



Stockport JSNA

joint strategic needs assessment



2015/16 Summary Report

Priorities for the health and wellbeing of Stockport

2016-2019

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Introduction



The 2015/16 Joint Strategic Needs Assessment (JSNA) is part of an ongoing JSNA process which develops a shared understanding of health and care needs in Stockport and uses intelligence to identify priorities to help local partners work together to deliver change which **improves the health and wellbeing of people in Stockport and reduces health inequalities** – the JSNA is not an end in itself.

The 2015/16 JSNA will be used to underpin the development of the revised **Stockport Health and Wellbeing Strategy** by the Health and Wellbeing Board in 2016/17. The Health and Wellbeing Strategy will set out the ways in which partners across Stockport plan to make change over the next three years to address the priorities identified by the JSNA.

The JSNA will also be used to inform the health and health determinant elements of other Stockport strategies including the development of:

- Stockport Together
- Stockport Family
- Investing in Stockport

Evidence from the JSNA will also be used to directly influence the commissioning of health, social care and preventative services by Stockport Council and Stockport Clinical Commissioning Group (CCG).

More widely, the evidence from the JSNA will be used to set the context for Stockport, helping to shape the ambitions for the locality within the Greater Manchester Healthier Together and Devolution programmes and providing an evidence base for councillors and other key decision makers.

The 2015/16 JSNA has been produced in partnership, under the leadership of the **Health and Wellbeing Board**, with the particular involvement of Stockport Council, Stockport HealthWatch and Stockport CCG.

Introduction - Report Structure



This summary document **identifies the key priorities for health and wellbeing for the next three years** and **provides an overview of key trends in health and wellbeing** arising from the detailed analysis.

Section 1 - Identification of Priorities

Following the analysis of key trends across a range of themes work has been undertaken to identify the key **priorities for health and wellbeing in Stockport** for the next three years. These are the major issues that leaders, commissioners and providers of health, care and wider services will need to consider or address when making decisions.

In this document these priorities are presented before the analysis on which they are based, as they are the **key messages arising from the 2015/16 JSNA analysis**. The priorities for Stockport, and reasons for selection can be found from [page 7](#) onwards.

Section 2 - Overview of key trends

This section summarises the **findings of the in depth JSNA analysis**, which has been undertaken for a range of topics over the later part of 2015. A series of topic briefings have been developed and consulted upon, each examining trends in health and wellbeing for a particular issue.

In this document the **findings of each briefing report are summarised in one or two pages**, and key issues highlighted. These summaries can be found from [pages 14](#) onwards. The full briefing reports will be available from March 2016 as part of the new JSNA web hub www.stockportjsna.org.uk.

Introduction - JSNA Evidence Base



This summary report is only one part of the 2015/16 Stockport JSNA, and a range of more in depth analysis are available. The JSNA suite of documents will be hosted on the JSNA hub (from March 2016 moving to www.stockportjsna.org.uk) and includes:

- More detailed JSNA briefings on specific topics, currently:
 - 2015 JSNA – Demographics & Population
 - 2015 JSNA – Vulnerable and at risk groups
 - 2015 JSNA – Health Service Locations
 - 2015 JSNA – Public Opinions
 - 2015 JSNA – Long-term Condition Prevalence
 - 2015 JSNA – Mortality & Healthy Life Expectancy
 - 2015 JSNA – Socio-Economic Trends
 - 2015 JSNA – Adult Lifestyles
 - 2015 JSNA – Cancer
 - 2015 JSNA – Looked After Children
 - 2015 JSNA – Health at a glance summaries
 - 2015 JSNA – Mental health and wellbeing
 - 2015 JSNA – Outcome Frameworks
 - 2015 JSNA – Health Care and Service Use
- Demographic and health profiles for wards and neighbourhoods
- Full needs assessments for certain conditions, including:
 - Eye Health Needs Assessment
 - Autism
 - Healthy Weight
- Health profiles from Public Health England on a range of topics
- CCG and NHS Outcome Frameworks tools



A further key source of information is the **Director of Public Health Annual Report**; this is a personal professional report by the Director of Public Health with recommendations to all those with the ability to influence the health of the people <http://www.stockport.gov.uk/services/socialcarehealth/healthandwellbeing/publichealth>

Introduction - JSNA Future plans



The publication of the 2015/16 JSNA Summary is part of an ongoing JSNA process; and work is already under way on a number of ongoing projects.

