

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

NHS
Stockport Clinical Commissioning Group

Stockport LINk

Stockport JSNA

joint strategic needs assessment

2012 Update of Key Trends

Stockport JSNA 2011

September 2012

Contents

1. Summary

This report updates the key themes from the 2011 JSNA adding insights gained in the last year to the evidence presented in year 1. Stockport's full JSNA is available at https://interactive.stockport.gov.uk/IAS/profile/hubs/JSNA.

1.1. Key Issues & Trends

The **key needs of the Stockport population remain unchanged from last year.** Stockport remains one of the **healthier places in the North West** and is average in national terms for most health indicators.

There continues to be good progress in reducing deaths from circulatory disease; **cancer is for the first time the biggest killer overall,** heart disease is now only the most common cause of death for those aged 80+. Cancer mortality remains high, although target for a 20% reduction over the last 15 years have been met. New data suggests 42.7% of all cancer and **89.2% of lung cancer (the biggest killer) are caused by lifestyles.**

New experimental evidence for **healthy life expectancy** suggests that females, although living longer, experience disability at an earlier age than males. The release of the 2011 Census data this year will enable a thorough examination of local trends and the impact ill health may have at the end of life on independence, isolation and as a trigger for service use.

Lifestyles continue to drive significant and enduring health inequalities within Stockport. **Disadvantage starts early in life** with mothers in the most deprived areas being 40% less likely to initiate breastfeeding and more than twice as likely to smoke at delivery. **Alcohol related harm admissions continue to rise** and alcohol related causes of death are an increasing cause of health inequality.

There is still work to be done in **assessing mental wellbeing**, and a full in depth needs assessment is planned following the release of the 2012 Stockport Adult Lifestyle Survey later this year. Full needs assessments are currently underway for the priority groups of carers and those with autism; both will be available in by the end of this year.

Early release of data from the 2011 Census confirms the population of Stockport as being stable and matching closely to the 2010 estimates. The trends of an ageing population and recent rise in birth rates are corroborated.

A Mental Wellbeing Impact Assessment of the Health and Wellbeing Strategy has highlighted the key vulnerable groups and recommended fuller analysis of the health and wellbeing needs of these; this will be undertaken following the publication of the 2012 Adult Lifestyle Survey.

Further developments have been made in **understanding of voice** and insights have been gathered as part of the development of the health and wellbeing strategy. The findings show that there is appetite from the public for taking action to improve their own health and that statutory bodies should aid this, but that services are needed and these should be consistent, joined up and be the 'right service at right time, from the right person in the right place'.

1.2. JSNA Development

Workstreams to develop the local JSNA are continuing, particularly to develop in-depth assessments for priority themes, develop on-line reports and the JSNA hub, to involve the public in the JSNA and to develop asset based approaches.

The Health and Social Care Act has reemphasised the role of JSNAs and placed a joint and equal duty on CCGs and Local Authorities to work together through the Health and Wellbeing board to develop the local JSNA; all organisations must give due regard to the findings of the JSNA and can be held to account for failing to take action.

2. Introduction

2.1. What is a Joint Strategic Needs Assessment?

Joint Strategic Needs Assessments (JSNAs) aim to ensure that current and future services are planned effectively to meet the health and wellbeing needs of local communities and to reduce health inequalities. JSNAs use public health intelligence along with other local data and information from local residents to identify needs and lead to the generation of commissioning priorities to inform high level strategies of local organisations.

The needs and priorities identified by the JSNA have underpinned the development of the Health and Wellbeing Strategy and also inform the health elements of other corporate strategies. The JSNA findings directly influence the commissioning of health, social care and preventative services, and the intelligence gathered is an important part of the commissioning cycle.

It is a DH requirement that Councils and CCGs work together in partnership to undertake regular JSNAs (at least once every three years) and this requirement has been restated by the coalition government as a responsibility for local councils in the recent Health and Social Care Act 2012. The act places JSNA at the very centre of Council, CCG and joint commissioning arrangements through the Health and Wellbeing Board.

2.2. JSNA in Stockport

In 2007 Stockport Council and NHS Stockport jointly produced the first JSNA for Health and Wellbeing. The 2007 JSNA analysed a large body of data and identified priority issues for the borough. The priorities were then adopted by Stockport's Health and Wellbeing Partnership Board and have since been integrated into the strategic plans of both the council and the NHS.

In 2011 the Stockport JSNA was refreshed to see whether the priorities identified three years earlier had altered. Priorities were amended in the light of the new analysis and agreed by the shadow Health and Wellbeing Board. The JSNA has informed the development of the joint Health and Wellbeing Strategy as well as CCG and Local Authority strategic planning.

It is important to note however that the JSNA is not only a one off piece of analysis conducted every three years and the intention is that, in the years between the full refreshes, more in-depth analysis are undertaken to inform particular priority areas.

This report presents updated information about the key priorities identified in 2011 as well as information about other key issues and progress report about the continuing development of the JSNA locally.

This report should therefore not be seen as the end of a piece of work, but rather the continuation of an on-going process of developing a shared understanding and vision for health and social care in Stockport, and how we can best improve health and wellbeing in the borough.

