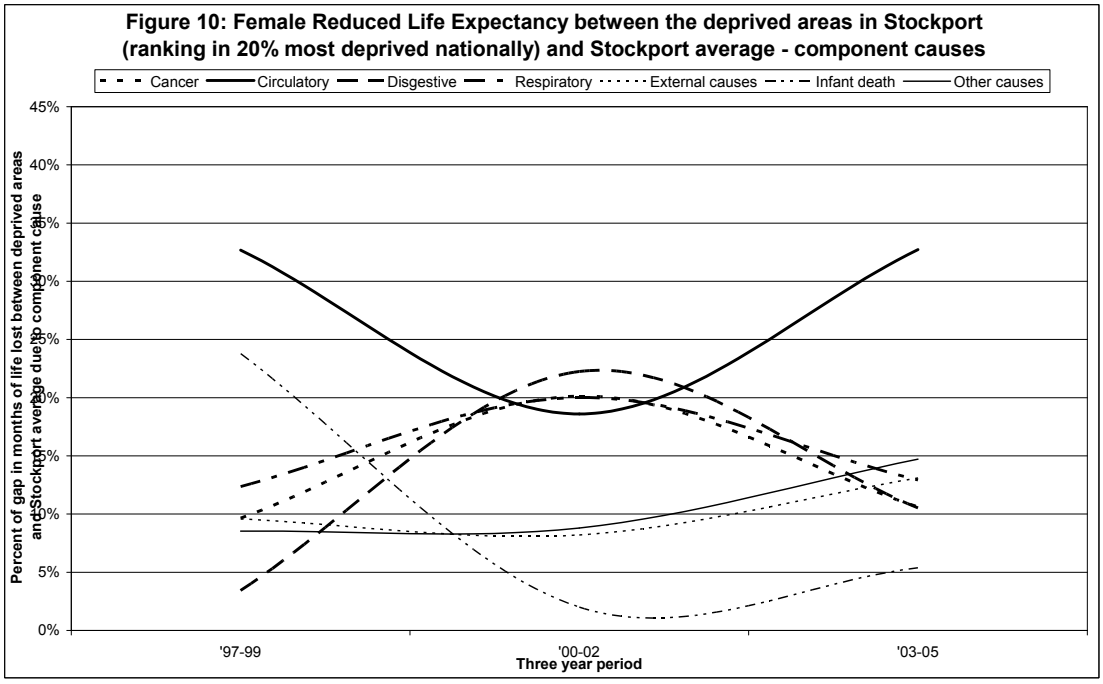
Figure 8: Reduced Life Expectancy between the deprived areas in Stockport (ranking in 20% most deprived nationally) and Stockport average - component causes 2003/05



If we look at trends over time we can also see significant changes in contributing causes. This partly explains why rates of improvement vary over time and efforts to sustain improvements have to be regularly revisited and refocused. Many of the trends we see in Stockport are consistent with those across the North West.



For men between the three year periods 1997 to 1999 and 2003 to 2005, there has been a significant reduction in the life expectancy gap related to CHD and respiratory disease. However, there has been an opposing increase in life expectancy gap relating to deaths from digestive causes (mainly alcohol related), cancers and external causes of death.



For females the picture is slightly different, there was a significant decrease between the three year periods between 1997 and 1999 and 2000 and 2002 in the relative significance of CHD as a contributory cause of inequality, however this has been matched by an equally significant rise during the years between 2003 and 2005 and therefore currently it is still a significant cause of difference. Further analysis shows that although the total numbers of deaths from circulatory disease have fallen they

have done so at a faster rate in non-deprived areas as compared to the deprived areas, particularly in the period since 2000. The differential for circulatory diseases between the two areas has increased rapidly in the most recent period and therefore the proportional contributory cause has increased. However, in a pattern similar to that shown by males, the relative importance of digestive disease in contributing to differences in life expectancy has also risen over the period.

The additional resources and health promotion interventions targeting smoking, are clearly achieving their goals as the causes of death where the life expectancy gap is reducing are those attributable wholly or in part to the consequences of smoking. Diet and exercise are also important to coronary heart disease but it is not clear whether programmes in these areas are equally effective.

The significant and increasing impact of alcohol upon life expectancy is cause for concern. Not least because alcohol attributable deaths are more common in younger populations (i.e. those aged 55 to 59 years) as opposed to those older age groups (75 to 79 years). Therefore, an alcohol related death contributes to a greater reduction in projected life expectancy, than deaths due to smoking related causes.

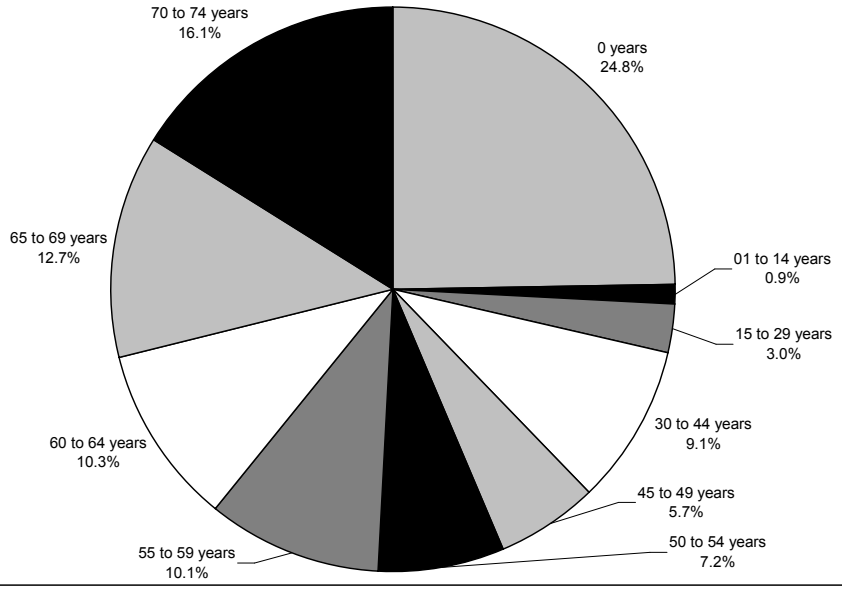
Emerging priorities

Obesity is also an increasing area of concern and is directly related to increased mortality and lower life expectancy. The National Audit Office (NAO) in their 2002 report 'Tackling Obesity in England' estimated that 30,000 deaths a year (roughly 6% of the total) were directly attributable to obesity; 9,000 of which occurred prematurely, before retirement age. Obesity is most strongly associated with increased prevalence of and mortality from circulatory disease and diabetes, both of which within Stockport contribute to the inequalities gap in life expectancy, and deprivation. Nationally the prevalence of obesity has trebled since the 1980s, and without intervention it is expected that this trend will continue, potentially impacting adversely on the trend of the decreasing significance of CHD deaths to inequalities shown in figure 9.

Contribution of age groups

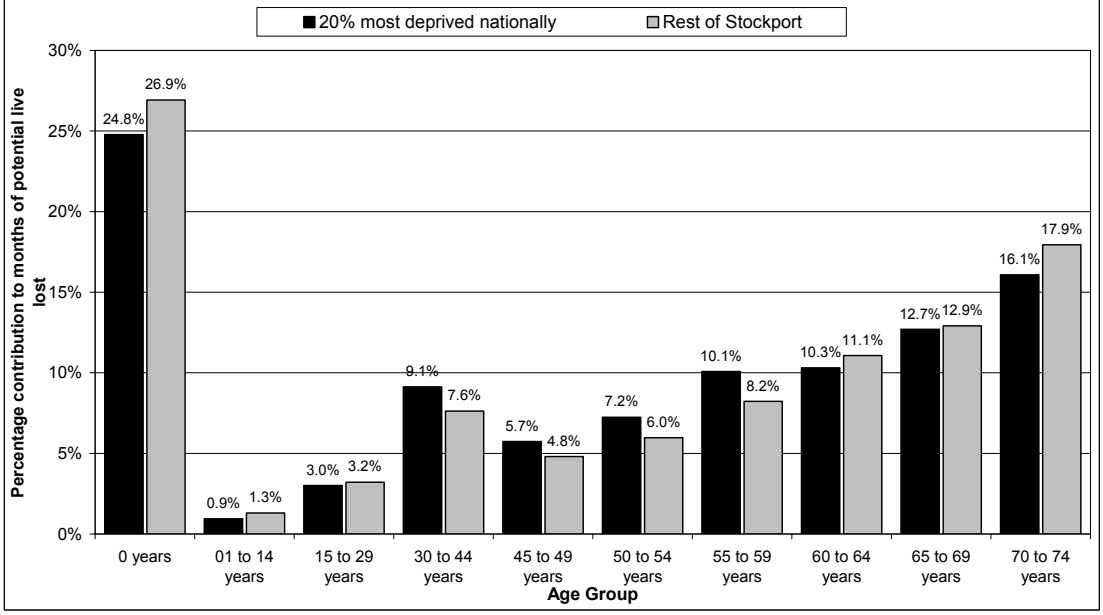
Figure 11 shows the breakdown of the months of life lost in the most deprived areas by age group. The over 50's contribute an estimated almost 60% of the months of life lost in both men and women (56.4%), increasing to two thirds for the over 30 age bracket. The data also indicate the importance of addressing mortality in childhood, principally infancy. Deaths under 10 contributed around 25% of the months of life lost in these areas, mainly comprised of deaths under 28 days.

Figure 11: Contribution of age groups to months of potential live lost for people aged under 75 in most deprived 20% of Stockport



The age contribution differences between the deprived areas and the rest of the borough are shown in figure 12. Data suggests that it is deaths for those aged 30 to 59 years that are driving the gap in life expectancy; as it is in these age groups where the deprived areas differ from the non-deprived average. The low numbers of deaths that occur in childhood mean that there is little significant difference between the non-deprived and deprived areas for younger age groups.