Development of JSNA briefings for key partnerships

A report highlighting the key findings for the Children's and Young Peoples Partnership board is already being developed, and will be used by the Partnership to identify gaps and to help the development of the Stockport Family programme.

CCG Neighbourhood Profiles are also in development to further support the design of Stockport Together teams and systems.

Over the next few months a report will be produced for the Stockport Partnership, highlighting the priorities for wider services to promote healthier lives.

Development of further JSNA Briefings

Over the course of 2016/17 it is intended to develop and publish further in depth JSNA analysis focussing on:

- Dementia – primarily to support the refresh of the joint Dementia Strategy
- Housing needs – particularly focusing on older people
- Planning – to set out the evidence base for place as a determinant of health

Each new briefing will be released on the web hub, and stakeholders alerted to the key new findings.

Identifying Priorities - Introduction

The overall objectives for health and wellbeing in Stockport are to **improve life expectancy** and **reduce health inequalities**. These remain unchanged since the last JSNA review in 2011.

A number of priorities have been identified in 2015/16 JSNA to help us achieve these objectives and are set out on the following pages. These priorities have been identified as a result of the review of the evidence base and in consultation with the JSNA partnership organisations, through meetings with key stakeholders and via online consultation with wider groups.

These priorities of course cannot fully describe all the health and wellbeing needs of the population of Stockport, but do highlight the key strategic issues for the next three years.

- Page 8 sets out all the identified priorities by life stage, on a single page
- Pages 9-12 presents the priorities for each life stage and provide a snapshot from the key findings to set these in context

Information on the full range of needs across Stockport is presented in the detailed JSNA briefings.

Priorities 2016-2019



The overall objectives for health and wellbeing in Stockport are to **improve life expectancy** and **reduce health inequalities**. The priorities identified in 2015/16 JSNA to help us achieve these objectives are set out below, and are developed in further detail over the next four pages:

	All Ages	Start Well	Live Well	Age Well
Prevention	Increasing levels of physical activity as an effective preventative action at any age.	Taking action to improve the outcomes in early years health and education in deprived communities .	Prioritising a whole systems approach to reducing smoking, alcohol consumption and obesity as the key causes of preventable ill health and early death.	Supporting healthy ageing across Stockport, recognising that preventative approaches that promote self care and independence are essential at every life stage.
Wellness	Focus on improving healthy life expectancy for all as the priority, focussing especially in the most deprived areas and in a person and family centred way .	Promoting the mental wellbeing of children and families, especially for older children and young adults.	Improve the prevention, early detection and treatment of both cancer , now the major cause of premature death, and liver disease , which is increasing.	Aim to prevent and delay the need for care whilst responding to the complexity of needs that older people with multiple long term conditions may have.
Systems	Continue work to integrate and improve care systems , especially minimising the use of unplanned hospital care - ensuring that the healthy economy is sustainable and prevention focussed .	Ensuring that the acute care needs of children and young people, especially for injuries, asthma and self harm are dealt with appropriately and opportunities to promote prevention are maximised.	Giving equal weight to mental wellbeing as a key determinant of physical health and independence; especially for people of working age.	Providing services and housing that are suitable for the changing needs of our ageing population and those with specialist needs.
Support	Understanding the size and needs of our vulnerable and at risk groups, especially carers , and using JSNA intelligence to inform the appropriate levels of response.	Supporting and safeguarding the most vulnerable children and young people and families , especially looked after children and those with autism, so that they have the opportunity to thrive.	Improving the physical health and lifestyles of those with serious mental health conditions.	Continuing to improve the identification of and support available to those with dementia and their carers .