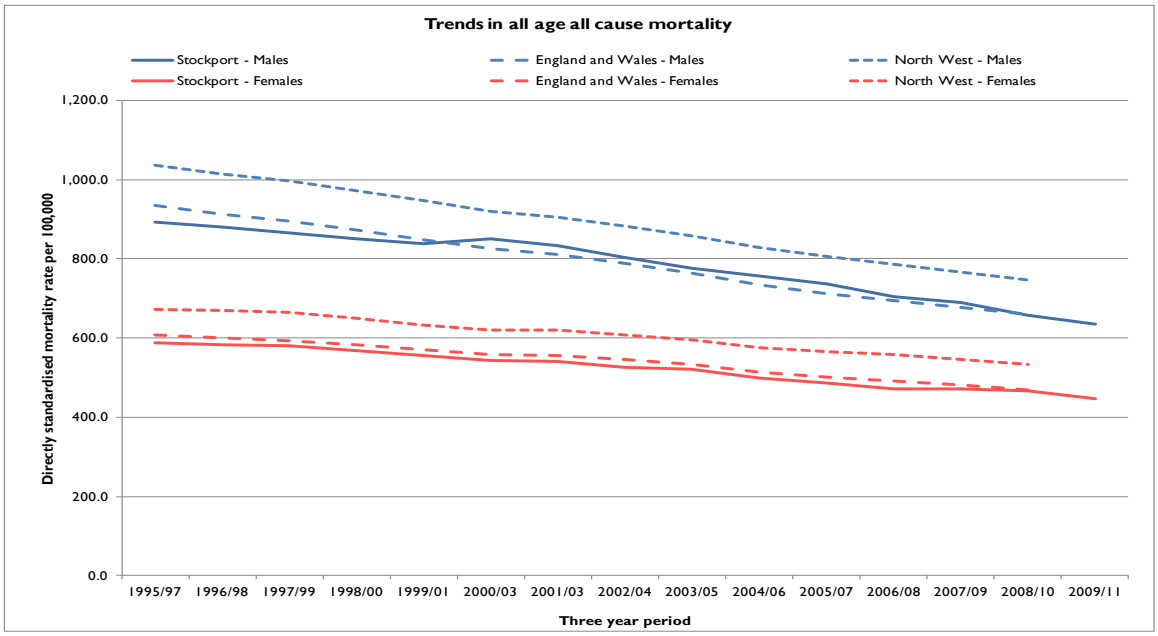
This report is underpinned by many other reports and analysis, all of which are hosted on the Stockport JSNA Hub at https://interactive.stockport.gov.uk/IAS/profile/hubs/JSNA. The hub includes copies of the complete data reports, detailed topic analysis, consultation reports and Director of Public Health Annual Report. It also provides a link to the live data hub, where updates of the JSNA data and analyses by different geographies can be accessed.

3. Trends in key priorities

3.1. Improve Life Expectancy & Healthy Life Expectancy

Life expectancy in Stockport has continued to rise and is currently 79.1 years for males and 83.2 years for females,

2011 targets for All Age All Cause Mortality for both males and females have been met and show a sustained downward trend; rates are similar to the national average and below the regional average.



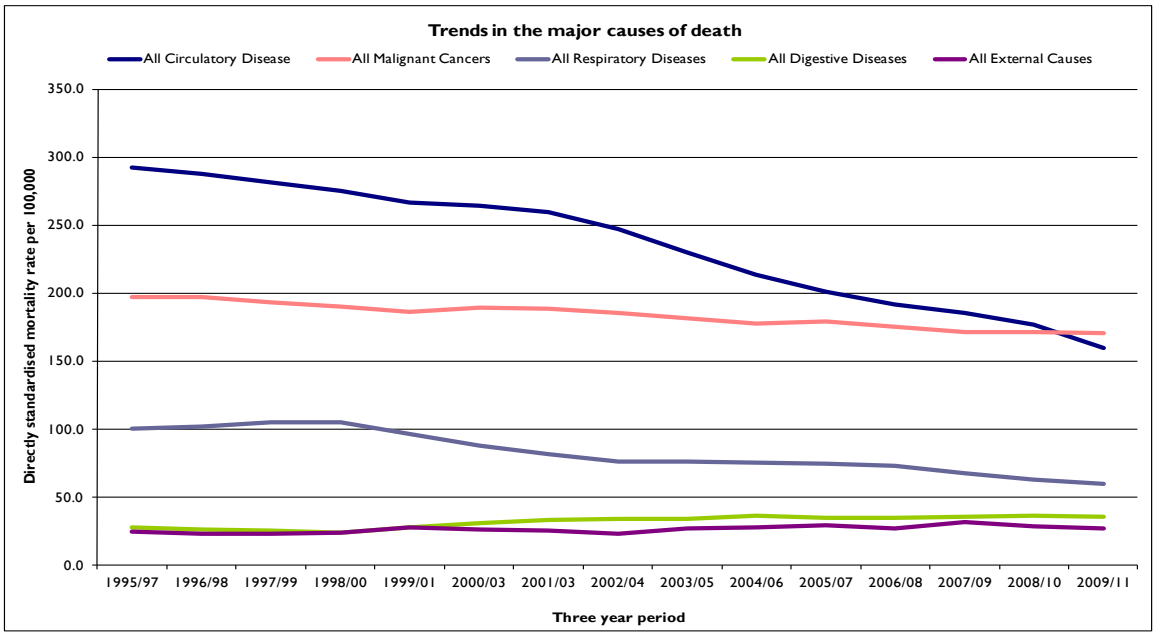
Around 2,600 people in Stockport die a year. For the first time in 2011 the **most common cause of death is cancer** (around a third of deaths), in other words more people in Stockport died from cancer than from circulatory disease. Circulatory disease is now only the most common cause of death for those aged 80 or more years.