Figure 12: Comparison of the contribution of age groups to months of potential live lost for people aged under 75 in most deprived 20% and the rest of Stockport



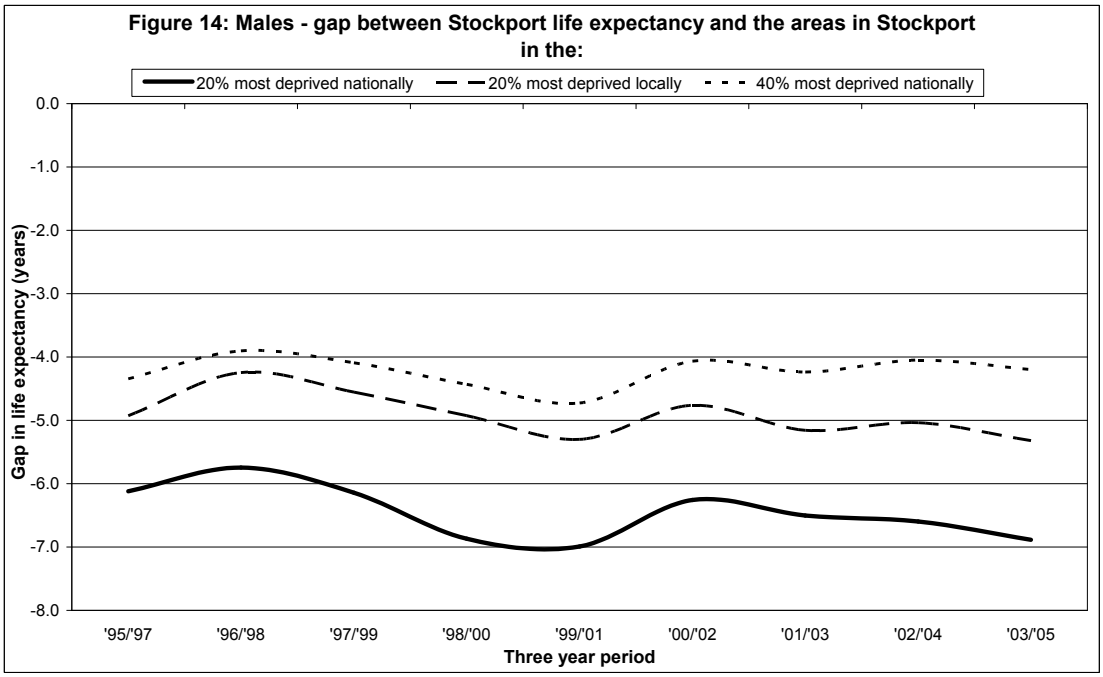
2.4.1.4 LAA targets for reducing life expectancy gaps within Stockport

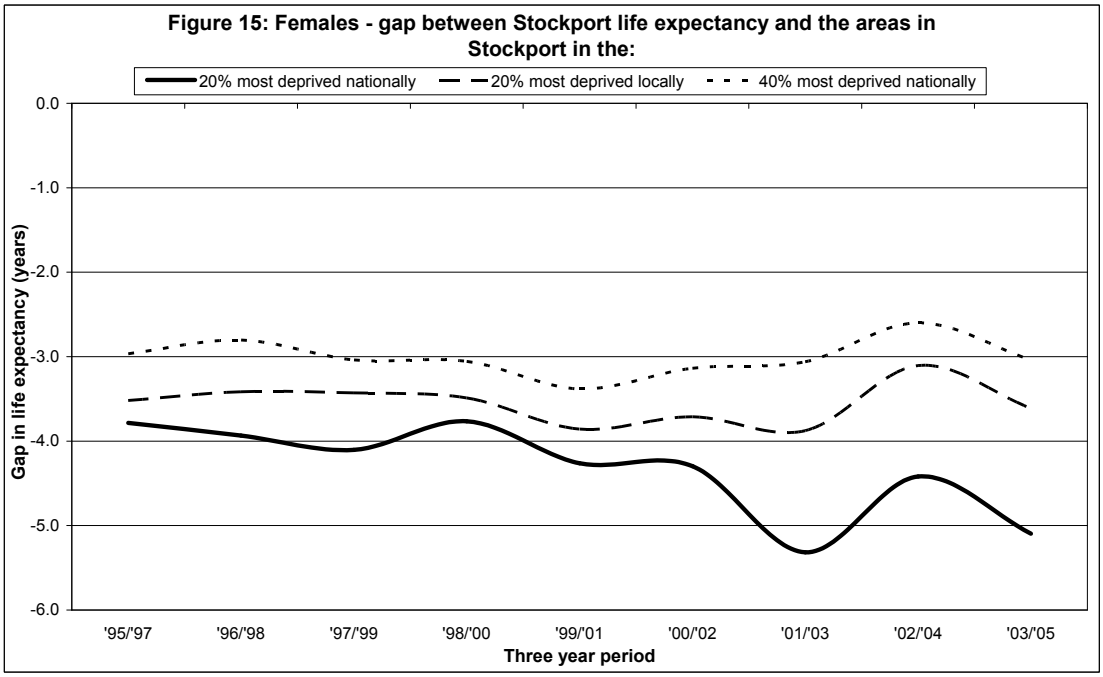
Table 13: LAA targets for life expectancy inequalities - 3-year average					
	02/04 (BASE)	03/05 (Year 0)	04/06 (Year 1)	05/07 (Year 2)	06/08 (Year 3)
MALES					
Trajectory (Gap in years)	-6.60	-6.53	-6.46	-6.38	-6.31
LE for areas in Stockport in the most	69.9	70.0	70.7		
Stockport	76.5	76.8	77.1		
Actual (Gap in Years)	-6.60	-6.89	-6.47		
Achievement	-	105.5	100.3		
FEMALES					
Trajectory (Gap in years)	-4.42	-4.39	-4.36	-4.32	-4.29
LE for areas in Stockport in the most	76.9	76.2	77.3		
Stockport	81.3	81.3	81.9		
Actual (Gap in Years)	-4.42	-5.10	-4.58		
Achievement	-	116.1	105.1		

Local Area Agreement targets for reducing the gap in life expectancy inequalities have been agreed with the Government Office North West, see table 13. These targets reflect the national target of a 10% reduction over a fourteen year period (from a base in 1995/97 to a target year of 2009/11) applied over the four year LAA period (from a 2002/04 base to a target year of 2006/08).

These targets are challenging, as is demonstrated by the lack of progress in the first year, and a key priority of the health inequalities strategy must be to work towards reducing this gap and achieving an improvement in the summary measure. It is also important, as part of the overall strategy, to monitor changes in the gap in life expectancy in other deprived areas within Stockport (see figures 14 and 15).

Figure 14: Males - gap between Stockport life expectancy and the areas in Stockport in the:

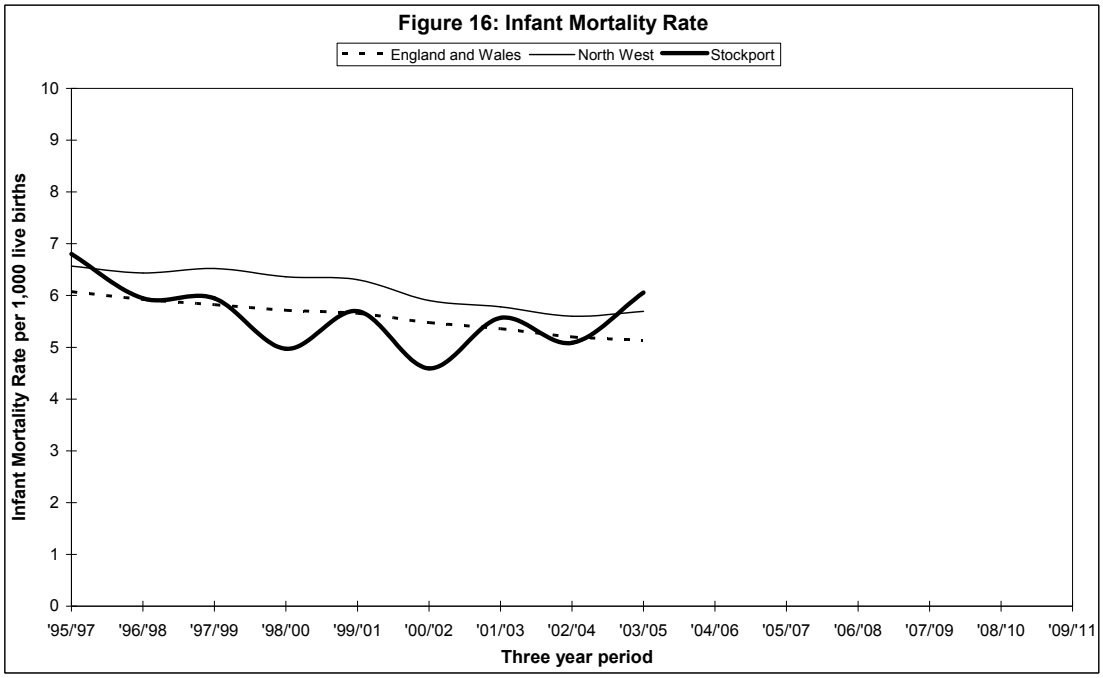




2.4.2 Infant mortality

The second key national target for reducing health inequalities focuses on giving children the best start in life and again uses a summary mortality measure to capture the range of health experiences, stating:

- *To reduce by at least 10 per cent the gap in mortality for children under one year between routine and manual groups and the population as a whole by 2010*



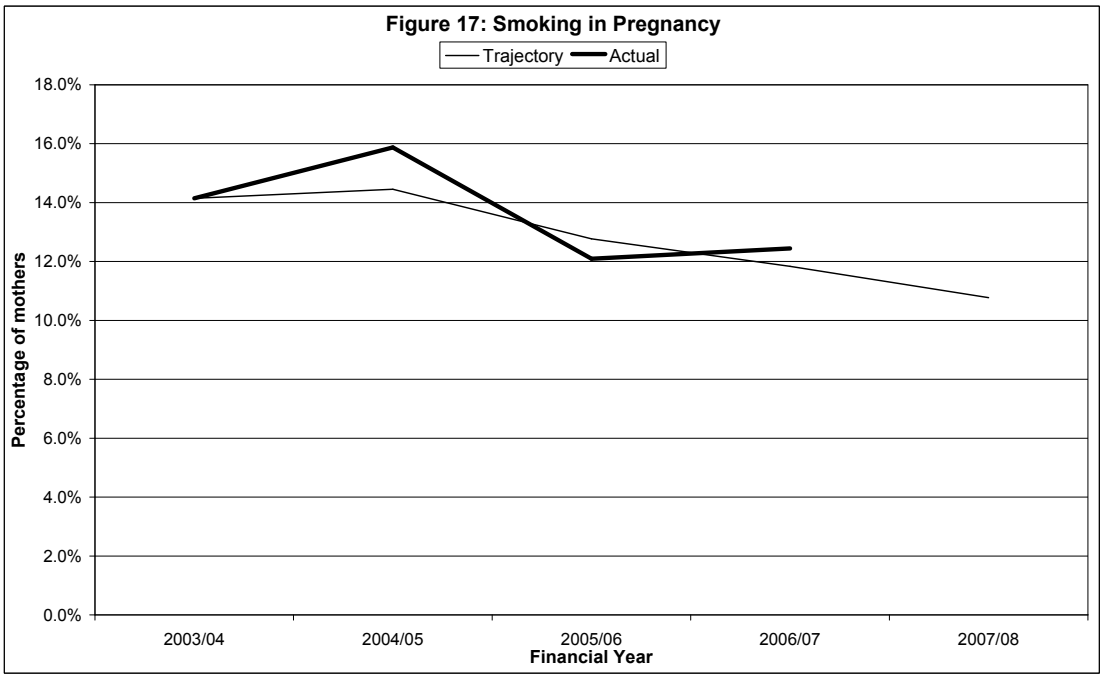
Trends in infant mortality at the Stockport level are shown in figure 16, rates fluctuate due to the low numbers of infant deaths as in Stockport there are usually fewer than 20 a year. Monitoring of the target in respect of within Stockport inequalities is therefore not reliable and PCTs are instead performance managed on two key local targets established through the Local Delivery Plan (LDP):

