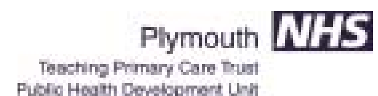
# Our City's Health

A framework to inform, influence and challenge partners to improve health and well-being and reduce health inequalities across Plymouth.

Plymouth Health & Well-being Partnership



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# SUMMARY

The worst health problems in Plymouth will not be tackled without dealing with their root causes. Improving well-being and quality of life is a key priority for most agencies and the Government makes it clear that responsibility for reducing health inequalities must be shared across a range of organisations.

**Our City's Health** is a city-wide framework promoting improvements in the health and well-being of the people in Plymouth and seeking to reduce health inequalities. To do this, it aims to support all partners to develop their own plans and work programmes and has a major role to play in helping to deliver Plymouth's City Strategy - in particular, the goal to become a safe and healthy city.

The 'health' theme group of the Plymouth 2020 Partnership is responsible for setting the direction for **Our City's Health**, with organisations' own strategies the key mechanism for achieving the targets. A wide range of partners can address the causes of poor health as well as contributing to local health improvement. In terms of what affects people's lives on a day-to-day basis, it is not so much the traditional health services but more the environment in which they live. Working in partnership is therefore essential.

The root causes or 'determinants' of good and bad health include some unavoidable factors like age. Most, however, can be avoided. Poverty and deprivation are amongst the most important of these. Marked variations in health across Plymouth (e.g. levels of infant mortality and circulatory diseases) closely reflect levels of deprivation and poverty. Residents of deprived areas suffer more from major illnesses and die from them earlier.

Such health inequalities and their causes have influenced the selection of five key themes within **Our City's Health**:-

1) tackling the determinants of health.
2) strengthening the health of disadvantaged communities.
3) promoting the health of children and young people.
4) promoting the health of older people.
5) preventing ill-health from major illnesses.

Progress can be measured against three overarching targets; infant mortality, life expectancy and child poverty.

Plymouth's Public Health Development Unit is responsible for ensuring the delivery of **Our City's Health** and providing partners with support. This includes developing a work programme, giving advice on interventions and employing Community Public Health Practitioners to support community organisations.

# 1 INTRODUCTION

**This section describes the background to the development of Our City's Health together with current and future working.**

## 1.1 Background

In 1999 the Government published a comprehensive public health strategy for England (*Saving Lives: Our Healthier Nation*, White Paper) with two goals: to improve health and reduce health inequalities. This strategy, which aims to prevent up to 300,000 untimely and unnecessary deaths by 2010, raised the profile of health improvement and partnership working at local level.

In June 2000, Plymouth's Health Action Zone (HAZ) and 2020 Partnership (the Local Strategic Partnership) endorsed the principle of establishing a city-wide health and well-being action plan. Both partnerships recognised the plan's potential for bringing together work aimed at improving health and well-being.

As a result of subsequent consultation, the focus of **Our City's Health** has changed - away from NHS targets towards cross-cutting issues that impact on health.

## 1.2 Ongoing work

Considerable progress has already been made towards improving health, reducing health inequalities and improving the planning of health and care services. For example, service planning has been merged for mental health, older people, children and learning disabilities. Health impact assessments of local policies are being developed, and area-based initiatives such as Devonport People's Dreams (New Deal for Communities) and priority Neighbourhood Renewal areas established. **Our City's Health** recognises these cross-cutting strategies and aims to compliment them, rather than propose new and different priorities.

## 1.3 Future developments

Although there is no statutory obligation to do so, **Our City's Health** provides the first city-wide health promotion framework for Plymouth. It is not a delivery plan, rather it seeks to inform, influence and challenge partners when considering how to meet responsibilities around reducing health inequalities and improving well-being. The aim is to help partners to continue developing their own plans and work programmes.

**Our City's Health**, together with the work of the Community Safety Partnership, has a major role to play in delivering the 'safe and healthy city' goal of the City Strategy.

# 2 HEALTH IN PLYMOUTH

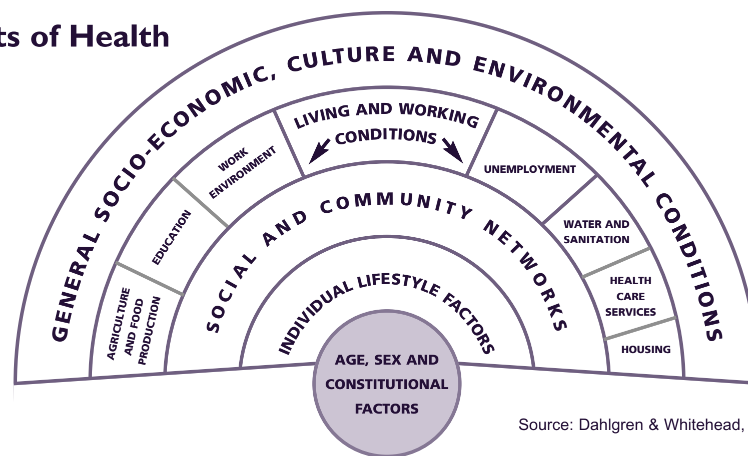
**This section describes the links between ill-health and a wide range of causes, together with the current picture in Plymouth.**

The following sections describe the current state of health in Plymouth, its causes, the themes on which **Our City's Health** is based, and the responsibilities, processes and support available for making improvements.

## 2.1 What Determines Health?

Most differences in health status are avoidable. The various aspects of life which determine the health of an individual are called the **determinants of health** (see figure 1). In addition to the fixed aspects such as age and gender, health inequalities are influenced by things such as; lifestyle factors, social factors, living and working conditions, and the general socio-economic, cultural and environmental conditions in which a person lives.

**Figure 1 - The Determinants of Health**




It is important to consider all these factors when thinking about health. Eating the right food, exercising or visiting the doctor are not the only things that make people healthy. Many of the determinants are not directly under a person's control, nor exist in isolation from one another. So it is also necessary to look at the context of people's lives, and not simply blame them for having poor health or credit them for having good health. The determinants include the following factors. These are broadly based on the model in figure 1:

- **Genetics** - inherited characteristics play a part in deciding how long a person lives, how healthy they will be and how likely they are to get certain illnesses.
- **Gender** - men and women tend to get different kinds of diseases and conditions at different ages. They also tend to have different income levels, and to work in different kinds of jobs.
- **Early life** - things that happen to people when they are children, and even in the womb, affect their later health during childhood and the rest of their lives.
- **Smoking** - smoking has been identified as the primary reason for the gap in healthy life expectancy between the rich and poor. Among men, smoking is responsible for over half of the excess risk of premature death between social classes.
- **Food** - a good diet and adequate food supply is central to health and well-being. Eating the wrong sort of food contributes to cardiovascular diseases, diabetes, cancer, degenerative eye diseases, obesity and dental caries. There are some areas where people cannot access healthy food. These are known as 'food deserts'.
- **Income and social status** - income is probably the single most important influence on health. Relative poverty is still a real phenomenon in the UK.

