

A group of people, including a man in a black jacket and blue jeans, and a woman in a light blue and dark blue tracksuit, are walking on a paved path. They are surrounded by green grass and a brick wall. In the background, there is a large brick building with many windows. The scene is outdoors and appears to be a public space.

NHS

Stoke on Trent

Health and Behaviour in Stoke-on-Trent

Director of Public Health Annual Report 2010

2010

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Introduction



I am pleased to present this Annual Report for Stoke-on-Trent. The first chapter of the report describes trends in health status of the population and sets benchmarks against which future progress can be measured. We have made good progress in some areas of health like circulatory disease but the gap between Stoke and the rest of the country remains a concern for many other areas.

The second chapter focuses on behaviour change which has been the subject of intense political and media debate. The report challenges much of the simplistic myths around behaviour change and furthermore it makes a compelling case for supporting individuals and communities to improve behaviours so we can have a healthier and more prosperous population.

We must continue to create services which support behaviour change of scale and intensity proportionate to the health challenges within Stoke-on-Trent. This will require approaches that focus on the many structural, cultural and environmental factors that can impact on an individual's likelihood to change, which are often referred to as social determinants of health. These wider determinants will be the primary influence on health outcomes and lifestyle behaviours.

Historically, the early pioneers of Public Health were the Medical Officers of Health who were based in Local Authorities and faced the challenges of epidemics of infectious diseases over a century ago. The major 21st century killers are chronic diseases such as heart disease, cancer and respiratory illnesses. There is increasing recognition that Local Authorities have a key role in contributing towards reducing the burden of disease, for example, in influencing housing conditions, the built environment, income and education.

The forthcoming return of the Public Health function to within the Local Authority provides great opportunities for tackling the wider determinants of health, consolidating the excellent partnership working to date with the Local Authority and Local Strategic Partnership.

I hope you will find this report stimulating and informative. The views expressed in this report are mine and I would welcome any questions or comments that the report raises.

Dr Zafar Iqbal
Acting Director of Public Health

Case Study 1: Smoking

Melanie's Story

A lifelong smoker for over 30 years, Melanie's addiction grew to a £140 month habit. It also left her suffering health problems, including shortness of breath.

So, in April this year, 45 year old Melanie decided that enough was enough.

She had heard about NHS Stoke on Trent's stop smoking group, held at the Britannia Stadium, and decided to take action.

During the weekly sessions at Stoke City Football Club, Melanie was able to share her experiences with other people who also wanted to give up smoking. She was given an inhalator and nicotine patches to help ease her off tobacco. She added: "It hasn't been an easy journey and I am taking one day at a time but I am getting there. Even after a few months I can really feel the benefits of giving up smoking. As you get older, things start to affect you more - you can't party like you did when you were younger and I had started to realise that. I feel a lot healthier now and the savings that I have made have been brilliant. I would really encourage anyone who wants to give up smoking to go to the Stoke City Stop Smoking Group - they really are a fantastic help".

Melanie is not the only one to benefit from her determination to quit smoking. She is using the money she would have spent on cigarettes to treat her family to a fabulous holiday in Menorca.

"I wanted to use the money that I had saved on something that would be really special for the whole family. The children haven't been on a plane before and have never been abroad so they are really excited about going on holiday".

Chapter 1

Health Status

Top Tip...

If you smoke, seriously think about stopping - there is a really friendly local service that can help you - call 0800 085 0928.

Health Inequalities

England and Stoke-on-Trent

The national targets for life expectancy are as follows:

- **To reduce the gap in life expectancy between the most deprived and most affluent areas of the country by 10% by 2010 (using 2009-2011 as the three year average)**
- **To increase life expectancy in England to 78.6 years for men and 82.5 years for women by 2010 (using 2009-2011 as the three year average)**

Based on this approach, our 2010* targets are to reduce the gap in life expectancy between Stoke-on-Trent and England from 2.19 years to 1.64 years for males and from 2.02 years to 1.52 years for females.

Life expectancy for both males and females has increased in Stoke-on-Trent between 1991 and 2008. For males it increased from 71.5 to 75.4 years and for females from 77.1 to 79.8 years (Table 1). Since about 2004, life expectancy in Stoke-on-Trent has increased at a faster rate compared with England, particularly for males. For males, the current gap in life expectancy between Stoke-on-Trent and England is 2.5 years; for females, the gap is 2.2 years. Overall, health is continuing to improve within the City and there is some evidence to suggest that in the last few years the gap between England and Stoke-on-Trent is narrowing.

Table 1: Life expectancy for males and females in Stoke-on-Trent in 2006-2008

	2006-2008	2006-2008 gap ¹	2009-2011 target	2009-2011 target gap
Males	75.4	-2.5	77.0	-1.6
Females	79.8	-2.2	81.0	-1.5

Source: Compendium of Clinical and Health Indicators 2010

¹ Gap between Stoke-on-Trent and England

Based on current trends, our targets are unlikely to be met, particularly when considered in the context of the current, ongoing and possible future economic downturn that both Stoke-on-Trent and the country as a whole are experiencing and the detrimental impacts this is likely to have upon people's health.

Life expectancy is a good overall measure of people's health, but it is not the only one. Another way of looking at people's health is to look at deaths from all causes of disease (among people of all ages). Using this indicator, we find that the overall mortality rate from all causes of disease in Stoke-on-Trent has fallen steadily since 1995-1997. This means that, within Stoke-on-Trent, there were nearly 900 fewer deaths in 2006-2008 compared with 1995-1997. Although the numbers of deaths have fallen in Stoke-on-Trent, the gap in the mortality rate between Stoke-on-Trent and England has increased.

* The 2010 targets are based on three years data (2009-2011) and we need to wait until 2012 to see if we hit our targets.

Within Stoke-on-Trent

To look at how life expectancy varies within Stoke-on-Trent, data from wards have been used. As only a small number of deaths occur within each ward on an annual basis, we have added together the numbers of deaths across six years (2003-2008) in order to calculate a more robust and accurate estimate of ward life expectancy.

Among males in Stoke-on-Trent, life expectancy ranged from 70.5 years in the ward of Hanley West and Shelton to 76.3 years in the wards of Trentham and Hanford and Meir Park and Sandon – a difference of 5.8 years (Table 2). For females, the corresponding figures ranged from 76.0 years in the ward of Burslem South to 81.3 years in Northwood and Birches Head – a difference of 5.3 years.

In a number of wards, life expectancy was **significantly lower** than England (highlighted by the red numbers in Table 1). This means that the difference between the wards in Stoke-on-Trent and England is more than we would have expected. Although the ward life expectancy figures contain some historical data (2003 and 2004) which may not accurately reflect more recent health experiences, there remain a number of areas within Stoke-on-Trent that are likely to be experiencing very low life expectancy.

Life expectancy can also be used as a measure of health inequalities by looking at the gap in life expectancy between the most affluent and most deprived people. In NHS Stoke on Trent (NHS SOT), the difference in male life expectancy between the most affluent and most deprived in 2001-2005 was 10.2 years, whilst in 2004-2008, this gap had reduced to 9.3 years. For females, this gap had remained at 5.1 years during this period. In England, the health inequalities gap had increased for males from 8.4 years to 8.6 years, whilst for females, the gap had increased from 5.6 years to 5.8 years. Whilst our health inequalities gap for males remains marginally above England, for females the gap is below.

In terms of deaths from all causes of disease in 2004-2008, the mortality rate in Stoke-on-Trent ranged from 605 (per 100,000 population) in the ward of Hartshill and Penkhull to 974 in Burslem South (see Appendix 1). This meant that, in Burslem South, just over 900 people died during this five year period (an average of 182 people a year compared with 126 in Hartshill and Penkhull).

Of the 20 wards in Stoke-on-Trent, 16 had mortality rates from all causes of disease that were **significantly higher** than England. This suggests that, whilst mortality rates from all causes of disease continue to fall across Stoke-on-Trent as a whole, the ward rates remain high when compared with England.

TOP TIP...

Don't skip meals, especially breakfast. It is important to make sure you eat regular meals each day to ensure that you are supplying your body with all the nutrients it needs.

Table 2: Life expectancy at birth for wards in Stoke-on-Trent between 2003-2008

Ward	Males	Females
Abbey Green	73.7	80.6
Bentilee and Townsend	72.9	79.0
Berryhill and Hanley East	75.9	78.9
Blurton	74.6	80.6
Burslem North	74.0	79.2
Burslem South	70.6	76.0
Chell and Packmoor	75.5	78.7
East Valley	74.8	80.3
Fenton	75.0	79.6
Hanley West and Shelton	70.5	77.4
Hartshill and Penkhull	75.9	80.9
Longton North	75.6	79.5
Longton South	74.4	79.7
Meir Park and Sandon	76.3	80.0
Northwood and Birches Head	75.2	81.3
Norton and Bradeley	73.5	78.8
Stoke and Trent Vale	74.0	79.0
Trentham and Hanford	76.3	79.7
Tunstall	72.7	77.6
Weston and Meir North	74.8	78.1
Stoke-on-Trent	74.5	79.3
England	77.3	81.3

Source: Dr Foster Population Health Manager 2010

Health inequalities – the future

There are three measures we are going to monitor over the coming years to see if health inequalities in Stoke-on-Trent are reducing. These are:

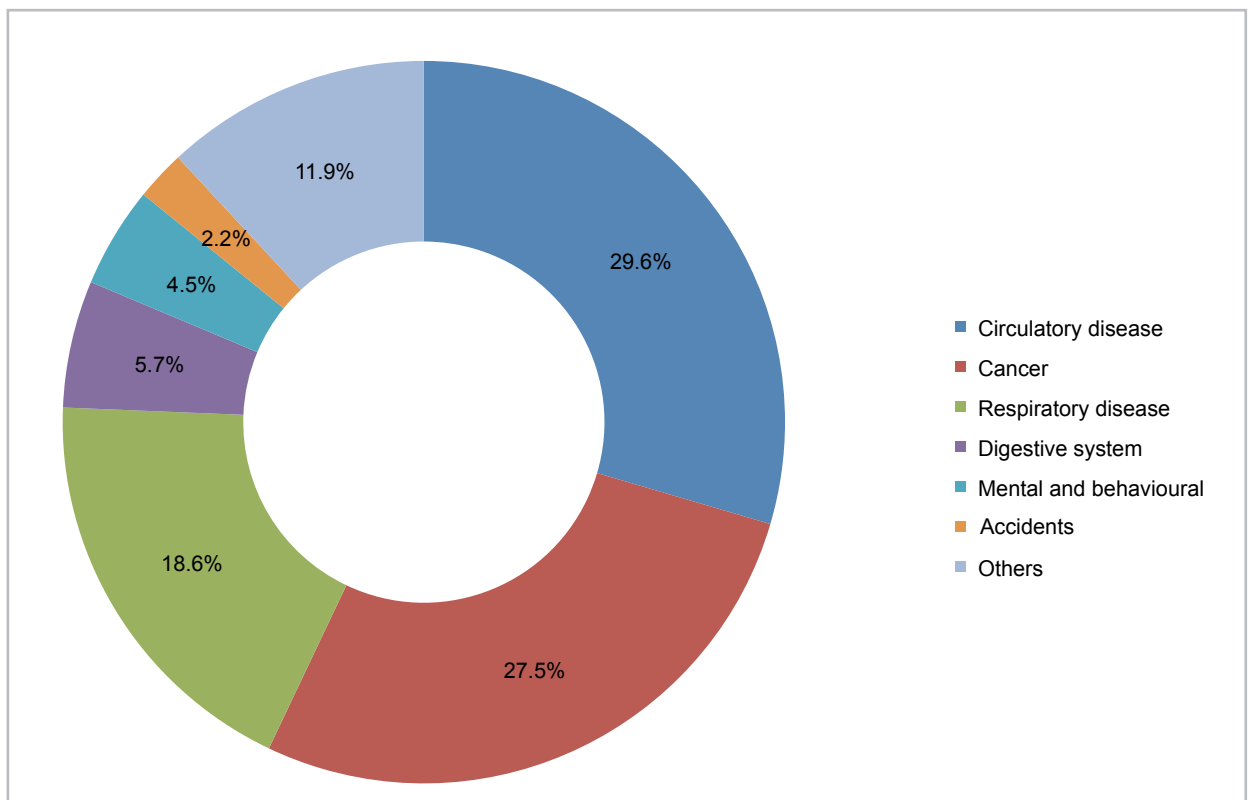
- Life expectancy (reducing the gap between Stoke-on-Trent and England)
- Life expectancy (reducing the gap between the most affluent and most deprived people in Stoke-on-Trent)
- Deaths from all causes of disease (reducing the gap between Stoke-on-Trent and England), in particular, deaths in those under 75

Through improvements to the health of the population, we hope to save half a million life years by 2015 and to create a further 4.5 million years of healthy life.

