REPORT TO: The Stockport Partnership Board

REPORT OF: Dr. Steve Watkins, Director of Public Health, Stockport PCT

DATE: 20 November 2007

SUBJECT: Health Inequalities Strategy

1. MATTER FOR CONSIDERATION

The report presents the new Health Inequalities Strategy for information and discussion in advance of the Stockport Partnership Forum on 'health' on 23 January 2008. It was considered important for the Stockport Partnership Board to have the opportunity to discuss the Strategy prior to the wider dissemination and engagement which is being planned through the Forum. The Strategy sets out a strategic framework within which local efforts to reduce health inequalities in Stockport will be delivered.

The Strategy is the joint work of the Council and the PCT and has been considered and approved by the Public Health Partnership Board (PHPB), which is the local body with responsibility for directing and overseeing joint public health activity in Stockport, the Council's Executive and the PCT Board. It has been consulted on formally with the Council's Health Scrutiny Committee and has also been discussed at the Adults and Communities Scrutiny Committee. For information, the PHPB currently consists of representatives from the PCT, the Council and Stockport CVS and is a sub-group of the Stockport Health Improvement Partnership (SHIP).

This report focuses on the five agreed strategic priorities and the local implementation of the Strategy. The full Strategy can be found at appendix 1.

2. BACKGROUND TO HEALTH INEQUALITIES

Inequalities are differences between people and places that, in theory, would not exist under different conditions. 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.

Since the issue of health inequalities was first highlighted in the late 1980's, successive national reports have repeatedly made the link between socio-economic deprivation and poor health. But while other European countries have been able to make progress by reducing the

gap between the most and least healthy in society, health inequalities in the UK would appear to be steadily widening.

For this reason, health inequality is high on the public health agenda which is all the more significant for Stockport as health inequalities are perhaps *the* health improvement issue for the Borough and have been for some years. However, rather than seeing a reduction in health inequalities in recent years, the gap between the most and least affluent areas is growing at *potentially* one of the fastest rates in Greater Manchester.

Health inequalities in Greater Manchester boroughs are changing in different ways and at varying rates. Comparing premature deaths under 75 over the periods 2000-02 and 2003-05, the boroughs of Salford, Oldham and Tameside have all seen a reduction in health inequalities.

However, most boroughs have seen an increase and Stockport, Bolton and Trafford show the largest overall difference and therefore represent the greatest levels of polarisation in health. A particularly stark example of this is the local comparison which shows men in Brinnington living on average 12 years less than men in Bramhall.

The absence of Spearhead funding (a DoH funding stream awarded to boroughs with significant borough-wide levels of health deprivation for the purpose of reducing health inequalities in the most affected neighbourhoods) or other significant grant funding for the Borough makes it all the more important that a clear strategic direction and priorities are agreed upon, which relevant partners in the Borough adopt and implement in their own spheres of influence, and towards which mainstream budgets are directed.

This new strategy seeks to ensure that the issue of health inequalities is highlighted to a wide local audience and that work to improve the health of the communities in Stockport that are most disadvantaged by poor health and premature death is evidence-based, locally appropriate and delivered through a co-ordinated multi-agency response.

It should be noted that 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 within the target communities – those falling in the 40% most deprived nationally as ranked by the Index of Multiple Deprivation (IMD) 2004 - are made at a *higher rate of health gain* than in affluent communities.

The Strategy will be delivered alongside and in conjunction with neighbourhood renewal and other programmes and initiatives to improve the environmental, educational and economic profile of Stockport. This

complementary work will help to ensure that the wider determinants of health such as access to good quality housing, support services & leisure facilities and increasing educational attainment & job opportunities will support the specific health and lifestyle-related goals of the Health Inequalities Strategy.

3. THE STRATEGIC PRIORITIES

The Strategy proposes five priority areas which are driven by the public health evidence-base or by local views as to the most significant issues that contribute to health inequalities in Stockport.

The rationale for each priority is covered in detail in section 2 of the Strategy entitled 'Health Inequalities Needs Assessment' but a brief explanation is given below against each priority area and provides a sense of on what types of issues the implementation of the strategy will be focused. The action plan at section 4 of the Strategy provides more detailed information.

The Major Killers – nationally and locally the two diseases that people in the UK most frequently die from prematurely are circulatory disease (heart disease, strokes etc) and cancer; lung cancer in particular. However, the frequency of these diseases is higher in socio-economically deprived communities and people in these communities are also more likely to die from these causes than people living in more advantageous circumstances. Death from these diseases is therefore one of the main reasons for differences in life expectancy between poor and affluent neighbourhoods.

These diseases are also significant to health inequalities because the major factors that increase the probability of these conditions occurring - such as poor diets, low rates of physical activity and especially smoking - are also strongly associated with socio-economically disadvantaged communities.

Smoking / tobacco – it is well known that the effects of smoking and second hand smoke can be significant for health at an individual and a population level. Ongoing legislation in the area of smoking i.e. the ban on smoking in public and workplaces on 1 July and the upcoming legislation to increase the age of sales of tobacco in October this year are a reflection of this. Smoking remains the single greatest risk-factor in death from the diseases referred to above and it is estimated that about half of all regular cigarette smokers will eventually be killed by their habit.