- **Social support networks** - support from families, friends and communities is linked to better health. This kind of support helps people handle difficult situations.
- **Social exclusion** - social exclusion including; poverty, unfair discrimination, unequal access to services and jobs, and a lack of social relations, has a major impact on health and premature death. The harm to health comes from material and relative deprivation, including the social and psychological problems of living in poverty.
- **Stress** - social and psychological circumstances can cause long-term stress. For example; continuing anxiety, insecurity, low self-esteem, social, ethnic or sexual discrimination, social isolation and lack of control over work and home life have powerful effects on health. Such psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. Long periods of anxiety and insecurity and the lack of supportive relationships are damaging in whatever area of life they arise.
- **Problematic substance use** - this is both a response to social breakdown and an important factor in worsening the resulting inequalities in health.
- **Unemployment** - the health effects of unemployment are linked to both its financial consequences including debt and loss of focus and self-esteem.
- **Working conditions** - employees are healthier if they have control over their working conditions. Stress at work plays an important role in contributing to the large differences in health, sickness absence and premature death that are related to social status.
- **Education** - low literacy skills are linked with poor health and people with low literacy skills can suffer from stress and reduced self-confidence. This makes it hard for them to seek employment or social support.
- **Housing** - housing involves both a site (dwelling) and a situation (neighbourhood). The location, physical quality, levels of overcrowding and cost of housing all impact directly on health.
- **Health services** - it benefits people's health when they have access to services that prevent disease, as well as maintain and promote health. Often however, the people that need health services most are least able to access them. It is important to ensure that treatment and preventative services are targeted appropriately.
- **Transport** - cycling, walking and the use of public transport promote health in four ways. They provide exercise, reduce fatal accidents, increase social contact and reduce air pollution.
- **Physical environments** - clean air and water, healthy workplaces and safe houses, communities and roads, all contribute to good health.
- **Culture** - people's customs, traditions and the beliefs of their family and community all affect their health. This is because these factors influence what they think, feel, do and believe.

## 2.2 A picture of health in the city

As there is no single measure of health in existence, a number of alternative (proxy) measures are often used. A number of these measures are outlined below in an attempt to describe the picture of health in the city. Should a more detailed health profile of the city be required, then copies of the November 2002 Plymouth Health Profile Statement can be made available from the Public Health Development Unit.

### Self-perceived health status

In 2000 MORI carried out a survey of health and well-being in the city. Questionnaires were sent to 4,000 16-74 year-olds living in Plymouth asking for information on; general health, diet, exercise, alcohol consumption, smoking, stress and support from others, health and social services, and the environment. The two key objectives of this survey were:

i) to establish baselines for the city as a whole, against which improvements in health and well-being can be measured,

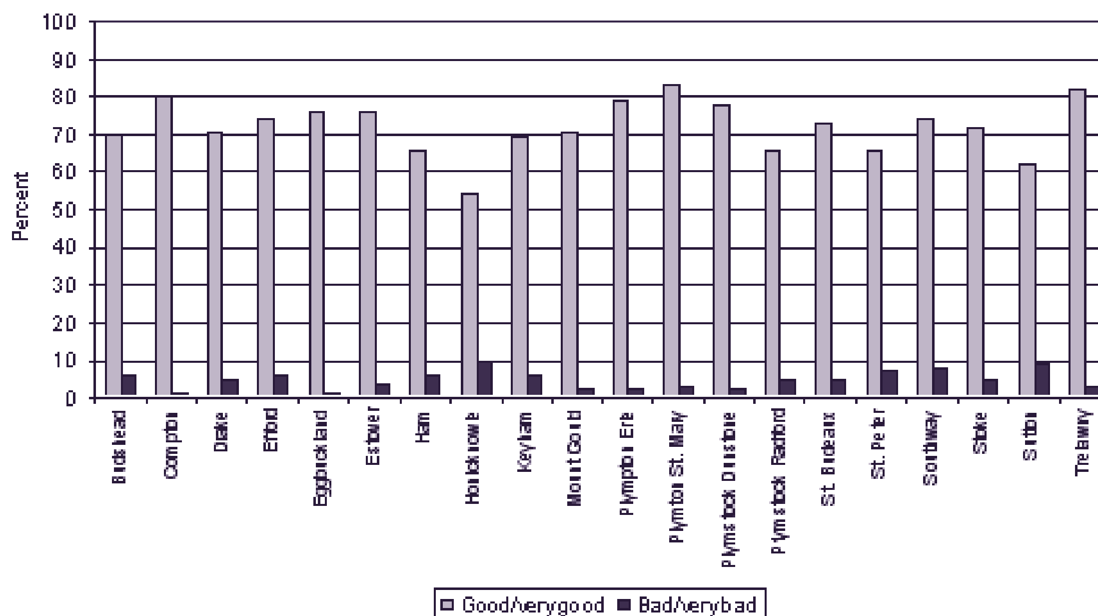
ii) to identify variations between areas of the city to allow the targeting of service provision

The results of the MORI survey were based on a total of 2,038 self-completed questionnaires (an overall response rate of 51%).

Respondents were asked "how is your health in general?" 72% of residents said "good or very good", only 5% said "bad or very bad". On this basis it would appear that overall Plymouth's residents are relatively healthy. However, statistics presented for

the city as a whole often hide the variation that exists at a lower geographic level. Figure 2 (below) shows this variation for all of the Plymouth wards in 2000.

**Figure 2 - Health in general in the Plymouth wards**




83% of Plympton St Mary respondents rated their health as "good or very good", compared with only 55% in Honicknowle. Indeed 10% of Honicknowle residents rated their health as "bad or very bad", compared to only 1% in both Compton and Eggbuckland.

### Life expectancy

How we rate our own health is, by definition a subjective measure of health. It is however possible to look at other, less subjective, health measures to analyse patterns of health in the city. One such measure is life expectancy at birth. Table 1, below, shows life expectancy at birth for England & Wales and Plymouth.

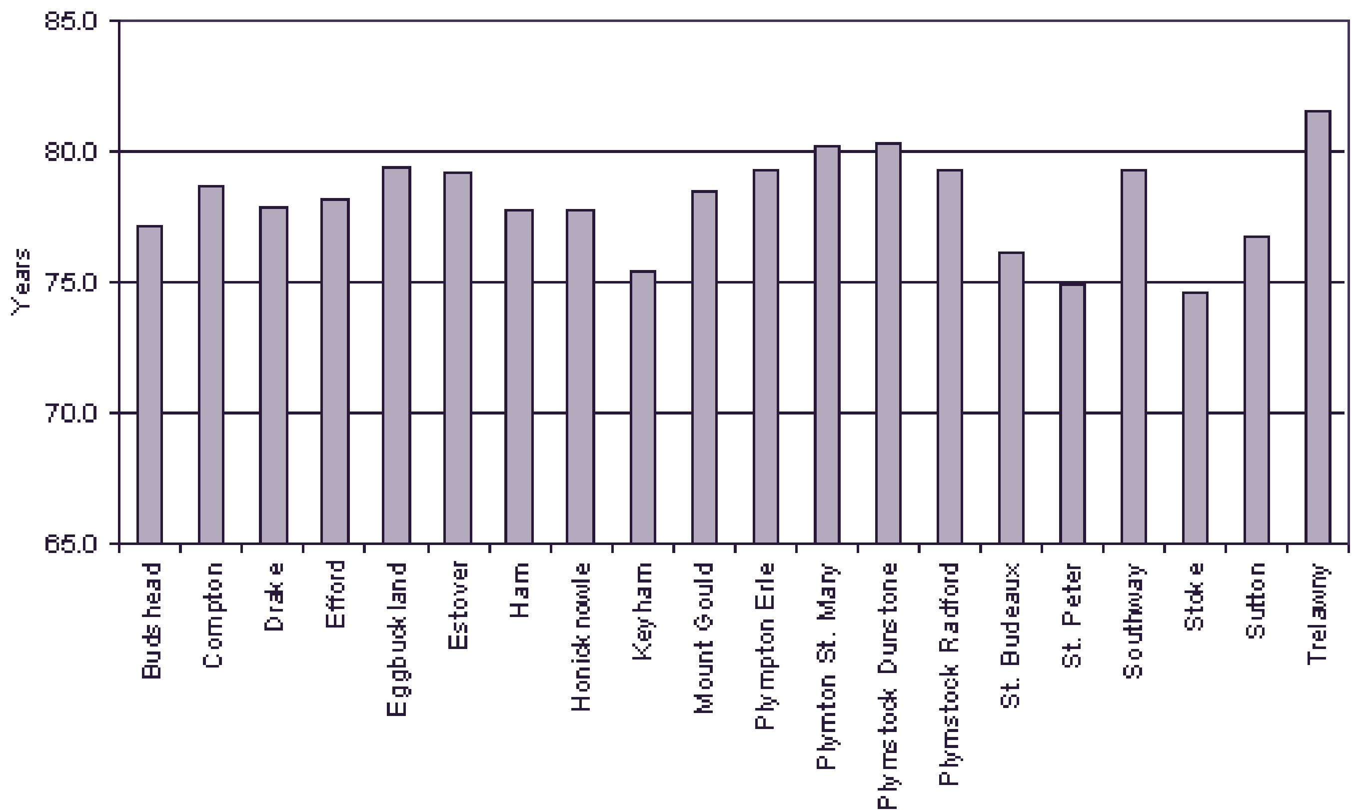
From this it can be seen that life expectancy overall in Plymouth is not significantly different from England & Wales. However these city-wide figures once again hide the considerable variation that exists across Plymouth. This is illustrated by figure 3 below which shows that life expectancy at birth ranges from 74.6 years in Stoke to 81.6 years in Trelawny.