Major Killers

The aim of this section is to examine changes in a number of high level public health targets, particularly within circulatory disease and cancer. In 2008, 2,636 people died in Stoke-on-Trent. The three major killers are the same as they are nationally: circulatory disease (such as heart disease, strokes, hypertension and many others), cancer (deaths from lung, breast, colorectal, prostate and stomach cancer are the most common) and respiratory disease (which includes a range of different diseases such as influenza, pneumonia, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD) and asthma). Between them, these three conditions accounted for approximately 75% of all deaths in Stoke-on-Trent in 2008 (Figure 1). Table 3 also shows the number of deaths by age group in Stoke-on-Trent in 2008.

Figure 1: Major causes of deaths in Stoke-on-Trent in 2008 (people of all ages)



Source: Office for National Statistics 2009

TOP TIP...
 Cut down on your salt intake. Adults should aim to have no more than 6 grams of salt a day and for children no more than 3 grams a day.

Table 3: Number of deaths by selected age groups in Stoke-on-Trent in 2008

Age	Number	Major causes
Under 1	20	Congenital malformation and prematurity
1 to 34	41	Various causes, includes suicides and trauma
35 to 74	881	Circulatory disease/cancer/respiratory disease
75 and over	1,694	Various causes

Source: Office for National Statistics 2009

If we look at the three major killers in Stoke-on-Trent in more detail (Table 4), we find the majority of mortality ratios for circulatory disease, cancer and respiratory disease were **significantly higher** compared with England in 2006-2008 (highlighted by the red numbers).

Table 4: Mortality ratios for various conditions in Stoke-on-Trent between 2006-2008 (people of all ages)

Cause of mortality	SMR ¹
All circulatory disease	113.4
Coronary heart disease	114.1
Stroke	105.9
All cancers	123.1
Lung cancer	141.4
Colorectal cancer	129.6
Breast cancer	110.9
Bronchitis, emphysema and other COPD	146.5
Pneumonia	132.8

Source: Compendium of Clinical and Health Indicators 2010

¹ SMR = Indirectly standardised mortality ratio (England SMR = 100)

CIRCULATORY DISEASE

England and Stoke-on-Trent

Circulatory disease is the major killer of people in Stoke-on-Trent. In 2008, 29.6% of all deaths in the City were caused by circulatory disease.

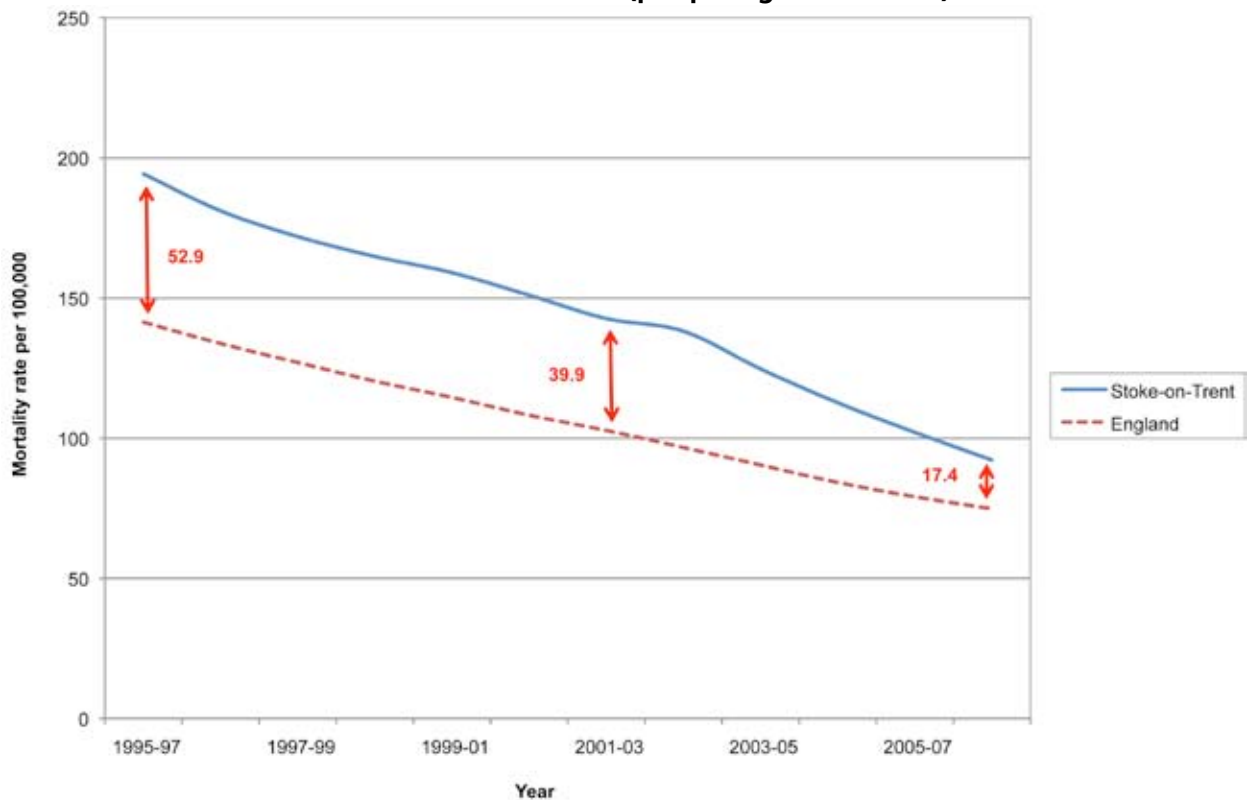
The national targets for circulatory disease are as follows:

- **To reduce mortality from circulatory disease by 40% in people aged under 75 by 2010 (using 2009-2011 as the three year average; Our Healthier Nation (OHN) target)**
- **A reduction of 40% in the gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 2010 (using 2009-2011 as the three year average; Inequalities target)**

We have interpreted these targets locally as needing to achieve a 40% reduction in mortality from circulatory disease in Stoke-on-Trent by 2010 (OHN target) and a further 40% reduction in the gap between Stoke-on-Trent and England by 2010 (Inequalities target).

Mortality rates from circulatory disease have improved considerably and at a much faster rate in Stoke-on-Trent than England since 1995-1997, although the current rate in Stoke-on-Trent remains above England (Figure 2). Locally, both of our 2010 targets for circulatory disease – OHN and Inequalities – have already been achieved.

Figure 2: Mortality rates¹ from circulatory disease in Stoke-on-Trent and England between 1995-1997 and 2006-2008 (people aged under 75)



Source: Compendium of Clinical and Health Indicators 2010

¹ Directly age standardised mortality rates per 100,000

This is very encouraging and suggests that the various initiatives and interventions aimed at reducing the numbers of deaths from circulatory disease are working locally. It remains important, however, that the good work already undertaken over the past years continues.

Stoke-on-Trent and comparable areas

Compared with our comparator areas, the mortality rate from circulatory disease in Stoke-on-Trent fell by 52.5% between 1995-1997 and 2006-2008 – the largest fall of all areas.



Within Stoke-on-Trent

The mortality rate (2004-2008) from circulatory disease ranged from 73.9 (per 100,000) in the ward of Norton and Bradeley to 151.4 in Hanley West and Shelton (see Appendix 2).

Compared with England, 11 of the 20 wards in Stoke-on-Trent had mortality rates from circulatory disease that were **significantly higher**. This indicates again that, whilst overall rates of mortality from circulatory disease are falling in Stoke-on-Trent, they continue to remain high in certain areas of the City. If we want to reduce the mortality gap, both within Stoke-on-Trent and between Stoke-on-Trent and England as a whole, we will need to have an impact on communities living in all wards.

Although deaths within the wards have been added together over five years, the actual number of deaths from circulatory disease that occur at ward level is relatively small and, as a consequence, small changes in numbers can lead to very large changes in rates. This can make interpretation of the results difficult.

Circulatory disease programmes in Stoke-on-Trent

Reducing deaths due to circulatory disease in Stoke-on-Trent is a high priority. These are some of the major programmes we are carrying out in Stoke-on-Trent that have the potential to further reduce the numbers of people with circulatory disease. These include:

- **Smoking cessation and tobacco control programme**
- **The Primary Care Strategy focuses on the prevention of circulatory disease and the optimal management of pre-existing cases**
- **Cardiovascular disease primary prevention and improved secondary prevention through lifestyle management**
- **Cardiac rehabilitation**
- **Improved detection and management of atrial fibrillation**
- **Stroke thrombolysis**
- **Improved detection and management of hypertension on GP registers through the Primary Care Strategy**
- **Early interventions for alcohol misuse**
- **Community heart failure programme**
- **Primary angioplasty for heart attacks**

CANCER

England and Stoke-on-Trent

Cancer is the second largest killer of people in Stoke-on-Trent. In 2008, 27.5% of all deaths in the City were caused by cancer.

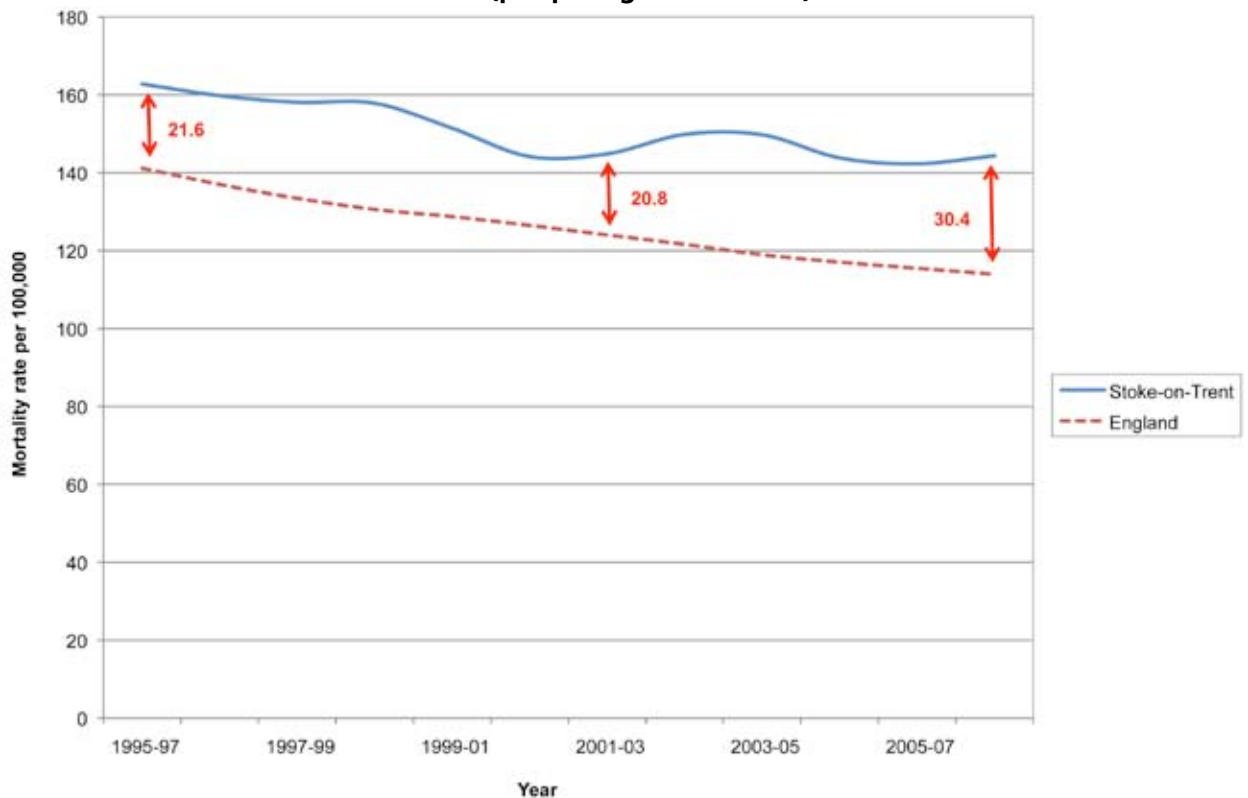
The national targets for cancer are as follows:

- To reduce mortality from cancer by 20% in people aged under 75 by 2010 (using 2009-2011 as the three year average; OHN target)
- A reduction of 6% in the gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 2010 (using 2009-2011 as the three year average; Inequalities target)

We have interpreted these targets locally as needing to achieve a 20% reduction in mortality from cancer in Stoke-on-Trent by 2010 (OHN target) and a further 6% reduction in the gap between Stoke-on-Trent and England by 2010 (Inequalities target).

The mortality rate from cancer has fallen in Stoke-on-Trent since 1995-1997 (Figure 3). However, a further look at this figure shows that the gap in the rate between Stoke-on-Trent and England is widening. If these trends are maintained then both the OHN and Inequalities targets are unlikely to be met.

Figure 3: Mortality rates¹ from cancer in Stoke-on-Trent and England between 1995-1997 and 2006-2008 (people aged under 75)



Source: Compendium of Clinical and Health Indicators 2010

¹ Directly age standardised mortality rates per 100,000

Stoke-on-Trent and comparable areas

When compared with our comparator areas, the mortality rate from cancer in 2006-2008 in Stoke-on-Trent was actually the highest at 144.4. The mortality rate in Stoke-on-Trent was significantly higher compared with Wigan, which had the lowest rate of 123.7. The fall in mortality rate in Stoke-on-Trent between 1995-1997 and 2006-2008 was 11.3% and was the smallest fall among comparator areas – the largest being 20.1% in Tameside.

Within Stoke-on-Trent

The mortality rate (2004-2008) from all cancers ranged from 105.7 (per 100,000) in the ward of Meir Park and Sandon to 172.5 in Abbey Green (see Appendix 3).

As was the case with circulatory disease, there were 11 wards in Stoke-on-Trent which had mortality rates from cancer that were **significantly higher** than England.

There were eight wards in Stoke-on-Trent where mortality rates from both circulatory disease and cancer were **significantly higher** than England: Abbey Green, Bentilee and Townsend, Burslem North, Burslem South, Chell and Packmoor, Hanley West and Shelton, Longton North and Tunstall. This suggests that the burden of disease in Stoke-on-Trent is falling disproportionately on these wards.

As mentioned previously, although deaths within the wards have been added together over five years, the actual number of deaths from cancer that occur at ward level is relatively small and, as a consequence, small changes in numbers can lead to very large changes in rates. This can make interpretation of the results difficult.

Cancer programmes in Stoke-on-Trent

In light of the generally high rate of deaths from cancer in Stoke-on-Trent, we need to ensure that a number of issues within the City continue to be addressed. These are some of the major programmes we are carrying out in Stoke-on-Trent that have the potential to further reduce the numbers of people with cancer. These include:

- **Smoking cessation and tobacco control programme**
- **Primary prevention (for example, improved nutrition to reduce the development of cancer)**
- **Cancer screening programmes (for cancers such as bowel, breast and cervical)**
- **Early diagnosis and improved care offered to people with cancer at all stages**
- **Early presentation through improved public awareness of cancer symptoms**

RESPIRATORY DISEASE

England and Stoke-on-Trent

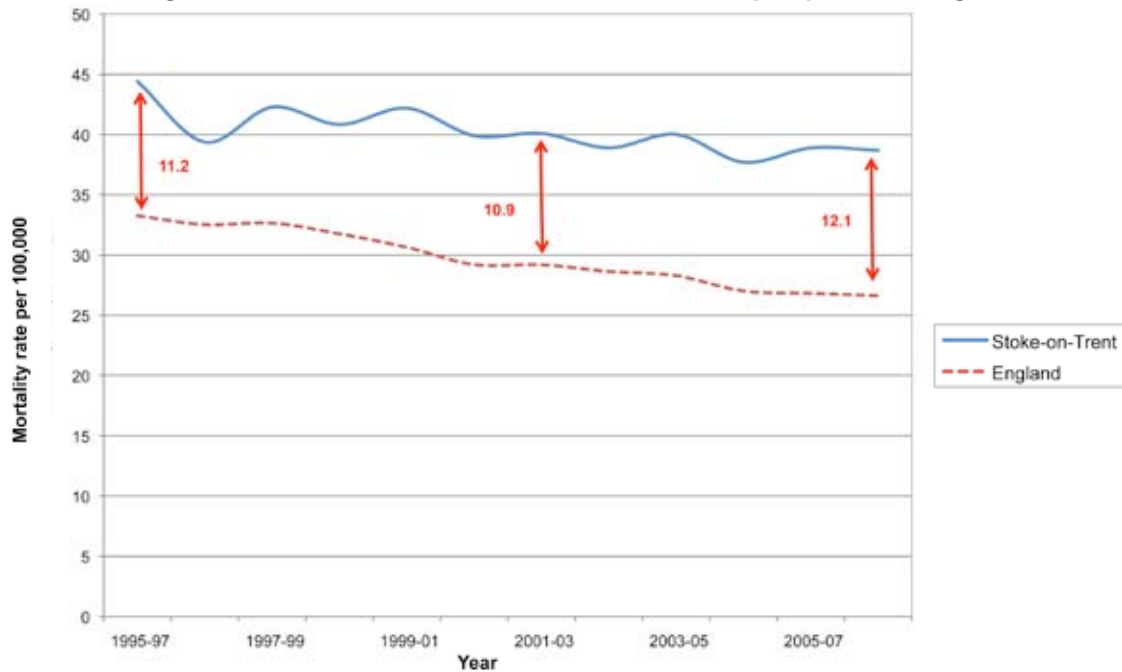
Although there are no specific national targets for respiratory disease, it remains a major killer in Stoke-on-Trent, in part due to the mining and manufacturing heritage of the City. In 2008, 18.6% of all deaths in Stoke-on-Trent were caused by respiratory disease – the third largest killer of people in the City. The challenge in Stoke-on-Trent is to reduce the burden of smoking related respiratory diseases and levels of mortality and morbidity due to COPD in particular.

The mortality rate from respiratory disease in Stoke-on-Trent has stalled in recent years and this has meant that the gap between Stoke-on-Trent and England has increased (Figure 4). It is not clear whether this stall is a consequence of the small numbers effect

TOP TIP...
Aim for 30 minutes of activity a day. You can 'bank' activity time by doing small chunks. Don't forget - 30 mins is only 2% of a 24 hour day.

(around 150 deaths per year) or as a result of something more substantial, such as the need for better prevention services.

Figure 4: Mortality rates¹ from respiratory disease² in Stoke-on-Trent and England between 1995-1997 and 2006-2008 (people of all ages)



Source: Compendium of Clinical and Health Indicators 2010

¹ Directly age standardised mortality rates per 100,000

² Respiratory disease = bronchitis, emphysema and other COPD

Within Stoke-on-Trent

The mortality rate (2004-2008) from respiratory disease ranged from 27.9 (per 100,000) in the ward of Hartshill and Penkhull to 57.3 in Burslem South (see Appendix 4).

There were 10 wards in Stoke-on-Trent which had mortality rates from respiratory disease that were **significantly higher** than England.

It is important to note that the mortality rates for respiratory disease are based on very small numbers (an average of approximately 10 deaths per year in Burslem South for instance) and this can make interpreting the findings extremely difficult.

Respiratory disease programmes in Stoke-on-Trent

These are some of the major programmes we are carrying out in Stoke-on-Trent that have the potential to further reduce the numbers of people with respiratory disease and associated morbidity. These include:

- Smoking cessation and tobacco control programme
- Improved diagnosis and management of COPD and asthma in primary care
- Improvement of care pathways for respiratory disease
- Implementation of a Specialist Community Respiratory Service and Pulmonary Rehabilitation
- Working with the British Lung Foundation to raise public awareness of COPD symptoms

WARD MORTALITY FOR MAJOR KILLERS

We have seen how deaths vary between the wards of Stoke-on-Trent. Table 5 attempts to capture this variation and summarises how wards in the City were ranked with regard to deaths from the three major killers. Each ward was ranked from one (lowest mortality rate) to 20 (highest mortality rate) for each condition.

Three of these 10 wards – Abbey Green, Burslem South and Tunstall – had mortality rates that were **significantly higher** than England for all three of the major killers in Stoke-on-Trent (circulatory disease, cancer and respiratory disease).

Burslem South was ranked the worst of all the wards in Stoke-on-Trent with regard to the three major killers; Hartshill and Penkhull was ranked best. Looking at the five worst ranked wards shows they tended to be ranked consistently poorly across the major killers. Notwithstanding the issue of small numbers, this table highlights how the burden of disease is likely to be falling disproportionately on certain wards in the City.

Table 5: Rankings of mortality rates from major killers for wards in Stoke-on-Trent between 2004-2008

Ward	Circulatory	Cancer	Respiratory	Rank ¹
Hartshill and Penkhull	4	2	1	1
Meir Park and Sandon	6	1	3	2
Trentham and Hanford	2	6	7	3
Longton South	7	3	11	4
East Valley	5	9	9	5
Northwood and Birches Head	8	4	12	6
Norton and Bradeley	1	11	14	7
Blurton	10	7	10	8
Longton North	16	10	4	9
Stoke and Trent Vale	12	8	13	10
Burslem North	14	14	5	11
Weston and Meir North	3	12	18	12
Berryhill and Hanley East	13	5	16	13
Chell and Packmoor	15	15	6	14
Hanley West and Shelton	20	16	2	15
Fenton	9	18	17	16
Bentilee and Townsend	18	19	8	17
Tunstall	17	17	15	18
Abbey Green	11	20	19	19
Burslem South	19	13	20	20

Source: Adapted from Dr Foster Population Health Manager 2010

¹ Rank: 1 = lowest (best); 20 = highest (worst)