In terms of health inequalities, the number of smokers in disadvantaged communities typically tends to be much higher. While smoking prevalence in Stockport is generally low at around 18 - 21% of the whole population, this rises to around 40-50% in the Priority 1 neighbourhoods. Two recent surveys in Brinnington and Adswood & Bridgehall suggest that rates of smoking are 51.8% and around 45% respectively in these

neighbourhoods. Additionally, there would appear to be less of a tendency to want to give up smoking and a higher rate of failure after 4 weeks for smokers from these communities.

Alcohol – rates of alcohol consumption and harmful drinking patterns are on the rise nationally and this issue is a particular problem in the North West. The rise in digestive disorders is thought to be alcohol related and after circulatory disease and cancers, the third most likely cause of early death in Stockport is digestive disease. In the last decade the average number of deaths due to alcohol related causes has almost doubled in Stockport from a rate of 12.2 (per 100,000 population) in the mid 1990s to 22.6 in the period 2003-05.

Evidence from the Stockport Health Survey 2006 points towards higher rates of alcohol consumption and more damaging patterns of drinking in disadvantaged neighbourhoods, but it is not a simple picture, with rates and patterns varying between genders and frequent drinking also linked to affluence. However, the general message that can be drawn from the survey is that drinking more than twice (and more than four times) the safe daily limits, binge drinking and dangerous drinking seem to increase with socio-economic deprivation.

Obesity – the rise in people who are overweight and those who are classed as obese (people with a BMI of over 30) is rising at a worrying rate in the UK and has trebled since the 1980s. It is estimated that 1 in 3 adults and children in England will be obese or overweight by 2020. The effects of obesity on health and life expectancy have been estimated and it is thought that around 6% of deaths each year in England (circa 30,000) are directly attributable to obesity. Based on these national findings, it is thought that in Stockport over the course of a year, 170 deaths will probably be due to obesity.

Obesity can be linked to health inequalities but the case is not as strong as for the other priority areas. There is a clear link between being overweight, gender and socio-economic deprivation as the rate of women who are overweight is higher in disadvantaged communities. Nonetheless, the pace at which obesity is predicted to rise over the next decade, and its contribution to premature death, suggests that it is an issue which may become a stronger factor in health inequalities than is currently the case and early preventative action is necessary to avoid deepening health inequalities.

Mental well-being – the issue of mental well-being is one that has emerged as a local priority via the professionals and practitioners that work with the most disadvantaged and vulnerable members of the Stockport community, many of whom live in the Priority Neighbourhoods. It is recognised, as much through intuition as through experience and evidence, that people who are living in challenging circumstances are more likely to suffer mental distress. This in turn can have a negative impact on other aspects of health, both of the individual themselves and

the people around them e.g. partners, children and elderly relatives for whom they may be providing care.

The 2006 Stockport Health Survey found that the average mental health score for residents increased with affluence, with Bramhall having the highest score and Brinnington the lowest. The challenge for the Strategy will be to sign-post and support the development of community-based resources which promote positive mental well-being and develop a tool which helps us to better understand and measure mental well-being.

4. LOCAL IMPLEMENTATION

While the five strategic priorities will provide the focus for the work in the target communities, local flexibility will be built into the process to allow for the differing statistical pictures in different communities and the issues that arise from the community engagement process.

The initial geographical focus for the work for the remainder of the current financial year will be in the three Priority 1 neighbourhoods as health inequalities in these communities are the most severe and persistent in the borough and will be the most challenging to tackle. The Strategy will be rolled out to the other Priority Neighbourhoods following March 2008 at a timescale and on a neighbourhood footprint to be agreed with the Public Health Partnership Board.

Implementation of the Strategy in each locality will follow a similar pattern as follows:

- Organisation and delivery of the appreciative enquiry / community consultation process;
- Development of a local health inequality action plan which reflects the 5 priorities within the strategy but which also allows for some flexibility to meet health needs as identified by the community itself;
- Formation of a relevant group of multi-agency professionals who are best placed to lead the delivery of the local health inequality plan and who have the appropriate influence to enact the change that is required. It is expected that the group would meet regularly in the initial stages of the work but may later become a virtual group once established. It will be important to ensure that pre-existing locality arrangements such as the Inclusive and Supportive Communities governance structures are appropriately linked to the locality health inequalities work; and
- Each locality will need to determine how to ensure that there is regular and ongoing community engagement in the process, beyond the initial appreciative enquiry – this will be for discussion locally and a decision arrived at that will fit with the existing structures within the particular community. It may be appropriate that the local IMPACT groups (a series of area-based public health community groups which are funded by the PCT and managed by Stockport CVS) could be the

focus for this. These decisions will also need to be taken in light of the Council's emerging Community Engagement Strategy.

5. RECOMMENDATIONS

The Board is asked to:

1. Note the report and comment on it, prior to discussion at the Stockport Partnership Forum.