**Table 1 - Life expectancy at birth (1999-2001)**

| | Males | Females |
|---|---|---|
| England & Wales | 75.7 | 80.4 |
| Plymouth | 75.1 | 80.4 |

*Source - Office of National Statistics*

**Figure 3 - Life expectancy at birth in the Plymouth wards 1999-2001**




**Deaths: standardised mortality ratios and death rates**

A standardised mortality ratio (SMR) is the ratio of observed to expected deaths in an area multiplied by 100. The number of expected deaths is generated by applying the death rates in a reference population (usually England & Wales) to the local area (in this case Plymouth). The SMR for the reference population is 100. A value greater than 100 indicates more observed deaths than expected (a 'bad' situation), whereas an SMR less than 100 indicates fewer observed deaths than expected (a 'good' situation). Table 2 shows SMRs for all causes of death for all ages in the period 1998-2000

**Table 2 - SMRs (all causes, all ages) 1998-2000**

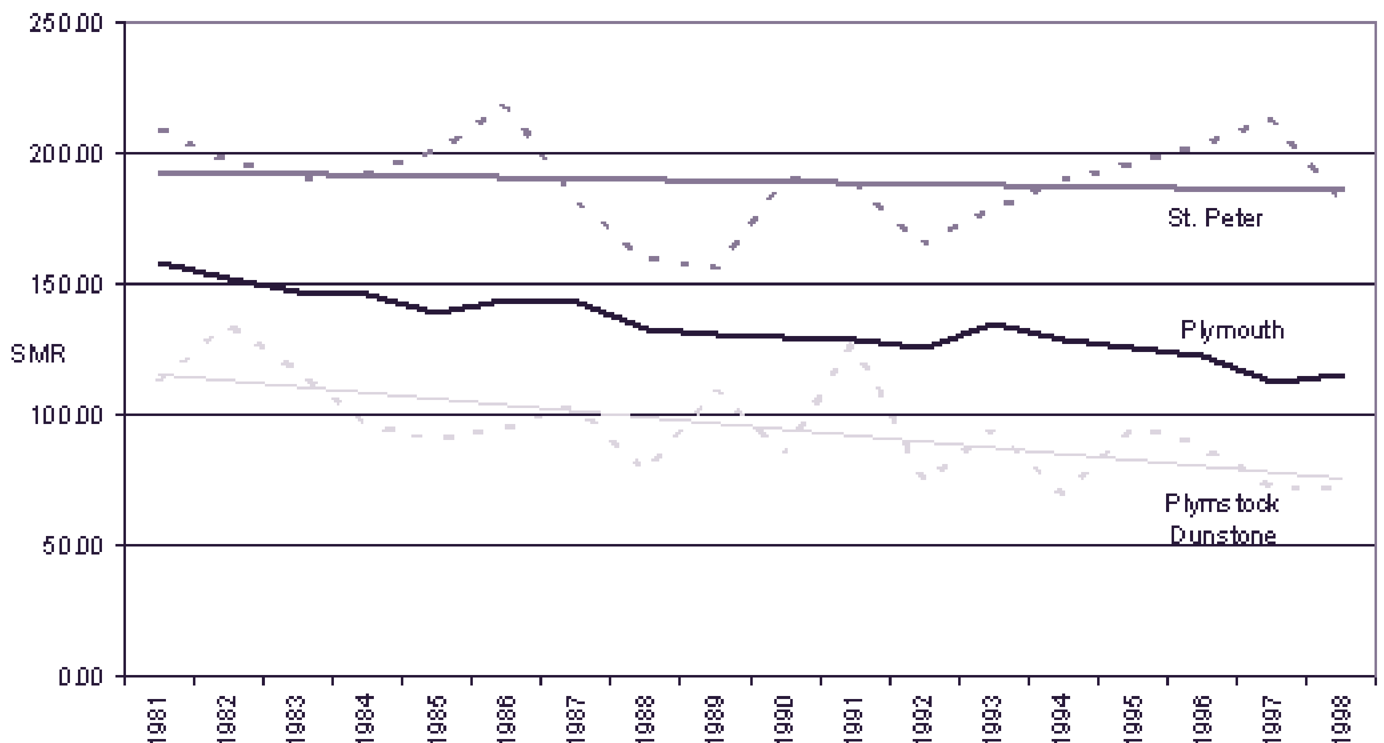
| | Males | Females | Persons |
|---|---|---|---|
| England & Wales | 100 | 100 | 100 |
| Plymouth | 100 | 96 | 98 |

*Source - Compendium of clinical and health indicators 2001*

As the SMR (all age, all cause) for Plymouth is below 100, this indicates that the Plymouth population is relatively healthy when compared to England and Wales.

It is possible to calculate SMRs for specific causes and/or for specific age groups. Figure 4 below shows the trends in SMRs for persons aged less than 75 years for the period 1981 to 1998 for; Plymouth as a whole, St Peter and Plymstock Dunstone. The latter two areas represent the most deprived and least deprived areas of the city (respectively) according to the Index of Multiple Deprivation 2000.

**Figure 4 - Trends in SMRs (under 75s) 1981 - 1998**




As is clear from the graph, the SMRs have fallen in each area across the period in question. However it is also apparent that there has been a greater decrease in SMRs in the least deprived areas. What this means in reality is that over the period 1981-1998, health inequalities (as measured by SMRs for under 75s) have actually increased.

In the same way that the generation of data for the city as a whole can hide the inequalities that exist within it, electoral ward based data can also hide the patterns that exist at a smaller 'neighbourhood' level. This is because electoral wards are geographical, political, and administrative areas that very often do not correspond with residents' perceptions of the area in which they live.