Infant Mortality

England and Stoke-on-Trent

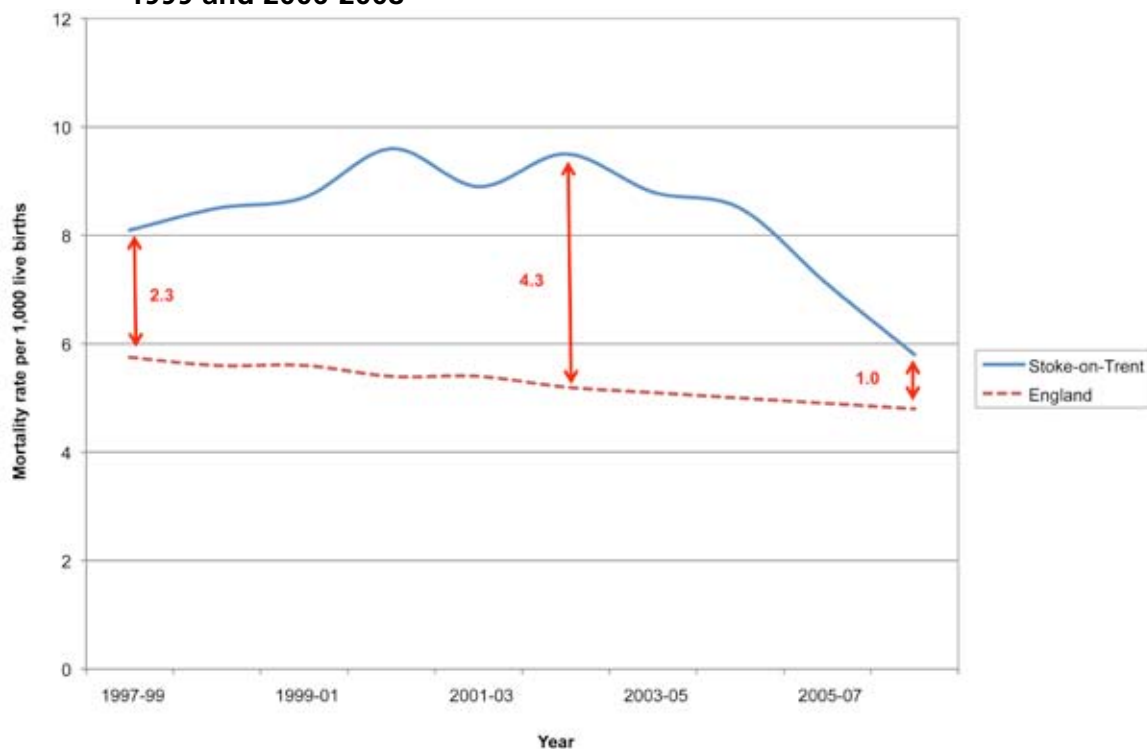
Infant mortality refers to deaths among children in the first year of life. The national target for infant mortality is as follows:

- **To reduce infant mortality by 10% by 2010 (using 2009-2011 as the three year average)**

Since increasing steadily between 1997-1999 and 2002-2004, infant mortality rates in Stoke-on-Trent have fallen and have improved at a faster rate than England since 2002-2004 (Figure 5). This marked fall has meant our 2010 (2009-2011 three year average) national target has already been achieved. At present, infant mortality has fallen by 28.4% in Stoke-on-Trent since 1997-1999 (compared with the 10% target).

We need to interpret the trends in infant mortality very cautiously because the numbers of deaths are very small (approximately 20 per year).

Figure 5: Infant mortality rates¹ in Stoke-on-Trent and England between 1997-1999 and 2006-2008



Source: Compendium of Clinical and Health Indicators 2010

¹ Mortality rates per 1,000 live births

When considering the types of interventions we need to implement locally to address infant mortality, it is important to understand patterns of infant mortality during the first year of life. To help us do this, we usually divide the first year of life into three periods: less than seven days, seven to 28 days, over 28 days and up to one year. We do this because the health of an infant during the first week of life is totally dependent upon their experience in the womb and any interventions, therefore, need to be focused on the mother. During the two later time periods, interventions focus more on the infant.

The pattern of infant deaths in Stoke-on-Trent during the first year of life was very similar to England (Table 6). The majority of infant deaths occur in the first week of life.

This trend is confirmed by Figure 6 which looks at perinatal deaths (that is, stillbirths and deaths less than seven days old). The perinatal mortality rate fell sharply in Stoke-on-Trent in 2006-2008 and is at its lowest rate in over a decade.

These are some of the actions we are taking to reduce infant and perinatal mortality in Stoke-on-Trent.

They include:

- High quality pre-conception and antenatal care
- Antenatal and newborn screening programmes
- Early booking for antenatal care
- Supporting women to quit smoking
- Monitoring and detecting restricted foetal growth
- Reducing cot deaths
- High quality care for sick and small babies
- Reducing teenage pregnancies

Table 6: Number of infant deaths at various times during the first year of life in Stoke-on-Trent and England between 2006-2008

Area	Less than 7 days		7 to 28 days		More than 28 days		Number
Stoke-on-Trent	36	(57.1%)	9	(14.3%)	18	(28.6%)	63
England	5,049	(53.1%)	1,519	(16.0%)	2,935	(30.9%)	9,503

Source: Compendium of Clinical and Health Indicators 2010

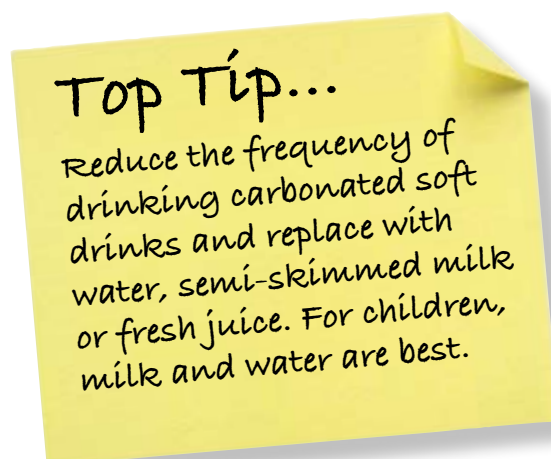
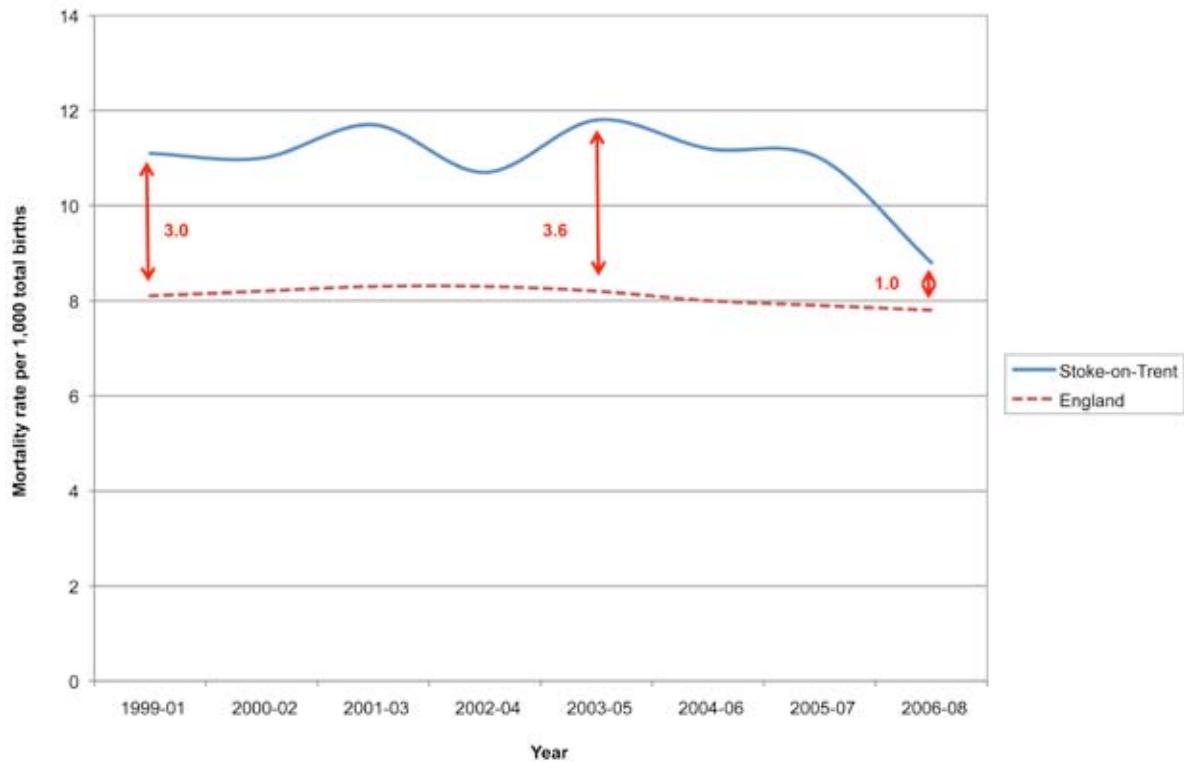


Figure 6: Perinatal mortality rates¹ in Stoke-on-Trent and England between 1999-2001 and 2006-2008



Source: Compendium of Clinical and Health Indicators 2010

¹ Mortality rates per 1,000 total births

Teenage Pregnancy

England and Stoke-on-Trent

Teenage pregnancy can have a detrimental impact upon the health of both mothers and their babies. Babies born to teenage mothers are more likely to be born prematurely, to have a low birth weight, to have a higher risk of cot death and more likely to be born into poverty. For mothers, teenage pregnancy can increase the likelihood of poor educational attainment, poverty and unemployment.

The numbers of teenage pregnancies in Stoke-on-Trent has fallen (Figure 7). In 2006-2008, there were 918 teenage pregnancies to girls aged 15-17 in Stoke-on-Trent compared with 969 in 2005-2007, a fall of 51. Record numbers of under 25's are accessing contraceptive services in the city centre and this may be linked to the decrease in teenage pregnancies. However, it is too early to draw definitive conclusions on trends and further data is required.

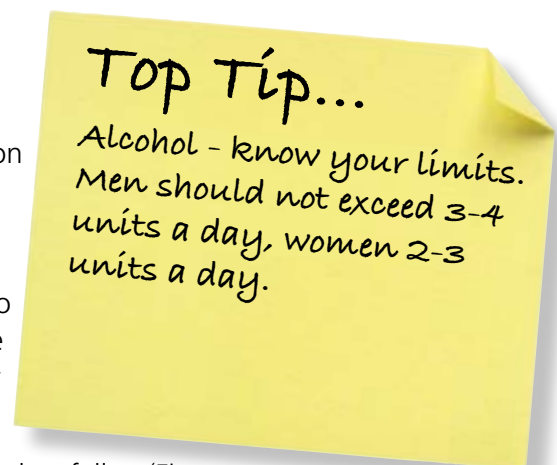
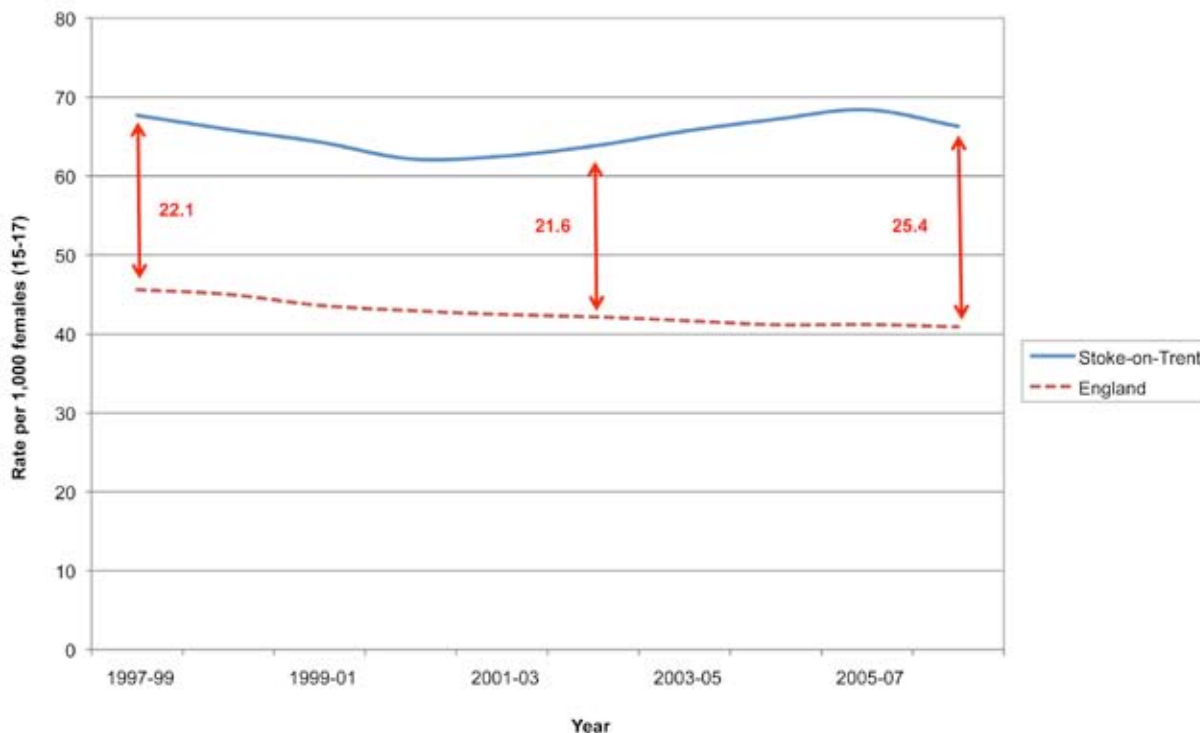