Cancer is also the most common cause of early death (i.e. under 75 years) causing around two-fifths of premature deaths. 2011 targets for early deaths from both circulatory disease and cancer have been met, however while circulatory mortality has declined by more than 50% since 1995/97, cancer has reduced by only 20%.

Around 1,900 people in Stockport are diagnosed with cancer each year; the most common cancers being female breast and lung cancer. Survival rates vary significantly by the type of cancer and by deprivation. New evidence from Cancer Research UK suggests that 42.7% of all cancers are caused by lifestyle behaviours; again with variation by cancer - **89.2% of lung cancers (the biggest killer) are seen to be preventable**.

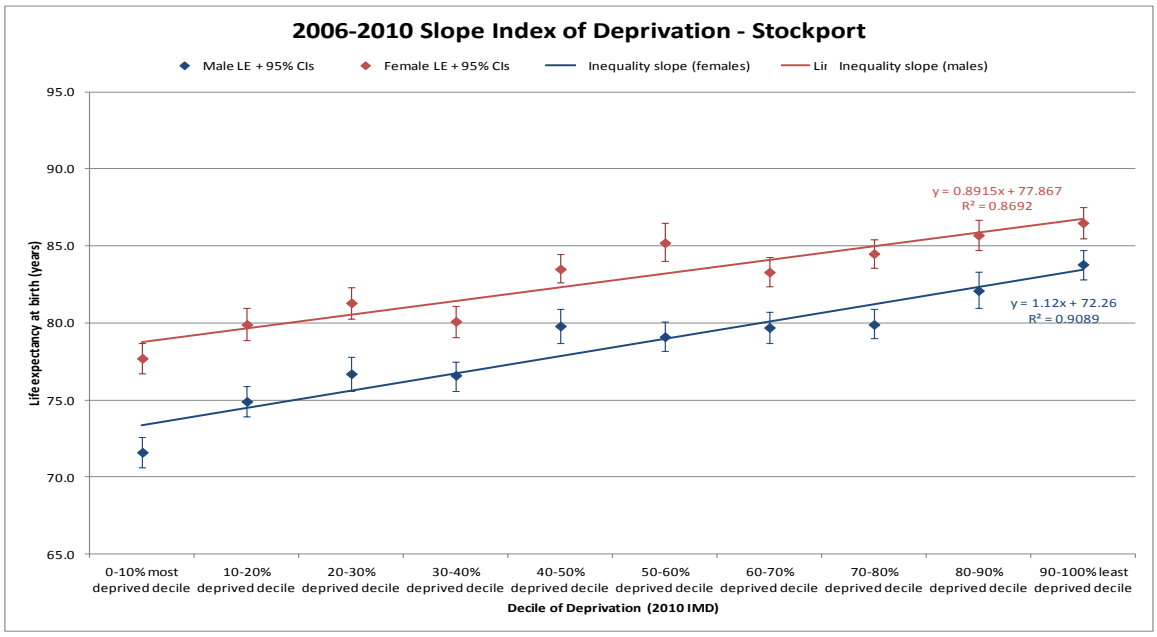
Death rates from digestive disease continue to go against the general trend and remain at a static level following a rise over the last decade.

There are around 70 deaths from accidents and 20 deaths from suicide or of undetermined intent a year, low numbers but for causes that should largely be preventable.



New experimental statistics from ONS suggest that males in Stockport can currently expect disability to affect them for 11.4 years towards the end of life whereas females can expect 16.5 years of disability affected live. This new data suggests that **although females live longer, their health starts to deteriorate at an earlier age than males**. This is an important finding if proven; the publication of the 2011 Census data in early 2013 will enable a thorough investigation of healthy life expectancy locally over the next year. The impact of ill health at the end of life on independence, social isolation, mental wellbeing and as a trigger for use of services is likely to be significant and will be included in the analysis to support a fuller understanding of those with complex needs,