In recent years, many Government initiatives aimed at improving social and economic conditions (known as 'Area-Based Initiatives') have tended to be targeted at neighbourhoods rather than at complete electoral wards. In recognition of this a group drawn from the Statutory, Voluntary and Community sectors within Plymouth met over a number of months to devise a neighbourhood map of the city. Once agreed within the group, the proposed map was subject to extensive consultation throughout the city before being officially adopted in January 2003. 43 neighbourhoods were identified in this exercise with an average population of approximately 5,600 people.

Adoption of this neighbourhood map by partners within the city has made it necessary to start producing facts and figures at this level. One of the first indicators generated by the Public Health Development Unit was premature mortality by neighbourhood. This information is shown on the map below. This map highlights the significant variation that exists in rates of premature mortality (under 75s) within the city. Indeed there is a greater than three-fold variation by neighbourhood across the city.

## Figure 5 - Neighbourhood death rates 2000-2002

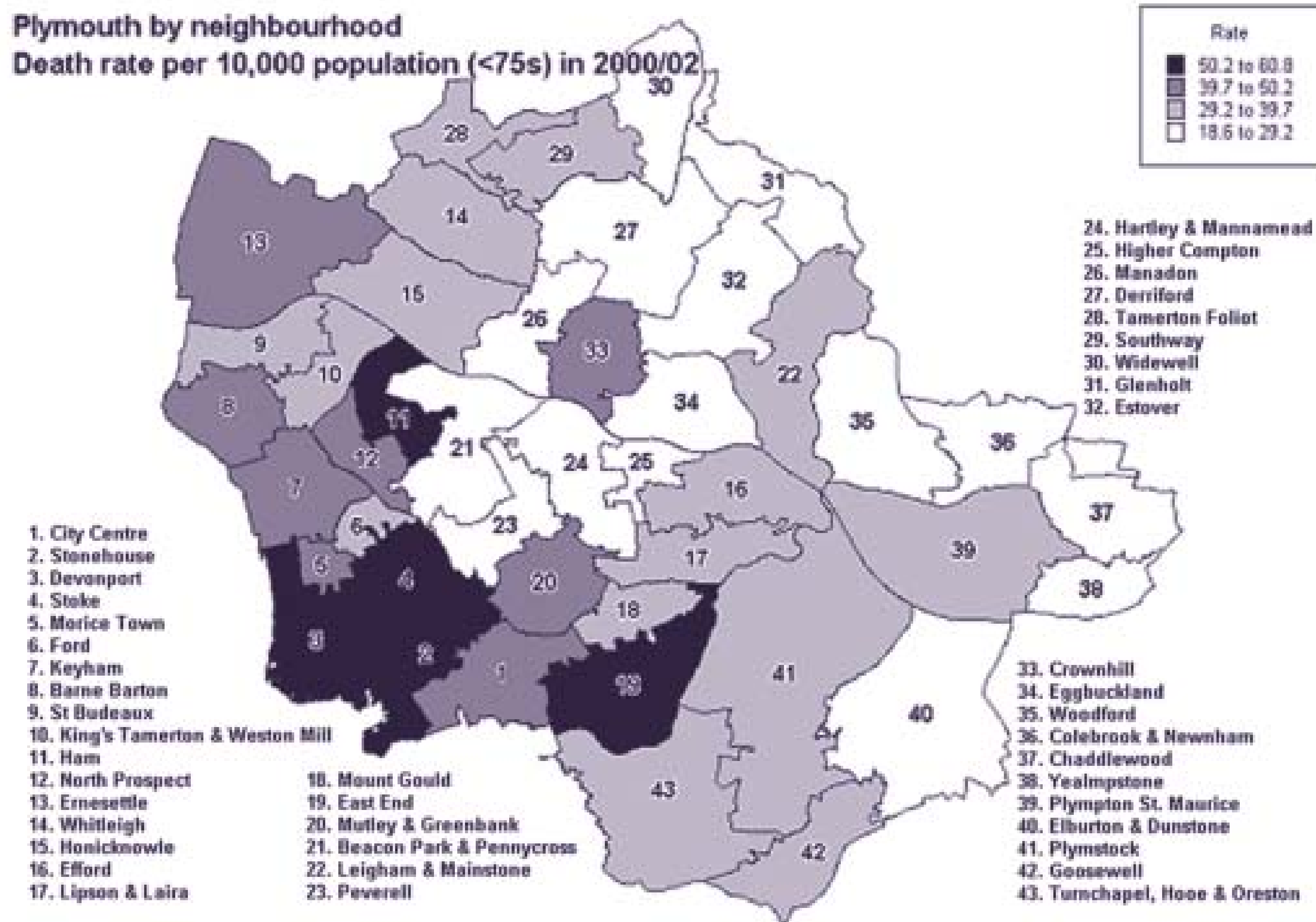
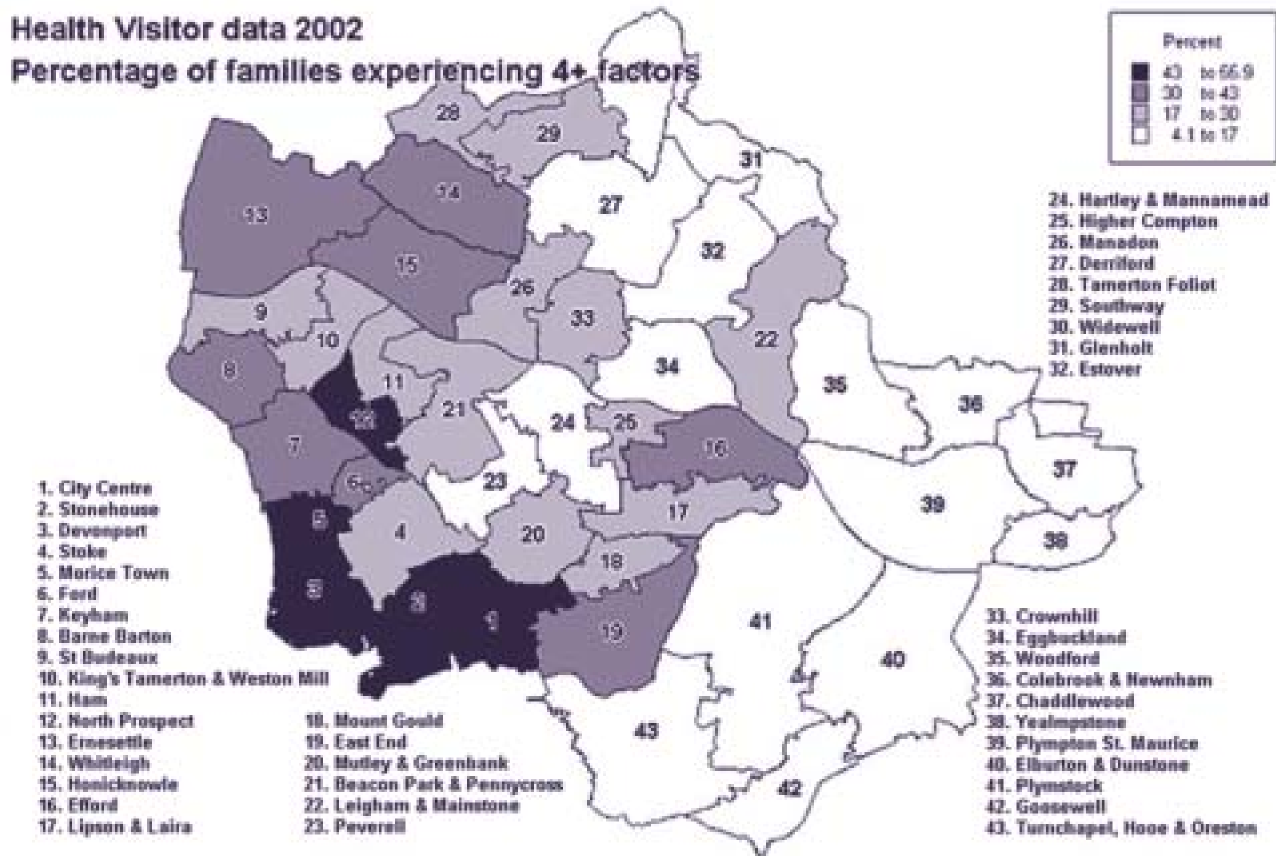


