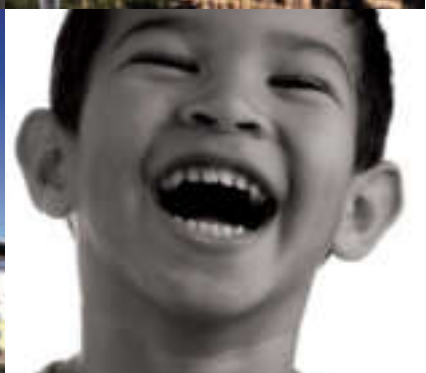




Our Life in the North West

A report by the Regional Director of Public Health 2008



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Acknowledgements

I would like to thank everyone who contributed some information to this report, and in particular Ann Hoskins, Dominic Harrison, Kate Arden, Christine Owen, Jude Stansfield, Mark Bellis, Karen Tocque, Neil Cumberlidge, Melanie Ogden, Frank Whiteford, Mark Gilman, Jackie Brennan, Alayne Robin and Angela Towers. Thanks to Directors of Public Health for their initial discussion and steer on the content of this report, to Tom Hennell for his data analyses, Danila Armstrong and Rachel Pugh for the editing and Clare Dooley and Keith Megginson for coordinating publication of the report.

Laying Down the Challenge

Despite action to address health inequalities and general improvement in health, the gap in life expectancy is still widening in many local authority areas across the region – and between the region and England as a whole.

We need to create a climate for change that views health inequality in the North West as simply unacceptable. Far from being inevitable, surprising or arising from factors beyond our control, it is avoidable and, in large part, arises from factors we have already identified and can do something about.

The regional agencies have a leading role to play in the support of better service delivery, coordination of wider public policy, and the creation with the people of the North West of new approaches to health improvement and disease prevention.

Delivering this will require strong public support and a more urgent and more visible focus than we have yet collectively mobilised in the North West. The challenge is to make a sustainable improvement to the health of everyone in the region by levelling up to the best.

Rather than presenting a more comprehensive public health report, I have focussed on the significant challenges that we need to address. There is much good work going on however, the time is right for a greater focus on health and well-being. I very much hope this report will act as a catalyst for discussion by regional agencies on how they can – separately and together – make a sustained impact on reducing inequalities and improving health and well-being in our region.

I also make a direct appeal to the people of the North West to join the decision makers in creating a movement for better health with **health for all** as our shared goal.



Dr Ruth Hussey OBE
Regional Director of Public Health/Medical Director



The Health of the North West in Summary



Despite good progress and excellent examples of action on health inequalities we are not living better in the North West compared to other regions and England. We have the:

Highest rate for:

- Deaths from heart disease and stroke
- Long-term mental health problems
- Alcohol-related hospital stays
- Hospital admissions for depression, anxiety disorders and for schizophrenia
- Self-reported violence
- Violent injuries serious enough to require hospital treatment
- Claiming incapacity benefits for mental and behavioural disorders

Second highest rate for:

- Deaths from cancer and smoking-related illnesses
- Death rate from suicide and injuries of undetermined intent in males
- Reported levels of feeling in poor health by the population

Second lowest :

- Breastfeeding rate

We also have:

- Low life expectancy for both males and females
- Infant mortality rate above the England average

AND

- Nine per cent (400,000 people) of the working-age population are on incapacity benefit, largely for preventable or manageable conditions

Equality Statement

The North West is a diverse, vibrant and dynamic region, and as a result has key challenges in addressing health needs of diverse groups and individuals. However, there is evidence to show that some minority groups are experiencing exclusion and disadvantage across all sectors on the economy.

Ethnic minorities are more likely to report poor or very poor health than white populations. There is also evidence of poorer access to health services including diagnosis and elective procedures.

Minority groups have higher rates of diabetes, mental health and other health problems. A quarter of all gypsy and traveller households in the North West have someone with either a disability and/or ill health. New migrant groups are emerging and have diverse needs and issues of equality. It is essential that good health and service provision is tailored to the needs of minority and disadvantaged groups, to ensure services and practices are promoting diversity.

The North West Equality and Diversity Strategy is a key regional plan to address many of the issues in this report.

The use of Equality Impact Assessments will help to ensure equality and diversity is addressed as part of promoting equity of outcomes.

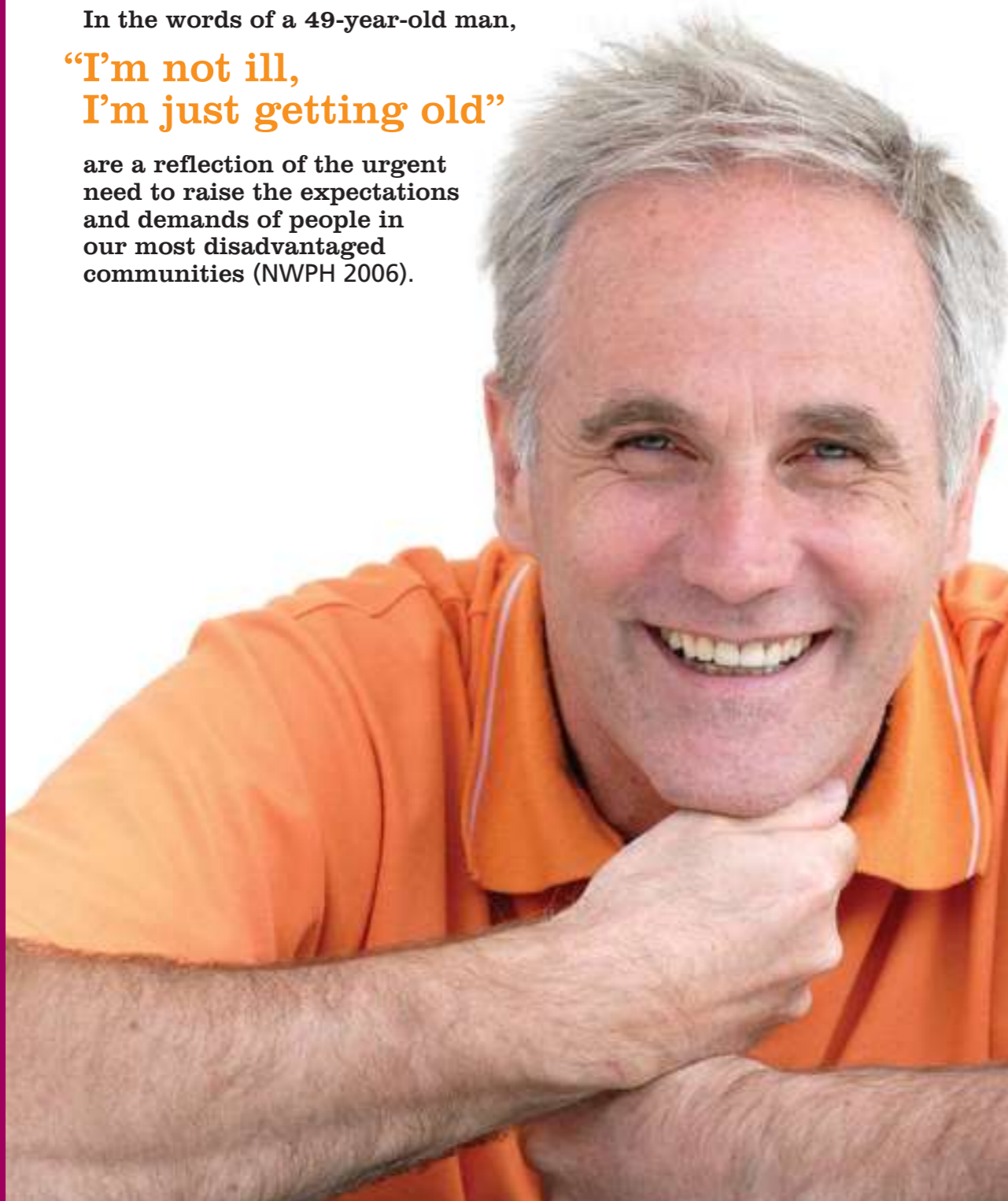


Action Towards the 2010 Targets and Beyond

In the words of a 49-year-old man,

**“I’m not ill,
I’m just getting old”**

are a reflection of the urgent need to raise the expectations and demands of people in our most disadvantaged communities (NWPH 2006).



When considered alongside the data on the regional profile, it is clear that the North West has a long way to go before it can enjoy the better health seen in other regions.

Much more local action and interventions are required if the region is to improve its health profile and achieve a measurable change in life expectancy by 2010 and beyond. This requires systematic action with effective interventions and a long-term commitment to funding.

Action is already underway, to prevent deaths from early middle age, particularly in those people who already have cardiovascular disease, cancer and respiratory disease.

Short-term solutions include action to reduce smoking and control blood pressure and cholesterol, underpinned by effective primary care. Many of these actions will be achieved through NHS activities.

However, to achieve sustainable long-term improvement in health and well-being, multi-agency action is required to tackle the wider socio-economic causes of poor health - employment, education, housing, transport and the environment – along with longer term disease prevention programmes.

Government Office for the North West (GONW) and the North West Strategic Health Authority (SHA) are in a position to influence action on the wider causes of poor health through links with key government departments. This will help to strengthen national policies, integrate regional strategies and drive local delivery. The GONW Corporate Plan 2007-2010 (GONW 2007) has already

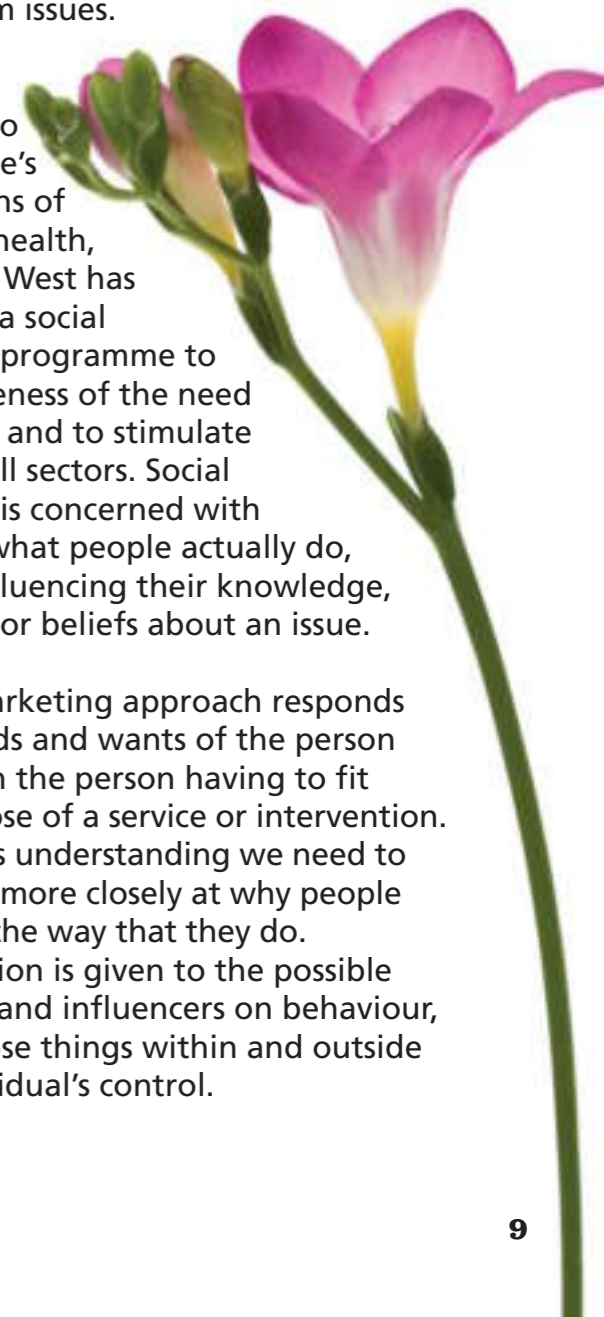
identified health inequalities as an issue that would benefit from a cross cutting GONW approach and the SHA has made reducing health inequalities a strategic aim.