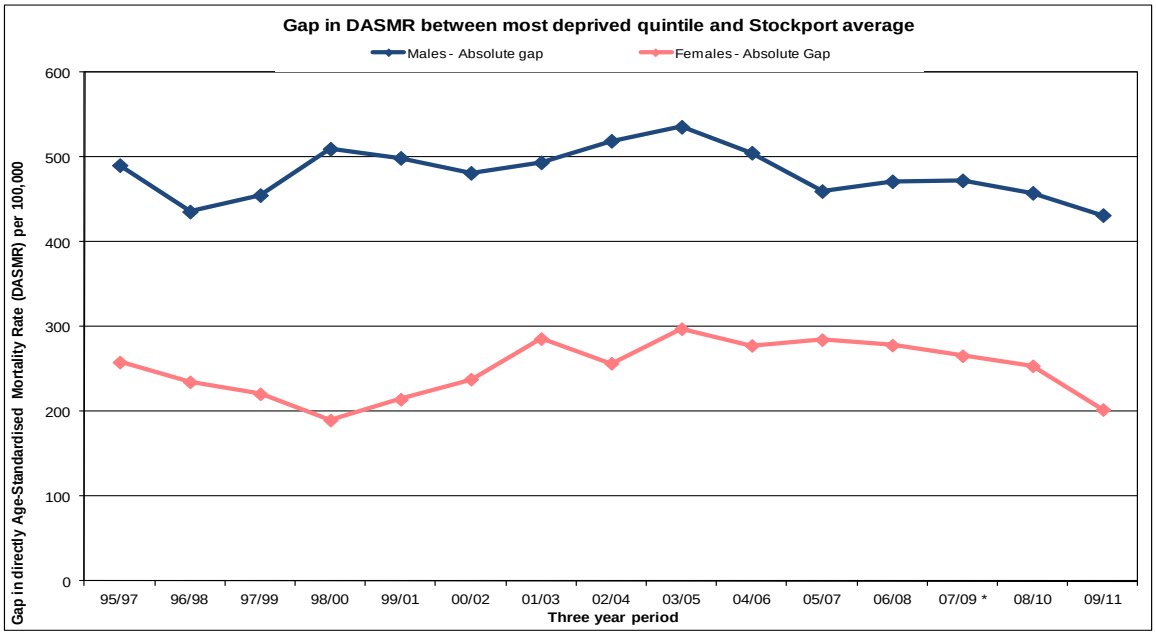
3.2. Reduce Health Inequalities



The national slope indicator of inequalities (SII) shows that **Stockport has one of the biggest internal gaps in life expectancy** in the country, at 11.3 years for males and 8.9 years for females, a level of inequality that has endured over the last decade. These inequalities are driven by the polarisation of deprivation in the local population.

Life expectancy in the most deprived areas is rising, currently males in Brinnington & Central can expect to live to 71.9 years and females to 77.3 years; however life expectancy is rising at a similar rate in the least deprived areas too, over the last decade there has been no significant change in the size of the gap between wards.

Analysis at larger geographies suggests that some initial progress in narrowing inequalities may be beginning to be made as trends since 2003/05 show a reduction in the absolute gap in inequalities between the most deprived quintile and the Stockport average. Longer term trends however show that we are now reaching levels of inequality previously seen in the mid to late 1990's before gaps widened at the turn of the millennium.



The causes of death contributing to inequalities in life expectancy are changing although lifestyles remain the key driver. Heart disease remains a major, though decreasing, cause of inequalities but the impact of deaths from digestive disease and cancer, thought to be mainly driven by alcohol, are increasing. In all areas **cancer is now the biggest premature killer; however the inequalities slope is still greatest for circulatory disease** where the under 75 mortality rate is 3.5 times greater in the most deprived quintile. Together these three causes of death contribute to two-thirds of the inequalities in life expectancy in the most deprived quintile.

Further work to investigate these trends and trends in inequalities in healthy life expectancy within Stockport will be undertaken in 2013 as the 2011 Census data is released.

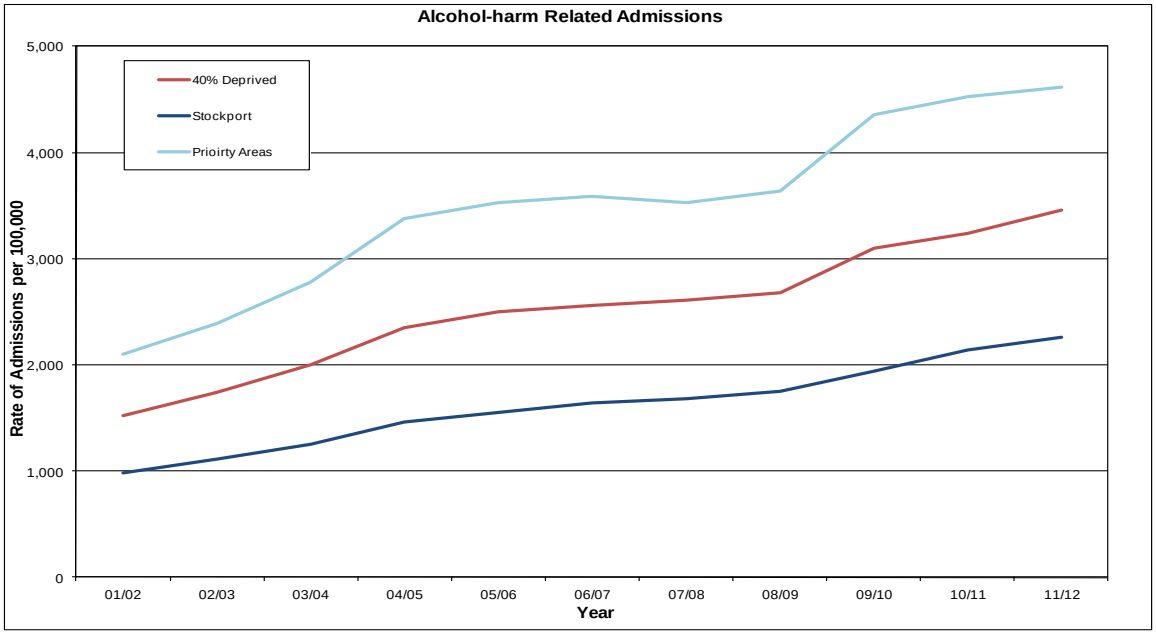
The Marmott Review 2010 (Fair Society, Healthy Lives) recognised that disadvantage starts before birth and accumulates throughout life; therefore the highest priority was placed on "giving every child the best start in life". Analysis shows that while overall breastfeeding rates in Stockport are reasonably high there are significant inequalities in these rates so that new mothers in the more deprived areas are 40% less likely to initiate breastfeeding. Smoking in

pregnancy rates remain higher in Stockport than the national average a trend driven by mothers in deprived areas who are more than twice as likely to smoke as average.

3.3. Reduce the consumption of and harm relating to alcohol

The impact of unhealthy drinking behaviours is seen in the rising mortality rates from digestive disease shown in section 3.1, Alcohol directly causes 50 deaths a year in Stockport and specific mortality rates have risen by 50% in a decade.