**Figure 6 - Vulnerable families (%)**




As well as making use of routinely available statistics, the PHDU co-ordinates the collection of data from health visitors locally. Each year the health visitors fill out a form for every family on their caseload. These forms indicate the presence or absence of one or more of 27 health needs factors. The completed forms are then analysed to reveal patterns of need throughout the city. One such piece of analysis is to calculate the percentage of 'vulnerable' families, i.e. families experiencing four or more of the 27 factors. In Plymouth as a whole, 25% of families experience 4 or more factors, however the range is from only 4% in Glenholt to 56% in Stonehouse.

## Teenage pregnancy

The reduction of teenage pregnancy is a key Government target. Teenage pregnancy and parenthood is associated with deprivation. Between 1998 and 2001 conceptions amongst women aged 15-17 years have reduced by 18.7%.

## What does this all mean?

From the information presented above, it is clear that no matter which indicator is chosen (self-perceived health status, life expectancy, SMRs and death rates, or the health of families), the pattern is the same. In other words, although the city as a whole appears to be relatively healthy, there are significant inequalities within it. More importantly perhaps, these inequalities persist regardless of the health measure chosen.

# 3 THEMES

**This section describes the five themes on which Our City's Health is based:**

1. **Tackling the determinants of health**
2. **Strengthening the health of disadvantaged communities**
3. **Promoting the health of children and young people**
4. **Promoting the health of older people**
5. **Preventing ill-health from major illnesses**

## 3.1 Introduction

As explained in section two, income and social isolation have a powerful influence on health with some communities being especially vulnerable. Therefore the first themes in **Our City's Health** are 'tackling the determinants of ill-health' and 'strengthening the health of disadvantaged communities'. Within these, there are two particularly vulnerable groups - young people and older people. These are the focus of the next two themes. Finally, theme five tackles the major causes of mortality (death) and morbidity (ill-health) within the city; circulatory disease, cancer, accidents, and mental health.

Many important health concerns feature across a number of these themes. One example is mental health - not only an important determinant but also a factor which leads to disadvantage and a major illness group. Thus mental health comes under different themes, though most specifically under theme five.

Community safety and substance misuse are also key areas with important influences on health and well-being, but are currently dealt with through strategies overseen by the Community Safety Partnership.

Each theme contains a chart showing areas of influence, with the rationale for their inclusion, based on available evidence. The kind of actions which can be taken towards improvements are also included. The actions are, however, just examples, not a comprehensive list and not all will feature in the **Our City's Health** work programme.

## 3.2 Theme 1: tackling the determinants of ill-health

Since the beginning of the industrial revolution, poor health in a population has frequently been associated with the social, physical and economic conditions in which people live. For instance, low levels of income are linked to poor diets and inadequate heating. Poverty and debt frequently lead to anxiety, depression and the breakdown of family relationships. Poor quality housing can have effects ranging from accidents to respiratory illnesses (*Independent Inquiry into Inequalities in Health Report,* Acheson 1998).

Regeneration policies have determinants of health at their heart. For example, *Plymouth Neighbourhood Renewal Strategy*, Plymouth 2020 Partnership 2002, (NRS), expects progress to be made on improving many determinants such as income and poverty, educational attainment, employment and the local environment (e.g. housing and transport).

However, although health is affected by the social and physical conditions in which we live, this effect is different for different communities. The difference can lead to big variations or inequalities in health across a city like Plymouth and provides an explanation for why death rates from circulatory diseases vary six-fold between wards in the West and East of the city.

So it is very important in our collective attempts to improve and promote the health of Plymouth's residents, that we address some of the longer-term known causes of ill-health and poor well-being. Although this theme can cover a very wide range of determinants of concern to communities, we are highlighting six, five of which are singled out in the Department of Health document, *Tackling Health Inequalities; A Programme for Action*, Department of Health 2003:-

| Area | Rationale | Examples of Actions |
|---|---|---|
| Poverty<br>(in particular amongst families with children) | Major objective of City strategy.[1]<br>Priority theme in national Tackling Health Inequalities strategy.[2]<br>Child poverty reduction is objective one of the Neighbourhood Renewal Strategy.[3] | • Ensure decent family incomes through work or support.<br>• Provide family support for parents.<br>• Improve quality of all local services particularly in low income areas.<br>• Welfare benefits take-up work. |
| Housing | Features as a Plymouth Public Service Agreement.[4]<br>Identified in Affordable Warmth Strategy. [5]<br>Priority theme in national Tackling Health Inequalities strategy.[2]<br>Housing standard is an objective of the Neighbourhood Renewal Strategy.[3] | • Improve the quality of housing, public and green spaces ("Decent Home Standard" level).<br>• Tackle fuel poverty through improved insulation |
| Transport | Goverment expects local transport plans to target health improvement.[6]<br>Priority theme in national Tackling Health Inequalities strategy.[2] | • Improve public transport to reduce isolation and provide access to jobs and key services (Social Exclusion Unit action plan).<br>• Improve transport access to services through local transport plans.<br>• Promote cycling and walking as an alternative to private car use and promote sustainable travel to school. |
| Education, training and skills | Priority theme in national Tackling Health Inequalities strategy.[2]<br>Features as a Plymouth Public Service Agreement.[4]<br>Adult numeracy and literacy is an objective of the Neighbourhood Renewal Strategy.[3] | • Improve adult literacy and numeracy.<br>• Enhance life skills such as cooking healthily on low incomes. |
| Jobs and income | Priority theme in national Tackling Health Inequalities strategy.[2] | • Enforcement of the national minimum wage.<br>• Reduce levels of long term unemployment and inactivity.<br>• Increase employment rate of people with disabilities. |
| Environmental conditions | Clear links identified between health and range of environmental conditions such as air and water quality. | • Minimum standards of drinking water quality<br>• vehicle exhaust emissions standards |

1. *Plymouth's City Strategy: Visions and Goals. Plymouth 2020 Partnership 2003.*
2. *Tackling Health Inequalities; A Programme for Action. Department of Health 2003.*
3. *Plymouth Neighbourhood Renewal Strategy. Plymouth 2020 Partnership 2002.*
4. *Local Public Service Agreements: Plymouth City Council Potential Targets and Freedoms 2003.*
5. *Plymouth Affordable Warmth Strategy. Plymouth City Council 2002.*
6. *Local Transport Plans Guidance and Good Practice. Department for Transport 2003.*

Most public sector organisations now have a responsibility to improve well-being and quality of life and to tackle many of the determinants of health through their own targets, public service agreements and plans. Considerable work is already under way and it will be important for health (and health inequalities) to be a key driver locally in shaping decisions and priority setting. The development of Local Neighbourhood Action Plans under the NRS is one important vehicle for addressing the determinants of health. In addition, many public sector plans will need to make explicit reference to tackling inequalities in health as an indicator of performance.