A multi-agency approach can, and must, reduce health inequalities across the North West. Raising life expectancy in the areas with the worst deprivation is a key priority and we need to challenge the view that little can really be done about health inequalities.

At a local level, Local Strategic Partnerships are in a unique position to coordinate the actions of their partners to deliver on some of the longer-term issues.

As part of its efforts to raise people's expectations of their own health, NHS North West has sponsored a social marketing programme to raise awareness of the need for change and to stimulate action by all sectors. Social marketing is concerned with changing what people actually do, not just influencing their knowledge, awareness or beliefs about an issue.

A social marketing approach responds to the needs and wants of the person rather than the person having to fit around those of a service or intervention. To gain this understanding we need to look much more closely at why people behave in the way that they do. Consideration is given to the possible influences and influencers on behaviour, and on those things within and outside of an individual's control.



A social marketing approach considers ways to increase incentives and remove barriers to behaviour change. It also considers all the factors that compete for people's attention and willingness or ability to adopt a desired behaviour.

There is strong evidence to show that interventions based on this understanding of the customer are more successful than interventions or messages crafted in its absence.

The programme, called *Our Life* aims to:

- Deliver research and consumer insight into what influences people's health choices
- Campaign to increase public awareness of health issues and to galvanise the public to demand change, and to make changes themselves
- Work with politicians, decision makers and public interest groups to increase awareness of the impact of health issues
- Share information and best practice to support local action
- Build public sector capability and capacity for social marketing throughout the North West



Primary Care Trusts (PCTs) and local authorities are key players in the agenda to reduce health inequalities, working in particular through local delivery plans and local area agreements towards shared goals. In the short term, in order to achieve the government's target to reduce the gap in life expectancy between the fifth worst areas (spearhead*) and the population as a whole by 10 per cent by 2010, the following have been identified as priorities in need of the most urgent action, many for the attention of the NHS:

- Cardiovascular disease: a focus on enhanced primary care-based prevention by using practice registers to identify and treat people for high blood pressure, encouraging smoking cessation and prescribing lipid-lowering drugs as appropriate
- Organising stroke services to enable early treatment with drugs
- Provision of stop smoking, alcohol and weight management services accessible to all groups of the population

***A "spearhead" is defined as an area within the worst 20 per cent of health and deprivation indicators. These are 70 Local Authority areas, and PCTs that align them, which are in the bottom fifth nationally for three or more of the following five factors:**

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Cardiovascular disease mortality rate in under 75s
- Index of multiple deprivation 2004 (Local Authority Summary), average score

- Continued efforts to reduce smoking across the region through further action on tobacco control
- Increase early presentation and treatment for cancer
- The Mental Health Commission to advise on the NHS's role in prevention of mental illness
- Action on infant mortality by improving use of maternity services
- Prevention of seasonal excess deaths through flu vaccination and action on fuel poverty
- Improve access to contraception services

However, more needs to be done across agencies to address the wider causes of poor health in the region.

The following sections describe the current challenges in more detail and serve as a basis for discussion on ways in which better health and well-being can be achieved.



Our Health in the North West



What is health inequality?

Health inequality is the product of a number of factors such as income, education and employment alongside material environment and lifestyle.

It can arise in the following ways:

- Inequality of risk conditions – where groups within the community are exposed to different social, economic and environmental risks from the organisation of employment, housing, education, transport, pollution and other health determinants.
- Inequality of risk factors – where certain age, socio economic groups, minority ethnic groups or genders are more likely to suffer particular risk. For example, young men are more likely to have risky lifestyles.
- Inequality of access – where differences exist between groups in accessing effective services that improve health outcome, such as, differences in access to cardiac procedures compared to levels of need.

The impact of ill health on the region springs into relief when seen within the context of its relationship to sustainable economic growth.

In the North West nine per cent (400,000 people) of the working age population do not work and are on incapacity benefit – largely for preventable or manageable conditions.

The Regional Development Agency estimates £3 billion of the GVA (gross value added) gap between the North West and England as a whole is caused by worklessness. At 73 per cent, the employment rate is two per cent behind the England average (NWRDA 2006). This means that the region would need 80,000 more people in work to bridge the gap.

Given this picture of a region suffering both preventable ill health and unemployment, the NHS in the North West (working with other regional agencies) has an important role to play in making the region healthier, wealthier and more equal in its distribution of jobs, income and general life chances.





The challenge for the region is to address the net effect of these inequalities – the poor health experienced by many people. There is an interaction between risk conditions, risk factors and access to health services. Taking the well-accepted association between rates of mental illness and poverty, education, unemployment and social isolation, it is clear that psychiatric disorders and suicidal attempts are most likely to occur in people facing socio-economic disadvantage, such as those in unskilled occupations or unemployed, and who lack formal qualifications (Meltzer et al, 2002).

The straightforward response to health inequalities is simply to ensure that everyone has fair access to the same quality service. The more challenging agenda is to address the underpinning social conditions giving rise to inequalities in risk behaviour and the development of disease.

Some risk factors affect a large proportion of the population and require whole-population solutions with a particular focus on the most disadvantaged. History shows that more affluent populations adopt healthier lifestyles in general more quickly than the least well-off. This may mean targeted actions and adapted solutions.

Work under way by the World Health Organisation, led by Professor M. Marmot has brought together all the evidence on this issue and will be published in 2008. This will be a key resource to provide the necessary evidence to inform action, along with the Department of Health review of health inequalities, also due in 2008.

The current national programme to address health inequalities includes the target to reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.

Starting the change process will require:

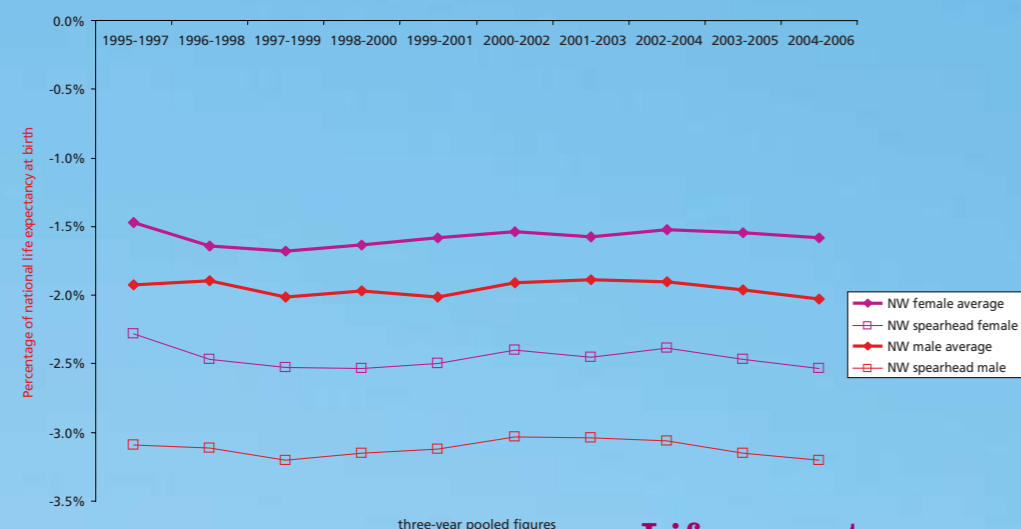
- A 10 per cent reduction in the life expectancy gap between the fifth of areas (known as the Spearhead Group of local authorities) with the 'worst health and deprivation indicators' and the population as a whole, by 2010. Of the 70 Spearhead local authorities in England, 23 are in the North West.
- A reduction of more than 10 per cent (by 2010) in the gap in the mortality of children under one year old born to routine and manual groups and to the population as a whole.

The Current Picture

Figure 1.1

**Life expectancy gap:
local authorities in the North West, and England**

Trend 1995-97 to 2004-06, comparing the North West average with the Spearhead Group

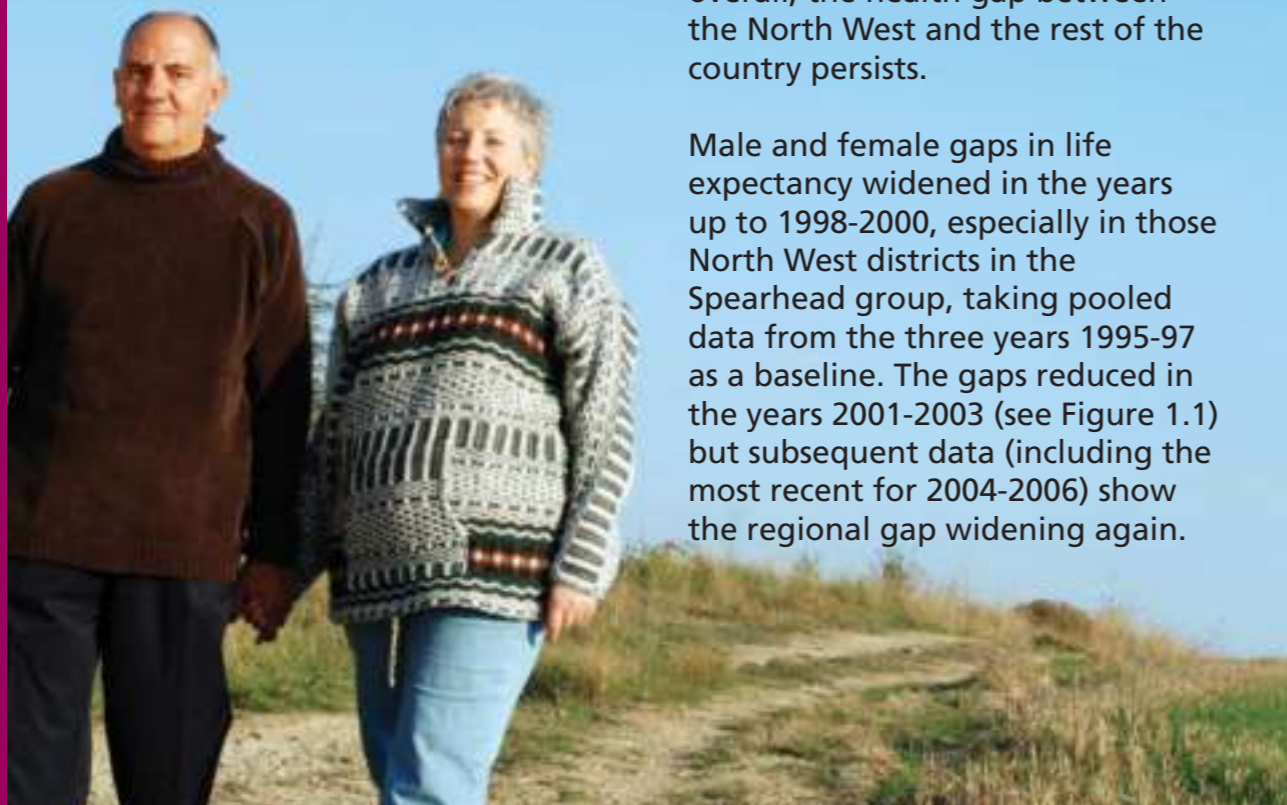


Source: Analysis by T Hennell, ONS data

Life expectancy

Whilst the health of people within the region continues to improve overall, the health gap between the North West and the rest of the country persists.

Male and female gaps in life expectancy widened in the years up to 1998-2000, especially in those North West districts in the Spearhead group, taking pooled data from the three years 1995-97 as a baseline. The gaps reduced in the years 2001-2003 (see Figure 1.1) but subsequent data (including the most recent for 2004-2006) show the regional gap widening again.



Averaged across the North West, **men can expect to live to 75.8 years** (some 2.7 years less than the South East and South West regions), whilst **women can expect to live to 80.3 years** (2.4 years less than the South West). Looking from a local authority level perspective reveals a worse picture.