Identified priorities – all ages

	All Age Priorities	Key analysis to support priority
Prevention	Increasing levels of physical activity as an effective preventative action at any age.	<ul style="list-style-type: none"> 75% of the population as a whole are not active enough More than 200 deaths a year in Stockport could be saved if every adult met the target of 5 x 30 minutes moderate activity a week Physical activity reduces the risk of most diseases by 30-40% Activity in later life reduces frailty as well as the likelihood of and injuries from falls – both of which are a major cause of loss of independence for older people
Wellness	Focus on improving healthy life expectancy for all as the priority, focussing especially in the most deprived areas and in a person and family centred way .	<ul style="list-style-type: none"> 18-20% of a typical Stockport resident's life will be spent in fair or poor health; 5-6% will be spent in poor health Patterns of health care use closely mirror the trends in healthy life expectancy In the most deprived areas men have 7 years poor health compared to 3 years in the most affluent areas. In the most deprived areas the decline in health starts at age 55, compared to 71 in the least deprived areas. Many people in Stockport have a range of health and lifestyle conditions rather than only one issue
Systems	Continue work to integrate and improve care systems , especially minimising the use of unplanned hospital care - ensuring that the healthy economy is sustainable and prevention focussed .	<ul style="list-style-type: none"> The benchmarking position of Stockport in relation to the use and performance of unplanned hospital care remains poor The use of specialist outpatient services follow ups in Stockport is high (identified as a better care, better value opportunity) Analysis from Stockport Together highlights future financial and workforce sustainability risks
Support	Understanding the size and needs of our vulnerable and at risk groups, especially carers and using JSNA intelligence to inform the appropriate levels of response.	<ul style="list-style-type: none"> This JSNA comprehensively estimates the people within our community who are more likely to be vulnerable or at risk due to their personal circumstances Highlights for all age groups include carers, those with learning disability and those with sensory disability <ul style="list-style-type: none"> There are an estimated 32,000 unpaid carers in Stockport, National estimates suggests that there are 5,250 adults with a learning disability in Stockport, 1,256 people have been registered as such with Stockport GPs 1,400 people in Stockport have been registered as blind or partially sighted, 2,500 have been diagnosed with glaucoma

Identified priorities – Starting well

	Start Well Priorities	Key analysis to support priority
Prevention	Taking action to improve the outcomes in early years health and education in deprived communities .	<ul style="list-style-type: none"> Inequalities in health outcomes mean that children in our most deprived areas are not necessarily given the best possible start for a healthy life <ul style="list-style-type: none"> 42% of mothers smoke during pregnancy in Brinnington, compared to 12% Stockport average 21% of mothers breastfeed at 6 weeks Brinnington, compared to 50% Stockport average 37% of year 6 children in the most deprived areas are overweight / obese, compared to 30% Stockport average For children who are eligible for Free School Meals the performance gap rises from 26 percentage points at foundation stage to 41 percentage points by key stage 4
Wellness	Promoting the mental wellbeing of children and families, especially for older children and young adults.	<ul style="list-style-type: none"> The risk of low mental wellbeing is highest at beginning of adulthood where 15% of the population score below average Anxiety is the major long term condition affecting young adults in Stockport (more than 2,700 cases aged 15-24)
Systems	Ensuring that the acute care needs of children and young people, especially for injuries, asthma and self harm are dealt with appropriately and opportunities to promote prevention are maximised.	<ul style="list-style-type: none"> Rates of hospital admissions for children with injuries, asthma and self harm in Stockport are higher than national benchmarks <ul style="list-style-type: none"> There are around 720 emergency admissions for injuries aged 0-14, and 590 emergency admissions for injuries aged 15-24 each year There are around 230 admissions for asthma aged 0-18 each year There are around 290 admissions for self harm aged 10-24 each year Asthma is the major long term condition affecting school aged children in the borough (more than 2,000 cases aged 5-14)
Support	Supporting and safeguarding the most vulnerable children and young people and families , especially looked after children and those with autism, so that they have the opportunity to thrive.	<ul style="list-style-type: none"> There are many circumstances which may make children and young people more vulnerable including poverty, domestic abuse, child sexual exploitation, parental alcohol or drug use, low mental wellbeing, neglect or family dysfunction – the JSNA estimates the numbers of children who may be at risk due to these factors. 8,500 children and young people are estimated to live in poverty 40% of adults in treatment services for drug and alcohol live with children.