## 3.3 Theme 2: strengthening the health of disadvantaged communities

The communities in which people live have an important effect on their health and this theme broadly reflects the *social and community networks* determinant seen in figure 1. Communities can be:

- geographically based - people living or working in the same estate or neighbourhood,
- communities of interest - based on shared beliefs and culture such as faith communities or shared experiences of discrimination such as disabled people or Black & Minority Ethnic communities. (Definitions based on *A Community Development Framework for Plymouth consultation draft, 2003*.)

The most disadvantaged **communities of geography** in Plymouth are identified at ward level by the *Index of Multiple Deprivation 2000* (IMD2000) and *Plymouth Social Exclusion Mapping & Evaluation Report* (University of the West of England 2002). Both draw on a range of health and well-being factors and their determinants to create a deprivation 'score'.

Wards are subject to change for electoral reasons, and boundaries have altered since publication of the IMD2000 and University of the West of England Report. Plymouth has however, agreed 43 natural neighbourhoods which do not rely on ward boundaries. Sixteen of these are recognised within the *Plymouth Neighbourhood Renewal Strategy* (Plymouth 2020 Partnership 2002) as priorities (chosen because they fall within the most needy eight former wards based on the IMD2000). There is a clear correlation between these priority neighbourhoods and the areas with the poorest health status (see section 2).

There are many **communities of interest** in Plymouth. Those identified by the Social Inclusion Partnership (SIP) in *Promoting Social Inclusion: a strategy for Plymouth* (2003) as priorities for action include:

- Black and minority ethnic people
- Asylum-seekers and refugees
- Disabled people
- Lesbians, gay men, bi-sexual and transexual community
- Children and young people
- Homeless people.

Health inequalities amongst different communities of interest have been highlighted nationally. For example, the *Independent Inquiry into Inequalities in Health Report* (Acheson 1998) concludes that "*inequalities by socio-economic group, ethnic group and gender can be demonstrated across a wide range of measures of health and the determinants of health*". In Plymouth further work is needed in order to fully identify the **health** priorities amongst these and other communities of interest.

Wards with the highest levels of deprivation and the 16 neighbourhoods prioritised within the *Plymouth Neighbourhood Renewal Strategy* (Plymouth 2020 Partnership 2002) together with communities of interest such as those listed above are central to strengthening the health of disadvantaged communities theme. However, in order to effectively manage activity, initial interventions will focus on the communities in the areas shown below.

| Area | Rationale | Examples of Actions |
|---|---|---|
| Neighbourhoods developing Local Neighbourhood Action Plans | Prioritised, under criteria developed as part of Neighbourhood Renewal process.[1] | • Employment assistance.<br>• Pre-school support.<br>• Basic skills initiatives.<br>• Sports promotion.<br>• Tackling domestic violence.<br>• Homesafe initiative.<br>• Multi-cultural centre.<br>• Outreach services for disabled people. |
| Asylum-seekers and recent refugees | Prioritised by Social Inclusion Partnership[2], health highlighted as particular issue[3], physical health of new arrivals declines over first 2 or 3 years.[4] | • Co-ordinator of services for new arrivals.<br>• Interpretation and translation service.<br>• Leisure opportunities for asylum-seekers.<br>• Outreach mental health services.<br>• Targeted smoking cessation work. |
| Homeless people | Prioritised by Social Inclusion Partnership[2] and health highlighted as particular issue.[5] | • Improve access to primary care for homeless.<br>• Rent arrears intervention worker.<br>• Supported lodgings for older people. |

1. *Plymouth Neighbourhood Renewal Strategy. Plymouth 2020 Partnership 2002.*
2. *Promoting Social Inclusion: a strategy for Plymouth. Social Inclusion Partnership 2003.*
3. *Service Provision for Refugees and Asylum Seekers in Plymouth. Plymouth University 2003.*
4. *Parliamentary Health Magazine 2003.*
5. *Plymouth Homelessness Review. Insight Social Research 2001.*

## 3.4 Theme 3: promoting the health of children and young people

This theme covers pregnancy, early life, younger children and young people. It is during **pregnancy and in early childhood** that many of the factors that affect health in later life are set. For example, it has been shown that birth weight is related to circulatory disease, diabetes, blood pressure and stroke in later life. Breast feeding, diet, exercise and parenting all have an affect on a person's physical and mental well-being as children and adults. Parent education training for example, not only leads to appropriate use of health services but also to a reduction in child behavioural problems. This results in reductions in criminality and better educational results in later life. As described in section 2, a major underlying cause of ill-health in this group is poverty.

Many of the habits that lead to poor health in later life are set in **childhood and the teenage** years and the effects of these have a big influence on health in later life. For example it is during this time that smoking begins, later perhaps to become addictive. Also dietary habits and exercise patterns are set at this time, the results of which are leading to an obesity epidemic in young children. Exercise and eating patterns when young also affect the chances of developing osteoporosis and hence fractures in later life.

Drugs and alcohol misuse can also become a problem at this age leading to both short and long-term health problems. Finally, the importance of education and self-esteem at this time and the effect of this on future employment, life skills and mental health should not be under-estimated.

Such factors, together with personal health education and provision of appropriate health care services, prevent teenage pregnancy and the growth of sexually transmitted diseases. Again, overlaps occur across the themes covering emotional well-being and self-esteem, teenage pregnancy and sexual health. Substance misuse is covered elsewhere.

Examples of possible areas of work and their rationale are shown below :

| **Area** | **Rationale** | **Examples of Actions** |
|---|---|---|
| Prevention of infant death | All these actions are key to both prevent death and help parents provide appropriate care to infants and hence prevent death e.g. through infections, respiratory disease and cot deaths.[1] | • Increase breast feeding.<br>• Smoking cessation.<br>• Support to mothers.<br>• Food supplementation.<br>• Parent education.<br>• Identification of post-natal depression.<br>• Better support to teenage parents. |
| Prevention of illness in under fives | Integration of services tailored to need is an important component to supporting children.[2] | • Better and shared information systems.<br>• Screening.<br>• Improved uptake of immunizations. |
| Improvement of self-esteem | Can improve behaviour and social relationships.[3] | • Life skills management. |
| Prevention of and support to teenage pregnancy | Leads to better health of both baby and parents.[4] | • Appropriate access to contraception.<br>• Life skills management. |
| Health promotion in schools | Education plays an important role in promoting better health and emotional well-being.[5]<br>Schools identified as supporting the health inequalities agenda.[1] | • Healthy schools programme.<br>• Food in schools programme.<br>• School fruit scheme. |

1. *Tackling Health Inequalities: A Programme for Action. Department of Health 2003.*
2. *National Services Framework for Children. Department of Health 2001.*
3. *British Medical Journal Editorial (327: 574-5). Michael Marmot 2003.*
4. *Teenage Pregnancy. Social Exclusion Unit 1999.*
5. *How the National Healthy Schools Standard Contributes to School Improvements. Department for Education and Skills 2003.*

## 3.5 Theme 4: promoting the health of older people

England is an ageing society. Since the early 1930s the number of people aged over 65 has more than doubled and today a fifth of the population is over 60. Between 1995 and 2025 the number of people over the age of 80 is set to increase significantly and the number of people over 90 will double (*Older People's National Service Framework,* Department of Health 2001). Plymouth's current population of older people closely reflects national averages.