Figure 7: Teenage pregnancy rates¹ in Stoke-on-Trent and England between 1997-1999 and 2006-2008



Sources: Office for National Statistics 2010, Teenage Pregnancy Unit 2010

¹ Rate per 1,000 females aged 15-17

Teenage pregnancy and sexual health in Stoke-on-Trent

A full review of contraception provision for young people was undertaken and a redesign of services was carried out in February 2007. The aim of this redesign was to improve access and uptake of the City Centre contraception service by young people whilst maintaining young people’s access at the locality clinics. The key elements of the redesign were as follows:

- Use of touch screen information
- Walk in
- Open 6 day a week (including late opening)
- Young person focussed

If we look at the numbers of young people aged 17 and under accessing the Hanley CASH (Contraception and Sexual Health) clinic since the redesign, we see an increase in attendances of 1,299 (158%) in 2008 and an increase of 2,107 (257%) in 2009. Teenage pregnancy statistics for Stoke-on-Trent have also fallen by 10.6% from the previous year. This work has been shortlisted for a national award.

Lifestyles

A person's health is determined by many things, including the lifestyles we lead. Smoking, drug addiction, drinking, physical activity, the food we eat, and many other lifestyle issues all have an impact upon our health, both good and bad. In this final section, we consider some of these lifestyle issues and the impact they have upon people's health.



SMOKING

England and Stoke-on-Trent

An average of 600 people die of smoking related diseases in Stoke-on-Trent every year. Smoking related diseases in Stoke-on-Trent are estimated to cost the NHS over £9 million, whilst wider costs to the local economy are estimated at £51 million per year, with the cost of smoking related sick days estimated at approximately £11 million.

It is estimated that 30.9% of adults in Stoke-on-Trent were smokers in 2008 compared with 24.1% in England. The percentage of adults smoking in Stoke-on-Trent was **significantly higher** than the 2008 national average.

Within the City, the percentage of adults smoking in 2008 was highest in the ward of Bentilee and Townsend (36.4%), which is the most deprived ward in the City (see Appendix 5 for ward deprivation levels in NHS SOT).

4 WEEK SMOKING QUITTERS

England and Stoke-on-Trent

Smoking kills people. Smoking continues to be the main cause of preventable illness and premature death in the country. It is the major cause of cancer, heart disease and COPD and is the single most important causal factor for the socioeconomic difference in the incidence of cancer and heart disease. Giving up smoking remains the most effective action people can take to protect both their own health and the health of others through reducing the impact of exposure to second hand smoke. We have looked at the numbers of people who have attempted to quit smoking and who have remained stopped at four weeks (as an indication of giving up smoking).

The percentage of people in NHS SOT who had quit smoking at four weeks in 2009/2010 was 39.1%. This means that of the 5,825 people who set a four week quit date, 2,278 had quit at four weeks in NHS SOT. The percentage of people quitting at four weeks locally has remained largely unchanged since 2005/2006 and the current percentage of quitters in NHS SOT in 2009/2010 was **significantly lower** than the England figure of 49.4%. Over the next year, we are aiming to increase the number of four week quitters in NHS SOT to 3,000.

SMOKING DURING PREGNANCY

England and Stoke-on-Trent

Smoking during pregnancy is harmful to the unborn child. Smoking during pregnancy can increase the risk of early miscarriage and the likelihood of stillbirth, and babies born to women who smoke are more likely to be born prematurely, to have a low birth weight, are at increased risk of cot death, to have poorer lung function and are at increased risk of respiratory disease. Smoking remains one of the modifiable risk factors that women can change during pregnancy.

In 2009/2010, 21.1% of women in NHS SOT smoked during pregnancy compared with 14.1% in England. This equates to approximately 800 women smoking during pregnancy in NHS SOT in 2009/2010. Compared with England, where the percentage of women smoking during pregnancy has fallen since 2006/2007, in NHS SOT, the percentage has increased from 19.3% to its current level of 21.1%. This percentage is **significantly higher** than England.

Stopping smoking in Stoke-on-Trent

The Stoke-on-Trent Stop Smoking Service has developed successful partnerships with both Port Vale and Stoke City Football Clubs. These partnerships have enabled the service to communicate, target and gain credibility among people in routine and manual occupations (a group which traditionally has higher levels of smoking compared to the general population). First team players from both sides have acted as health champions, and podcasts using players, sponsorship of games and leafleting opportunities at games have all been used to raise awareness amongst the public. A successful Stop Smoking group also takes place at Britannia Stadium.

ALCOHOL ADMISSIONS

England and Stoke-on-Trent

As a leisure activity, drinking is widely accepted and considered a harmless part of everyday life. However, the latest UK figures show that 29% of men and 17% of women drink above recommended safe levels per week. This has serious health and social consequences, not only for the person drinking, but also for those around them. Drinking excessively is associated with higher death rates from circulatory disease, stomach cancers, cirrhosis of the liver, injuries, suicides and violence. The health of other people is also affected through increases in assault, motor accidents, domestic abuse and child abuse.

To examine the impact of alcohol in Stoke-on-Trent, we have looked at levels of hospital admissions for alcohol related harm. In Stoke-on-Trent, the number of hospital admissions for alcohol related harm has increased from 4,162 in 2004/2005 to 5,619 in 2008/2009. Whilst the number of hospital admissions also increased in England during this period, the hospital admission rate for alcohol related harm remained **significantly higher** in Stoke-on-Trent compared with England in 2008/2009.

Within Stoke-on-Trent, there are an estimated 9,600 dependent drinkers from a harmful drinking population of approximately 11,000. Of the total, it is estimated that over 3,000 people are in need of access to specialist alcohol services.

Alcohol in Stoke-on-Trent

During 2009/2010, over 2,300 people were screened for alcohol consumption in the community and given either a brief intervention or a referral as required. This was well in excess of our annual target of 1,400. National evidence suggests that 1 in 8 people screened for brief advice will reduce the amount of alcohol they consume. We have also significantly increased the capacity of the community alcohol service and the acute service for dependent drinkers.

OBESITY AND PHYSICAL ACTIVITY

England and Stoke-on-Trent

Levels of obesity continue to rise in England. In 2008, it was estimated that 23.4% of adults were obese, a rise of over 4% since 1998. In Stoke-on-Trent, it was estimated that 30.4% of adults were obese in 2008 compared with 23.4% in England (this figure was significantly higher than England).

Obesity is also becoming a serious problem among children. In 2008/2009, 21.8% of 11 year old schoolchildren in NHS SOT were classified as obese compared with 18.3% in England (this figure was significantly higher than England). The percentage of obese children in NHS SOT is also projected to increase over the next decade.

A lack of physical activity is one of the main factors leading to these increasing obesity levels. A look at physical activity levels in Stoke-on-Trent reveals that 58.1% of adults in 2008/2009 were not taking any physical activity at all (compared with 48.5% in England). This was significantly higher than England. Among those who were physically active, 18.3% were undertaking the recommended levels of physical activity in Stoke-on-Trent compared with 21.6% in England.

Obesity and physical activity in Stoke-on-Trent

The Closer to Home Health Walks initiative offers a varied and easily accessible programme of walks across the city. We have a key relationship with the Federation of Stadium Communities (FSC), who develop and deliver regular walks as part of the programme offered. The FSC have worked with Stoke City Football Club to deliver a regular Match Day walk, and this is an initiative that is being mirrored at Port Vale Football Club. Many walks can be undertaken in groups with the help of experienced health walk leaders, with many of the walks accessible as self led walks using easy to follow Circular Walk Maps. Regular media releases are provided to local press and radio highlighting what is happening on a weekly and monthly basis and there is a dedicated website with the full programme of walks offered and links to downloadable Circular Walk Maps. Over 1,000 people have so far taken part in these walks. The Closer to Home Health Walks include two key outcomes: first, increasing the number of volunteer walk leaders (of which there are over 150); and second, encouraging people to develop personalised health walk objectives, which in turn motivate people to attend at least 12 walks over a 12 week period.

Case Study 2: Lifestyle Programme

"I'm a completely different person".

In 2009, Sharon Salt felt that she needed to make some big changes in her life. "I was overweight and suffered bouts of depression", she said. "I had other health problems too, including asthma".

Sharon joined the Lifestyle Support Programme and found a warm and friendly welcome right from the first day. Her coach Ann explained to her all the different options that the programme offers.

"There were lots of things I could try out", said Sharon. "I decided to have a go at the Healthy Walks a couple of times a week. That was when I found out how much fun exercise can be".

Many people are put off exercise because they think it's all hard work and sweat, so we asked Sharon what makes the Healthy Walks different. "Being in a group and chatting to other people is great. The walks are taken at a steady pace so no-one feels uncomfortable or like they're having to struggle. It doesn't actually feel like exercise, just getting out in the fresh air and enjoying yourself".

Sharon also came along to the Think Well and Cook and Eat sessions. "Think Well was brilliant, it made me see myself differently and helped me become much more positive", she said.

"The Cook and Eat sessions really opened my eyes. I found out how healthy eating means you enjoy much nicer and tastier foods. I had been on diets before and they hadn't worked. This is completely different to being on a diet though".

So at the end of Sharon's programme, what were the results? "Well, I lost two and a half stones for starters:, she smiled. "But I also feel good and happy about myself now. Even my husband says I'm a much happier person! I can also control my asthma better, so I feel like getting out and trying new things".

"I've never felt better".

TOP TIP...

Be active - go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Physical activity makes you feel good.

Chapter 2

Health Behaviour

“Health-related behaviour is all about resolutions to give up the things you do not want to give up and to do the things you do not want to do. You cannot do that; you cannot make the resolutions and stick to them, unless you are feeling on top of life”.

(Richard Wilkinson giving evidence to the House of Commons Health Select Committee, 2008)

Introduction

Individual health is supported or undermined by complex factors that interact with each other in dynamic ways. Any discussion about individual lifestyle choices needs to be set in the context of the wider determinants of health. Social, environmental and economic conditions, such as housing, education, low incomes, disability or limiting long term illness, and ethnicity, influence not only how each individual is able to live his or her life, but also their health outcomes. These “upstream factors” that influence health work with “downstream” factors such as lifestyle and access to services, and are the causes of health inequalities. Any programme of action which focuses on tackling lifestyle behaviour change must start from this point to avoid a judgemental and victim blaming approach.