Identified priorities – Living well

	Live Well Priorities	Key analysis to support priority
Prevention	Prioritising a whole systems approach to reducing smoking, alcohol consumption and obesity as the key causes of preventable ill health and early death.	<ul style="list-style-type: none"> • Smoking is the biggest single cause of poor health –rates in most areas of Stockport are falling (average 18%) so priorities for smoking therefore focus on inequalities, in deprived areas smoking rates are more than twice the average • Alcohol also remains a key concern, although rates of consumption are no longer rising the impacts on health are still significant and are felt disproportionately in the most deprived areas. • Obesity is also of concern with more than 25% of adults being obese, and being a significant cause of liver disease, heart disease and diabetes
Wellness	Improve the prevention, early detection and treatment of both cancer , now the major cause of premature death, and liver disease , which is increasing.	<ul style="list-style-type: none"> • Cancer is now the major cause of premature death (45% of deaths under 75 years) • 40% of all cancers are preventable, with smoking being the key risk factor • Many cancer screening opportunities are not taken up, especially in the more deprived areas of the borough • Liver disease mortality has seen an increase, and rates in Stockport rank poorly compared to the national average. This is linked to both alcohol use and obesity.
Systems	Giving equal weight to mental wellbeing as a key determinant of physical health and independence; especially for people of working age.	<ul style="list-style-type: none"> • 40% of out of work benefits in Stockport are due to mental wellbeing • Depression and anxiety prevalence peaks in those aged 40-49 and is strongly correlated with deprivation • 1 in 4 adults (56,000 people) in Stockport are likely to be living with a mental health condition in any given year
Support	Improving the physical health and lifestyles of those with serious mental health conditions.	<ul style="list-style-type: none"> • Mortality rates are almost 4 times higher for people in Stockport with serious mental health conditions, than the Stockport average. • 85% of this difference is attributable to smoking • Research being undertaken by Stockport HealthWatch shows that the physical health needs and especially physical activity needs of patients in inpatient psychiatric care are not being met

Identified priorities – Ageing well

	Age Well Priorities	Key analysis to support priority
Prevention	Supporting healthy ageing across Stockport, recognising that preventative approaches that promote self care and independence are essential at every life stage.	<ul style="list-style-type: none"> Stockport's population is older than average and is ageing <ul style="list-style-type: none"> By 2020 the 65+ population of Stockport is expected to increase by 5,400 people (10%) By 2020 the 85+ population of Stockport is expected to increase by 1,800 people (24%) 33% of older people in Stockport live on their own Most adult carers provide care for a frail older person (62%) 11,400 people in Stockport have a history of falling, a key risk for loss of independence In the most deprived areas the decline in health starts at age 55, programmes promoting ageing well will need to start at an earlier age in these areas.
Wellness	Aim to prevent and delay the need for care whilst responding to the complexity of needs that older people with multiple long term conditions may have.	<ul style="list-style-type: none"> By age 65, 58% of the population have one long term health condition, 20% have two or more By age 85, 87% of the population have one long term health condition, 53% have two or more
Systems	Providing services and housing that are suitable for the changing needs of our ageing population and those with specialist needs.	<ul style="list-style-type: none"> The frequency of use of hospital care - inpatient, outpatient and ED, increases with age, and rates increase significantly from age 65 onwards Levels of hospital use have increased over the last decade There are more than 245,000 district nurse contacts in Stockport each year, numbers have increased 13% in two years Care homes and specialist housing provision for older people is spread throughout the borough, regular reviews of the capacity for our ageing population will need to be undertaken to ensure needs are met
Support	Continuing to improve the identification of and support available to those with dementia and their carers .	<ul style="list-style-type: none"> 2,700 people have been diagnosed with dementia in Stockport Dementia client groups are an increasing part of the caseload for adult social care

Identifying Priorities – Taking Action

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 is in terms of real changes in commissioning and outcomes.