Older people want access to health services that maintain and promote their physical and mental health, treat illness and do not discriminate on the grounds of age. Access to services which have a direct impact on their general well-being, or ability to access healthcare is just as important as the health care provision, e.g. transport, suitable accommodation, income maximisation.

Public Health programmes need to include older people and be pertinent to their particular health needs and issues. Services need to promote independence and physical and mental well-being.

Older people may be at increased risk of developing poor health or shorter life expectancy in relation to health determinants. Policies therefore need to specifically include improving conditions for older people experiencing inequalities (*Health Policy Position Statement,* Age Concern 2002).

Despite being a huge untapped resource within our society, older people often feel excluded from Government initiatives. Many have specific fears such as loss of independence, isolation and mobility problems all of which can lead to social exclusion and deterioration of health.

Age discrimination is reported to still manifest itself in health policy, public health and health care (*Health Policy Position Statement,* Age Concern 2002 & *Stakeholder Review of Implementation of the National Service Framework*, Commission for Health Improvement 2003).

The *National Service Framework for Older People* (Department of Health 2001) seeks to provide a national focus on the needs of older people and respond to "…. reports of poor, unresponsive, insensitive, and in the worst cases, discriminatory, services". It focuses on rooting out age discrimination, providing person-centred care, promoting older people's health and independence, and fitting services around older people's needs.

Examples of possible areas of work and their rationale are shown below: -

| Area | Rationale | Examples of Actions |
|---|---|---|
| Prevention of falls | A reduction in the number of falls would lead to a reduction in emergency hospital admissions. It is one of the main precursors to admission to long-term care. One of Older People's National Service Framework standards.[1] | • Home adaptation.<br>• Exercise and balance.<br>• Hip protectors.<br>• Medication review.<br>• Housing planning criteria, improves accommodation standards. |
| Maintaining independence | Key issue to promote health and prevent illness.[1] | • Improving access to social support.<br>• Welfare counsellors in primary care.<br>• Improved access to transport.<br>• Repairs on prescription.<br>• Improved access to community facilities |
| Preventing isolation | Contact is crucial to quality of life. Isolation can be a real threat to a person's life. Every year in the UK up to 12,000 older people die friendless and alone.[2] | • Befriending.<br>• Employment policies and practices which discourage ageism.<br>• Schemes, which encourage older, people to contribute to society and community. |
| Preventing fuel poverty | See Theme 1 (housing area). | See Theme 1 (housing area) |
| Promoting oral health | Inconsistent standards of oral health care across nursing and residential homes.[3] | • Training of residential and nursing home staff. |

1. *Older People's National Service Framework*. Department of Health 2001.
2. *February Appeal.* Age Concern undated.
3. *Older Persons' Oral Health Project Plan*. Plymouth Health Action Zone, Day 2003.

## 3.6 Theme 5: preventing ill-health from major illnesses

Four out of five of us will be affected by the 'big four' illnesses; circulatory disease (heart disease and stroke), cancer, accidents and poor mental health. It is therefore important to address these within any health planning document. To ensure these illnesses are effectively prevented and treated there are a number of areas to this theme which are laid out with examples in the table below:

| **Area** | **Rationale** | **Examples of Actions** |
|---|---|---|
| Reducing risk through effective prevention. | Underlying causes of the major illnesses (apart from age, sex and family history) are diet, and levels of exercise, stress and smoking. All of these are potentially modifiable. | • Encouraging adoption of a healthy lifestyle through exercise, diet, giving up smoking, and dealing with stress.<br>• Improving opportunity of access to healthy food, exercise and smoking cessation services.<br>• Tobacco control measures e.g. no smoking in restaurants.<br>• Multi-agency obesity strategy.<br>• Health(including mental health) promotion in the workplace and schools. |
| Early detection intervention and treatment. | Some groups have poor access to screening which needs addressing.[1] | • Encouraging screening for illness.<br>• Oral health promotion in work places |
| Ensuring equality of access to effective treatment. | Ensuring services are provided according to need is essential in order to tackle health inequalities.[2] | • Investigating early indications that some of the most deprived parts of the city are not benefiting from available health services. |

1. *Interventions Targeted at Women to Encourage the Uptake of Cervical Screening.* Forbes, Jepson, Martin-Hirsch 2001.
2. *The Inverse Case Law.* Tudor Hart 1971.

# 4 TARGETS

**This section describes the different targets associated with tackling health inequalities.**

## 4.1 Overarching targets

Three overarching targets reflect all the work of **Our City's Health** *(Tackling Health Inequalities: A Programme for Action*, Department of Health 2003):

- **Infant mortality (deaths in the first year of life)** - starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole. Baseline: number of infant deaths in 1998.
- **Expectation of life** - starting with Local Authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. Baseline: 1997-1999.
- **Child poverty** - reducing the number of children living in poverty by 2004, as a contribution towards the broader target of halving child poverty by 2010 and eradicating it by 2020. Baseline: 1998 - 1999.

## 4.2 Specific targets

In addition to these overarching targets a number of more specific targets exist in other plans and programmes which help towards improving health across the city. The Department of Health report, *Tackling Health Inequalities: A Programme for Action, 2003* describes a number of these:

- **Housing** - proportion of households living in non-decent housing.
- **Homelessness** - number of homeless families with children living in temporary accommodation.
- **Education** - proportion of those aged 16 who get qualifications equivalent to five GCSEs at grades A-C.
- **Physical education and sports** - percentage of schoolchildren who spend a minimum of two hours each week on high quality P.E. and school sport within and beyond the curriculum.
- **Accidents** - road accident casualties in disadvantaged communities.
- **Teenage pregnancy** - to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter. Baseline: 1998
- **Influenza vaccinations** - percentage uptake of flu vaccinations by older people (aged 65+).
- **Mortality from the major killer diseases** - age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases) ages under 75 (for the 20% of areas with the highest rates compared to the national average).
- **Smoking prevalence** - prevalence of smoking among people in manual groups and amongst pregnant women
- **Diet** - proportion of people consuming five or more portions of fruit and vegetables per day ('Five-A-Day') in the lowest quintile of household income distribution.
- **Access to primary care** - the number of primary care professionals per 100,000 population.

## 4.3 Local Public Service Agreements (LPSAs)

Because tackling health inequalities is a priority for local government, local authorities are encouraged to develop PSA targets to tackle the problem (Tackling Health Inequalities: A Programme for Action, Department of Health 2003).

Plymouth City Council's LPSA has responded by agreeing seven targets (out of a total of 12) covering health and well-being (Plymouth City Council, Local Public Service Agreements 2004-2007):

- Improve the quality of life and independence of older people.
- Increase the participation of problem drug users in treatment programmes.
- Improve the quality of private sector housing.
- Improve the life chances of looked-after children.
- Reduce the number of teenage conceptions.
- Increase bus patronage.
- Increase in physical activity levels of primary school children.

# 5 ROLES AND RESPONSIBILITIES

This section describes the responsibilities for different aspects of **Our City's Health** together with accountability mechanisms, structures and support available.

## 5.1 Overall direction

The Health and Well-being Partnership is responsible for setting the direction for **Our City's Health**, prioritising work and monitoring progress. Organisations' own strategies are, however, the key mechanism for achieving **Our City's Health** targets.