The impact of alcohol on health can also be seen in the rapid increase in admissions to hospital due to alcohol related harm. This increase is most significant in the deprived areas, but is evident in all areas of the borough. **Alcohol related harm admission rates in Stockport are significantly higher than the national average.**



Findings from the Stockport Adult Lifestyle 2009 showed that at least 28% (64,000-69,000) of adults drink unhealthy in Stockport; this data will be updated in 2013 as the results of the 2012 survey are processed.

3.4. Improve and promote mental wellbeing & resilience at all ages

Mental wellbeing became a new priority in 2011 and it is an area of the JSNA where our in-depth understanding of the issue and the ways we can respond locally are the least well-developed. However, there is evidence that poor mental wellbeing has multiple effects on overall health and life chances. Local data from the 2009 Adult Lifestyle survey shows that people with lower mental well being are more likely to smoke, drink unhealthily, be obese, have lower physical activity levels and eat unhealthily; all of which contribute to lower life expectancy. In 2009 **12.5% of the adult population had lower than average mental wellbeing** (28,000-31,500) and rates show a significant inequality gradient. This data will be updated in 2013 as the results of the 2012 survey are processed; a full needs assessment focussing on mental wellbeing is planned to support the local response to this JSNA priority.

Evidence from social care suggests that mental health is the most prevalent condition resulting in younger adults (18-64) needing social care support and mental health is also the most common condition resulting in health related benefits being accessed.

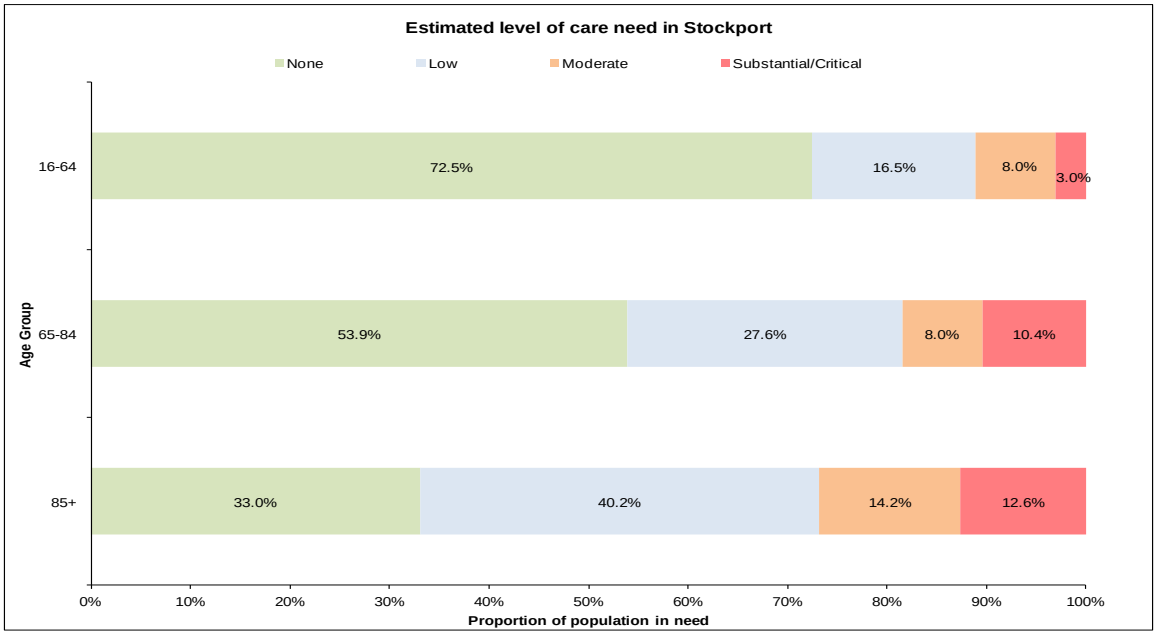
Recent national profiles have highlighted that Stockport benchmarks poorly for emergency hospital admissions due to self harm; although it is likely that this higher rate is due to the underlying issues in unscheduled care that generate the overall higher rate for all emergency admissions seen locally it is worth noting that more than 700 people a year are admitted to hospital because of self harm, the vast majority for short stays following a drug overdose. Trends show that there is a significant inequalities gradient and that young women account for the majority of admissions.

3.5. Assess and respond to the increasing future need for complex packages of care

This is an area where the need for further analysis was recognised in 2011; and a number of pieces of work are underway or planned.

A full needs assessment for autism is in progress at the present time and results will be published by 2013. Interim data suggests that around 2,500 Stockport residents have an autistic spectrum disorder, around 700 of whom are recorded on GP practice systems. A full needs assessment for learning disability is planned for next year.

The best method we currently have for estimating the total number of people needing social care support, and those with low level needs that may need support in the future is to look at self-reported well being and long-term difficulties with mobility, personal care, sensory abilities, and communication. An initial analysis was conducted in early 2012, to be updated when the 2012 Adult Lifestyle Survey and 2011 Census data are available. Initial findings are that 19.3% (44,000) of the adult (16+) population have low level needs, 8.2% (18,700) moderate level needs and 4.7% (10,700) substantial or critical level needs, with the proportion in need increases with age.



For older people a significant element of the challenge relates to the ageing population, especially with the increasing numbers of frail elderly with complex needs. An assessment of the changing demographics of Stockport and the impact this has on services will be undertaken in 2013 once the full results of the 2011 Census are released.