In Stockport we continue to develop our JSNA and are in a position where we have been able to demonstrate clear links between the 2011 JSNA and the development of strategies (including healthy weight, physical activity and autism), system reform (Stockport One pilot) and individual commissioning decisions, as the analytical team supporting the JSNA development, continue to work with strategic commissioners in health and social care to answer particular commissioning questions.

It is important that the 2015/16 JSNA is also used across the partnership and in order to assess the utilisation of the JSNA in future, the Stockport HWB may choose to develop some tests of the degree to which the Stockport JSNA has influenced commissioning within the local economy e.g.

- What services have been commissioned / decommissioned as a result of the JSNA or subsequent analyses?
- What has the impact been on the integration of services?
- What has the impact been on reducing health inequalities and other health outcomes?
- Can commissioners and providers across Stockport demonstrate that they have considered the JSNA and identified priorities as part of their evidence base?

There are challenges to delivering comprehensive JSNA assessments for every commissioning area, and priority will be given for further analysis over the period 2016-2019 to support commissioning for the 2015/16 JSNA priority areas and to support major system reform.

Key Findings - Introduction

For the review of evidence for the 2015/16 JSNA a series of briefings on specific topics have been created.

- 2015 JSNA – Demographics & Population
- 2015 JSNA – Health Service Locations
- 2015 JSNA – Socio-Economic Trends
- 2015 JSNA – Vulnerable and at risk groups
- 2015 JSNA – Health at a glance summaries
- 2015 JSNA – Public Opinions
- 2015 JSNA – Mortality & Healthy Life Expectancy
- 2015 JSNA – Long-term Condition Prevalence
- 2015 JSNA – Cancer
- 2015 JSNA – Adult Lifestyles
- 2015 JSNA – Mental health and wellbeing
- 2015 JSNA – Health Care and Service Use
- 2015 JSNA – Outcome Frameworks

These will all be published on the new JSNA hub in March 2016 www.stockportjsna.org.uk

The following pages summarise each of these briefings into one or two pages, highlighting the key findings and giving baseline information for planning. More analysis and evidence can be found in the full reports. The section starts with five “at a glance” summaries for the different life stages.

Over the next few years further evidence and briefings on other key topics will be added to the evidence base.

2014 Health at a Glance

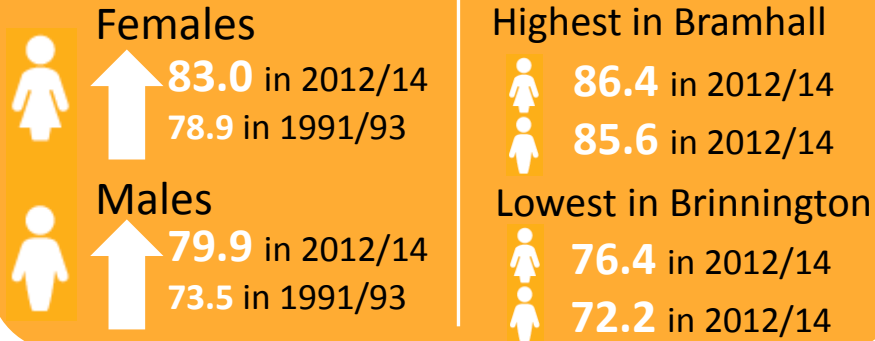
Stockport has 285,000 residents



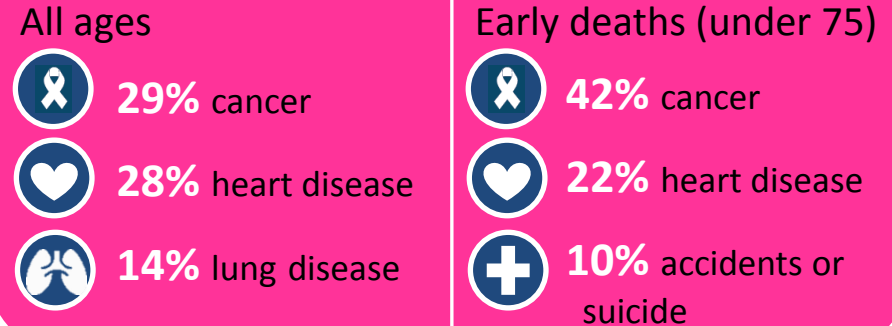
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Life expectancy at birth