Supporting communities and individuals to become co-producers in their own health and well-being has long been the goal of successive governments and is characterised by the following:

- Awareness and understanding of ‘health’ in its widest sense, including well-being
- Awareness and understanding of one’s own health and well-being and the needs of those in the wider community
- Prioritising for optimum health and well-being and choosing ‘health’
- Supporting others to achieve their optimum health and well-being

Benefits of Behaviour Change in Stoke-on-Trent

From a public health perspective there are long-term sustainable health benefits to be gained from successfully supporting and enabling individuals and communities to take more responsibility for their own health outcomes. Some long term outcomes of this approach would include:

- Reduced mortality rates from circulatory disease and cancer
- Reduced unplanned attendances and admissions at the University Hospital of North Staffordshire
- Improved self-management of a range of long term conditions
- Improved healthy life years

In 2004, the Department of Health estimated that physical inactivity in England cost £8.2 billion annually (this included the rising cost of treating chronic diseases such as coronary heart disease and diabetes). It is estimated that a further £2.5 billion each year is spent on dealing with the consequences of obesity. Again, this can be caused, in part, by a lack of physical activity.

A recent study conducted by Sheffield Hallam University for NHS SOT explored the clinical and economic impact of investment in a public health based, population level health risk reduction programme within NHS SOT. In a scenario with a 5-6% reduction in risk factors such as smoking and obesity rates, we could see an annual reduction of 322 deaths, 1,128 acute hospital admissions avoided with savings in revenue costs of £3,229,875. In a more realistic scenario of a 3-4% reduction in mean risk levels, we still see an annual

reduction of 214 deaths, 709 acute hospital admissions avoided and £2,087,733 in costs avoided. Furthermore, this model only took into account the savings accrued from acute admissions only. Therefore, overall savings are likely to be much higher once other areas such as welfare services are factored in.

Nature and Scale of the Challenge

Residents of Stoke-on-Trent have a poorer standard of health on average than the country as a whole, with almost half of all people over 50 reporting having a long term illness. Unhealthy lifestyles are a major factor contributing to inequalities in health in Stoke-on-Trent. Over 1 in 4 adults are obese, only 8% of adults exercise 5 times a week, there are high teenage pregnancy rates, higher rates of hospital admissions for alcohol specific conditions and higher than average smoking rates. Even within the City there are extreme inequalities with up to a six year difference in life expectancy between those that live in different parts of Stoke-on-Trent, echoing the area's socio-demographic characteristics. Although health within the City is improving, it is not improving fast enough to close the gap between Stoke-on-Trent and the rest of the country.

TOP TIP...

Read a book - it's good for beating the blues, and also helps with relaxation.

Evidence and Theories

Bartholomew et al map out the complexity of supporting behaviour change on a large scale, and make a distinction between what is in an individual's gift to change, and the physiological, ecological and structural factors that individuals and communities cannot necessarily change alone. Importantly, therefore, co-production between individuals, communities and services is essential to ensure a positive approach to behaviour change, as one always needs to be supporting the other. Change must occur on a number of levels to have maximum impact; that is, individual lifestyle change, organisational change, community, societal and supra-national change (see Diagram 1).

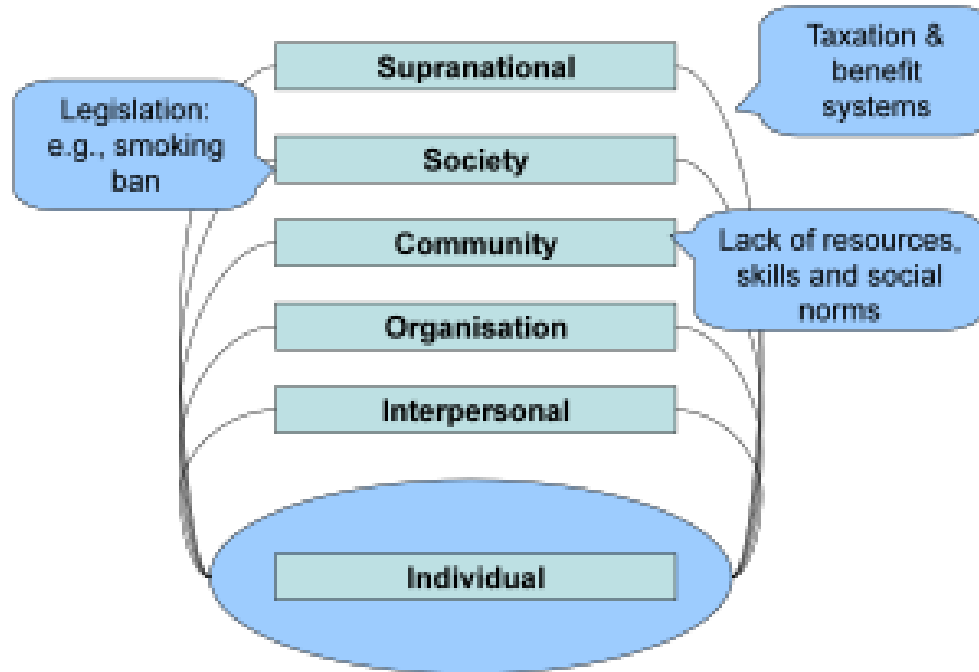
Whilst there are pockets of excellent practice in enabling social action for health and supporting people to change behaviour, there is little evidence of such work being carried out systematically and with rigorous evaluation, or on sufficient scale, to really demonstrate a difference to the population's health.

The *Marmot Review, 'Fair Society, Healthy Lives', focuses on the social gradient of health inequalities - people with a higher socioeconomic position have a greater array of life chances, more opportunities to lead a flourishing life and also have better health. The review concludes that such health inequalities are unfair, not inevitable and can be significantly reduced. They stem from avoidable differences in society that are present before birth and set the scene for poorer health and other outcomes accumulating throughout the life course. We must, therefore, focus our resources along the social gradient, in accordance with the level of need, to reduce these inequalities. One of the

* The Marmot Review (2010). *Fair society, healthy lives*. Strategic review of health inequalities in England post 2010. (www.marmotreview.org)

key recommendations of the Marmot Review is to give every child the best start in life by supporting families through parenting programmes and ensuring access to quality early years services.

Diagram 1: Levels of behaviour change interventions



Source: Adapted from Bartholomew et al 2006*

The use of effective, evidence based approaches and strategies to support behaviour change are essential to maximize the return on investment of time, resources and personal commitment. The National Institute for Health and Clinical Excellence (NICE) has produced guidance to support the use of a multifaceted approach to developing an effective behaviour change programme, which includes a number of steps from planning to evaluation of effectiveness and cost effectiveness. Despite this, there are significant gaps in the evidence and the availability of reliable long term health outcomes.

The Kings Fund review on commissioning and behaviour change echoes NICE guidance. Greater investment in good quality research is necessary to evaluate the impact of behaviour change interventions associated with social class, ethnicity and deprivation, with an emphasis on cost effectiveness, consideration of short term financial gains as well as longer term gains of improved public health.

The review provides a number of suggestions to commissioners and service providers to enable the identification of effective ways to change people's behaviour. This includes:

- The strengthening of skills in data analysis, population social marketing and behavioural techniques in order to understand who should be targeted with which interventions
- Designing effective behaviour change interventions through a variety of means including the provision of information, individual support and financial or non-financial incentives. Evidence has shown that incentives can influence engagement in behaviour change programmes, but long term effectiveness has yet to be established

* Bartholomew LK et al (2006). *Planning health promotion programs: an intervention mapping approach*. San Francisco, CA: Jossey-Bass.

- Robust evaluation of programmes including cost effectiveness
- Transforming the NHS from a service focused on treating illness to one that also promotes good health

Levels of Intervention

Population level interventions

National policies can make an important contribution in promoting health and well-being and reducing inequalities.

An example of effective fiscal and legislative interventions to support behaviour change is tobacco control within the UK. This includes:

- Smokefree law which bans smoking within enclosed public places and workplaces
- Increasing the price of cigarettes and tobacco to deter people from smoking
- Ban on tobacco advertising to reduce promotional opportunities which may encourage young people to start smoking
- Picture and health warnings on cigarette and tobacco packaging

TOP TIP...
 Connect with people around you - family, friends, colleagues, neighbours. These connections will support and enrich you every day.

Consideration is being given by the government to setting a minimum price per unit of alcohol. It has been estimated that setting a minimum price of 50p per unit would prevent 9,000 hospital admissions nationally. Given the scale of alcohol related problems within the City, this policy would benefit the health of Stoke-on-Trent residents.

Community level interventions

An example of community based interventions that aims to tackle physical inactivity is increasing access to usable green spaces, to prevent circulatory disease. Studies in England have shown that the amount of green space in an area is generally associated with better health, including reduced mortality. Overall, the evidence indicates that improving access to good quality green space in urban areas may be a promising means of increasing physical activity.

The design and layout of towns and cities can encourage or discourage travel and access on foot or by bicycle. Similarly, building location and design can encourage (or discourage) the use of stairs and other physical activities. These modifications can be achieved by public sector agencies working in partnership with other organisations, including those in the voluntary and community sectors. A good example of this is the NHS SOT Primary Care Strategy, which aims to ensure that patients with long term conditions not only get optimal medical care but also get support on making lifestyle changes.

Individual level interventions

For most people, a change in behaviour occurs gradually, with the person moving from being uninterested, unaware or unwilling to make a change, to considering a change, to deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behaviour occur. Relapses are almost inevitable and become part of the process of working toward lifelong change.

There is growing evidence on the provision of a personalised form of intervention, using the brief intervention method, which involves the provision of opportunistic advice, discussion, negotiation or encouragement. The level of evidence available relating to brief intervention varies depending on the lifestyle behaviour. In this section the focus is on alcohol and smoking.

Brief intervention for alcohol

There is consistent evidence from a large number of studies that brief intervention can reduce total alcohol consumption and episodes of binge drinking in hazardous drinkers, for periods lasting up to a year. There is, however, limited evidence that this effect may be sustained for longer periods.

Screening is the first step in the process of alcohol brief intervention. A validated screening instrument, such as the Alcohol Use Disorders Identification Test (Table 1), developed by the World Health Organisation, could be used to identify at risk individuals and provide each patient with an appropriate intervention, based on their level of risk

Table 1: Audit C Questionnaire on alcohol use

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:

A total of 5+ indicates increasing or higher risk drinking and should lead to a further assessment of drinking and related problems. (See Appendix 6 for a full version of the Audit C Questionnaire).



Brief intervention for smoking

Smoking remains the leading cause of preventable morbidity and premature death in England. Brief interventions have consistently been found to be effective at increasing the number of people who successfully quit smoking.

Brief interventions in smoking cessation typically take between 30 seconds and 10 minutes, and may include one or more of the following:

- Simple opportunistic advice to stop
- An assessment of the person's motivation to quit
- An offer of stop smoking medicines and/or behavioural support
- Provision of self-help material and referral to more intensive support, such as the NHS Stop Smoking Service

Financial incentives

There is some evidence to suggest that financial incentives can help change behaviour in the short term where well defined and simple goals are met. However, there is no evidence to show that these changes can be sustained.

Developing Insight to Support Behaviour Change

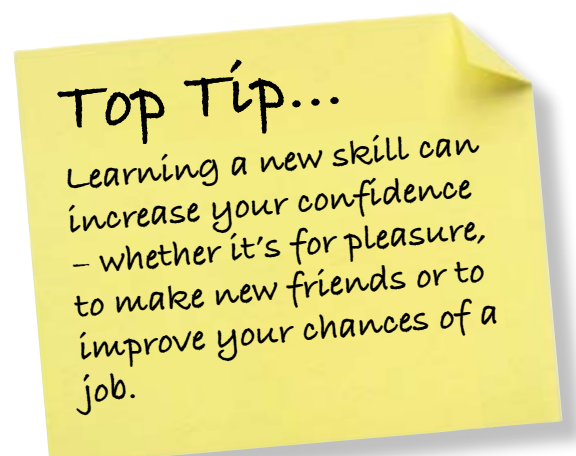
“Individual behaviours are deeply embedded in social and institutional contexts. We are guided as much by what others around us say and do, and by the “rules of the game”, as we are by personal choice”.