Whilst understanding the needs of the very elderly (80+) population is the most immediate priority, there is a shared recognition, through the work to develop the Joint Health and Wellbeing Strategy that in Stockport preventative interventions from early older age will have a long-term positive effect on the Stockport population as it continues to age. Maximising independence and prevention is likely to become a topic for early consideration by the Health and Wellbeing Board.

3.6. Recognise the value of and support carers

At the 2001 Census more than 8,500 people in Stockport reported that they provided more than 20 hours of unpaid care a week, a rate slightly lower than the national average. In 2009/10, 2,500 people were identified as carers for adult clients by Stockport Social Services. There are therefore many more carers who are not directly known to Adult Social Care (as would be expected), but who are likely to have contact with their GP relating to their own health or that of the person they provide care for.

A full needs assessment for carers is in progress at the present time, and results will be published by 2013. Interim data suggests that GPs in Stockport have identified 2,400 carers on their registers, suggesting that there are significant numbers of carers who are not being supported in this role by primary care.

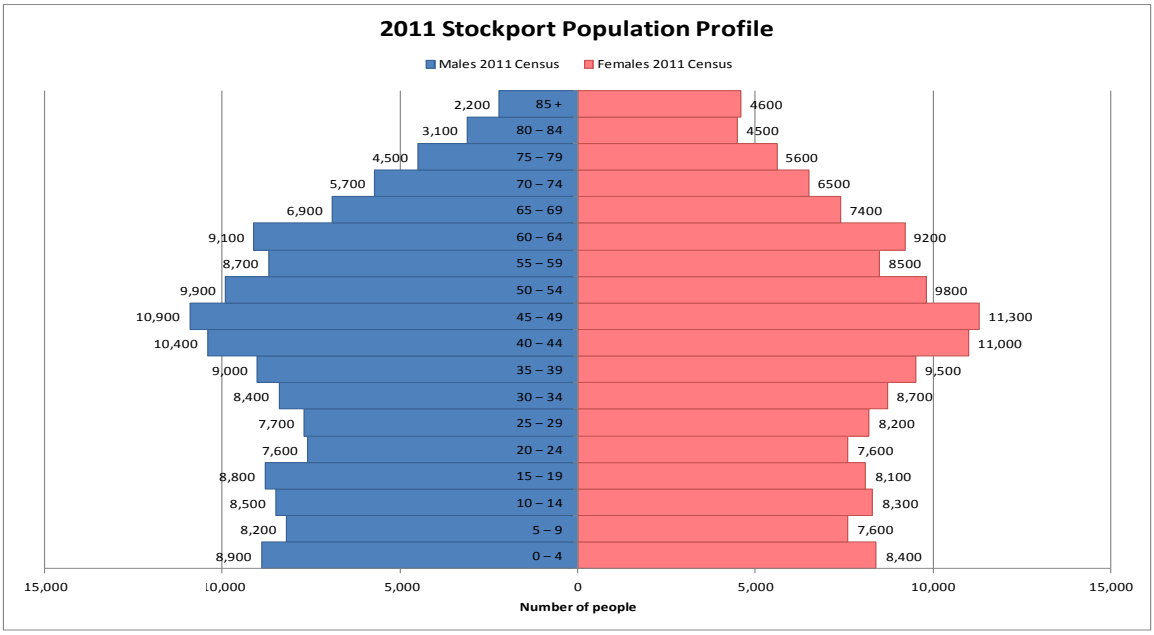
4. Other Trends

4.1. Population Trends

July 2012 saw the first release of data from the 2011 Census with the publication of population figures for local authority areas. There has been a slight contraction in the population of Stockport, which is now estimated to have a total population of 283,300 people compared to the Census 2001 level of 284,500 and the ONS mid year estimate 2010 of 284,600.

The age profile of the2011 Census is similar to 2010 mid-year estimate at all ages and only really differs around the ages of 30 to 44 years; the Census found 1,200 more people aged 30 to 34 years but 1,300 fewer aged 40 to 44 years. The early evidence therefore suggests that population estimates have been on the whole accurate for the last decade.

The well established trends of an ageing population and the recent rise in birth rates have been confirmed in this early data release. More 2011 Census data will be released over the coming months and detailed analysis will be undertaken.



4.2. Vulnerable Population Groups

A Mental Wellbeing Impact Assessment of the Health and Wellbeing Strategy has been undertaken this year and identified the following key vulnerable groups as priorities:

- Carers as a group for whom not enough is done and about whom not enough is known. Comments were made about the need to think about all types and all ages of carers, and specifically carers who may lose their caring role due to bereavement.
- Similarly, the various BME groups resident in Stockport were felt to be under-using services and this deserved further investigation: for example, in relation to alcohol, physical activity, healthy aging. However, these groups were felt to be over-represented within mental health services.
- Lesbian Gay Bisexual and Transgender (LGBT) groups were a specific concern to participants in both the early intervention with children and families workshop and the healthy aging workshop, again primarily due to a lack of sufficient local information and understanding of the specific support these groups may require.
- Another group felt to be not getting enough priority attention was young men aged 13-25, particularly if not in employment, education or training.
- Those who are new to parenthood and expectant mothers were singled out as especially important in the early intervention workshop.
- People in low-paid employment experiencing reductions in financial resources due to government changes to the welfare system were identified as a key group.
- People living in residential settings were also felt to be particularly vulnerable with insufficient consideration of their specific needs.