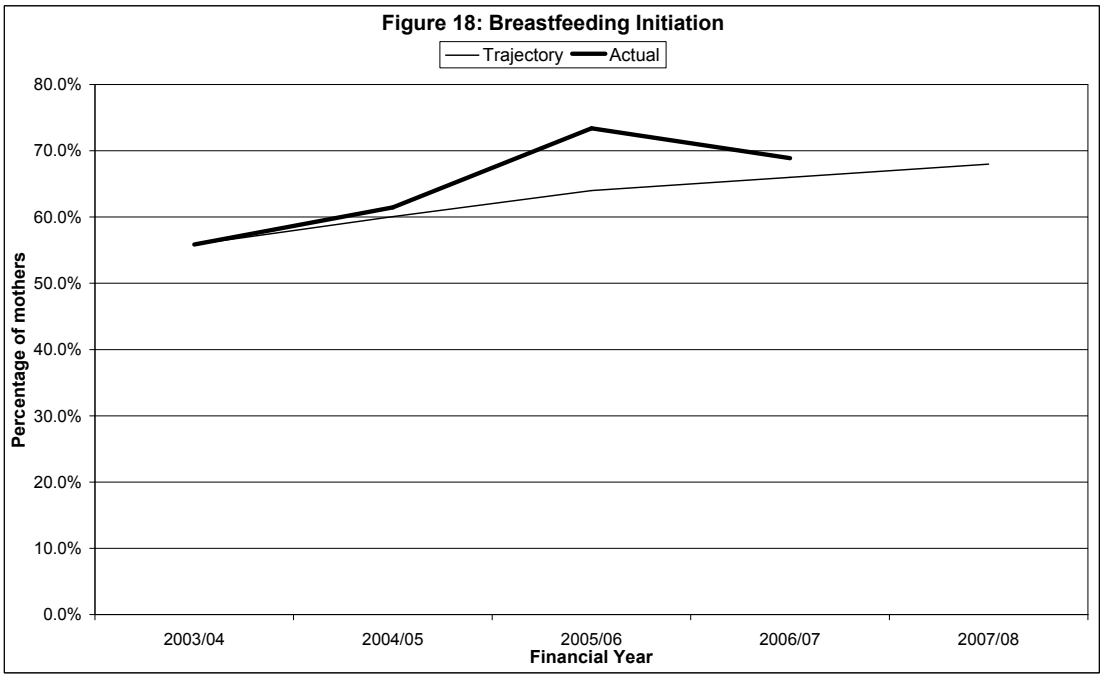
- *To reduce the number of mothers who smoke during pregnancy.*
- *To increase the number of mothers who breastfeed.*

Figures 17 and 18 below illustrate the overall performance for Stockport PCT towards these two targets since 2003/04. The trends for smoking in pregnancy show a general downward trend, although currently levels are not low enough to meet the target for this year.

Breastfeeding initiation rates have increased since the 2003/04 baseline, and although there has been a slight dip in performance over the first two quarters of 2006/07 levels are still on trajectory.

Data is not yet of sufficient quality to perform an analysis of trends for inequalities within these indicators, however figures for 2005/06 suggest that there are significant differences in rates between the deprived and non-deprived areas of the borough. Levels of smoking in pregnancy in the most deprived areas appear to be more than twice that of those in the rest of the borough whilst breastfeeding initiation rates are around two-fifths less.



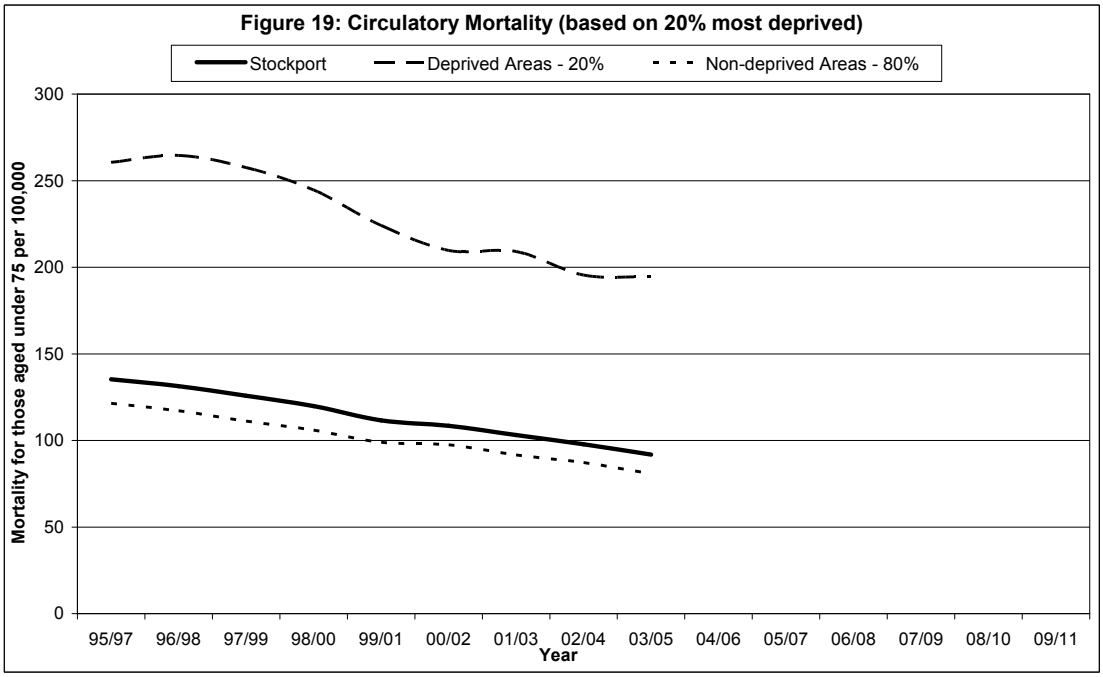


2.5 Drivers of health inequalities

2.5.1 The big killers: Circulatory Disease & Cancer

Nationally there have been significant improvements in death rates from cancer and heart disease since 1995/97, including improvements in disadvantaged areas. There have been some signs of a narrowing of inequalities in heart disease death rates in absolute terms but the same trend can not be identified for cancer deaths.

Circulatory disease mortality patterns within Stockport have mirrored the national trends, with a significant decrease in rates in all areas of the borough occurring since 1995/97 (see figure 19). Again, as has happened nationally, there has been a decrease in Stockport in the absolute gap between the most deprived areas and the average (from a gap of 125.2 per 1,000 to one of 102.6 per 1,000) as overall mortality rates have fallen. Relative inequalities however have increased over the same period, as whereas mortality rates in the deprived areas were 193% higher than the Stockport average in 1995/97 they have risen to a level 212% above the Stockport average in 2003/05.

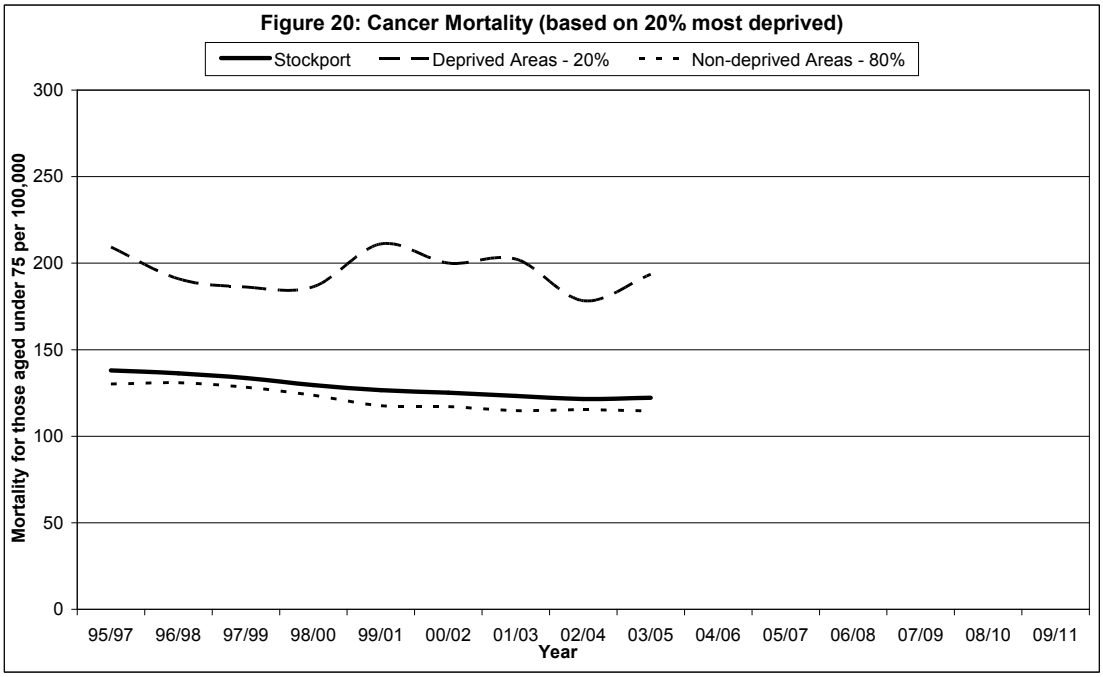


Patterns within Stockport for cancer mortality are less clear, although overall there has again been a decrease in death rates in all areas within Stockport since 1995/97 (see figure 20). In terms of inequalities however there has been a maintenance in Stockport in the absolute gap between the most deprived areas and the average, with the gap remaining constant at 71.4 per 1,000. Relative inequalities have increased slightly from a level 152% above the Stockport average in 1995/97 to one of 158% above average in 2003/05.

Figure 20 however shows that this overall pattern was not maintained in the most deprived areas for the whole period and in fact between 1999/01 and 2001/03 mortality rates for cancers in these areas increased back to the baseline levels experienced in 1995/97. The trend is worrying and is thought most likely to be due to differences in the rate of smoking between these areas and the rest of borough (see section 2.2).

Stockport PCT has long recognised the importance of the 'big killers' to health of the population of the borough and their role as major contributory cause of health inequalities. The PCT has therefore recently completed a health equity audit of primary and secondary care for circulatory disease and is currently undertaking a health equity audit for cancer.

Analysis of information for circulatory disease has unsurprisingly shown a link between levels of deprivation, prevalence and mortality but also showed that overall rates of procedures linked to circulatory disease and prescribing for statins were higher in deprived areas; in other words suggesting that the equity of care was not displaying an inverse pattern as is often the case in other areas. The question remained however, whether the rates of intervention were high enough in deprived areas to compensate for the inequalities experienced and this therefore led to a change in focus of the audit away from general trends and instead focusing on individual GP practices.