Manchester and Blackpool have the lowest average male life expectancy in England - at 73 years, a substantial 10 years less than the English local authority with the highest male life expectancy (Kensington and Chelsea at 83 years).

Life expectancy for females shows a similar pattern. Liverpool has the lowest female life expectancy - at 78 years, nine years less than the England best of 87 years.

**Inequalities within
Local Authority Districts**

In addition to a widening life expectancy and mortality gap between districts in the North West Region and the national average, recent years have also seen a general widening of gaps within the region. This applies when the most deprived 20 per cent of areas in a district are compared with the district average.

Around 26,000 people under 75 years old die in the region every year (see Table 1.1 on page 19). Many of these premature deaths are preventable in that they could have been avoided by improvements to the environment, an increase in healthy behaviours by individuals, and access to effective and targeted care.



Figure 1.2

Male reduced life expectancy by cause of death – compared to E&W average

Persons under 75 dying in Spearhead districts in the North West: 1995-97 to 2004-06

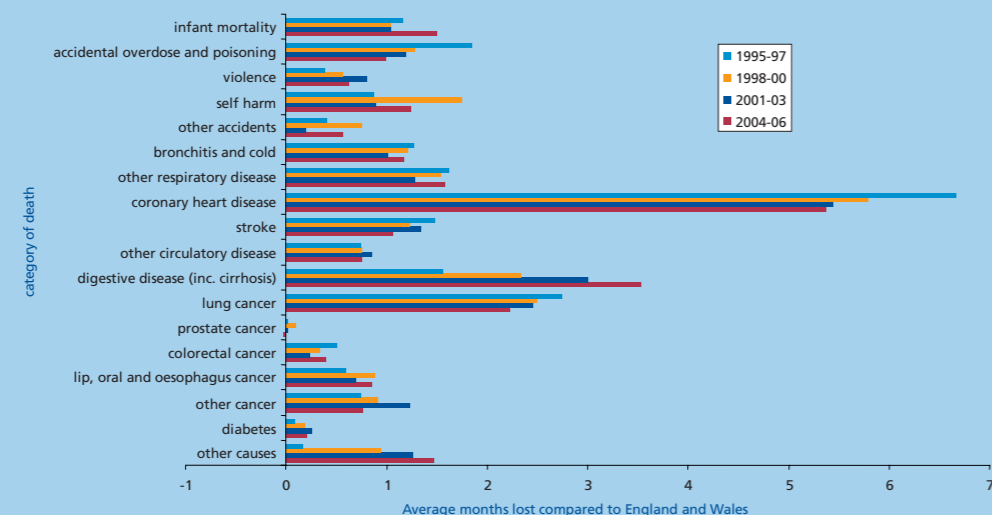
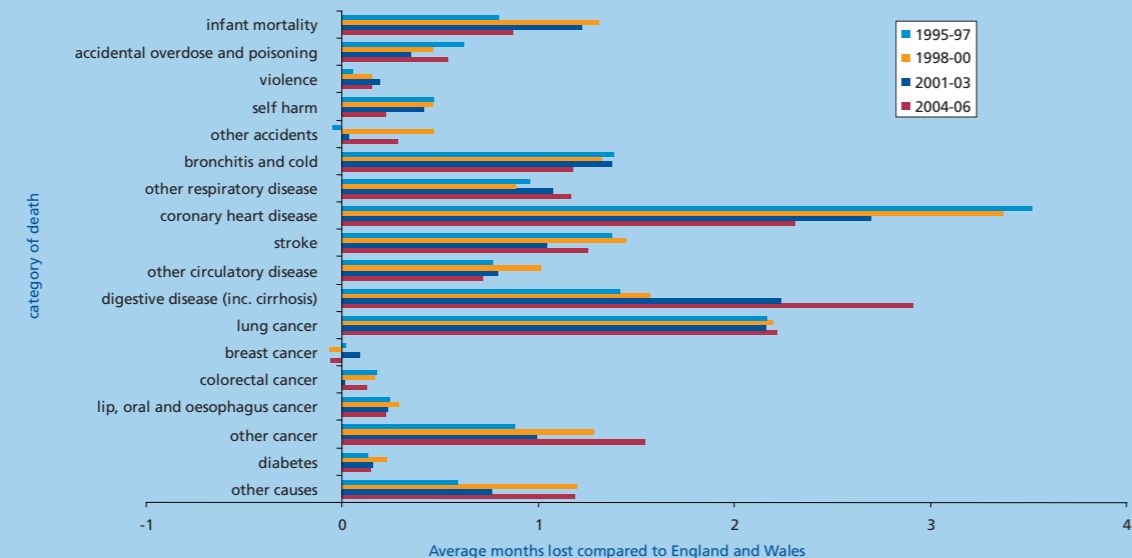


Figure 1.3

Female reduced life expectancy by cause of death – compared to E&W average

Persons under 75 dying in Spearhead districts in the North West: 1995-97 to 2004-2006



Source: Analysis by T. Hennell, ONS data

Table 1.1: Total number of deaths registered in 2006 in the North West (including Glossop) by main cause and age group

Causes	Age Groups			Total Under 75	75+
	0-17	18-64	65-74		
Neoplasms	36	4,605	5,057	9,698	9,427
Circulatory	26	3,104	4,142	7,272	17,315
Respiratory	30	889	1,575	2,494	7,976
Digestive	9	1,383	598	1,990	1,793
External Causes	91	1,353	213	1,657	822
Other Causes	549	1,339	993	2,881	6,802
Total				25,992	44,135

Source ONS (2006) Regional deaths extract

Figures 1.2 and 1.3 illustrate the causes of death, in the North West Spearhead

Group of local districts, which contribute to the gap in life expectancy in males and females.

The greatest contributors to the regional life expectancy gap between 1995 and 1997 were coronary heart disease and lung cancer. Since then the relative importance of coronary heart disease has decreased for both men and women, as has the contribution of lung cancer for men, though cancer remains a significant contributor overall.

Deaths from digestive diseases (of which the most important is cirrhosis of the liver), have however increased markedly for both men and women; so that, by 2004-2006, the female months of life lost due to digestive diseases was greater in the Spearhead districts in the North West as a whole, than the months of life lost due to coronary heart disease.



Figure 1.4

Males dying under 75 years in the North West

Comparing 1995-97 to 2004-06

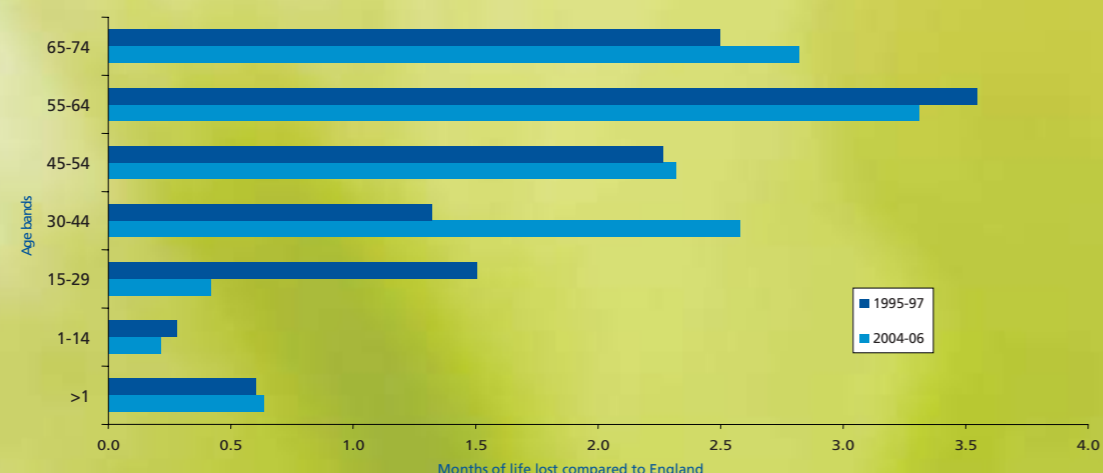
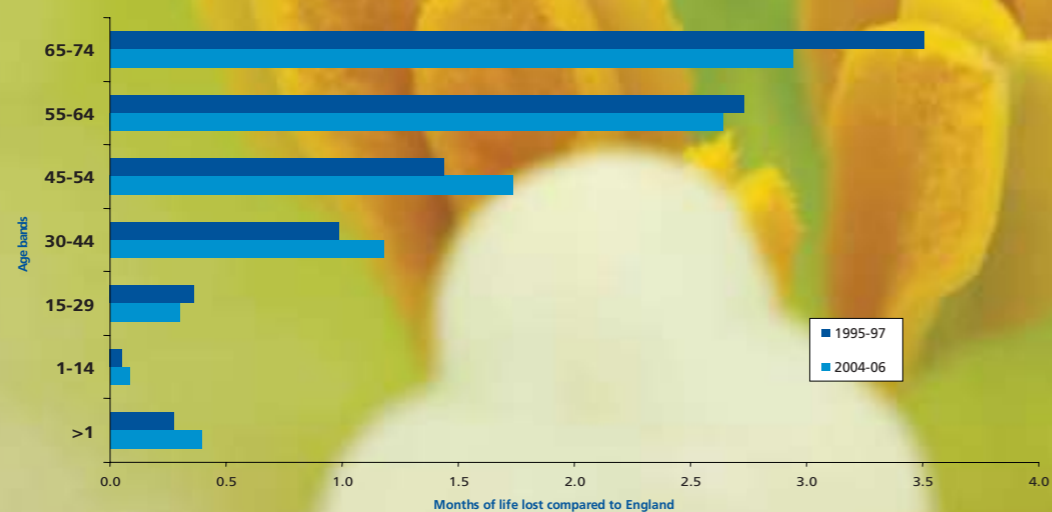


Figure 1.5

Females dying under 75 years in the North West

Comparing 1995-97 to 2004-06



Source: Analysis by T. Hennell, ONS data

Deaths of younger people – an unequal impact

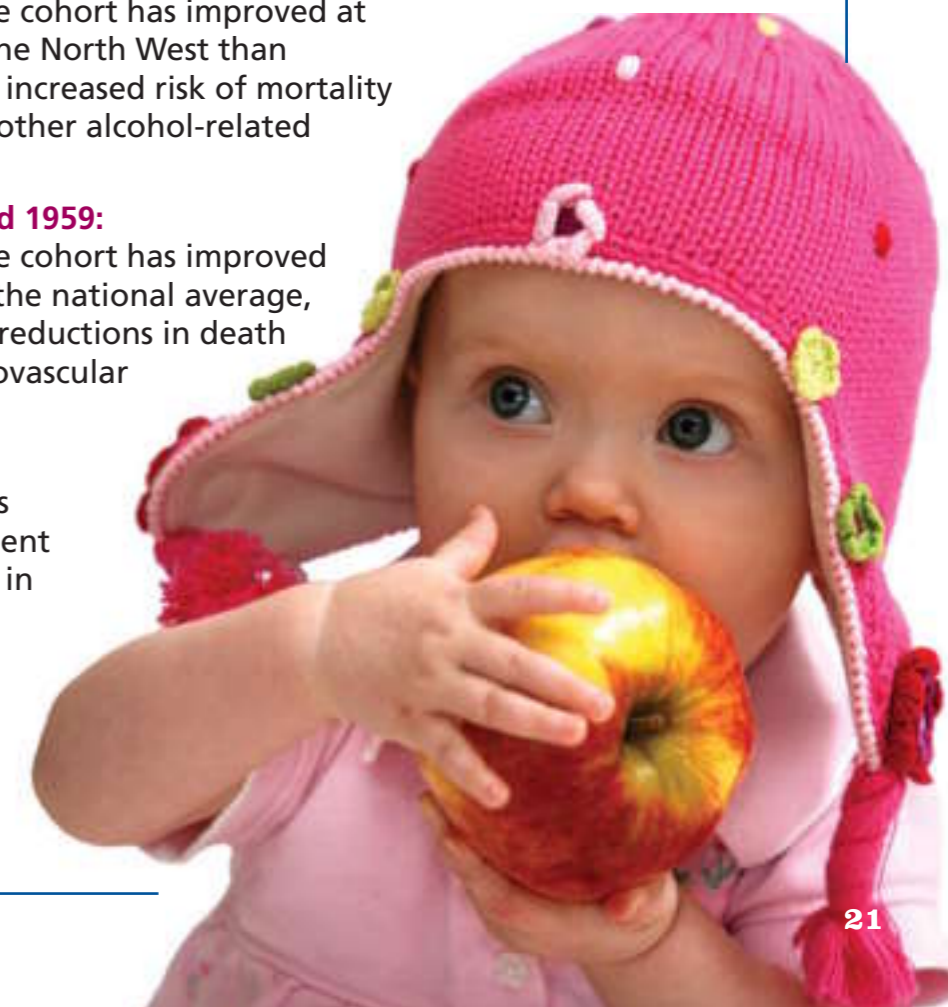
Deaths of younger people are relatively rare, but each such death makes a bigger impact on the region’s lower average life expectancy, than would the death of an older person.

have the most impact on average male life expectancy, while deaths between 65 and 74 have the most impact on average female life expectancy.