## 5.2 Accountability

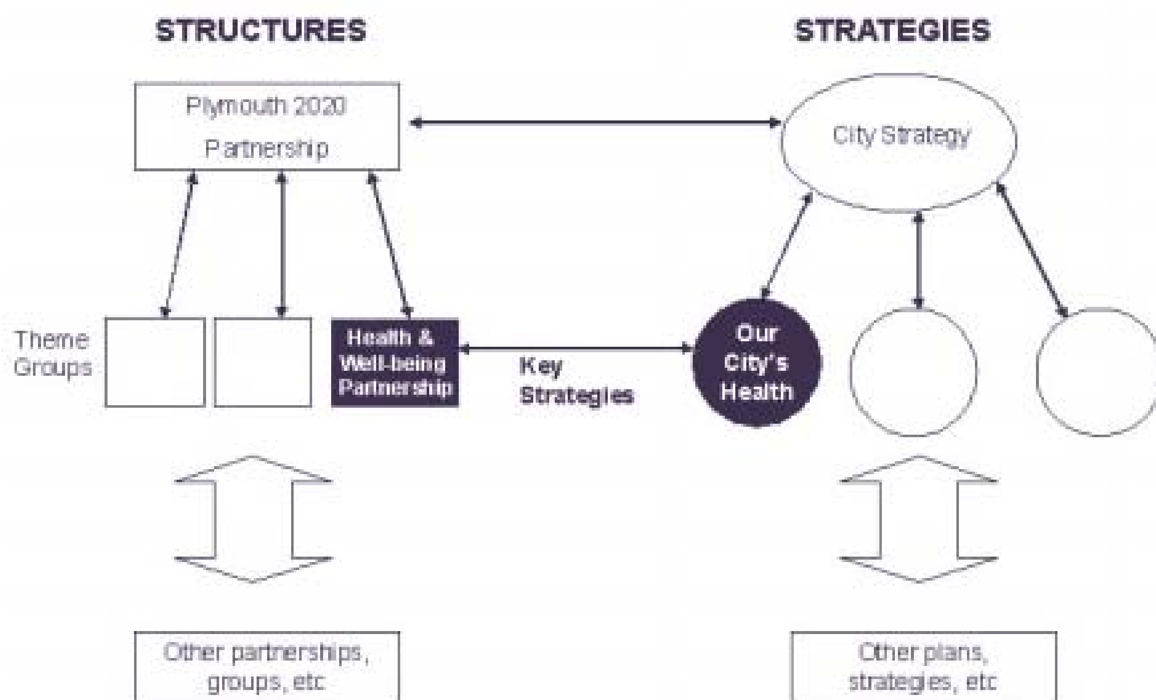
Monitoring will focus on the overarching targets described in section four, together with specific targets in the work programme. Partners are accountable for delivery against these at two levels:

i) through internal accountability mechanisms operating in the usual way,

ii) to the Health and Well-being Partnership

The Health and Well-being Partnership is in turn, accountable to Plymouth 2020 Partnership Board through annual progress reports, linked to delivery of the safe and healthy city goal of the City Strategy. **Our City's Health**'s relationship with current city-wide structures and strategies is shown in figure 7.

**Figure 7 - Our City's Health place in city-wide structures and strategies**



## 5.3 Support

Plymouth's Public Health Development Unit (led by the Director of Public Health) is responsible for keeping **Our City's Health** work on track, overseeing performance management, and providing partners with advice and support to help meet their responsibilities. This support is offered by the Unit in a number of ways:

- **Secretariat and advisers** to the Health and Well-being Partnership.
- Development of an **annual work programme** containing interventions.
- **Direct delivery** of a number of interventions.
- **A named person** for each **Our City's Health** theme to advise and work with partners.
- **Community Public Health Practitioners** to support community organisations with public health work, primarily within neighbourhoods identified in Plymouth Neighbourhood Renewal Strategy (Plymouth 2020 Partnership 2002).
- **Workforce development** to help strengthen the public health role of volunteers, activists and staff.
- **Assistance to partners** in developing appropriate policies and practices.
- **Communication** through regular updates on **Our City's Health** work.
- **Provision of information** including advice on health impact and equity assessments and research (see below).

## 5.4 Further information

Further information is available to support **Our City's Health**. This is a largely web-based resource to support partners to identify, plan and deliver public health interventions work using evidence-based good practice:

**http://www.phwb.org.uk/och**

## 5.5 Health Impact Assessment

A Health Impact Assessment (H.I.A.) is an approach that uses a range of activities to help work out both the healthy and unhealthy impacts of new or existing plans and services. Getting the views of local people on the causes of good and bad health is an essential part of this. H.I.A.s encourage policy-makers and communities to become more aware of the causes of good health and help the decision-makers improve their plans and services.

An Integrated Impact Assessment (I.I.A.) takes the process a step further, using an inter-disciplinary approach to assess affects on the whole environment including physical, economic, and social aspects. A city-wide I.I.A. framework could offer Plymouth 2020 Partnership and other organisations a single co-ordinated approach to policy assessment, to help improve well-being generally.

## 5.6 Health Equity Assessment Cycle

A Health Equity Assessment Cycle offers an evidence-based assessment of health needs across communities. The aim is to ensure data on health inequalities and needs is used to inform policy and leads to a cycle for improvement.

## 5.7 Research

Research and development in public health offers evidence on which to base improvements. There are a number of opportunities for different people involved in research to work in partnership, share learning and build capacity for mutual benefit.

## 5.8 Joint working

Various **Our City's Health** interventions demand joint working between different agencies, groups and disciplines. To be effective, this requires people to understand each others philosophy, values, priorities and functions. The list of principles below (based on *Plymouth Health Action Zone Implementation Plan,* 1998) helps develop this understanding.

- **Equity** to reduce health inequalities and promote equality of access to services between groups and neighbourhoods across the city. Resources are targeted on need rather than historical allocation, requiring a broader understanding of limitations so that priorities can be openly discussed. There is accountability and an evidence-based approach.
- **Inclusivity** where action 'involves' rather than 'imposes'. Communities are engaged through participation and empowerment, with community development approaches being recognised for their effectiveness in helping to reduce inequalities. Community leadership is provided. Front line staff are given influence in shaping the future of services they deliver. The need for popular understanding and support, and person-centered services that meet people's needs appropriately, is acknowledged.
- **Sustainability** of all policies and practices to ensure they conform to the sustainability objectives in Plymouth Local Agenda 21 Plan. The investment value of resources is maximised, seeking a balance between consumption now and investment in the future.
- **Partnership working** where value can be added and the advantage of collaboration is clear. No single agency solution is sought where joint action is needed. Each partner, the community and individuals are given a stake in the regeneration of the city and respect each other's positive contribution.

# 7 FURTHER INFORMATION

For support, advice or further information on **Our City's Health**, please contact the Public Health Development Unit:

| | |
|---|---|
| Tel: | **01752-515470** |
| Fax: | **01752-515481** |
| E-mail: | **och@phdu.nhs.uk** |
| Address: | **The Public Dispensary,<br>18 Catherine Street,<br>Plymouth,<br>PL1 2AD.** |

For further information including the work programme, visit:

| | |
|---|---|
| Website: | **http://www.phwb.org.uk/och** |

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تەلەفۆنی 01752 515470


**Plymouth Public Health Development Unit**
Public Dispensary, 18 Catherine Street, Plymouth, PL1 2AD
Tel: **01752 515470** Fax: **01752 515481**
**www.phwb.org.uk/och**
**och@phdu.nhs.uk**