Through the audit the PCT has identified a number of practices where further work is needed, namely practices that do not appear to be identifying or treating patients at risk of dying from cardiovascular disease as well as their peers. These findings have formed the basis of a reconfiguration of the enhanced service for CHD.

One important general finding from the audit was that smoking was found to be correlated with deaths from CHD in all areas, but that the link was shown to be stronger in deprived practices than in non-deprived practices; in other words smokers in deprived areas are more likely to have worse health outcomes relating to CHD than smokers in non-deprived areas.

The cancer health equity audit is currently being undertaken and results are expected to be published by summer 2007. Interim findings have shown an especially strong statistical link between the incidence of and mortality from lung cancer (the cancer most associated with use of tobacco) and levels deprivation.

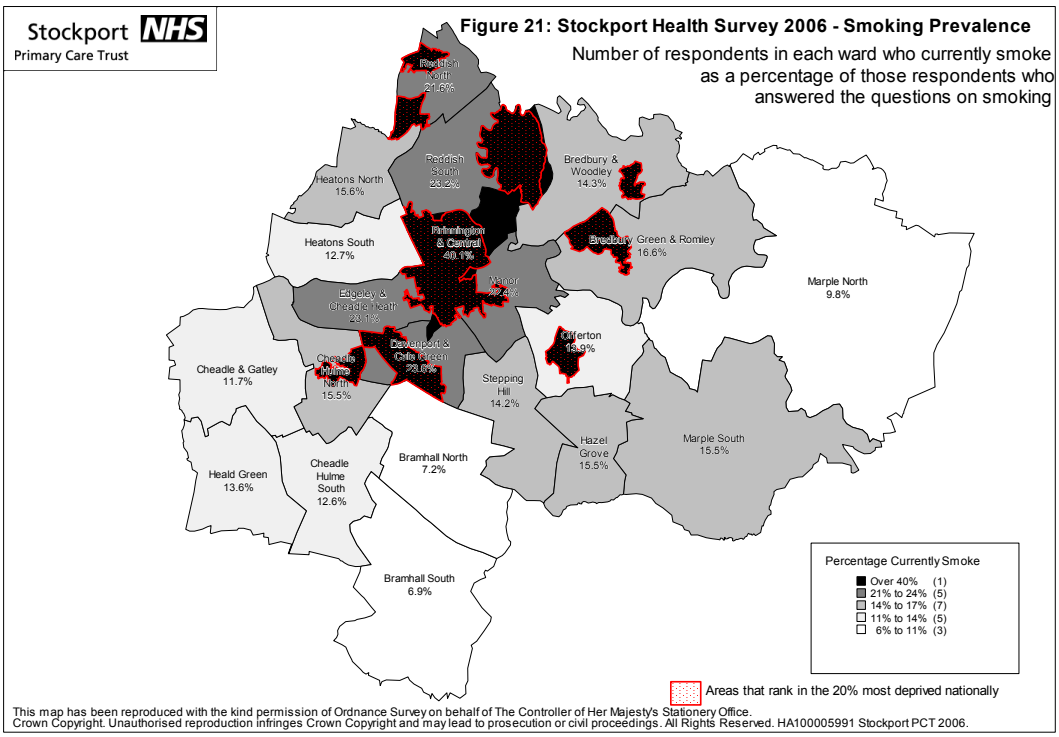
Findings have also shown a link between the incidence of and mortality from breast cancer in deprived areas, but no statistical link between the two indicators in non-deprived areas; in other words women with breast cancer in deprived areas are more likely to die from the disease than women with breast cancer who live in other areas. Further work is being under taken to investigate whether this is due to patterns of screening, identification or treatment.

2.5.2 Tobacco

As already been mentioned above smoking is one of the key contributory causes for premature mortality and as such is one of the significant drivers of inequalities in health and life expectancy. Indeed, smoking has been identified as the principal reason for the inequalities in death rates between rich and poor in the United Kingdom and about half of all regular cigarette smokers will eventually be killed by their habit.

Evidence suggests that the overall prevalence of tobacco use in Stockport is low, estimates for the local smoking rate, ranging from 18.5% (weighted estimated from the 2006 Stockport Health Survey) to 21.6% (based on the most recent audit of GP practices for measures taken in the last 15 months), are all below the national average of 25%. The Stockport Health Survey showed that more men than women reported being current smokers and older adults were less likely to smoke than younger adults.

Smoking is closely associated with deprivation nationally, and this picture is mirrored in Stockport, results from the 2006 Stockport Health Survey showed a significant deprivation profile, with rates of smoking increasing for all ages as level of deprivation rose. Figure 21 shows the unweighted smoking prevalence results by electoral ward, rates vary from a low of 6.9% in Bramhall South to a high of 40.1% in Brinnington and Central.



Further evidence from a recent local survey conducted in the renewal area of Brinnington Estate, with a larger sample size than the Stockport survey, suggests that figure of 40.1% may mask variation within the ward, and that the prevalence in the most deprived parts of the borough may well be over 50%.

Stockport has a well established smoking cessation programme which has helped around 6,500 Stockport residents to stop smoking since 2003/04. A health equity analysis of the service however has showed that people from the more affluent areas are more likely to attempt to quit and are also more likely to have a successful quit attempt than people from deprived areas. Indicative data suggests that in the most recent complete financial year (2005/06) around 10.3% of Stockport's smokers attempted to quit using the Stockport Stop Smoking service; however rates for the Brinnington Estate were estimated to be much lower at around only 4.6%, with the average for the 'priority 1' areas being 7.1%. Analysis went on to show that while 35% of quit attempts from residents from the 'priority 1' areas were successful after 4 weeks, the Stockport average success rate was at a higher level of 43%. These

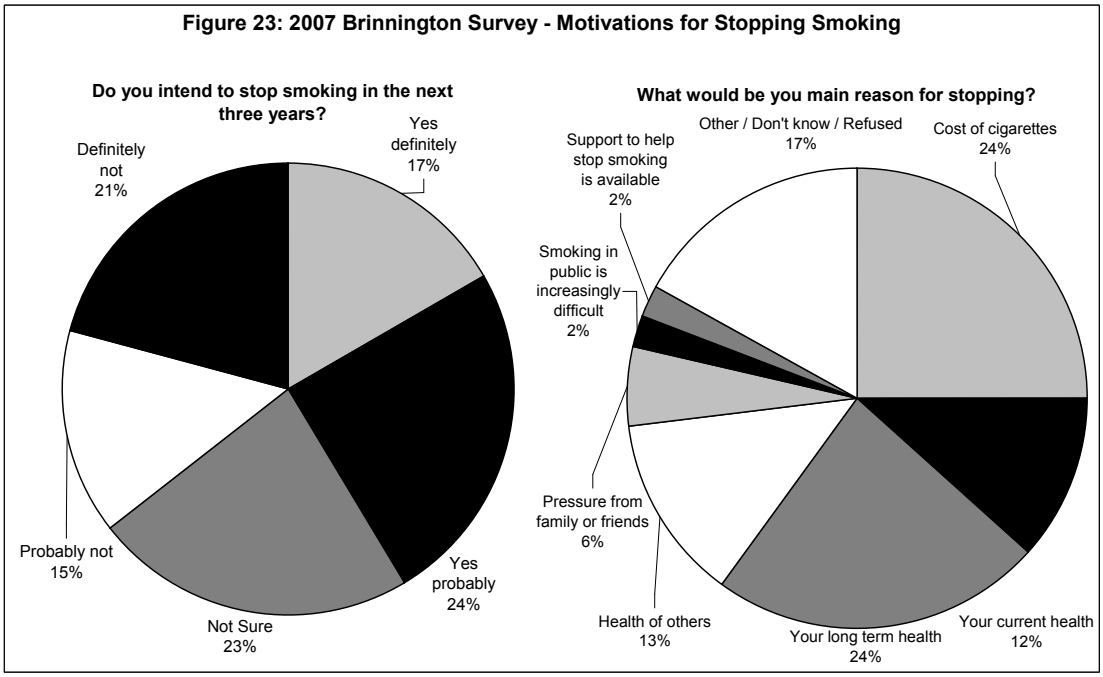
trends, if they continued, could lead to a greater divergence in smoking prevalence between the different areas of the borough.

The findings of these audits have led to a refocusing of the service and the LAA has provided a mechanism for setting local targets for the deprived areas (see figure 22), to complement the overall Stockport target included in the LDP.

Table 22: LAA Targets for Smoking Cessation – Deprived areas

	06/07					07/08	08/09
	Q1	Q2	Q3	Q4	TOT.		
People from deprived areas	-	-	-	-	Year 1	Year 2	Year 3
Trajectory							
Cumulative no. of 4-week smoking quitters	173	328	483	691	691	1,432	2,373
Actual							
Cumulative no. of 4-week smoking quitters	146	273	413		413		
Achievement							
Cumulative no. of 4-week smoking quitters	84.4%	83.2%	85.5%		59.8%		