If both absolute numbers of deaths and loss of life years are taken into account – deaths between the ages of 55 and 64

Different age groups do not contribute in the same way to life expectancy across the region (see Figures 1.4 and 1.5).

- **Infants (aged less than one):** Mortality has improved in the North West since 1995-1997, but not quite as fast as the national rate of improvement. Consequently, deaths in this age group contribute an increased element of the gap.
- **Persons born since 1975:** Mortality of persons in this age cohort has improved in the North West much faster than in the country as a whole – especially for males, and particularly related to reduced risk of death from accidental drug overdose. Some parts of the region however still experience higher rates of younger deaths due to road traffic injuries.
- **People born between 1960 and 1974:** Mortality of persons in this age cohort has improved at a considerably slower rate in the North West than nationally, primarily due to an increased risk of mortality from cirrhosis of the liver and other alcohol-related causes of death.
- **People born between 1940 and 1959:** Mortality of persons in this age cohort has improved in the North West faster than the national average, mainly because of more rapid reductions in death rates due to cancers and cardiovascular disease in this group.
- **People born in the 1930s:** This birth cohort nationally has experienced a rapid improvement in mortality, but improvement in the North West has tended to lag behind the national average – especially for cardiovascular diseases.



Contributing Factors

What factors contribute to the North West's poor general health profile?

The stark reality in the North West is of a large part of the population living in poor general health. This is well illustrated by data from the Community Health Profiles (APHO 2007a) (see Figure 1.6) which compares the health of people living in the North West with the England average and other Government Office regions.

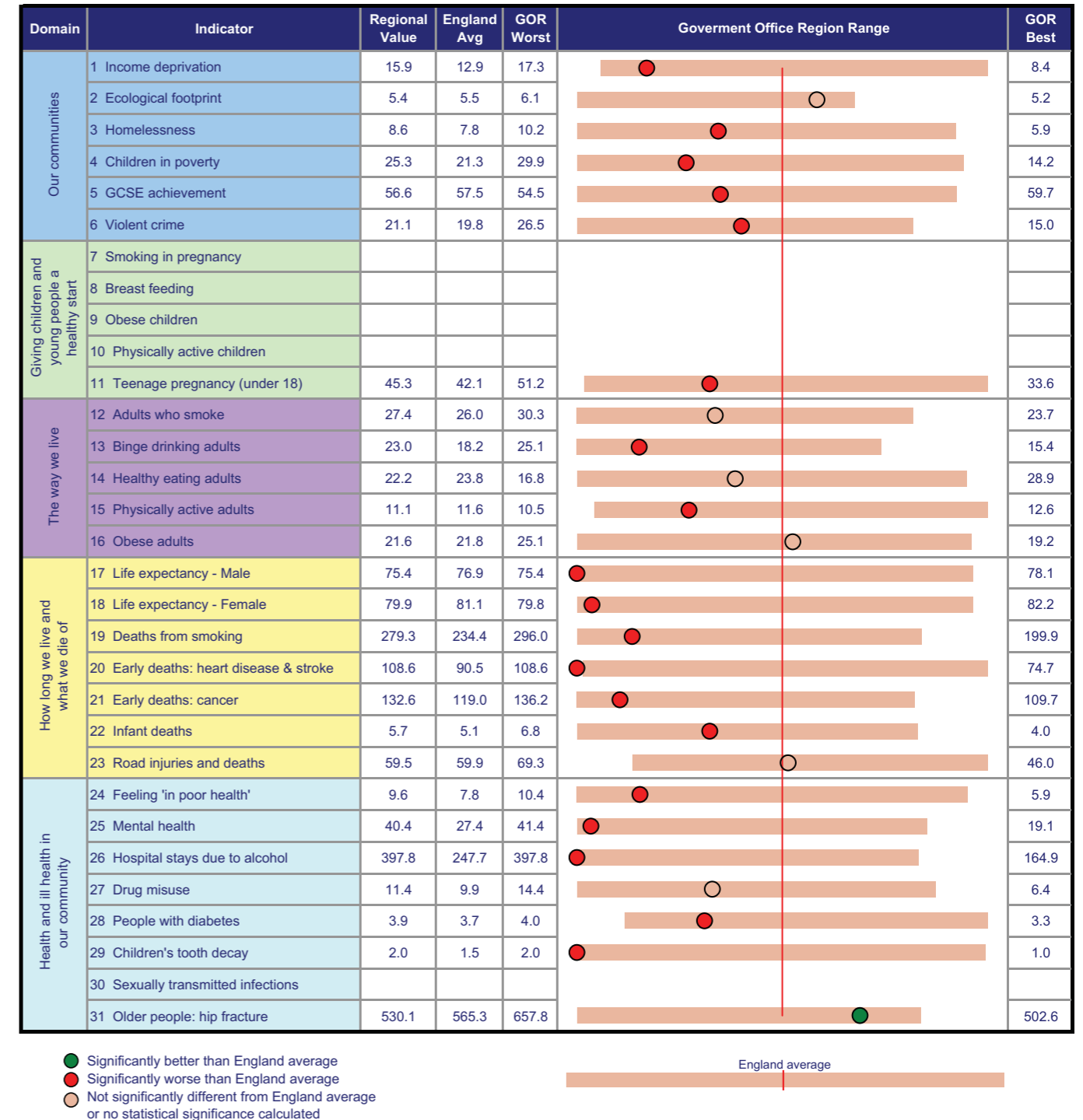
Out of the 26 indicators for which there are data, 19 are significantly worse and only one significantly better than the England average. Although the region compares poorly with the rest of the country, Figure 1.6 masks the significant variation across local areas in the region, which is described in the next section.



Figure 1.6

Summary of health in the North West region

Compared to the England average and ranges for all Government Office regions



Produced by NWPHO using data from the Community Health Profiles (APHO 2007a)
 Note data for indicators 7 to 10 not available at the time these profiles were published.

Income deprivation

Income deprivation is high in the region, with 15.9 per cent of residents dependent on means-tested benefits in 2003, compared to the England average (12.9 per cent). Of the 10 local authorities with the worst income deprivation in England, three are in the North West: Knowsley (28.6 per cent), Liverpool (27.9 per cent) and Manchester (27.5 per cent).

Feeling in poor health

Of the North West population 9.6 per cent rate their health as 'not good' compared to an England average of 7.8 per cent. This is second only to the North East (10.4 per cent). The local authorities in England with the second, third and fourth highest reported rates of feeling in poor health are Manchester (13.2 per cent), Liverpool (13.1 per cent) and Knowsley (13.0 per cent).

Early deaths from heart disease and stroke

Although showing some improvement, early deaths¹ from heart disease and stroke in the North West remain significantly higher than the England average and higher than any other region (with the exception of the North East which has an equal value of 109 deaths per 100,000 population). Of all the local authorities in England, Manchester has the greatest rate of early deaths from heart disease and stroke (151 deaths per 100,000 population).

Early deaths from cancer

These have shown a slight improvement over the last year, however levels are significantly higher than the England average (133 deaths compared with 119 deaths per 100,000 population). Only the North East has higher levels (136 deaths per 100,000).

At a local level, 29 of the 43 North West authorities have levels of early deaths from cancer that are higher than the England average. The local authorities with the top five highest rates for early deaths from cancers are all in the North West - Halton (168 deaths per 100,000 population), Liverpool (166 deaths per 100,000 population), Manchester (165 deaths per 100,000 population), Knowsley (161 deaths per 100,000 population) and Salford (157 deaths per 100,000 population). Inequalities in incidence of breast cancer are shown in Figure 1.7. The data are shown using the P2 People and Places² classification of neighbourhood types. The incidence of breast cancer is lower in urban challenge, disadvantaged households and multi-cultural centres than the England average (but not lower than the regional average).

Road injuries and deaths

The rate in the North West is similar to the England average. However Eden District, Cumbria has the second-highest local authority rate in England (179 per 100,000 population).

¹ 'Early deaths' are deaths that occur in people aged under 75 years.

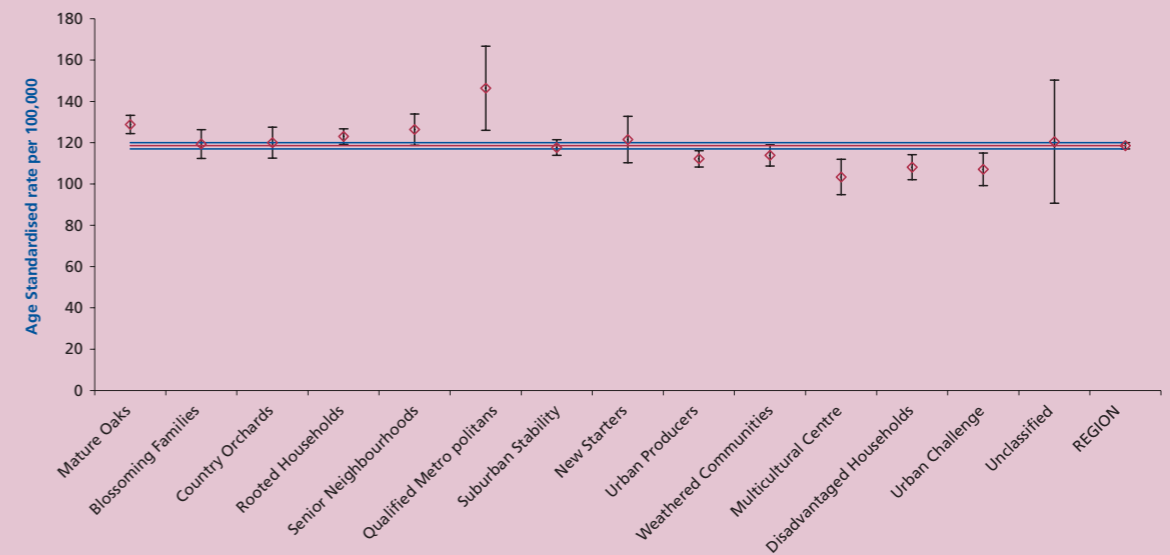
² Copyright © Beacon Dodsworth Ltd. www.beacon-dodsworth.co.uk



Figure 1.7

North West cancer registered annual incidence by area type

Breast Cancer annual incidence in the North West: 2000 to 2005



"People and Places" local neighbourhood classification
 >>>> increasing income deprivation >>>>



Inequalities in children and families

Any consideration of health inequalities is inadequate if it does not focus attention on children's health and well-being. Health inequalities begin, for many of our citizens, from birth and childhood. Economic and social factors impact on their development and for many these inequalities continue into adult life.

A key underlying issue is the proportion of children living in poverty - 1 in 4 of children in the North West - which has an impact on a wide range of issues for families. Some young people face even greater challenges, such as looked-after children, disabled children and children with complex needs, who are among the most vulnerable groups of young people.