Jackson T (2005). *Motivating sustainable consumption: a review of evidence on consumer behaviour and behavioural change*

Simply informing people of the health benefits and risks of a particular behaviour is not sufficient to affect positive change. In order to facilitate long term changes in behaviour, we need to understand what encourages and motivates people. We need to develop an insight into the everyday lives and aspirations of the people of Stoke-on-Trent, to enable us to develop messages, services and interventions that grab their attention and interest and support them to adopt behaviours that will have a positive impact on their health.

“It would be easy to give the public information and hope they change behaviour but we know that doesn't work very satisfactorily. Otherwise none of us would be obese, none of us would smoke and none of us would drive like lunatics”.

Ian Potter, Director. New Zealand Health Sponsorship Council. New Zealand Herald, June 2007.



Residents of Stoke-on-Trent Views on Health

Health is important to us...

"Obviously I don't want to smoke because it makes me feel healthier when I don't smoke. I can run and you know climb higher mountains and go longer on my bike"

"Health comes first"

Unhealthy behaviour offers immediate rewards...

"It's just my time. My time you know...it just relaxes me. I look forward to it. Especially when my child's gone to bed...a cup of coffee and a cigarette"

Breastfeeding...

"It's time consuming, relentless and demanding"

We have mixed feelings about health services and professionals...

"If I call the GP I don't always get an appointment so I assess myself, if it's an emergency I go to hospital"

"It all depends on the doctor you've got. Some are brilliant but others aren't and that can put you off going"

"My midwife and health visitor were both great"

We don't want to be told what to do...

"You're being told what you can and cannot do, you should have your own freedom of choice"

We feel disempowered...

"I didn't ask to be a smoker...It just happened...that's the way life is"

"I tried to lose weight. My metabolism doesn't seem to lose any weight"

We don't expect to live a long, healthy life...

"When your time comes, you'll go. I always say here today, gone tomorrow"

"If we wake up every morning it is a bonus"

Healthy behaviours are difficult...

"They have an idealised situation of how you are supposed to live, but it isn't a real life. I am not going to stand and cook a separate meal for myself, then another one for the rest of the family"

"Exercise is the last thing I want to do at the moment, I can't motivate myself to even think about that. You go to the gym and feel there's all these young lads running around, you feel inadequate and overweight, they could be laughing"

Life gets in the way of looking after our health...

"We're more work orientated I believe, priorities are the work not the health I think. That's Asians for you, isn't it"

"Making an appointment is awkward when you're self-employed, you can't lose time"

We want support and encouragement...

"Give me encouragement. When you are told you are doing well you keep going"

There is no blueprint for the most effective intervention strategies to support behaviour change on the scale and depth required in Stoke-on-Trent.

What we do know is that:

- We cannot rely on people to make rational decisions based on the information provided, and we cannot assume that changing attitudes will lead to a change in behaviour
- Social factors are powerful, and social norms are deeply entrenched. Change in social norms is often slow to happen, and communications are likely to be most effective when working with other interventions to change behaviour

In order to move forward, we need to learn lessons from the past, and develop strategies for behaviour change which address all influences on behaviour at a policy, population, community and individual level.

Disadvantaged groups

There are a range of population groups within our communities which have poor health and unhealthy lifestyles. For example, people living in poverty, disability, people with mental illness, ethnic minority groups, the homeless and those with poor housing. It is important that measures are taken to enable these groups to access mainstream services for both prevention and care. However, the needs of some of these groups are such that dedicated services may be required. We note that these groups are less likely to take advantage of health promoting programmes such as screening, quit smoking, exercise referral programmes etc. We need to work with local communities and leaders to ensure that the services are flexible and tailor-made to their needs, whilst recognising that these groups may need more additional resources and support. Key to success is shared ownership of personalised plans and ensuring that health promoting messages and interventions recognise and reflect the diversity and richness of our local population.

Making every contact count

We should tap the potential of the public and voluntary sector workforces to promote health and well being. We advocate a philosophy of every contact counts. One of the challenges is to ensure that services are joined up for an individual and prevention is considered. For example, when Mrs Smith (aged 79), who lives alone, is visited by a health or social care worker, the following are considered and if necessary referrals are made to other agencies:

- Reducing risks of falls
- Working smoke alarm
- Benefits advice if appropriate
- Brief advice on smoking and alcohol if needed
- Consideration of nutrition
- Risk of cold in winter

CONCLUSION

Strong local partnerships that works closely together through the application of shared assets, resources and expertise is the key to a social movement for health which will deliver the large scale change required in the City. The greatest challenge in Stoke-on-Trent remains our ability to persuade and encourage people to adopt and embrace healthy lifestyle choices, the diversity of the local population must be recognised when building behaviour change interventions. We have achieved some success in supporting behaviour change but we need to revisit and refresh our approach.

We need to strengthen our skills in information gathering and analysis, capturing and using public insight to inform local health improvement interventions, and make sure these interventions are robustly evaluated and refined to demonstrate effectiveness and outcome.

Our Vision is a City where local, regional and national partnerships work together to engage and support all people in Stoke-on-Trent to enjoy optimal health and well-being. We want to support our residents in becoming forceful champions for their own health and well-being. To achieve this we must mobilise the endeavour, creativity and energy of local communities to raise aspirations and expectations of all our communities.

Case Study 3: Lifestyle Programme

When Jawid visited his doctor in 2008, he was told that his health was at serious risk. “I have Type 2 Diabetes and my sugar levels were out of control”, he explained. “That caused me to put on a lot of weight. Also, my cholesterol levels were very high, and my doctor said I was at risk of heart disease and other health problems”.

Jawid’s doctor suggested that he begin taking some gentle exercise, and put him in touch with the Lifestyle Support Programme to help him get started.

When he was younger, Jawid enjoyed swimming. He felt that this could be the right exercise for him, but he had never visited a pool in the UK.

“I didn’t know whether I would feel comfortable”, he said. “But Emilio, my lifestyle coach, arranged a class and I went along to try it”.

Jawid was in for a shock though, as he described: “When I was young I could swim very strongly and I thought I would be able to do that again. As soon as I got in the pool I realised I couldn’t. Even a few yards was a struggle that left me out of breath”.

Regular swimming classes soon helped Jawid regain some fitness though. “It was very good. I was never pushed but encouraged to make progress at my own steady pace. It was great fun and I looked forward to every session”.

As well as swimming, Jawid began walking and playing badminton too.

“My coach Emilio was always there for support and advice when I needed it. He arranged water aerobics sessions for me and introduced me to someone else on the lifestyle programme who became my badminton partner”.

Within just a few weeks, Jawid was feeling the positive effects of the programme. “I felt a lot better”, he said. “Thanks to the lifestyle programme, I was fresher, fitter and able to enjoy life better”.

But the full effects of the programme only became clear when Jawid visited his doctor for a check up. “I had not only lost well over a stone in weight, but my sugar levels were under control. My cholesterol level was a big surprise – it was actually lower than average”.

The Lifestyle Support Programme changes lives for the better. If you want proof, just ask Jawid!

TOP TIP...

Drink plenty of water
- we should drink
approximately 6 to 8
glasses of water every
day to stop us getting
dehydrated. Our bodies
need water to work properly.

Chapter 3

Conclusions

Conclusions

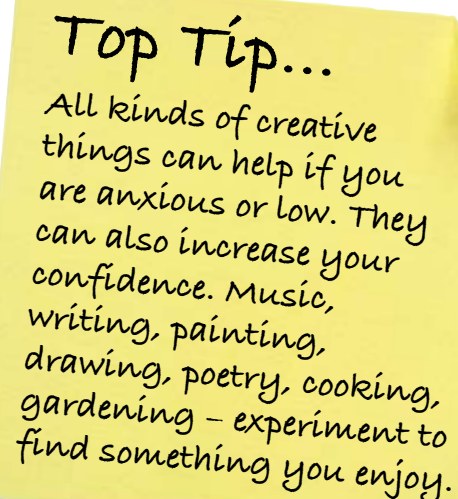
In absolute terms, the health of the people of Stoke-on-Trent has improved over the last decade but has failed to keep pace with the rest of the country. In some health areas, such as circulatory disease, the gap has narrowed but for most other areas health outcomes are of serious concern. This picture is closely mirrored by the extensive deprivation faced by the population and this adds to the complexity of the solutions required. For example, the high death rates in cancer is almost certainly a reflection of the deprivation, industrial legacy, decades of high smoking rates, late presentation and diagnosis of cancer. This requires a critical rethink of how to promote early presentation and diagnosis and also provide optimal management of cancer at all stages of care. Above all, our smoking cessation service and tobacco control strategy has to be amongst the most ambitious in the country in order make serious inroads into the unacceptably high smoking prevalence rates.

Supporting behaviour change on a mass scale in Stoke-on-Trent clearly requires a multi layered approach, including policies at the national level, local city wide approaches, neighbourhood interventions and services to support individuals. Individuals need to be supported by creating environments where they can take up opportunities to improve health and there should be no room for victim blaming. National policies on smoking within public places and increasing the age limit of purchasing tobacco from 16 to 18 years of age have had a significant benefit for Stoke-on-Trent residents. The government is considering providing a minimum price for a unit of alcohol and this policy is likely to be of particular local benefit in tackling the large scale problems caused by alcohol within the City.

In order to achieve improved health outcomes, we need to increase demand for health among the residents of Stoke-on-Trent. By having a better understanding of our population, we will be able to tailor, target and design services that will reduce the inequalities gap.

Local decisions made in schools, the workplace, at home and in local services all have the potential to help or hinder behaviour change and the improvement of health outcomes. Hence, we aim to work in partnership to influence the wider determinants and assist people to reduce the health risks in their lifestyle at individual, family and community level so they become co-producers in it.

The Local Authority is ideally placed to support local people to adopt healthier lifestyles and reduce health inequalities. Health needs to be a key consideration in the development of all local policy to ensure that it maximises opportunities for people to choose health. The existing built environment and major new developments must be managed and planned to maximise health, and health needs to be a key consideration in how we work with and through neighbourhoods to provide locally sensitive, accessible and appropriate services.



TOP TIP...
All kinds of creative things can help if you are anxious or low. They can also increase your confidence. Music, writing, painting, drawing, poetry, cooking, gardening – experiment to find something you enjoy.

The Marmot Review highlights the importance of the Local Authority in early years (0-5 years) on future health and social outcomes. The Local Authority and NHS SOT should review the interventions offered for pre-school children in the light of the Marmot Review recommendations. Schools can play an important role in developing skills to shape behaviours for the future. Our expectation should be that young people have access to the best possible environments within schools that maximise opportunities for health and well-being. The Local Authority should consider how schools can be supported to implement NICE guidance and best practice.

Whilst the health service deals with the consequences of unhealthy lifestyles, it has a vital public health role in supporting behaviour change, particularly through offering brief interventions and offering intensive personalised support where appropriate. The Primary Care Strategy should have a continued focus on developing Public Health approaches within the primary care and community settings and developing reactive care.

A whole partnership approach to improving health is required which can maximise the opportunity for all front line staff to support behaviour change in the community. In other words, public health is everybody's business. The public sector in Stoke-on-Trent already have trusted relationships with other local people. Staff with appropriate skills can 'make every contact count' by offering opportunistic support to the people who use their services in relation to lifestyle change, using brief interventions and sign posting people to the appropriate support as required.

There is a compelling case for supporting behaviour change in the City which requires continued investment into upstream interventions and helping people to take responsibility for their own health. We need to assess the baseline investment in prevention in the City and specifically behaviour change. This will enable both NHS SOT and the Local Authority to make judgments about resources required against the levels of need. The scale of the challenges in Stoke-on-Trent are such that only industrial size programmes of change will have the required impact. The City has made impressive progress in developing such programmes but it needs to continuously evaluate and review the investments to ensure cost effectiveness and that progress is being made to achieve the desired positive health outcomes.