Figure 23: 2007 Brinnington Survey - Motivations for Stopping Smoking

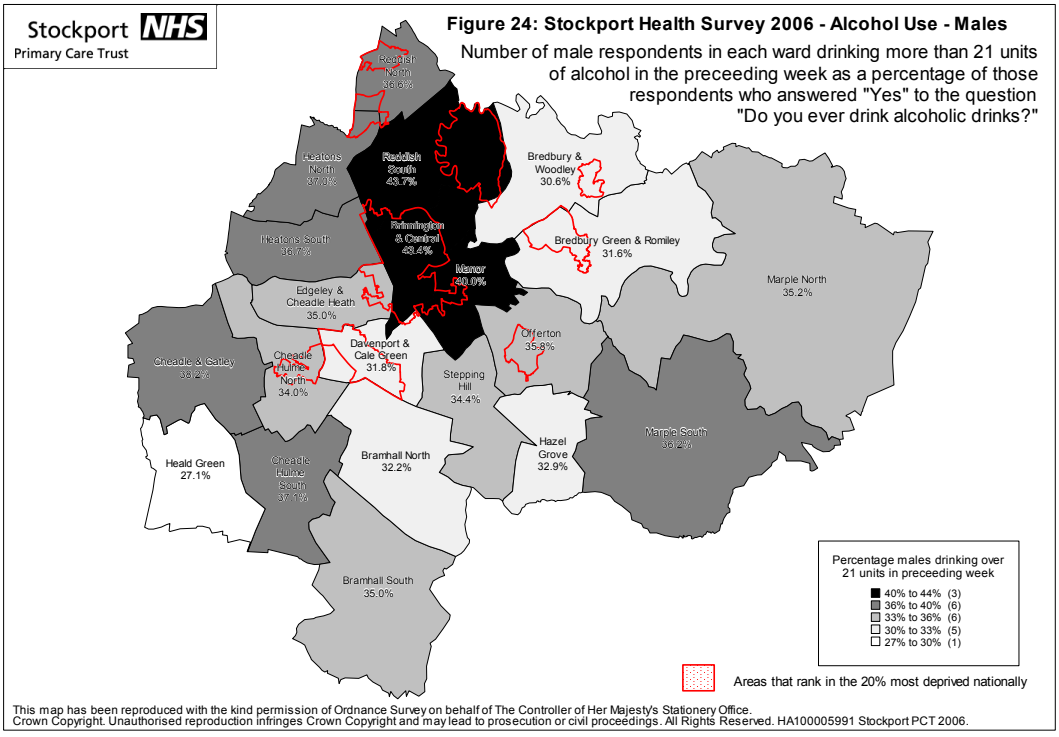


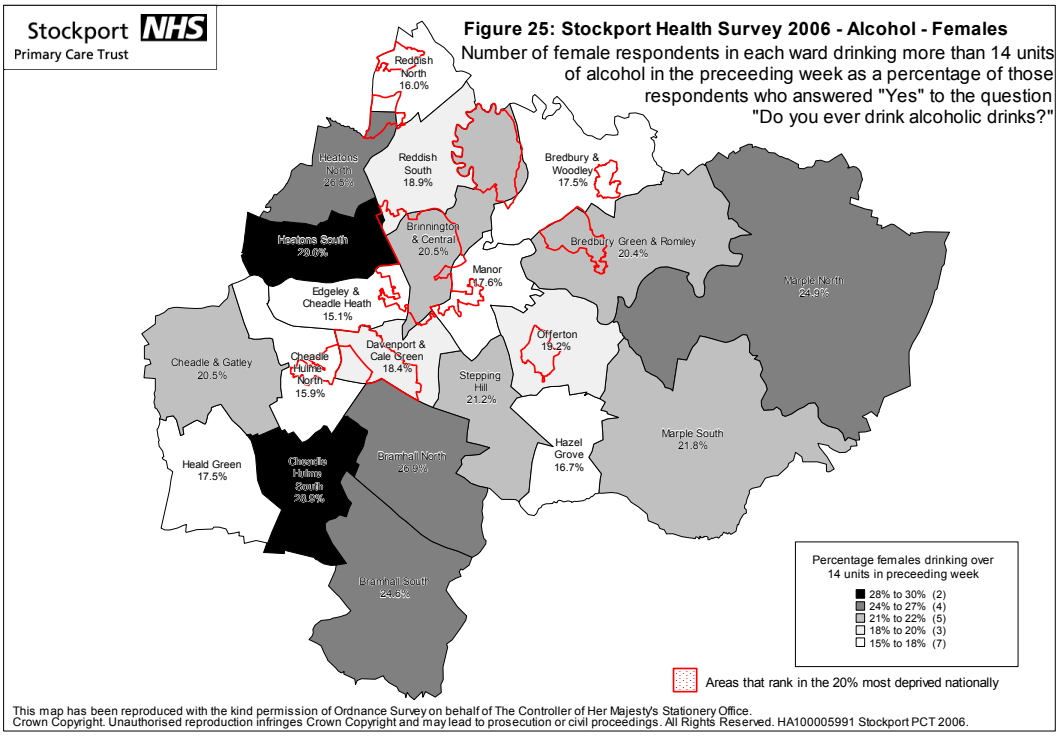
To work towards the aim of reducing smoking in Brinnington in particular, a social marketing initiative is being undertaken to try and understand the intentions towards stopping smoking by current smokers and what motivations might encourage people in the area to stop smoking, the results are shown in figure 23. The survey of 600 residents showed that 51.8% (311 people) were current smokers. Of these two-fifths either definitely or probably wanted to quit within the next three years whereas 59% said they were unsure or definitely did not want to quit. Of those who weren't definitely set against quitting the main reasons given for stopping were the cost of cigarettes and their own long term health needs.

2.5.3 Alcohol

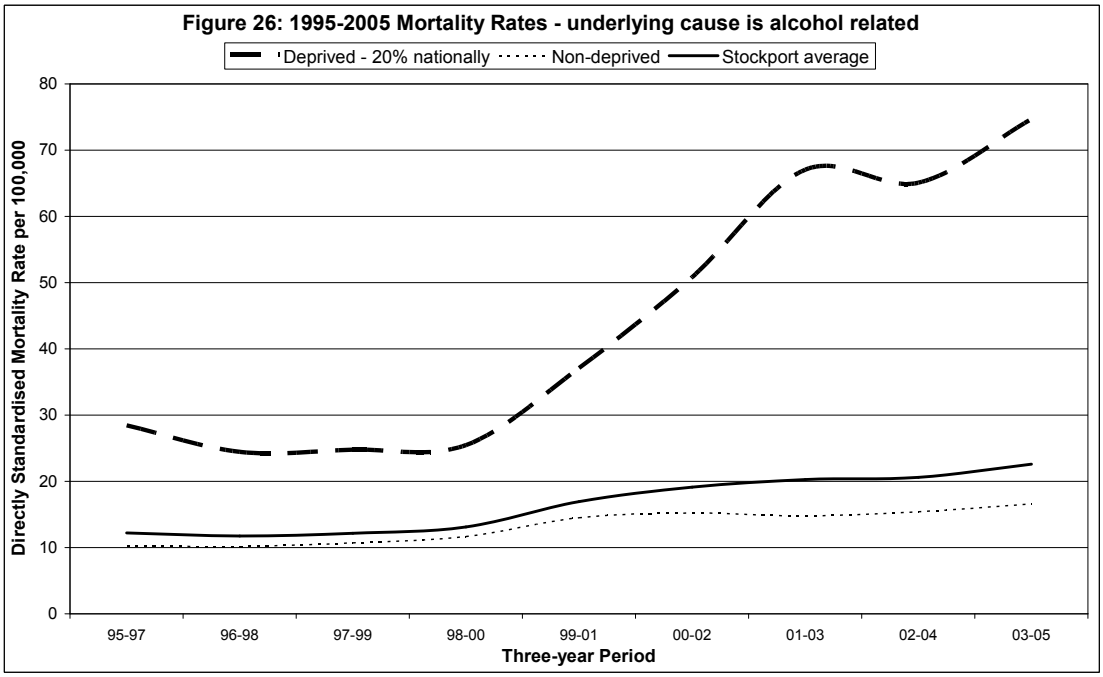
Data presented in section 1.1.3 above showed that alcohol is having an increasing impact on the inequalities in life expectancy in Stockport and this area has therefore become a significant focus for work by Stockport PCT. Evidence from the 2006 Stockport Health Survey found that the average weekly consumption of alcohol for males was 20.7 units of alcohol, which is just below the recommended weekly allowance of 21 units, and 9.3 for females, which is well below the recommended weekly limit of 14 units. Binge drinking (i.e. drinking more than twice the daily recommended alcohol limit) was found to be more prevalent amongst the younger age groups, for both men and women.

The survey found that the mean number of units reported to have been consumed in the preceding week increased with deprivation for males but fell with deprivation for females. However, for both males and females the proportion consuming more than twice the safe daily limits and more than four times the safe daily limits increased with deprivation. The proportion of frequent drinkers (drinking every day or on 5 or 6 days per week) increases with age and affluence, and is more common in men than women. The relationship between drinking and deprivation is therefore not simple, affluence leads to more frequent drinking, and in women is also associated with higher overall intakes of alcohol, however both binge drinking and dangerous drinking can be linked to inequalities.





Figures 24 and 25 show the respective proportions of males and females drinking more than the weekly recommended allowance of alcoholic units. For males there is an evident deprivation profile with the central wards of Brinnington and Central, Reddish South and Manor having the highest levels of weekly consumption. For females however the pattern is inversed with the highest levels of excessive drinking occurring in the wards of Heaton South and Cheadle Hulme South, wards that rank amongst some of the least deprived in the borough.



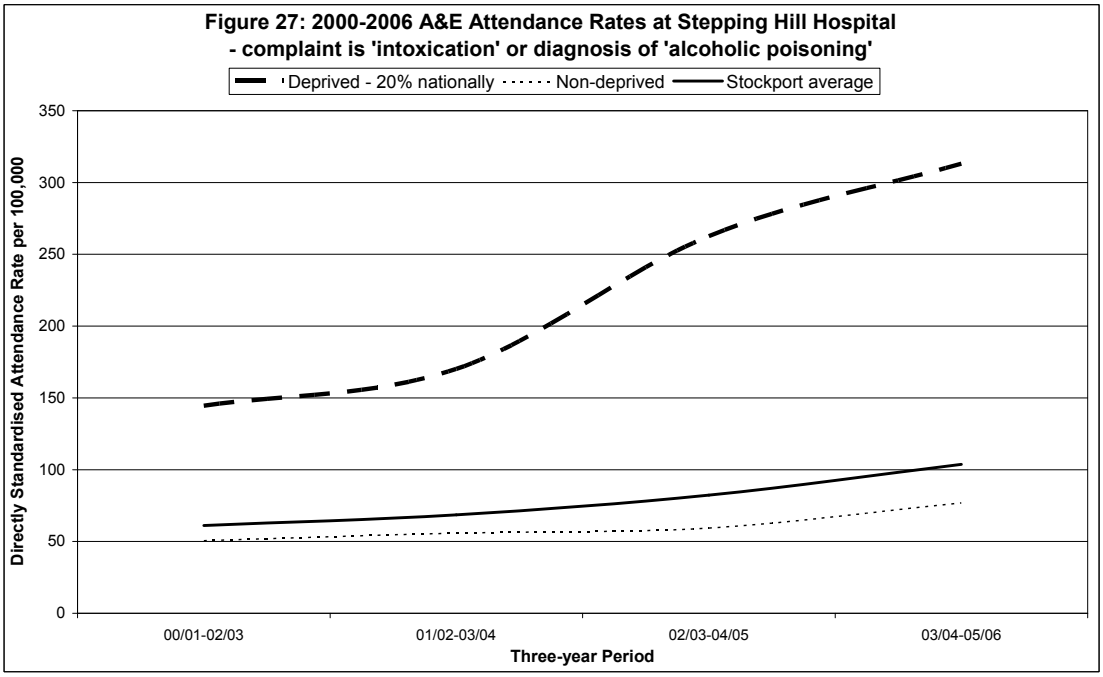
Overall mortality trends for alcohol related deaths have been increasing rapidly over the last decade, with the Stockport average almost doubling, rising from 12.2 per

100,000 in 1995/97 to 22.6 per 100,000 in 2003/05. There are now more than 80 deaths a year in Stockport where the underlying causes are related to alcohol. This rise has been most significant in the areas that rank in the 20% most deprived nationally where morality rates have increased by more than two and a half times, from 28.4 per 100,000 to 74.7 per 100,000 (see figure 26).