The health of North West children, compared to other regions, is worst across a number of areas. These include:

- The rate of infant mortality in the North West (5.6 per 1,000 births) is higher than the England average (5.0 per 1,000 births). Of the 10 English local authorities with the highest infant mortality rates, one is Pendle in the North West (9.4 per 1,000 births).
- The recent Infant Feeding Survey 2005 (Bolling et al, 2007) shows that the North West has the second-lowest rate of babies (66 per cent) breastfed at birth compared to 78 per cent for England. By six months, only 17 per cent of babies in the region are still breast-fed compared with 25 per cent for England.
- Wide differences in breastfeeding initiation rates exist between primary care trusts in the region - from 33 per cent to 73 per cent - (DH 2007).
- Other indicators where the North West is significantly worse than the England average (APHO 2006) include:
 - The number of under 15 year olds killed or seriously injured in traffic accidents
 - Males 0-14 years old with long-bone fracture admitted to hospital
 - Teenage conception rates
 - Number of children living in households where someone smokes.

Within the region, Children and Young People's Health Indicators (CAYPHI) provide an 'at a glance' profile across 50 indicators for every local authority in the region (www.nwph.net/cayphi). A summary statistic across the 50 indicators shows a very strong relationship with deprivation and illustrates just how large the challenge of tackling children's inequalities is today for the North West region.

In addition, substance misuse (including alcohol, smoking and drugs) is an important factor for young people, and can impact on other parts of their lives such as sexual health, crime and absence from school. **There is a strong link between educational attainment at 15 years of age and poor health.**

Increasingly, poor mental health is an important factor for children and their families. Children are affected by their own poor mental health as well as that of their parents. For some groups of young people, access to mental health services has been difficult, hence the national drive to improve access for 16 and 17 year olds, for children with learning disabilities and for young people in crisis.



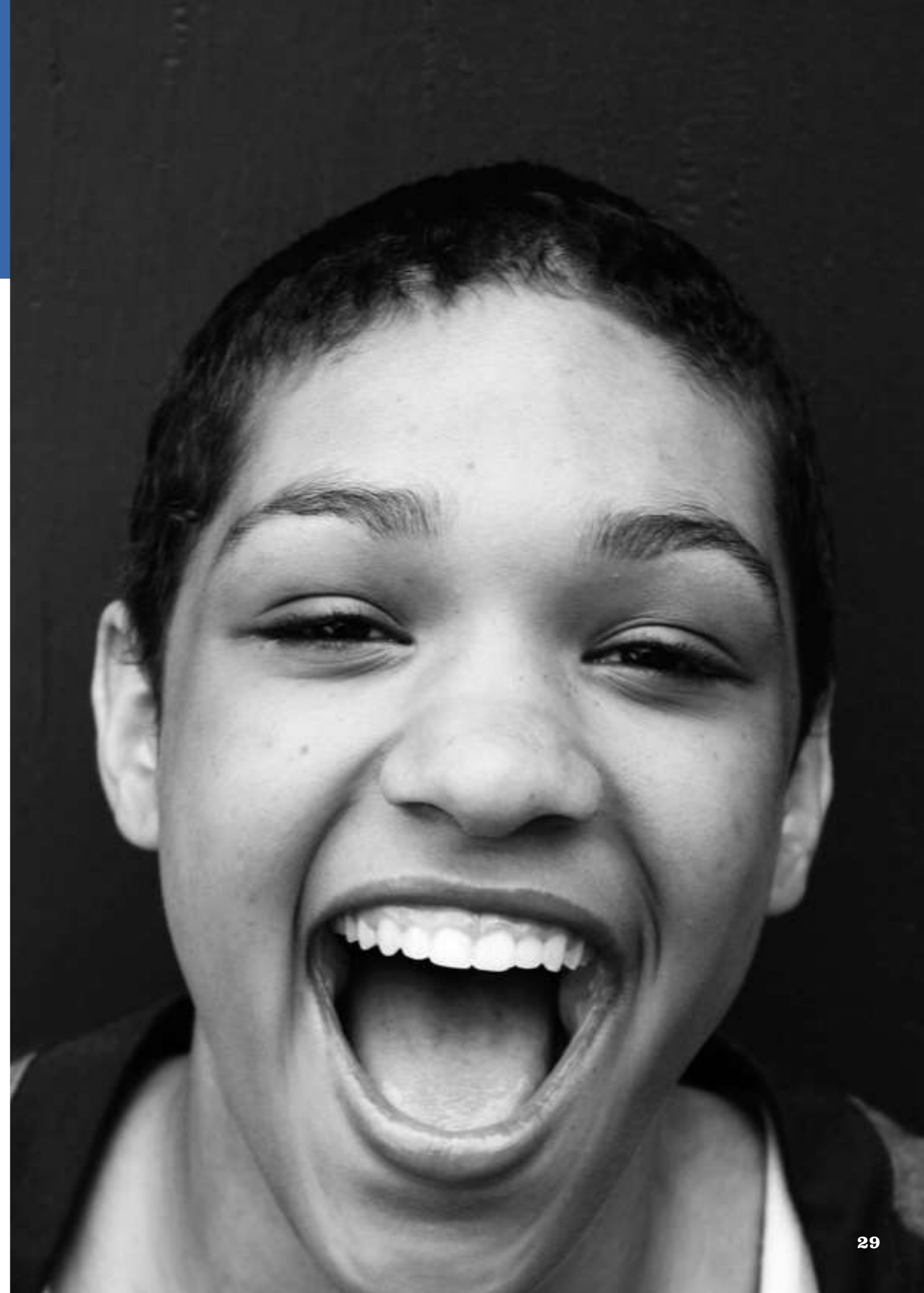
A Diverse Population

The region has also seen a considerable change in its demographics and will continue to do so in the future. These new changes in demography also bring about new and complex health and social care needs.

As the region's population in terms of race, ethnicity and inward migrants is rapidly diversifying this could cause a potentially inadequate response from the region's public services to match their delivery to rapidly changing demographic needs.

Some of the diversity and changes in the region's demography are shown below:

- We have one of the greatest number of dispersed asylum seekers in the UK (NW Regional Housing Strategy, 2005)
- A third of older people are unemployed compared to a quarter of those living in the south (Institute of Public Policy Research North, 2007)
- 20.6% of the working age population is identified as being disabled (Disability Rights Commission, 2007)
- Black, Minority and Ethnic (BME) population has increased from 5.5% in 2001 to over 7% in 2006. Future ethnicity projections for 2020 suggest a rise to 8.4% and for 2032 a rise to 9.7% (NWDA 2008 – Demography, Migration and Diversity in the NW)
- 10% (612,000) of the North West population identified themselves as Lesbian, Gay, Bisexual and Transgender (NWDA 2008 – Demography, Migration and Diversity in the NW)
- There is a growing presence of Gypsy and Traveller families in the North West by an annual increase of 3% (Salford and Housing Studies Unit – University of Salford, 2007 and NWRA Report, 2007: An Overview – Gypsies and Travellers in the NW)
- The ratio of pensionable age people (to working age) will increase to over 0.35 and by 2026 will reach 0.42 - 40% higher than currently in the North West (NWDA 2008 – Demography, Migration and Diversity in the NW)
- Recent figures from the Department of Work and Pensions show that migrant workers from the new European countries are now the largest arrivals with 37,000 in the North West – with Poland as the biggest single group (22,000)





The changing demography not only poses a health challenge for us to find the best ways to manage the emerging and diverse needs and issues of equality, but poses a wider community cohesion issue.

Research now shows an association between low indicators of community cohesion and poor life chances and mental health outcomes.

Work initiated within a regional non-governmental organisation on community cohesion and health in 2002 has provided a basis for the development of a toolkit for NHS engagement and community cohesion. Working with the National Institute for Community Cohesion we aim to launch “ten key questions” on the NHS contribution to community cohesion.

While migration is likely to have made a valuable economic and regeneration contribution to the region, there are still key gaps or limitations in our knowledge about the wider social and non-economic impacts of migration. We are addressing these by commissioning a report that will outline the health needs of migrants, service provision and practice and the impact of migration of health on the North West region.

We have set up a health interest sub-group of the North West Regional Strategic (Migration) Partnership (NWRSMPP). Membership of the group includes representatives from third sector groups, Care Services Improvement Partnership, Department of Health, PCTs, NHS North West, Government Office North West and the Health Protection Agency.

Older people

As birth rates continue to fall and life expectancy grows, the North West population is becoming older. Some areas may in the future experience specific health and social care problems as well as increases in health inequalities because of predicted increases in the proportion of people over 75 years, ill and living alone by 2011. This varies across the region and some areas (Ellesmere Port and Neston, Knowsley, Congleton, West Lancashire and Barrow in Furness) are projected to experience increases of between 20 and 43 per cent. Local authorities and PCTs will need to commission services to respond to these demographic changes.

However, the majority of older people will have a healthy and fulfilling retirement bringing positive influences, for example, the over 50 year olds are significant contributors to the economy and their buying power provides scope for the development of products and services targeted at older people.



Our Lifestyles

Figure 1.8

Percentage of adults currently smoking cigarettes by gender and area

Health Survey for England 2003 & 2005

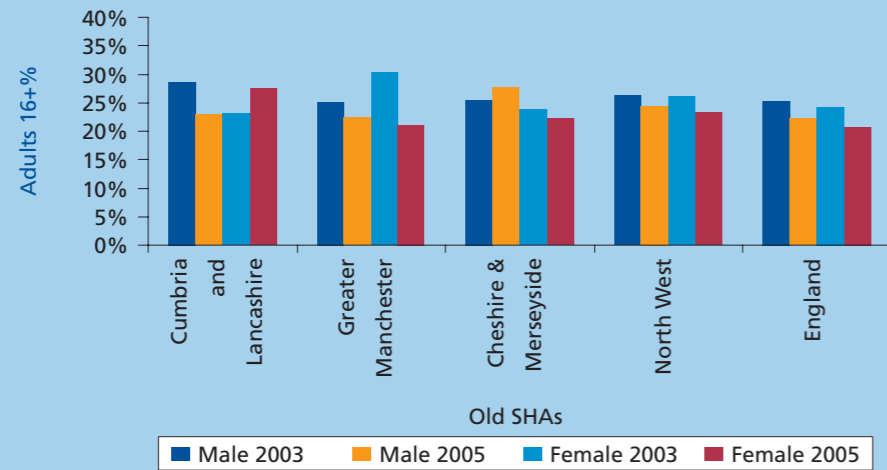
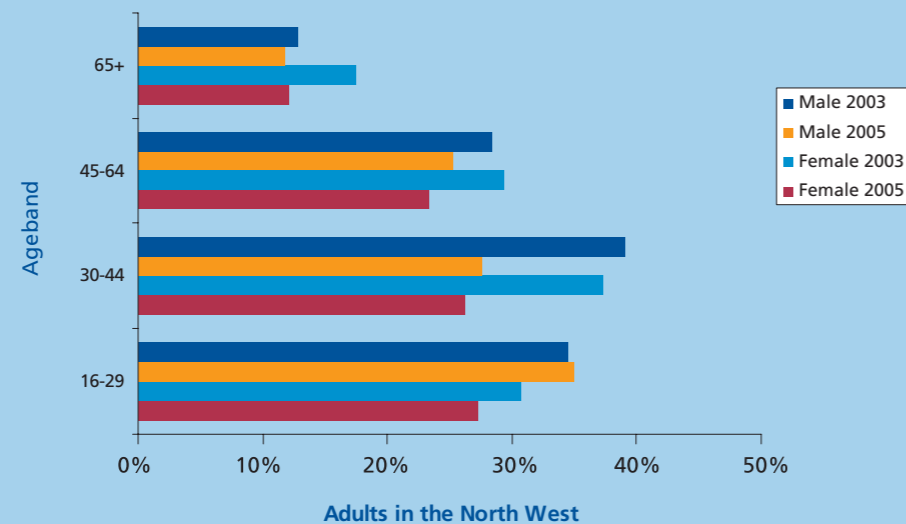


Figure 1.9

Percentage of adults currently smoking cigarettes by gender and age

General Household Survey 2003 & 2005



Source: Analysis of data between 2003 and 2005 from the Health Survey for England and the General Household Survey for Figures 1.7 to 1.9 by T Hennell

Smoking

The rate of adults who smoke in the North West at 25% is significantly higher than the England average of 22% (GHS 2006) and this regional rate masks a significant variation between local areas (APHO 2007a).