Data updates about the health and wellbeing status of some of these groups will be available on the publication of the 2012 Adult Lifestyle Survey later this year.

4.3. Patient and Public Voice

More progress has been made in engaging the public in decision making for health and wellbeing; the most significant work being an event in March 2012 attended by more than 180 people to develop the Health and Wellbeing Strategy. Attendees reinforced the wider

interpretation of health and wellbeing, naming factors as being important to their health and wellbeing such as: the environment, education, housing, financial security, being lonely, mobility, stress, where I live, friends and family support, being in control, prompt access to what I need, my independence, mental stimulation, feeling safe, readily available information when I need it, lack of choice, being active, poor health or health conditions, a good diet, a sense of personal worth, hope and belonging.

The following themes emerged as important to residents:

- Clear, simple messages and information applied consistently across all sectors are vital to encouraging change and choice for the average resident.
- Support for targeting messages and services to the right people and being very proactive in this.
- Tackling (all) issues early and enabling employees to do this confidently in whatever capacity they might work – making every contact count.
- Public services and the voluntary sector, working co-operatively together and communicating with each other, for the benefit of individuals and communities.
- Working with the community and specific target groups to develop services and solutions (e.g. parents, carers, older people) and promoting existing community resources, support groups, networks etc. It was clear that some contributors wanted more influence than they currently felt they had.
- There was some frustration with speed of response from services and delays (in diagnosis, receiving a service, appropriate support etc.) making problems worse – this covered public and voluntary sector services.
- There was a definite recognition of the need for people to be willing to help themselves – this ranged from eating healthily, to looking out for your neighbours and 'being realistic – accept you need help'.
- 'right service at right time, from the right person in the right place'.

The JSNA process is also developing further to engage the public more directly in the assessment of needs, for example the in-depth project for carers (see section 3.6) is being developed with members of Signpost for Carers as partners. Over 2012/13 a pilot assets assessment for physical activity (see section 5.2) will be co-produced by local residents, so that the public are involved from the beginning in the creation of intelligence, not just used as a knowledge resource.

The CCG and Council continue to actively consult and engage with communities on a range of health and wellbeing issues and ways are being sought to bring together the results of these workstreams to form a knowledge basis for commissioning as part of the JSNA.

4.4. Benchmarking Health and Wellbeing Needs – Spine Chart Analysis

National health profiles produced by the Association of Public Health Observatories (APHO) present spine chart analysis of key indicators and show how Stockport compares to other areas. In the past this analysis has been used to test the priorities generated by the JSNA.

The 2012 profile shows that Stockport performs significantly worse than the national average for smoking in pregnancy, alcohol and mental health– all priority issues identified in the 2011 JSNA.

The only issue identified in the 2012 spine chart analysis that has not been identified in the 2011 JSNA is the incidence of malignant melanoma (skin cancer).

Health summary for Stockport

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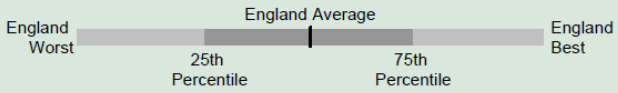
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	35144	12.4	19.8	83.0		0.0
	2 Proportion of children in poverty ‡	8605	16.6	21.9	50.9		6.4
	3 Statutory homelessness ‡	113	0.9	2.0	10.4		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1943	64.6	58.4	40.1		79.9
	5 Violent crime	2797	9.9	14.8	35.1		4.5
	6 Long term unemployment	986	5.5	5.7	18.8		0.9
Children's and young people's health	7 Smoking in pregnancy ‡	510	14.8	13.7	32.7		3.1
	8 Breast feeding initiation ‡	2548	74.2	74.5	39.0		94.7
	9 Obese Children (Year 6) ‡	476	16.5	19.0	26.5		9.8
	10 Alcohol-specific hospital stays (under 18)	49	81.5	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	189	35.7	38.1	64.9		11.1
Adults' health and lifestyle	12 Adults smoking ‡	n/a	21.5	20.7	33.5		8.9
	13 Increasing and higher risk drinking	n/a	23.0	22.3	25.1		15.7
	14 Healthy eating adults	n/a	29.2	28.7	19.3		47.8
	15 Physically active adults ‡	n/a	10.4	11.2	5.7		18.2
	16 Obese adults ‡	n/a	22.0	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	53	18.1	13.6	26.8		2.7
	18 Hospital stays for self-harm ‡	728	281.9	212.0	509.8		49.6
	19 Hospital stays for alcohol related harm ‡	7543	2185	1895	3276		910
	20 Drug misuse	1251	6.8	8.9	30.2		1.3
	21 People diagnosed with diabetes ‡	13092	5.4	5.5	8.1		3.3
	22 New cases of tuberculosis	16	5.6	15.3	124.4		0.0
	23 Acute sexually transmitted infections	1663	584	775	2276		152
	24 Hip fracture in 65s and over ‡	270	401	452	655		324
Life expectancy and causes of death	25 Excess winter deaths ‡	171	20.7	18.7	35.0		4.4
	26 Life expectancy – male	n/a	78.7	78.6	73.6		85.1
	27 Life expectancy – female	n/a	82.7	82.6	79.1		89.8
	28 Infant deaths ‡	14	4.0	4.6	9.3		1.2
	29 Smoking related deaths	501	219	211	372		125
	30 Early deaths: heart disease and stroke ‡	237	71.0	67.3	123.2		35.5
	31 Early deaths: cancer ‡	378	114.8	110.1	159.1		77.9
	32 Road injuries and deaths ‡	68	24.1	44.3	128.8		14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2009 3 Crude rate per 1,000 households, 2010/11 4 % at Key Stage 4, 2010/11 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2010/11 6 Crude rate per 1,000 population aged16-64, 2011 7 % mothers smoking in pregnancy where status is known, 2010/11 8 % mothers initiating breast feeding where status is known, 2010/11 9 % school children in Year 6 (age 10-11), 2010/11 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2008-2010 12 % adults aged 18 and over, 2010/11 13 % aged 16+ in the resident population, 2008/2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % aged 16 and over, Oct 2009-Oct 2011 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2006-2008 18 Directly age sex standardised rate per 100,000 population, 2010/11 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2009/10 21 % people on GP registers with a recorded diagnosis of diabetes 2010/11 22 Crude rate per 100,000 population, 2008-2010 23 Crude rate per 100,000 population, 2010 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2010/11 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.07-31.07.10 26 At birth, 2008-2010 27 At birth, 2008-2010 28 Rate per 1,000 live births, 2008-2010 29 Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010 30 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 31 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 32 Rate per 100,000 population, 2008-2010