Similar increasing patterns can be seen for A&E Attendances at Stepping Hill Hospital. Analysis has been conducted for attendances that are due to either a complaint of 'intoxication' or a diagnosis of 'alcoholic poisoning'; although it should be noted that this will include only a small proportion of the total number of attendances that are related to alcohol as it does not include attendances arising from injuries that are sustained while the patient, or someone else, is drunk. Currently the data systems do not allow this more detailed analysis.

Figure 27 shows that since 2000/01 the rates of attendance have increased by over 70% for Stockport as a whole, rising from 61.2 per 100,000 to 103.7 per 100,000 between 2000/01 and 2005/06. There are now over 300 attendances a year at Stepping Hill's A&E departments from Stockport residents for these complaints. Again the most significant rise has been in the areas ranking in the 20% most deprived nationally where rates have more than doubled to 313.7 per 100,000.

Figure 27: 2000-2006 A&E Attendance Rates at Stepping Hill Hospital - complaint is 'intoxication' or diagnosis of 'alcoholic poisoning'



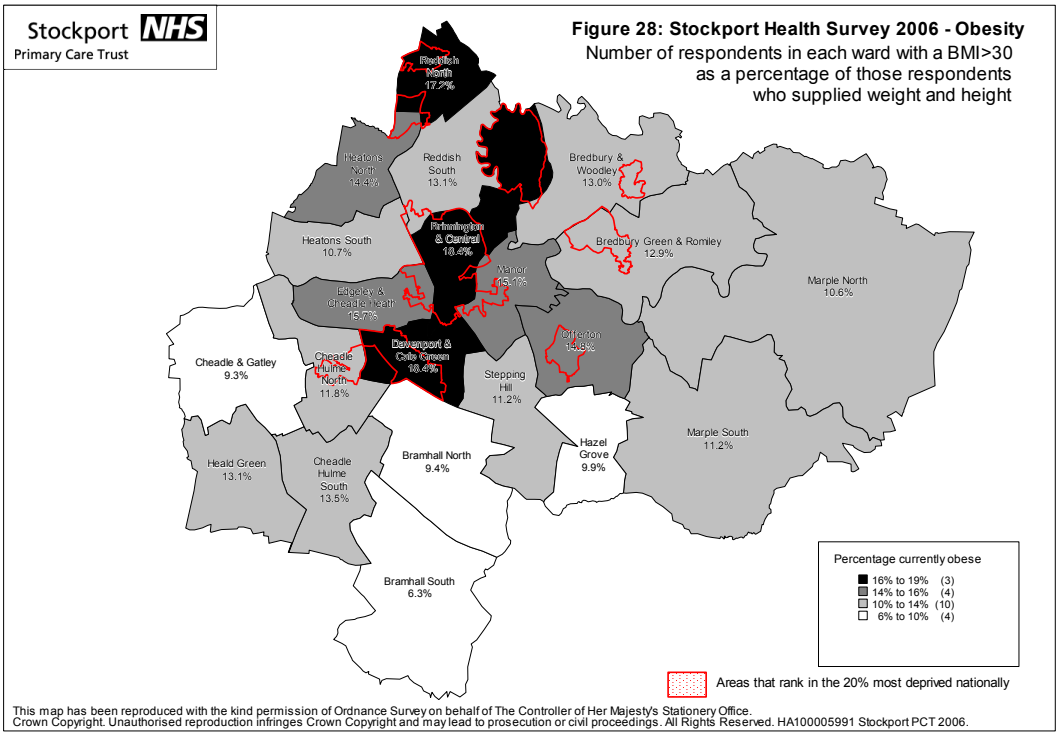
2.5.4 Obesity

As stated above the National Audit Office (NAO) in their 2002 report 'Tackling Obesity in England' estimated that 30,000 deaths a year (roughly 6% of the total) were directly attributable to obesity; 9,000 of which occurred prematurely, before retirement age. They found that as a whole these deaths led to an average 9 years reduction in life expectancy. By using the findings of the NAO of around 6% of deaths being related to obesity, we can estimate that around 170 deaths in the borough each year are linked to this condition; around 50 of which will be premature (aged below 65 years).

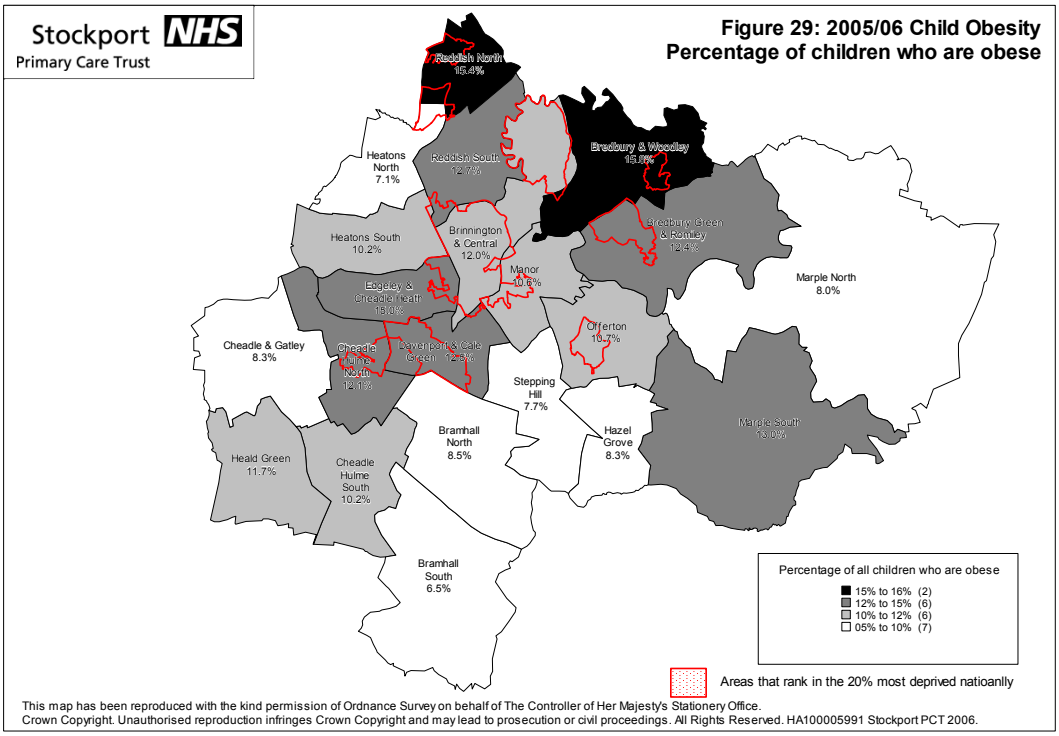
The 2006 Stockport Health Survey indicated that a smaller proportion of Stockport residents were overweight than the national average. From the height and weight

data supplied by respondents it was calculated that 54.2% of male respondents (compared with 67.5% for England) and 41.1% of female respondents (compared with 59.5% for England) were overweight (i.e. with a BMI greater than 25); while 12.2% of males (compared to 22.7% in England) and 12.6% of females (compared to 23.2% in England) were obese (i.e. with a BMI greater than 30). Problems with weight are linked to age and proportions of overweight and obese rise so by the time people reach their 50s more than a half of all people are overweight whereas less than a third of young adults are.

The survey found when analysing those classed as overweight, that for females the proportion in this group fell with affluence but that there was no clear relationship between the prevalence of overweight and deprivation for males. For those classed as obese the pattern was clearer for both genders with a marked deprivation gradient, figure 28 illustrates the pattern of obesity as reported in the survey across the borough.



The PCT also undertakes an annual screening of reception and year 6 children to measure the prevalence of overweight and obesity across the borough for this key group. In 2005/06 it was estimated that 23.1% of children were overweight and 11.2% of children were obese. Boys were slightly more likely to be overweight and obese than girls, and children in year 6 were much more likely to be overweight or obese than those in the reception year.



Geographical patterns of overweight and obesity were not entirely clear and varied by age and gender. Figure 29 shows the overall distribution of children identified as obese across the borough and does not show an evident link with patterns of known deprivation; although it is clear that areas with the lowest levels of obesity are also those with low levels of deprivation.

The 2006 Stockport Health Survey also asked respondents about their diet and physical activity. The percentage of respondents who reported eating the recommended five or more portions of fruit and vegetables per day was lower in Stockport (19%) than in England (25%). More females than males ate five or more portions of fruit and vegetables per day; however, this still amounted to less than a quarter of females eating their 5-a-day. For both males and females the most usual number of portions of fruit and vegetables to be consumed per day was three, so there is much scope for improvement in Stockport. The age bracket with the greatest proportion of individuals consuming the recommended daily amount of fruit and vegetables was the 40 to 59 year olds. For both males and females the proportion of individuals consuming five or more portions of fruit and vegetables per day increased with affluence.

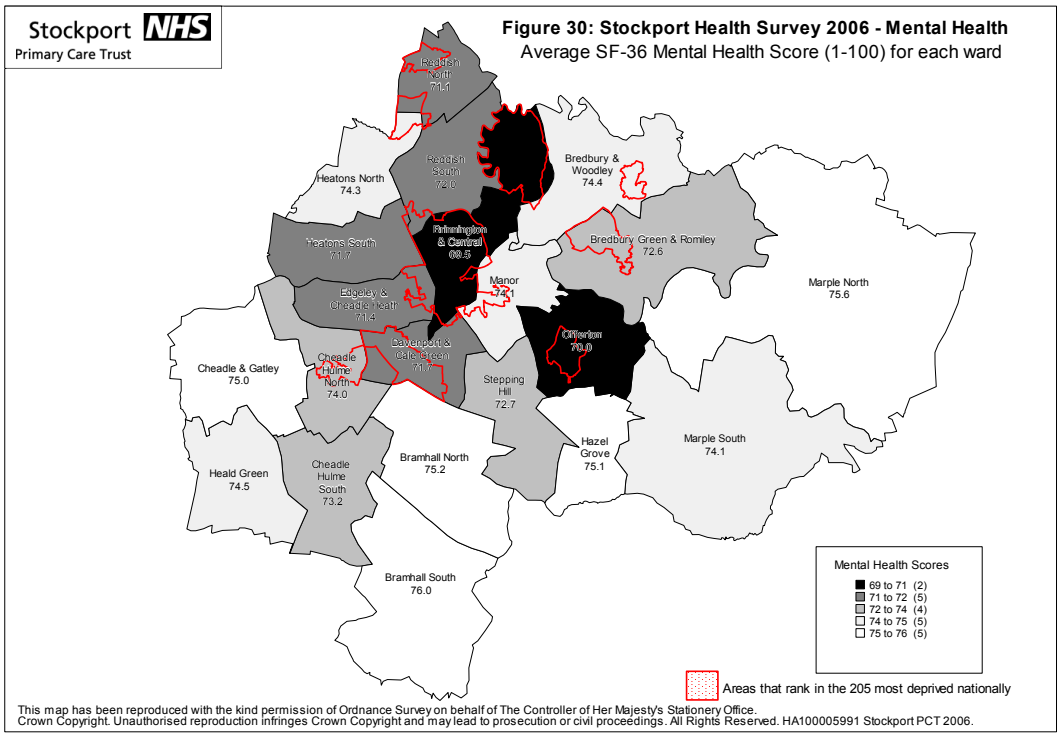
Adults who are physically active have 20-30% reduced risk of premature death, and up to 50% reduced risk of developing the major chronic diseases such as coronary heart disease, stroke, diabetes and cancers. Overall, physical activity levels are declining nationally. Approximately a quarter of respondents to the Stockport Health Survey reported that they undertook the recommended five or more 30 minute sessions of moderate physical activity each week. Compared with the national picture, the younger adult respondents were more sedentary than average, whereas the opposite is true for the older age groups, with Stockport older adults reporting being more physically active than average. No clear relationship was apparent between deprivation and the proportions of individuals in the sample undertaking physical activity.