Compared with the England average, 25 out of the 43 local authorities in the North West have a higher estimated prevalence of adults who smoke. Knowsley has the third-highest estimated smoking rate in England (35.4 per cent). Mortality related to smoking is significantly higher than the England average. A recent report from the North West Cancer Intelligence Service highlights the stark fact that about 60% of excess cancer deaths in the region are due to lung cancer, underlining the importance of bringing down smoking rates (NWCIS 2007).

At a local authority level, the three areas with the greatest number of smoking - attributable deaths are all in the North West: Knowsley (367 deaths per 100,000 population), Liverpool (363 deaths per 100,000 population) and Manchester (360 deaths per 100,000 population). While smoking rates in the North West are closely correlated to deprivation, evidence shows that even if the socio-economic circumstances of less well-off smokers improve, their health gain is likely to be minimal if they continue to smoke.

The decrease over time, in overall adult smoking in the North West as a region, mirrors the national picture but rates are decreasing too slowly in comparisons with the other English regions. A more detailed examination of the picture (see Figure 1.8) reveals a significant



decrease for adult females in Greater Manchester between 2003 and 2005. Elsewhere in the region, the reductions appear to be smaller.

Whereas nationally, more affluent population groups tend to experience the most consistent pattern of decline in smoking - with deprived populations lagging behind, the opposite appears to be the case in the North West. The survey indicates a small increase in affluent populations, but with the biggest drop in prevalence observed in the most deprived population.

The age profile of people making changes in their smoking behaviour also differs significantly in the North West from elsewhere. Nationally, there is evidence for reducing prevalence in all age groups and both genders. In the North West, by contrast, there is little reduction in prevalence for persons under 30 and rates of smoking for younger males may even be increasing. There is however evidence of large reductions in smoking rates for males and females in their 30s and 40s (see Figure 1.9).



Reducing smoking prevalence in the North West may be projected as delivering substantial benefits in reducing inequality in mortality and life expectancy and should therefore be a priority for the NHS and Local Government alike. However the contribution of stop smoking services to achieving this should sit within wider, well-funded, multi-agency tobacco control programmes at local, sub-regional and regional levels sustained by strong leadership.

Smokefree legislation, together with slowly falling smoking prevalence will bring long-term health and economic benefits to the region. However, many tobacco control challenges remain including bringing down still high smoking prevalence rates, tackling tobacco related health inequalities, reducing access to counterfeit and smuggled tobacco, reducing smoking amongst young people and young adults and protecting children from exposure to secondhand smoke from conception to adulthood.

A collaborative region-wide tobacco control programme aspires to deliver our vision of a tobacco free North West and rise to the challenges outlined above.



Food & Nutrition

The links between food, nutrition and health are many and well documented. Diet is a key lifestyle factor for health and well-being. A safe, healthy and balanced diet can help prevent many of the life-threatening degenerative diseases and conditions that are so prevalent in today's society, such as cardiovascular disease, some cancers, diabetes, hypertension and tooth decay.

Alongside the problems of excess, there are significant numbers of people who do not have access to an adequate supply of affordable foods for a healthy diet. For many people food poverty is a real issue and, as with many inequalities, it is faced day to day by people on the lowest incomes and who live in the most disadvantaged areas. Malnutrition, particularly in the elderly, and eating disorders also continue to be of concern.

The North West has some of the highest levels of dietary related ill health in the country, fostered by easy access to processed, ready meals, fast foods and snacks, which are often low in nutrients and high in fat, sugar and salt. People living in the more deprived areas and low income families have the worst diets





- consuming more unhealthy foods and less fruit and vegetables than those in more affluent areas. Children are one of the most vulnerable groups and at high risk of significant future diet-related ill health.

The public health and diet challenge is urgent, compelling and goes beyond obesity. The benefits to the North West of a healthier diet – in terms of improved health and well-being and increased regional productivity - are without question. This is particularly important in the context of the rising social and economic costs of diet-related disease.

The issues behind improving food and nutrition are complex and multi-sectoral. The North West Food and Health Action Plan³, launched early 2007 aims to

improve the health and well-being and narrow health inequalities across the North West population, through better food and nutrition. It sets out a range of actions and interventions, taking a Farm to Fork approach and working with a wide range of stakeholders, to increase access to and availability of healthier foods.

The Food Standards Agency has recently established a regional office in the North West and this brings added resource in our efforts to improve food safety and healthy eating. Improved consumer information supports healthier choices and we continue to promote traffic light labelling as the preferred system to provide clear and at-a-glance nutritional information for consumers at point of sale.

³www.nwph.net/food_health/Taskforce_Publications/Forms/DispForm.aspx?ID=12

Schools are a key platform for the promotion of healthy eating and food education. Work is underway to increase the take up of school meals in primary and secondary schools in the North West. The level of uptake of Free Schools Meals is also below the percentage of pupils known to be eligible. The National Healthy Schools programme includes a core theme on healthy eating. In the North West 96% of schools are participating in the programme and 58% have achieved accreditation.

Increased focus is now required on early years settings including Children Centres, which are required to meet the requirements of the Foundation Stage Framework which includes healthy eating, providing the opportunity to shape attitudes and behaviours in the pre school period.

Healthy Weight

The rate and extent of the national increase in overweight and obesity is related to several decades of societal and organisational changes which have created an obesogenic environment. To slow down the increase and prevent future obesity requires changes in the physical and food related environment as well as support for achieving and sustaining healthy lifestyles.

The Government has set itself a new ambition, through the Child Health and Well-being Public Service Agreement, to reverse the rising tide of obesity and overweight in the population by ensuring that all individuals are able to maintain a healthy weight. The initial focus is on children, so that by 2020 the proportion of overweight and obese children will have been reduced to the 2000 levels.





The national strategy, Healthy Weight, Healthy Lives (2008) sets out five themes where investment and action will be taken across Government. The North West Framework to Achieve Healthy Weight for Children and Families, complements the national plan, by defining the actions to be taken by regional stakeholders which will support local delivery.

Adult obesity

Epidemiological surveys in England indicate that the prevalence of overweight and obesity in adults has nearly trebled during the last 20 years, and that in 2004 nearly a quarter of men and women were obese⁴. In 2005, 22% of English men and 24% of women were classified as obese, an increase from 17.0% and 19.7% for men and women respectively in 1997.

Overall, the North West rates are not significantly different from the England average but almost two-thirds of North West authorities have estimated levels greater than the England average of 21.8 per cent. Allerdale is one of the 10 local authorities in England with the highest levels, with 26.6 per cent of the population estimated to be obese (see Figure 1.6 on page 23) (APHO2007a).

Childhood obesity

This is a key public health priority for the North West and reflects the poor diets and low levels of physical activity in the region. Although the North West is ranked the fifth highest region for obese children aged 2 – 10 years (2002-4) the region is following national trends and this must be considered against a national increase in childhood obesity (from 9.6 to 14.9 per cent in boys and from 10.3 to 12.5 per cent in girls from 1995 to 2005) and the projections of increases in obesity of 17 per cent in boys and 19 per cent in girls under 11 years by 2010 (Zaninotto et al 2006).

Children who are obese are likely to have one or more parents who are obese, which indicates the need for a whole-family approach to achieving and maintaining a healthy weight as part of an overall healthy lifestyle.

A new annual measure for the surveillance of childhood overweight and obesity was introduced in 2006/7 through the National Childhood Measurement Programme. This requires the weight and height measurement of primary school children in Reception Year (4-5 years) and Year 6 (10-11 years) to be carried out on an annual basis. These data provide prevalence of overweight and obesity in primary school children.

The North West Public Health Observatory has produced a regional analysis of child height and weight measurements⁵ from data provided by PCTs that will inform tailored interventions to tackle childhood obesity. This report shows that there is wide variation in obesity prevalence across the North West, ranging from 6.1% to 17.2% for boys in Reception Year and from 11.5% to 26% for boys in Year 6. For girls the range is from 4.6% to 13.1% in Reception Year to 8.3% to 21.6% for girls in Year 6. For both age groups and both sexes, there was a greater prevalence of obesity as deprivation increased across the region.

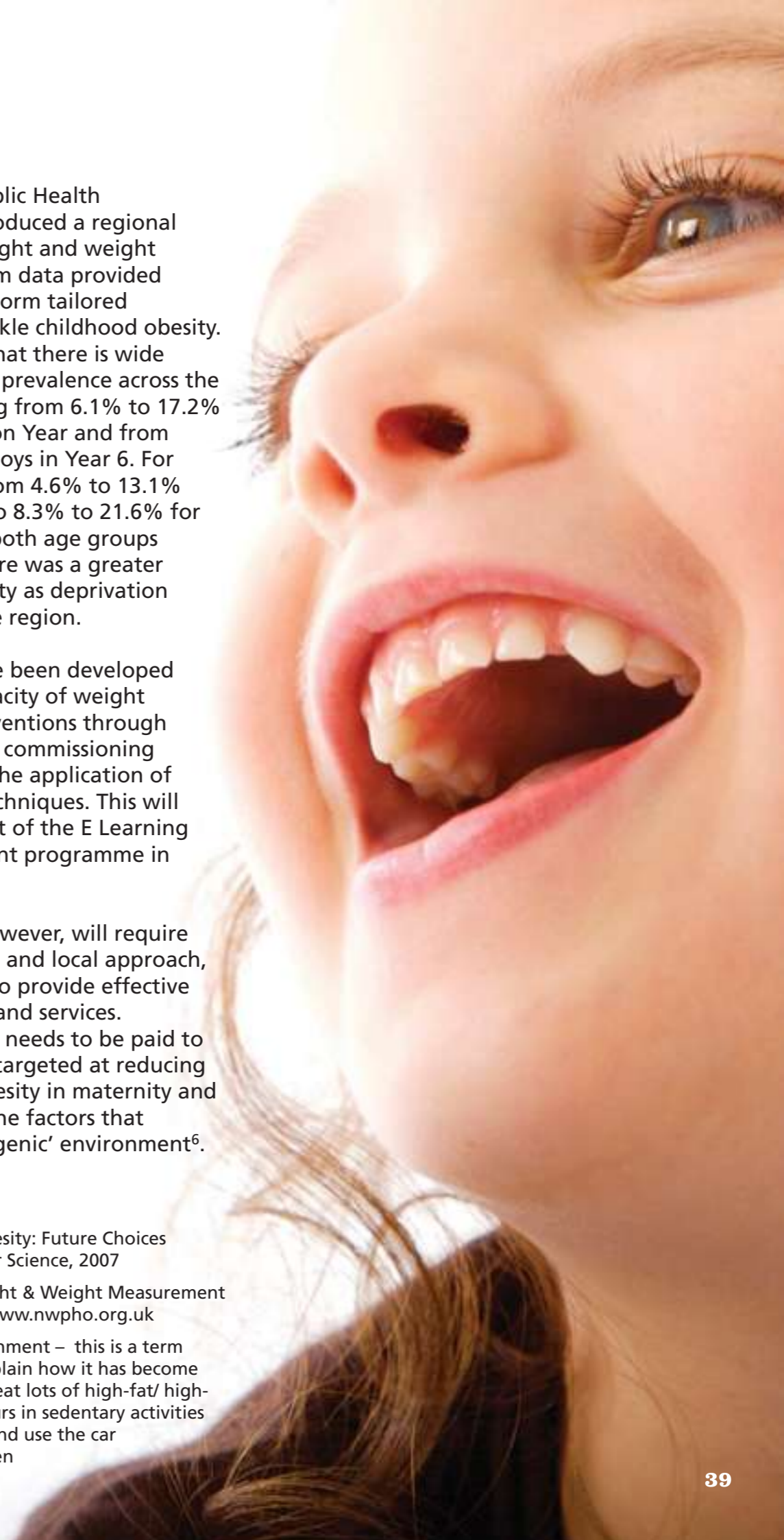
Regional plans have been developed to increase the capacity of weight management interventions through workforce training, commissioning opportunities and the application of social marketing techniques. This will build on the roll out of the E Learning Weight Management programme in primary care.