RECOMMENDATIONS

1. NHS Stoke on Trent and the Local Authority should lead by example and develop a programme of 'making every contact count' to support behaviour change within the public sector. Public health is everybody's business.
2. Pre-school services should be reviewed to ensure every child is given the best start in life, in line with the Marmot Review.
3. Young people should be encouraged to become health conscious and make healthy choices through the development of health improvement programmes in schools.
4. The NHS needs to consider how to build on the Primary Care Strategy to further shift its focus from reactive to preventative care.

5. The Local Authority needs to consider how it will maximise opportunities for improving health in the City as it takes on new Public Health responsibilities.
6. A cancer prevention awareness and early diagnosis plan should be developed and implemented.
7. Locally elected members, who in their leadership role are already promoting healthy lifestyles in their communities, should be supported to provide even further enhancements.





Appendix 1

Mortality rates from all causes of disease for wards in Stoke-on-Trent between 2004-2008 (people of all ages)

Ward	Number of deaths	DSR ¹	Rank ²
Abbey Green	690	720.6³	11
Bentilee and Townsend	646	783.6	17
Berryhill and Hanley East	629	665.1	5
Blurton	621	645.5	4
Burslem North	724	759.5	15
Burslem South	909	974.0	20
Chell and Packmoor	595	750.1	13
East Valley	705	681.7	6
Fenton	601	710.0	10
Hanley West and Shelton	424	870.2	19
Hartshill and Penkhull	630	605.0	1
Longton North	526	699.8	8
Longton South	799	691.4	7
Meir Park and Sandon	474	631.2	3
Northwood and Birches Head	494	623.8	2
Norton and Bradeley	652	749.4	12
Stoke and Trent Vale	592	709.1	9
Trentham and Hanford	887	752.0	14
Tunstall	768	811.6	18
Weston and Meir North	774	781.4	16
Stoke-on-Trent	13,140	724.4	
England	2,376,134	594.3	

Source: Dr Foster Population Health Manager 2010

¹ DSR = Directly age standardised mortality rates per 100,000

² Rank: 1 = lowest (best); 20 = highest (worst)

³ Red numbers = significantly higher than England

Appendix 2

Mortality rates from circulatory disease for wards in Stoke-on-Trent between 2004-2008 (people aged under 75)

Ward	Number of deaths	DSR ¹	Rank ²
Abbey Green	75	102.0³	11
Bentilee and Townsend	88	123.7	18
Berryhill and Hanley East	70	107.2	13
Blurton	67	100.3	10
Burslem North	69	109.1	14
Burslem South	87	150.0	19
Chell and Packmoor	64	112.9	15
East Valley	62	88.1	5
Fenton	58	100.1	9
Hanley West and Shelton	48	151.4	20
Hartshill and Penkhull	51	85.9	4
Longton North	70	116.7	16
Longton South	70	91.5	7
Meir Park and Sandon	57	90.5	6
Northwood and Birches Head	56	92.5	8
Norton and Bradeley	54	73.9	1
Stoke and Trent Vale	62	106.8	12
Trentham and Hanford	58	81.2	2
Tunstall	75	119.1	17
Weston and Meir North	64	83.7	3
Stoke-on-Trent	1,305	101.8	
England⁴	123,318	74.8	

Sources: Dr Foster Population Health Manager 2010, Compendium of Clinical and Health Indicators 2010

¹ DSR = Directly age standardised mortality rates per 100,000

² Rank: 1 = lowest (best); 20 = highest (worst)

³ Red numbers = significantly higher than England

⁴ Based on the years 2006-2008

Appendix 3

Mortality rates from cancer for wards in Stoke-on-Trent between 2004-2008 (people aged under 75)

Ward	Number of deaths	DSR ¹	Rank ²
Abbey Green	128	172.5³	20
Bentilee and Townsend	115	167.2	19
Berryhill and Hanley East	82	127.7	5
Blurton	89	133.2	7
Burslem North	100	158.1	14
Burslem South	92	157.8	13
Chell and Packmoor	90	158.9	15
East Valley	96	136.3	9
Fenton	98	166.4	18
Hanley West and Shelton	52	159.8	16
Hartshill and Penkhull	71	121.1	2
Longton North	88	145.9	10
Longton South	90	123.6	3
Meir Park and Sandon	66	105.7	1
Northwood and Birches Head	75	127.4	4
Norton and Bradeley	105	148.5	11
Stoke and Trent Vale	77	133.8	8
Trentham and Hanford	95	130.4	6
Tunstall	101	162.1	17
Weston and Meir North	113	154.0	12
Stoke-on-Trent	1,823	143.2	
England⁴	185,883	114.0	

Sources: Dr Foster Population Health Manager 2010, Compendium of Clinical and Health Indicators 2010

¹ DSR = Directly age standardised mortality rates per 100,000

² Rank: 1 = lowest (best); 20 = highest (worst)

³ Red numbers = significantly higher than England

⁴ Based on the years 2006-2008

Appendix 4

Mortality rates from respiratory disease¹ for wards in Stoke-on-Trent between 2004-2008 (people of all ages)

Ward	Number of deaths	DSR ²	Rank ³
Abbey Green	48	46.0⁴	19
Bentilee and Townsend	32	35.6	8
Berryhill and Hanley East	44	42.9	16
Blurton	39	39.5	10
Burslem North	37	33.2	5
Burslem South	50	57.3	20
Chell and Packmoor	29	33.4	6
East Valley	42	36.4	9
Fenton	36	42.9	16
Hanley West and Shelton	16	28.1	2
Hartshill and Penkhull	32	27.9	1
Longton North	26	31.3	4
Longton South	54	40.9	11
Meir Park and Sandon	21	29.7	3
Northwood and Birches Head	35	41.1	12
Norton and Bradeley	40	41.8	14
Stoke and Trent Vale	38	41.2	13
Trentham and Hanford	42	34.4	7
Tunstall	48	42.8	15
Weston and Meir North	48	44.8	18
Stoke-on-Trent	757	38.6	
England	111,348	26.8	

Source: Dr Foster Population Health Manager 2010

¹ Respiratory disease = bronchitis, emphysema and other COPD

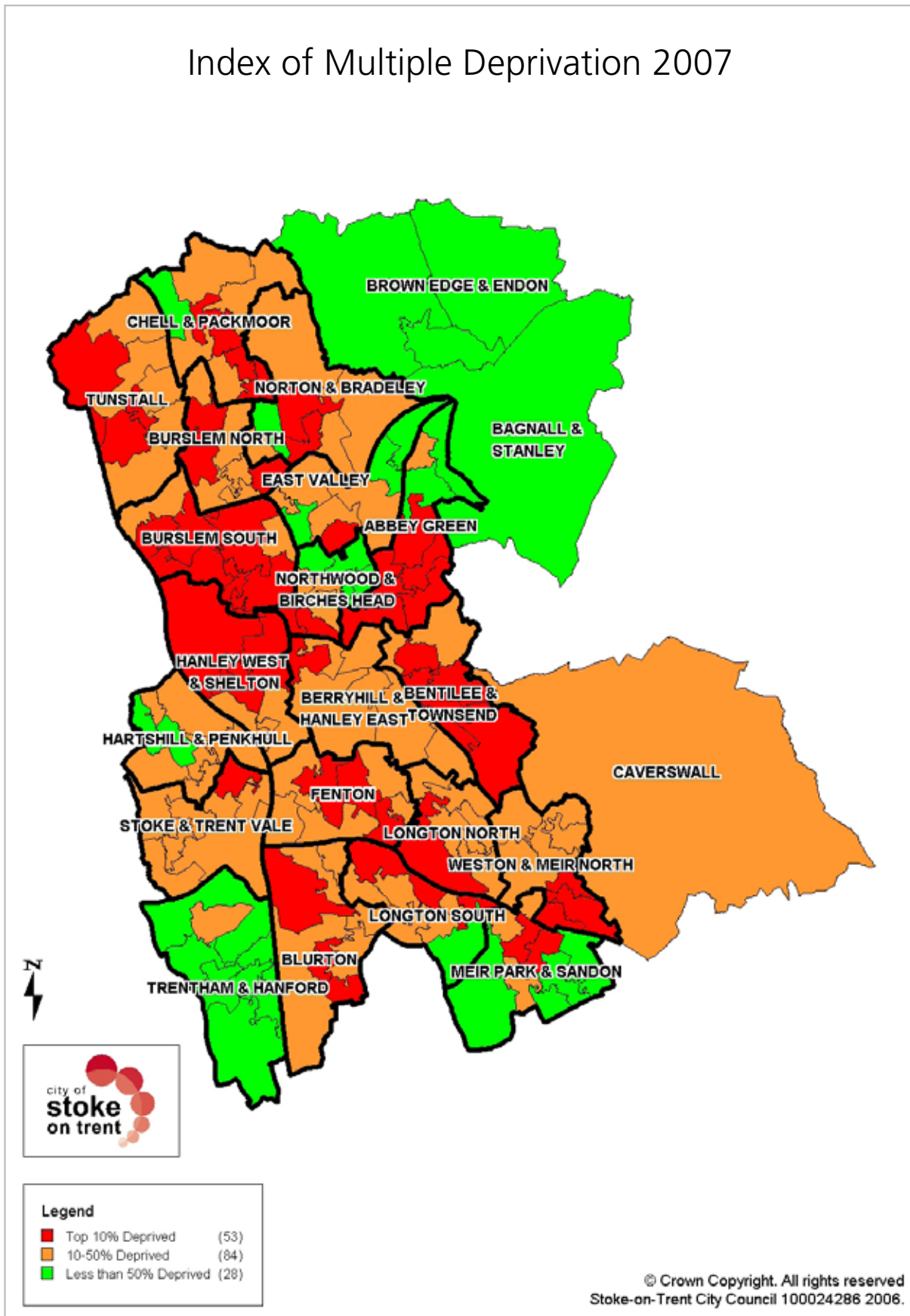
² DSR = Directly age standardised mortality rates per 100,000

³ Rank: 1 = lowest (best); 20 = highest (worst)

⁴ Red numbers = significantly higher than England

Appendix 5

Index of Multiple Deprivation 2007



Source: Stoke-on-Trent City Council 2008

Appendix 6

Full version of the Audit C Questionnaire on alcohol use

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates increasing or higher risk drinking.
An overall score of 5 or above is AUDIT – C positive.



How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 - 7 Lower risk
16 - 19 Higher risk

8 - 15 Increasing risk
20+ Possible dependency



This document is also available in other languages, large print and audio format upon request.

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هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Tento dokument je na vyžádání k dispozici také v jiných jazycích, ve velkém tištěném formátu a zvukovém formátu.

این مدرک همچنین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

Ce document est également disponible dans d'autres langues, en gros caractères et en cassette audio sur simple demande.

આ દસ્તાવેજ વિનંતી કરવાથી બીજી ભાષાઓ, મોટા છાપેલા અક્ષરો અથવા ઓડિઓ રચનામાં પણ મળી રહેશે.

نہم بہ لگہیہ ہر وہا بہ زمانہ کانی کہ، بہ چاپی درشت و بہ شریتی تہ سجیل دہس دہکہ ویت

本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਾਰਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

Hati hii vile vile inapatikana katika lugha nyingine, kwa maandishi makubwa na katika sauti kwa maombi.

நீங்கள் கேட்டுக்கொண்டால், இந்த ஆவணம் வேறு மொழிகளிலும், பெரிய எழுத்து அச்சிலும் அல்லது ஒலிநாடா வடிவிலும் அளிக்கப்படும்.

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درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔



Be bowel aware