2.5.5 Mental Well-being

Mental health is a positive sense of well-being, giving us the resources to cope with life. Efforts to promote good mental health will have positive knock-on effects in other spheres of life, including physical health, employment and quality of life. Mental distress has been shown to be associated with deprivation and improving mental health and well-being can make an important contribution to reducing health inequalities.

The 2006 Stockport Health Survey measured mental health using questions from the validated SF-36, where a higher score indicates better mental health. For both males and females the average score for the Stockport respondents was lower than those found in national surveys (i.e. they reported experiencing poorer mental health), with the exception of the 64 to 75 year olds who enjoyed better mental health than average for that age group.

The average SF-36 mental health score found in the Stockport Health Survey increased (better mental health) with affluence, with a range of 69.5 in the most deprived ward, Brinnington, to 76.0 in the least deprived ward, Bramhall South (see figure 30).



3.0 Approach and Process

3.1 Introduction:

This section sets out the rationale for the selected approach and outlines how this will be applied in practice.

The approach has been selected as the most appropriate in the context of limited resources. Due to its overall perceived affluence, Stockport does not receive additional national government funding to support work on inequalities. Despite this Stockport has a long and respected tradition of work in this area although progress has varied over time.

The approach provides an effective mechanism to refocus existing work and programmes to maximise their impact on inequalities within the borough, promising greater impact from existing resources. It offers a straightforward tool to bring stakeholders together at local level, build coalitions and partnerships between government, voluntary and private sectors, and bring local people actively into the process. In this respect it offers the promise of achieving the 'fully engaged' scenario advocated by Wanless II.

3.2 Background to Appreciative Inquiry in Stockport

During 2006 the Council Scrutiny department undertook an innovative review of health inequalities in Brinnington. The methodology proposed was that of an Appreciative Inquiry. The key characteristic of this approach is a focus on positive aspects of a situation, identifying what works and exploring ways to expand and improve on this. It is also unusual in that it requires that personnel from all levels within an organisation meet together 'at the same table' to discuss issues, identify potential and suggest forward directions (Cooperrider et al, 2005).

The Appreciative Inquiry (AI) events that took place in Brinnington involved well over 100 individuals. Participants included senior councillors, local residents, staff from a range of different organisations providing services within the area, schoolchildren and professional facilitators.

Before the AI many community members in Brinnington had become cynical about 'consultation' processes: many saw these as occasions when officials told them what would happen and what was good for them rather than opportunities for any real dialogue or exchange.

As a result of the AI a clearer picture of health inequalities in Brinnington emerged (Scrutiny Review Report). In particular alcohol was identified as an important focus for attention as failure to deal with this issue could undermine progress made on addressing inequalities relating to cardiovascular diseases.

The AI events created opportunities for face-to-face communication that was followed up with practical action. Examples of this are the organisation of a fun-run, a treasure hunt and a clean-up event. All these events involved local people both in organising and participating. They made connections between physical activity and the environment in a stimulating way attracting whole families.

Another benefit from the AI approach was sharing information to match available funds with realisable activities. Many small-scale local initiatives were supported as a result of connections made and ideas exchanged during the AI process. For example, a fruit and vegetable scheme, a Mums in Art project, additional parenting

support classes, expansion of antenatal classes to new venues, and development of specific action on alcohol.

It is this explosion of energy and commitment that the Health Inequalities Strategy seeks to replicate by applying Appreciative Inquiry as its fundamental process: a mechanism to secure enthusiastic community and professional engagement.

3.3 Addressing the wider determinants of inequality through partnership and community engagement

Reviews of effectiveness evidence in relation to addressing inequalities highlight the complex nature of the situation. There is no doubt that action must be taken on key issues that drive the inequalities gap: tobacco use, cardiovascular diseases, alcohol use, etc (DoH, 2004).

However, it is also true that action must be taken to address the broader underlying determinants of inequality. Education, employment, ethnicity, gender and geographical location are all important factors in the development of inequalities in health (Townsend & Davidson, 1980; Wilkinson, 1996; DoH, 2003).

While the more immediate drivers of inequality can be addressed through specific actions, as outlined elsewhere in this strategy, these wider issues require a different approach (DoH, 2004). Broad-based action is needed to improve the life chances of disadvantaged communities, to raise their expectations and engage them in decision making about services provided.

Partnership working has been identified as key to achieving progress in this respect. Bringing together the government and voluntary/community sectors in formal and informal partnerships enables them to deploy their various resources to maximum effect. In the same way creating partnerships that span different sectors – education, health, business, regeneration, transport – creates the possibility for synergies to be identified and joint action undertaken.

This partnership structure needs to be present at all levels within the system. Using the Appreciative Inquiry approach will encourage the formation of local level partnerships to address locally identified issues within the overall strategic partnership framework that already exists across Stockport.

The AI approach identifies and engages all local stakeholders. Through the various meetings and events, all partners have opportunities to state their own priorities, share their positive experiences and develop joint proposals based on these foundations.

Equally important is the fact that AI is accessible to community members from widely varying backgrounds and so enables them to participate in the process on an equal footing to professionals.

Finally, through the focus on actions that are already effective in supporting health, the confidence of community members is raised. Public recognition of the value of their contribution is important in validating their sense of self-worth and raising self-esteem. Low self-esteem is often accompanied by low expectations of life. Use of the AI process can help to foster a more positive outlook and raise expectations within these communities.

3.4 Identifying locality boundaries

Much of the evidence on effective ways of addressing inequalities emphasises the relevance of the neighbourhood as an entity upon which to focus. This provides both a sensible level for service providers at which many sectors can be brought together effectively and a natural identity through which community members may become involved.

The key lies in identifying locality areas that fit with local perceptions and boundaries so that there is a sense of belonging and commitment, of shared values and shared outcomes. This supports the development of civic pride and personal commitment important in sustaining positive mental health.

There is a need to balance the size of each locality area to maximise both the sense of community and the usefulness to service providers.

Currently there are several subdivisions made by different agencies working in Stockport. The boundaries relating to Inclusive Supportive Communities (ISC) upon which management of Children's Services is based; the IMPACT groups used within the PCT Public Health Department; the boundaries used for Practice Based Commissioning (PBC). Figure 1 shows the PBC boundaries and Figure 2 the ISC clusters: both also show the location of the 40% most deprived population in Stockport.

Figure 1: PBC Boundaries and 40% most deprived population

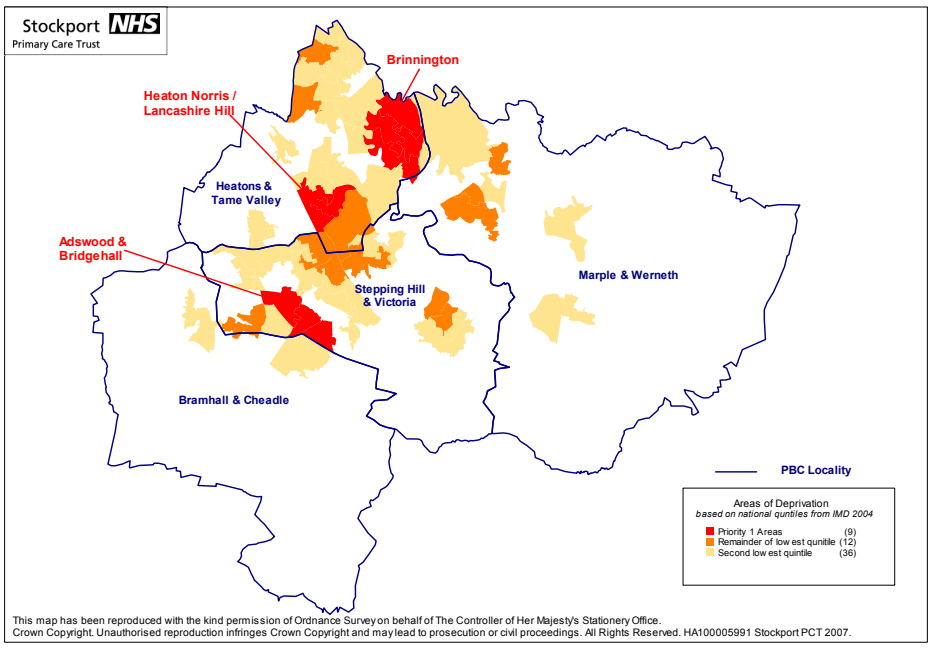
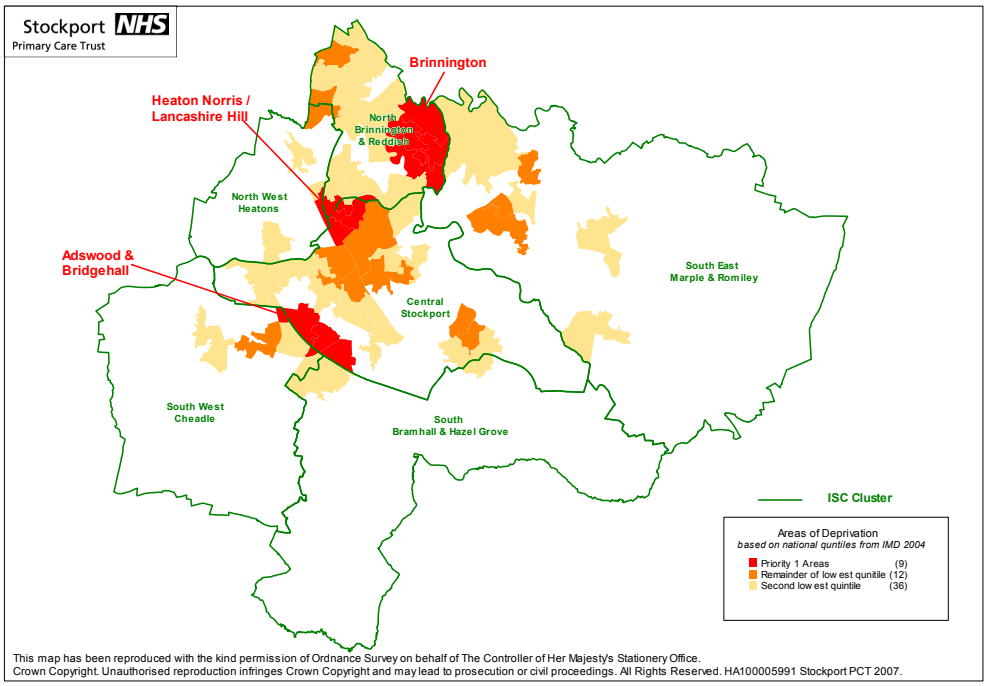


Figure 2: ISC Cluster Boundaries and 40% most deprived population



The distribution of deprived populations within Stockport is such that these form smaller areas within these larger clusters. The focus of inequalities work is on the 40% most deprived when measured locally. It is these smaller population groups that will be the main focus for AI activities. Where the larger boundaries do not coincide with these smaller divisions flexibility will be necessary to bring the relevant service providers into the process.