Tackling obesity, however, will require a coherent regional and local approach, with clear systems to provide effective local interventions and services. Particular attention needs to be paid to ensure policies are targeted at reducing overweight and obesity in maternity and early years and at the factors that promote an 'obesogenic' environment⁶.

⁴Foresight Tackling Obesity: Future Choices Government Office for Science, 2007

⁵North West Child Height & Weight Measurement 2007, NWPPO 2008, www.nwpho.org.uk

⁶An obesogenic environment – this is a term commonly used to explain how it has become normal for people to eat lots of high-fat/ high-sugar food, spend hours in sedentary activities such as watching TV and use the car instead of walking even short distances.



The North West Regional Framework to Achieve Healthy Weight for Children and Families brings together the regional contributors to food and nutrition, physical activity, active travel and the built environment, specifying the actions which will impact on overweight and obesity in the North West and support local delivery to achieve and sustain healthy weight.

Physical activity

Physical activity levels in the North West are only slightly lower than the national average (Active People Survey 2006). Across the region, 20.6% of adults take part on at least three days a week in moderate intensity sport and active recreation for at least 30 minutes continuously in any one session. The national average is 21%, with the South East achieving the highest levels at 22.6%. However, 52.4% of adults in the North West did not take part in moderate sport or active recreation for more than 30 minutes in a four week period.

Regular participation varies across different socio-demographic groups with 24.4% of males achieving these activity levels but only 17.1% of females, whilst 18.5% of black and other ethnic minority groups are active compared to 20.7% of adults of white origin. Activity by the lowest socio-economic groups is below the regional average at 15.9% whilst 24.8% of the highest socio-economic groups achieve these activity levels.

There is also a large variation between local authorities with Blackburn with Darwen experiencing low activity levels at 16.3% compared with 29.3% in Macclesfield.

Physical activity is a complex behaviour which does not sit neatly within one organisation. There are a range of delivery systems targeting different age groups and different settings. Agencies across the region, such as Sport England, The Youth Sport Trust, Natural England, the Forestry Commission and Play England, amongst many others, are working hard to increase activity levels. In order to harness this breadth of working, a NW Physical Activity Alliance is being developed as a network of organisations to drive up participation in a strategic and coherent way.

A North West 2012 framework and action plan is in place, "Be Inspired: Northwest Legacy Framework for the 2012 Games", which aims to use the London 2012 Olympics as a vehicle to increase participation levels in sport and active recreation levels.



Alcohol misuse

Alcohol misuse is of particular concern within the North West. Binge drinking is undertaken by 23 per cent of adults in the region (25.9 per cent of men and 11.4 per cent of women) compared with 18.2 per cent for England – a figure second only to the North East's 25.1 per cent. (APHO 2007c)

Consequently, most of the indicators of alcohol related harms are higher in the North West than in other regions (APHO 2007c). For example, the rate of hospital stays due to alcohol is the highest of all the regions (536 per 100,000 men and 270 per 100,000 women) and significantly higher than the England average (340 per 100,000 men and 164 per 100,000 women).

Of the 10 English local authorities with the highest rates of hospital stays due to alcohol, six are in the North West, with the two highest being Liverpool (915 per 100,000 for men and 422 per 100,000 for women) which is also England's worst, and Manchester (809 per 100,000 for men and 347 per 100,000 for women). Individual profiles across a range of alcohol related harms are available for every local authority in the country at www.nwph.net/alcohol

It is fair to say that the impact of alcohol on health in the North West is reaching a critical point and requires further concerted action by all agencies. Key actions include a public debate on tackling alcohol related problems, introduction of brief interventions and support for people suffering the effects of alcohol misuse.

Drug misuse

Drug misuse in the North West is not significantly different from the England average but almost one third of the local authorities have estimated levels greater

than the England average (9.9 problem drug users per 1,000 of the population). Blackpool - with 25.7 problem users per 1,000 of its population - is one of the 10 local authorities in England with the highest drug misuse rates (see Figure 1.6 on page 23) (APHO 2007a). The association between rates of problem drug use and population characteristics such as poverty, unemployment and social isolation are well established.

The Drug Intervention Programme aims to get drug-misusing offenders out of crime and into treatment and other support. The North West has adopted a twin track response to drug misuse. One track delivers against harm reduction principles e.g. access to clean injecting equipment and heroin substitutes such as methadone. This approach is producing a reduction in crimes and people are being supported in their daily lives. The other track is geared more towards regeneration and recovery. Clients who travel the regeneration and recovery track are able to access high quality accommodation in sober living houses. Residence in a sober living house and/or membership of a vibrant recovery community also provides routes into employment.

Successful recovery from a drug misuse problem also benefits the wider family. In some vulnerable families, the 'recovered addict' may be the first adult to attain and sustain employment in living memory. In the North West we are promoting models of "indigenous recovery communities". That is, people are encouraged to "get well where they got sick". In the past, the North West has exported treatment successes to other English regions whilst importing treatment failure. The Home Office's Drug Intervention Programme (DIP) has provided many of the recovery community members. The natural history of addiction usually means a seven year gap between the onset of addiction and

the first self referral into help. The DIP programme refers people into treatment much earlier. These people tend to be younger and have more personal and social capital. The engagement of these younger people in indigenous recovery communities undermines local drug economies and provides positive role models. When someone recovers from drug misuse their families and their communities recover with them. There are clear pathways from the harm reduction track to the recovery track and vice versa.

Mental health

Mental Health data (APHO 2007b) indicates that people in the North West have higher than average rates of mental ill health and severe mental illness compared with other regions in England.

Employment and education can protect mental health by boosting confidence and self-esteem, but the North West has one of the lowest percentages of people with a mental health problem in employment (20 per cent compared with 24.7 per cent for England) and the second-highest claimant rate of incapacity benefits for mental and behavioural disorders (388.1 per 100,000 compared with 262.6 for England).

Not surprisingly, given the patterns of risk factors for mental ill health, the North West displays relatively high rates of mental illness with:

- The second-highest age standardised death rate from suicide and injuries of undetermined intent in males aged 15 and over (18.5 per 100,000 compared to 16.4 in England)
- Higher age standardised hospital admission rate for self harm (199.7 per 100,000 compared to 158.8 in England)
- Higher age standardised hospital admission rate for poisoning (235.7 per 100,000 compared to 183.3 in England).





NHS North West established a regional Mental Health Commission in August 2007 to review and report on mental health services across the region. Its aim is to build on progress and ensure that world-class services are provided across the region. The commission draws upon the expertise of a reference group made up of user and family representatives, clinicians and managers, social care professionals and those involved in the criminal justice system.

Champions for Mental Health - which aims to improve employer awareness of mental health issues and tackle stigma - has been adopted in the North West. Both Bolton and Stockport PCTs are already on board and a number of other prominent business partners in the region have expressed an interest in becoming involved. This requires organisations to conduct mental health impact assessments of their policy or decisions, develop better means to deal with mental health problems within their workforce

and to consider offering supported return to work for people with mental health problems.

Sexual health

Risk-taking sexual behaviour is increasing and the diagnoses of HIV, chlamydia, genital warts and syphilis have increased in recent years. There are persistent and unacceptable patterns of inequality between areas, with the most deprived areas experiencing the worst sexual and reproductive health outcomes (Hughes et al 2006).

Statistics on sexual health for the North West in recent years show that the North West has a mixed picture of sexual health and that we have inequalities between localities:

- **Decreasing rates of teenage conceptions but wide variation across the Region:** ONS data for 2006 shows that the NW has reduced teenage conceptions by 12.5% overall between 1998 and 2006 and this is not far below

the English average reduction of 13.3%. However, four local authority areas have rates that are above their 1998 levels. The NW range is between an increase of 9.3% by 2006 and a reduction of 32.8% both the worst and the best performance are in areas of high deprivation leading to the conclusion that more needs to be done to spread best practice and that good schemes can make substantial improvements even in very deprived communities.

- **High numbers of diagnosed syphilis:** In 2005 there were 2,807 cases of diagnosed syphilis across England of which 487 were in the North West. (HPA 2005)
- **High rates of diagnosed cases of chlamydia:** 213 per 100,000 in 2005. (HPA 2005)
- **Highest rate of emergency hormonal contraception** dispensed in the community (54.8 per 1,000 females aged 15-44 in the North West compared to a national average of 49.6); (Hughes et al 2006)

- **Lowest uptake of voluntary confidential HIV testing** for people attending genito-urinary clinics and offered testing. For the North West it stands at 63.9 per cent compared with 66.6 per cent nationally. (Hughes et al 2006)
- **High diagnosed numbers of HIV across the North West.** The HPA reported that, outside of London, the North West saw the largest increase in diagnosed cases of HIV with 3,985 cases diagnosed and 4,126 cases treated in 2005. By mid-year 2007, this had risen to 4,661 individuals accessing care across the North West. The figures mask huge variation in scale across the Region with Cumbria having 89 cases by mid-year 2007 and Manchester having 2,783.
- **Variable coverage for cervical screening** ranging from 74.6 per cent in Manchester to 84.6 per cent in Chester, Congleton, Crewe and Nantwich, Macclesfield and Vale Royal. (Hughes et al 2006)

A three pronged approach is required if we are to make an impact on the sexual health of our communities in the North West:

- Prevention
- Increase uptake of screening
- Improve treatment services

Sexual health challenges in the North West are not just for the health service. Changes are also required in the way we discuss sex and sexual health at home, in schools and in the media.

In addition, understanding the interconnections of our lifestyle choices is an area that needs further joint work across partner agencies, especially the link between drug and alcohol use and risky sexual health behaviour. A recent review by the Independent Advisory Group for Sexual Health and HIV gives clear evidence of the link and advice on action that is needed to raise awareness and reduce risk (Independent Advisory Group on Sexual Health and HIV 2007).

Violence

This is a key issue, with almost 400,000 recorded incidents of violence committed against adults in the North West in 2006/2007 (British Crime Survey 2007), giving the Region the highest rate of self-reported violence in England (71.1 per 100,000 population compared with 56.9 per 100,000 nationally). This figure excludes incidents of child abuse, bullying and youth violence committed against children in the Region.

The impact of violence on victims and society extend far beyond physical injury and its treatment.

It includes psychological damage, fear of crime, reduced education, employment and economic prospects, and strain on public services particularly criminal justice. There is also an increased risk of a wide range of other negative health behaviours and outcomes, including substance use, obesity, cancers, heart disease and depression.

The disproportionate burden of violence in the North West is borne out by hospital data which show 90 out of every 100,000 residents suffer violent injuries serious enough to require hospital treatment each year; again the highest rate in England and more than double that in the least affected region. Further analysis of hospital data in the North West region shows wide variations in violence across the region with the burden of violence falling chiefly on those living in the most deprived areas, where hospital admission for violent injury is five times more likely than in affluent areas (CMO 2007). These are areas where residents are already disproportionately burdened by a wide range of other health and social problems.

Sexual violence against women also varies in the region, with higher rates of sexual assaults against women in more deprived areas. As an example, indecent assault on a female is more than five times higher in Manchester than in Congleton (1.8 compared with 0.3 per 1,000 females) (Hughes et al 2006).