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@sepho.nhs.uk

Further analysis of the incidence of skin cancer showed that following national trends, Stockport has experienced a rise in incidence and that incidence rates locally are above the national average. In 2009 67 people of all ages in Stockport were identified as having malignant skin cancer. Mortality rates from skin cancer are low, on average 10 to 15 people die each year in Stockport; local mortality rates for skin cancer benchmark at or below the national average, as expected given our demographic profile.

5. Stockport JSNA 2011-2013

5.1. 2012 Activity and 2013 Plans

The 2011 JSNA Priorities and Key Findings report set out plans for the future of JSNA in Stockport. It described a continual process of development and over the last 12 months work has been undertaken to move on local process and products. As well as supporting high level strategic plans through the identification of key priorities a number of other key workstreams are underway:

- to support the commissioning process at other levels through a programme of in depth needs assessments analysing the health and wellbeing needs of priority areas or key vulnerable groups. These needs assessments involve analysts working with commissioners to jointly assess local data and voice evidence alongside national evidence to make key recommendations; informing local plans and commissioning.
- to enable the delivery of high quality JSNA evidence to the partnership in a rapid and user friendly manner by developing on-line data tools and information hubs. This workstream is part of the Councils work to develop 'My Stockport' a new local information system and is the start of the process to build up to the next refresh of the Strategic JSNA in 2014 . This will also enable JSNA analysis for localities.
- to continue to develop the inclusion of patient voice within the JSNA by involving the public in the JSNA process and by developing ways of understanding key strategic themes from the range of existing engagement and consultation activities undertaken by the partnership organisations.
- to develop assets based approaches to complement the deficit based needs assessments already collated by the JSNA. This is an emerging model nationally and Stockport's longstanding interest in community development and current emphasis on mental well being and empowerment means we are piloting methods before clear guidelines have been established. The workstreams in this area are therefore experimental but the aim is to eventually create a systematic, area-wide approach to asset mapping firmly embedded in the JSNA. Assets assessments will provide a greater understanding of local communities and will enable evidence based alternatives to statutory provision to be offered about ways in which change can be delivered by communities.

The summary activities and plans for these workstreams are listed in the following table:

Workstream	2012 Activity	2013 Plans
In depth needs assessments	JSNA for Healthy Weight (complete) JSNA for Carers (in progress) JSNA for Autism (in progress)	JSNA for Mental Wellbeing JSNA for Learning Disabilities JSNA for Complex Care in Elderly

	2012 Adult Lifestyle Survey Report (in progress)	
Developing core data and the JSNA hub	2011/12 JSNA hub completed and all data added. Website refreshed	Migrate JSNA hub to 'My Stockport' (new local information system). Improve standard reports and build dynamic reports Develop locality based reporting.
Developing public, user and patient voice	HWB Strategy event Involvement of public in in-depth needs assessments	Develop collation of information from CCG consultation hub with LA consultation findings
Developing asset based approaches	Community mapping of priority areas complete Pilot assets assessment for physical activity in progress	*Further plans dependent on findings from pilot*

5.2. Strategic future of Joint Strategic Needs Assessment

From April 2013 JSNAs are to be the joint and equal duty of the Council and the CCG, to be delivered through the Health and Wellbeing Board; the NHS Commissioning Board must also participate, but can delegate their responsibility to others if the Board agrees. All organisations will be required to take proper account of the JSNA and this has given the JSNA a much stronger profile and place in the commissioning process.

The Health and Social Care Act 2012 states that although JSNAs are unique to each area, they must have regard to national guidance; they should include a range of quantitative and qualitative evidence and should include the local community and Healthwatch throughout the process. JSNAs must consider:

- the needs of the whole community including how needs vary for people at different ages, and may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services.
- wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, air quality, housing, community safety, employment.
- what health and social care information the local community needs, including how they access it and what support they may need to understand it.
- what local communities can offer in terms of assets and resources to help meet the identified needs.

A key test of JSNAs is to assess not what they contain, or how well written they are but to see how they are used and what the impact of the analysis has been in terms of real change. The three tests of a good JSNA are:

- how well it is owned by the local partnership
- how well organisations and the public are engaged in the process
- what improvements in outcomes can be demonstrated in the identified priority areas

The Stockport HWB may choose in the future to develop some basic tests of the degree to which the Stockport JSNA has influenced commissioning within the local economy.