By centring the AI process on appropriate local boundaries in this way the resulting Local Inequality Plans will link to commissioning at the same level.

It will be possible to fit this process into a rolling programme of AI events that can be integrated with existing planning and audit cycles. Local Inequality Plans may be dovetailed with plans covering larger areas through synchronising the AI cycle.

3.5 The Locality Based Appreciative Inquiry Process

Working through the Public Health Locality Teams, an Appreciative Inquiry will be implemented within each locality.

Local health intelligence will be collated providing a detailed picture of the key issues in each locality. This will be shared in an appropriate and accessible format with residents and staff working in the locality during meetings and events. The focus will be on exploring how people are able to sustain their health within this context, appreciating the various strategies and supports available. This data will also guide discussions to focus on the local issues most relevant to inequalities.

The number and type of meetings and events may vary across locality. Initial meetings may involve a higher proportion of local staff and community members while later events may bring in more senior personnel from key stakeholder organisations. Several meetings may well be necessary to complete the stages of the AI process: discover, dream, design and destiny (see appendix for further information on AI).

As a result of the AI process a range of local actions will be identified to support health and reduce inequalities. These activities will be included in the Local Inequalities Action Plan that is drafted as a result of the AI events. These activities will be additional to the standard services already delivered through statutory and voluntary agencies.

Specific funds will be allocated (from the public health budgets of the PCT Public Health Directorate, IMPACT groups, Health Innovations Fund and SMBC) for local community groups and organisations to undertake the proposed actions, supported by the public health workforce or other personnel as appropriate.

The Local Inequalities Action Plans may also identify innovative local delivery mechanisms for the standard services already delivered through statutory and voluntary agencies.

It is anticipated that the use of the AI process in this way will have positive unintended consequences through its impact on the low expectations and lack of ambition that is so often key in perpetuating disadvantage. This creation of positive energy changes the atmosphere within the community. Expectations are raised and the attitude of community members and service providers altered.

The eventual outcome of implementing this Strategy can be that Stockport becomes known for the way in which the efforts of local communities are appreciated, valued and built upon to achieve better health across the borough.

4.0 Action Plan

Overall Aim **To reduce intra-Stockport differentials in health as measured by life expectancy and infant mortality and achieve LAA targets for these.**			
Strategic Priority 1 (Major Killers) **To reduce early death among those with existing circulatory disease or at high risk of developing it and improve early detection rates for cancer …**			
Action	*Resources*	*Lead Responsibility*	*Date*
1.1 Provide a locally enhanced GP service in 6 practices in the most deprived areas to improve access to effective treatments and lifestyle behaviour change services for those with existing circulatory disease or at high risk of developing it	PCT allocation	J. Rossini	March 2008
1.2 To improve cancer detection and treatment in deprived communities by completing a health equity audit in relation to cancer services	PCT allocation	J Rossini; E Banister	March 2008
1.3 To develop innovative ways to engage and reach high risk individuals in deprived populations through the development and delivery of a national demonstration project for social marketing focused on smoking, alcohol misuse and condom use	Pilot project funds	J Pilkington	March 2009
Strategic Priority 2 (Tobacco) **To reduce smoking rates particularly in deprived populations, reduce the number of women smoking during pregnancy and reduce uptake of smoking by children and young people …**			
Action	*Resources*	*Lead Responsibility*	*Date*
2.1 To create a "quitting culture" within our 4 most deprived neighbourhoods that have the highest smoking rates, through continued delivery of the community smoking cessation project to achieve the LAA reward target	PCT / SMBC	S Clarke; Smokefree Stockport Group	March 2009
2.2 To launch the Smoke Free Homes project	PCT / SMBC	S Clarke; Smokefree Stockport Group	December 2007
2.3 To prepare the business case to release funding and establish the 'Stop before your op' project (to systematise referral to services for pre operative patients)	PCT allocation	S Clarke	March 2008
2.4 To review the current service model for smoking and pregnancy and revitalise efforts where necessary	PCT allocation	S Clarke; D Garrod	Dec 2007
2.5 Review and build capacity and capability to deliver the CYP section of the Smokefree Stockport Plan	PCT/ SMBC	S Clarke; Smokfree Stockport Group	March 2008
Strategic Priority 3 (Alcohol) **To halt the rise in unsafe alcohol consumption, reduce levels of binge drinking …**			
Action	*Resources*	*Lead Responsibility*	*Date*
3.1 To prepare the business case to release funding and establish the Brief Intervention/ Lifestyle service for alcohol misuse	PCT allocation	S Armour; Alcohol Treatment Services Group	March 2008
Strategic Priority 4 (Obesity) **To reduce levels of overweight/ obesity among adults and children through improvements to weight management services and increase levels of physical activity through promotion of walking and cycling opportunities …**			
Action	*Resources*	*Lead Responsibility*	*Date*

4.1 To prepare the business case to release funding and establish the new weight management CAT (care and treatment pathway)	PCT allocation	J Jefferson	March 2008
4.2.To intensify primary prevention programmes relating to food, walking and cycling in deprived communities	PCT / SMBC	J Jefferson; S Newsam	Dec 2008
Strategic Priority 5 (Mental wellbeing) **Increase capacity to assess need and develop a coherent approach to promoting positive mental health across 3 levels, individual, community and structural …**			
Action	*Resources*	*Lead Responsibility*	*Date*
5.1 To identify and apply an appropriate tool to measure mental wellbeing, establish a baseline measure and shape an improvement plan	TBC	PH Directorate	Sep 2008
5.2 To prepare the business case to release funding and establish the Health Trainer service	PCT allocation	E Hill; Stockport CVS	March 2008
Strategy Implementation **To develop Local Area Inequality Action Plans (covering the 40% most deprived population) to ensure full engagement of deprived communities in the implementation of the strategy …**			
Action	*Resources*	*Lead Responsibility*	*Date*
6.1 Develop a workforce plan for delivery of the strategy	PCT allocation	J Pilkington; S Newsam	Sep 2007
6.2 Provide training and support to staff in Appreciative Inquiry methodology and other techniques/ approaches required to implement the strategy	PCT allocation	J Pilkington; S Newsam; H Kettleborough	December 2007
6.3 To revise the health sections of the Brinnington NRLAAP, incorporate these into the Local Inequalities Action Plan and establish a local steering group		E Hill; A Huddleston; S Newsam; H Sharman	August 2007
6.4 To undertake an appreciative inquiry in the Adswood/ Bridgehall renewal area, develop the Local Inequalities Action Plan from this and establish a local steering group		E Hill; PH Locality team; S Newsam; H Sharman	March 2008
6.5 To undertake an appreciative inquiry in the Heaton Norris/ Lancashire Hill renewal area, develop the Local Inequalities Action Plan from this and establish a local steering group		E Hill; PH Locality team; S Newsam; H Sharman	March 2008
6.6 To ensure that funding is available to support the implementation of the Local Inequalities Action Plans from PCT, SMBC and other sources (ie, CVS IMPACT funds; Community Fund; HIF Small Grants)		S Watkins / G Lucas	2008
6.7 To undertake appreciative inquiries in the remaining deprived localities develop Local Inequalities Action Plans and establish local steering groups for each area		E Hill; PH Locality teams; S Newsam	2009

The Action Plan is monitored through the PHPB Performance Management Framework on a quarterly basis.

APPENDIX

The Appreciative Inquiry Process

Essentially an Appreciative Inquiry is a stepped process taking participants through the following four stages:

- Discover
- Dream
- Design
- Destiny

The Inquiry focuses on identifying what is already working or positive within the situation, what actions would make the situation better and how could the best possible outcomes be achieved.

A key underlying belief is that by asking questions that are framed in a positive way, participants will focus on positive aspects of the situation. This is in contrast to a problem focused approach which magnifies the difficulties faced by focusing on these.

It is important that the Inquiry process involves people from all levels. Positive experiences and solutions can emerge from anywhere and anyone. Bringing all levels of personnel together enables them to discuss issues on an equal basis, share their differing perspectives and identify potential for improvement. Solutions are owned by all those involved in the Inquiry process and are more likely to be practical and realistic in scope.

The language used within the inquiry process should be that of the 'everyday' and any information presented must be easily understood by all levels and types of participant. Before embarking on the first stage of the Appreciative Inquiry itself, a simple presentation would be made on the health profile of the area in relation to the priorities set out in this strategy.

NOTE: the phrase 'health improvement service' is used for illustrative purposes in the example below but it is not anticipated that this phrase would be used in the inquiry process.

Within this Appreciative Inquiry the overall aim is to answer the question: ***What makes 'health improvement services' effective and accessible in this area?***

Discover
Prompts: ***tell me about a time when you were able to get a 'health improvement service' you wanted; tell me about a time when the 'health improvement service' made a positive impact on your life*.**

In this stage the emphasis is on gathering stories about positive experiences in relation to the focus of the Inquiry. Participants do this in small groups. As the stories are shared, participants try to draw out the key characteristics that made these experiences positive for the individual and for those around them or the organisation within which they operated.

Dream
Prompt: ***Imagine a 'health improvement service' that was easy for everyone living in this area to access, provided the services people want and enabled them to live a healthy life*.**

In this stage participants are free to imagine what the 'best possible' would be like in relation to the focus of the Inquiry. They are encouraged to think in detail about what people would

be doing, how they would connect with each other, what the atmosphere would be like. Again the focus is on trying to identify what would be different and why it matters.

Design
Prompt: ***What needs to happen in order to realise our dream?***

At this point participants solidify the characteristics identified in the two earlier stages. They develop these into principles that should be followed in order to achieve the 'best possible' scenario. These design principles can apply to how people behave, how they interact with each other, how they organise themselves, what they spend their time doing, how resources are allocated, etc. In effect this becomes a blueprint detailing how the change can be brought about.

Destiny
Prompt: ***What can I / we do now to make our dream become a reality?***

In the final stage of the Inquiry, people apply the design principles to the 'here and now' by identifying concrete, immediate actions that can be taken by the individuals involved in the Inquiry process that will move the situation in the desired direction.