This section has illustrated the wide range of challenges facing our population. Despite this there are strong and vibrant communities in the North West and more action is required to create the necessary conditions for good health and well being to flourish.



The Changing Health Context



Many of the health issues that we face cannot be tackled at a local level alone. The best example of this is climate change.

How climate change may affect the North West by 2080:

- The average annual temperature could rise by up to four degrees celsius
- Winter rainfall could increase by up to 30 per cent
- Summer rainfall could decrease by 50 per cent
- Snowfall could decrease by as much as 100 per cent
- Sea levels could rise by 67cm
- There will be a significant increase in flood risk (sewerage systems, rivers and sea)
- Warmer, sunnier summers will increase incidence of skin cancer, heart attacks, strokes, respiratory complaints, cataracts and risk of seasonal deaths in very old people and infants
- Changes in climate will increase the likely emergence of new diseases such as tick borne illnesses like Lyme's Disease and the re-emergence of diseases like malaria
- Agricultural practices may change significantly to adapt to longer growing seasons and reduced soil moisture
- Significant issues for business continuity and emergency preparedness in preventing and responding to the impacts of flooding and heatwaves





Climate change is now recognised as being the greatest long-term challenge facing the world today. If unchecked, it will have a profound impact on our society and our way of life.

Climate change presents a number of social, economic and environmental challenges resulting from changing seasonal temperatures, rainfall patterns and rising sea levels. These will affect agriculture, food and water supplies, trigger population movement and impact on our economies and our security.

The Stern Review: The Economics of Climate Change (Stern 2006) recognises the economic, social and environmental challenges that will result from these changes and recommends a number of policy actions to reduce carbon emissions.

The North West Climate Change Action Plan has been developed in partnership with regional organisations and experts and will be delivered by the North West Climate Change Partnership over the next three years. It sets out 27 priority actions which need to be delivered within the context of the North West Sustainable Energy Strategy (NWRA 2006) and the Regional Economic Strategy 2006 (NWDA 2006).

There are already excellent initiatives happening throughout the region in response to these 27 key actions which will fulfil a number of the aims of the action plan. The challenge now is to draw this activity together, identify gaps and barriers and set priorities for future actions.



A climate change unit has been established, based in the North West Development Agency and resourced by all the key regional stakeholders, to support the partnership in delivery of the action plan. The priorities of the North West Climate Change Partnership are to:

- Establish carbon reduction targets for the region
- Set up a regional offsetting scheme
- Continue work to address fuel poverty
- Encourage installation of micro generation and energy efficiencies in commercial and domestic properties
- Further develop and deliver a climate change communications strategy
- Promote best practice in personal and work place travel planning

This approach will involve everyone making adjustments to their ways of working and living. It will also support better health through the encouragement of walking, cycling and use of public transport rather than car transport, sustainable local food production thereby reducing food miles (see section on Healthy Environments, page 55), supporting local employment and business by sustainable procurement practice ensuring existing and new buildings are energy efficient and able to withstand extremes of weather thus reducing risk of seasonal deaths.

Health with sustainability

The goal of sustainable development is to enable all people to satisfy their basic needs and enjoy a better quality of life, without compromising the quality of life of future generations. The key issue for the North West is to ensure that sustainable principles are fully incorporated into all regional and local strategies and actions; particularly the new Single Regional Strategy.

Priorities for action by the Regional Sustainable Development Group include:

- Understanding of environmental limits in the North West
- Raising the profile of sustainable procurement as well as sustainable consumption and production
- Improving levels of sustainable housing and construction including energy efficiency
- Developing regional sustainable development indicators

The NHS is approximately 9% of NW GDP. A strong North West economy will bring significant health benefits to the population. It is important that the health sector ensures that its contribution to this is fully maximised through a consistent commitment to sustainability and corporate citizenship. There are sound economic and business reasons for regarding sustainable development as mainstream business – inward investment creates jobs, supports local suppliers and increases local wealth retention, local employment improves health and life chances, reduces sickness absence, improves recruitment and retention.

Conducting our business sustainably reduces maintenance and revenue costs and supports business continuity and emergency preparedness.



The NHS in the North West has a well-established partnership with the North West Development Agency. The North West Corporate Citizen Group (established between NHS North West and North West Development Agency) is aligning NHS capital and revenue investment with wider economic development across the North West, and this includes sustainable development input into the NHS Capital programme and developing Social Enterprise. Work on public sector procurement across the North West is focussing on three key workstreams of:

Environment - Procurement policies that encourage effective use of resources and minimise impact on the environment

Local community - Support local enterprise and encourage an inclusive supplier base that benefits both the health economy and the wider community

Fair trade - Procurement of goods and services from sources that can demonstrate a commitment to fair trade.

Building on this long-standing partnership and previous good practice, NHS North West has made sustainable development and good corporate citizenship one of its priorities. To this end, NHS North West has incorporated Corporate Citizen guidance into its internal policies that cover the issues of transport, procurement, social impacts, facilities management, employment and skills, community engagement and new buildings. This is based on the Sustainable Development Commission toolkit issued by the Department of Health in February 2006. As part of its performance improvement agenda, NHS North West has promoted the use of this toolkit by all NHS organisations.

All North West Trusts and PCTs have identified sustainable development leads. Progress in implementing Sustainable Development Plans for PCTs and Trusts is included in the public health indicators for performance improvement and is linked to work currently being undertaken to align Local Delivery Plan and Local Area Agreement performance frameworks. NHS North West has collaborated with the Sustainable Development Commission to bench-mark the region's performance against the national picture – currently the North West has the highest proportion of NHS organisations signed up to the Corporate Citizen Self-assessment Tool out of the nine English health regions – the aim is to have encouraged all North West NHS organisations to commit to using the tool by the end of the audit. This will enable NHS North West working with Trust and PCT sustainable development leads to use this online facility to monitor progress and identify good practice.

NHS North West and the DH Regional Public Health Group, in partnership with key regional partners NWDA, Natural England, DEFRA, Forestry Commission, North West Regional Assembly, Environment Agency have raised the profile of the sustainable development work being undertaken in the North West and promoted its incorporation into mainstream NHS practice by holding a successful Regional NHS Summit on Sustainable Development in December 2007. This included the launch of the NHS North West Sustainable Development Work Programme which sets out the 10 High Impact Changes for the NHS in taking forward sustainable development to December 2009.

The High Impact Changes have been developed to ensure that there are no new duties or responsibilities placed on NHS organisations, which have not been covered in other national performance assessment or national policy documents such as the Sustainable Consumption and Production Framework and Securing the future: delivering UK sustainable development strategy.





Healthy environments

The North West has a rich inheritance of urban green space and parks, built to a large extent to promote public health (Wheater C P et al, 2007). However, the last 100 years, and especially recent decades, has seen this resource decline. Green spaces and parks provide opportunities for individuals to improve their health, for communities to develop, and for protecting the environment. Physical activity is effective in the treatment of mental illness and enhances well-being, however, the opportunities for 'green exercise', including use of allotments and parks, are not being maximised by the population. The cost of developing from nothing the current resource that parks present, would be enormous, and it is vital that we continue to build upon this resource for the benefit of current and future generations.



Recommendations from the Returning Urban Parks to their Public Health Roots report (Wheater C P et al, 2007) include action by local authorities and primary care trusts to:

- Use social marketing techniques to increase park usage, particularly within more deprived communities
- Increase the number of health schemes in parks and develop the role of park staff
- Review facilities in urban parks, particularly children's play areas
- Encourage use by schools of urban parks

In addition, allotments are enjoying a resurgence with more and more people benefiting from gardening as evidenced by growing waiting lists for allotments all over the country.

Allotments also provide a practical opportunity for physical activity, better nutrition; encourage more fruit and vegetable consumption, organic production and potential reduction of food miles.

However, allotment sites in the North West are on average the smallest in area in England and host the fewest tenant plots compared to any other region. The average cost per square metre is reported to be one of the highest; with the North West, North East and London charging 15-16 pence/m², with all other regions charging below 10 pence per square metre. Despite the large number of vacant plots in the North West, 31% of sites still have an average waiting time of over a year. (DCLG 2006).

Local authorities need to provide more allotments and investigate the relationship between vacant plots and waiting times.

Conclusions



To achieve improvement in health and well-being in the short term, the focus will be on NHS investment, early detection, treatment and prevention of cancer, cardiovascular disease and mental health for adults and a support for better children's health.



This should bring significant benefits and address the current pattern of inequitable ill health. It is however the approach least likely to bring long-term sustainable reductions in preventable illness and death in the most vulnerable communities.

In part, this is because the causal relationships between health inequality and health, social and economic determinants are not yet properly understood. For instance, we know that smoking is the biggest single cause of cancer and heart disease, which also accounts for the largest quantity of inequality in months of life years lost. Smoking itself is however a behaviour. If – as is the case – about twice as many people in poverty smoke as those who are wealthy, we need an intervention strategy that can effectively address this 'first cause'. Achieving smoke-free public places was a major step in support of tackling health inequalities.

Social, economic and environmental inequalities are prime contributors to cancer, cardiovascular disease and mental health. Interventions to reduce poverty or increase general life chances are therefore likely to be more sustainable and effective in reducing the consequent preventable deaths and health inequalities.

Health inequality is the embodiment of poor life chances expressed in low-income communities. Although poor health can itself also be a cause of poor life chances, evidence suggests that broader approaches, addressing whole-life circumstances at the household or community level, are more likely to bring sustained health outcomes.

Despite action to address health inequalities, the gap in life expectancy, as we have demonstrated in the earlier analysis, is still widening in many local authority areas across the region, and between the North West and England as a whole.

We need to create a climate for change that views health inequality in the North West as simply unacceptable. It is not inevitable, surprising or unaccountably arising from factors beyond our control. It is avoidable and in large part arising from factors we have already identified and can do something about. Reducing health inequalities must be central to our vision for the North West.

There is much that the regional agencies can do through support for more intelligent, targeted and improved service delivery, co-ordination of wider public policy, and the creation with the people of the North West, of new approaches to health improvement and disease prevention. Most importantly, we should set ourselves an ambitious goal to reduce health inequalities.

The following recommendations are proposed as the immediate steps to be taken at a Regional level over the next year by regional agencies⁷.

Delivering this will require strong public support and a more urgent and more visible focus than we have yet collectively mobilised in the North West. I urge all Regional agencies to take action now to create better health and well being for all of the North West population.

The forthcoming NHS North West Plan for “Our NHS, Our Future” provides an important opportunity to focus action on prevention through the NHS.

⁷ Government Office North West, Regional Development Agency, Regional Assembly, Strategic Health Authority and other regional government agencies and bodies

RECOMMENDATIONS

Regional agencies should:

1. Include tackling health inequalities in the **Single Regional Strategy** by using the **Regional Investment for Health Framework** which is a systematic review of factors affecting health by each regional level government department and agency to improve understanding and delivery
2. Drive **performance management and improvement** of local level action on health inequalities through Local Area Agreements, Local Delivery Plans, Comprehensive Area Assessments and Place-based interventions
3. Identify **preventative health spend** across all agencies and secure an increased investment in evidence based activity
4. Support, develop and integrate regional and local capacity for data, **intelligence, analysis** and knowledge management in relation to health inequalities to inform policy and service delivery
5. Invest in a regional programme of **Equity Audit** reporting initially on equity of access to public services
6. Invest further in and develop a robust **social marketing and wider communication** approach to engage the public in a debate about actions to reduce harmful drinking, use of tobacco, support healthy eating and increase physical activity, tailored to different communities' needs
7. Increase influence of **health impact considerations** on urban planning, including building design and promote walking, cycling and public transport
8. Adapt the entire **public health workforce** (NHS and other partner organisations) to respond to the health needs of the region through development programmes aimed at increasing knowledge and skills to support positive health choice

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Published by North West NHS.