Mortality causes (2,700 deaths a year)



Health Determinants



32% adults have three or more lifestyle risk factors

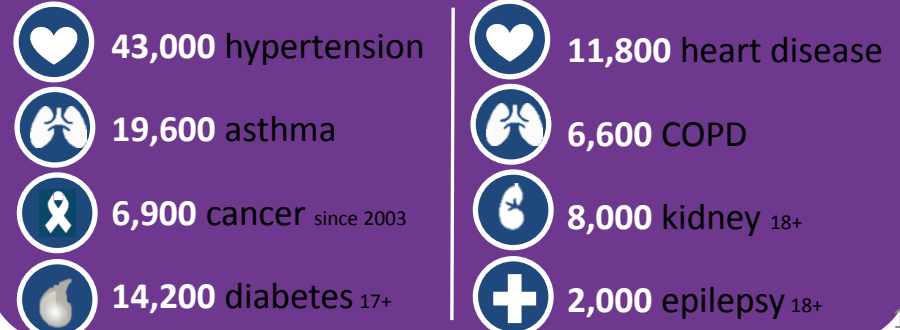
Mental wellbeing



Mental health



Long term conditions



at least 80,000 with ≥ 1

2014 Early Years Health at a Glance

Stockport has 17,800 under 5 residents



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Infant Mortality

(crude rate per 1,000)



3.9 in 2011-13

↔ 4.0 in England
6.0 in 2001-03

Number of deaths

40 in 2011-13

53 in 2001-03

Low birth weight



2.3% of live births at term <2,500 g

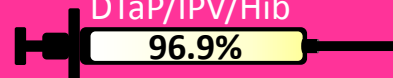
↔ from **2.2%** in 2013

↔ **2.9%** England rate

Health protection

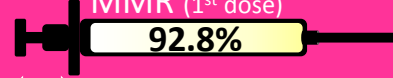
Immunised before 2 years

DTaP/IPV/Hib



↑ **95.7%** England rate

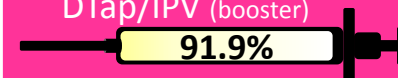
MMR (1st dose)



↔ **92.3%** England rate

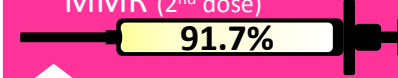
Immunised before 5 years

DTaP/IPV (booster)



↑ **88.5%** England rate

MMR (2nd dose)



↑ **88.6%** England rate

Prevention of ill health



11.7% of mothers smoking at delivery

↔ from **12.2%** in 2013-14

42% highest in Brinnington (three year rate)



73.7% of mothers initiating breastfeeding

↔ from **73.7%** in 2013-14

40% lowest in Brinnington (three year rate)



50.3% of mothers breastfeeding at 6 weeks

↔ from **48.6%** in 2013-14

21% lowest in Brinnington (three year rate)



15.0 teenage mothers (rate per 1,000 in age group)

↓ from **20.5** in 2011

↔ to **17.2** in England

Hospital admissions (crude rate per 1,000)



294.2 all hospital admissions



185.6 emergency admissions

- 31% respiratory
- 23% infections
- 12% ill defined conditions
- 9% injuries



18.6 Admissions for injuries

14.1 England rate ↑



448.2 ED attendances

525.6 England rate ↓

Long term conditions



300 history of fall



200 asthma



30 autism



20 downs



2014 School Age Health at a Glance

Stockport has 40,000 residents aged 5-16



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Childhood Mortality

(DSR per 100,000 aged 1-17)



9.9 in 2011-13



11.9 in England
17.9 in 2001-03

Number of deaths

17 in 2011-13

33 in 2001-03

Excess weight (children measured overweight or obese)

Reception



18.6% 2014-15



21.1% 2013-14



21.9% in England

Year 6



29.8% 2014-15



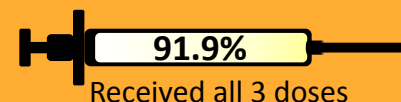
30.2% 2013-14



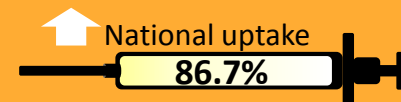
33.2% in England

HPV vaccine uptake

Stockport girls aged 12-13



Received all 3 doses



National uptake

Education



58.3% of pupils achieve
5 A*-C grades (inc Eng & Maths)



from 65.8% in 2012-13



56.8% England rate

(all figures state funded sector only)

% of pupils attending good or outstanding schools



93% Primary schools
82% Secondary schools



87% Primary 2012-13
72% Secondary 2012-13



82% Primary pupils in England
71% Secondary pupils in England

Children in need

(as at 31-Mar-14)



262.3 per 10,000 children

44% abuse or neglect
31% family dysfunction



346.4 England rate

Under 16 conceptions



5.1 rate per 1,000
72.0% result in abortion



from 6.0 in 2012



to 4.8 in England

Hospital admissions

(crude rate per 1,000)



118.5 all admissions



53.9 emergency admissions

- 23% injuries/poisoning
- 20% Ill defined conditions
- 14% respiratory



14.3 Admissions for
injuries (age 0-14)



11.2 England rate

Decayed, missing or filled teeth (d₃mft)



0.63 average number
of d₃mft per 5 year old



0.94 England average



23.7% with decay
experience



27.9% England average

Long term conditions



2,600 asthma



1,000 history of fall



500 anxiety



400 autism

Lifestyles by age 15



7.1% current
smokers



16.5% were drunk
in the past month



51.7% eat 5 a Day



13.6% physically
active

2014 Young adult Health at a Glance

Stockport has 31,000 residents aged 15-24



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Mortality

(Crude rate per 100,000)



42.1 in 2011-13



29.2 in England & Wales

30.3 Stockport 2001-03

Number of deaths

40 in 2011-13

28 in 2001-03

Causes of death:

40% of deaths due to external causes (accidents and harm)

↓ 57% in England

Sexual health



2,716 chlamydia detection rate per 100,000



1,978 in England

2,114 Stockport 2013



1,091 EHC items prescribed

Domestic violence

Women aged 16 to 19 are at the highest risk of

- sexual assault (7.9 %),
- stalking (8.5%)
- domestic abuse (12.7%).

Women aged 20 to 24 are only slightly less at risk

Education



4.9% 16-18 year olds not in education, employment or training



from 5.4% in 2013



4.7% England rate

Crime

(Crude rate per 100,000 10-17 year olds)



254.8 First time entrants to youth justice system



from 243.6 in 2012



440.9 England rate



5% victims of violent crime in 2014

Over twice the percentage of any other age group (CSEW)

Live births <20 years



15.0 rate per 1,000
120 live births



from 18.7 (150) in 2012



to 17.2 in England

Hospital admissions

(crude rate per 1,000)



230.1 all hospital admissions



101.8 emergency admissions:

- 19% ill defined conditions
- 17% pregnancy related
- 17% injuries/poisoning



18.9 Admissions for injuries



13.7 England rate



Age standardised rate per 100,000 for self-harm



618.3 age 10-24



412.1 England rate

Long term conditions



2,600 anxiety



2,000 asthma



1,800 depression



800 self harm

Lifestyle health risks



23.2% current smokers



22.8% binge drink



18.1% eat 5 a Day



70.2% not physically active enough

2014 Older people's health

Stockport has 55,600 residents aged 65+



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% of population

Age 65+



19.4% of Stockport population (55,600)

22.1% 2025 population projection (66,500)

Compared to England



17.6% (2014)

20.2% (2025 projection)

Age 85+



2.6% of Stockport population (7,400)

3.7% 2025 population projection (11,000)

Compared to England



2.6% (2014)

3.2% (2025 projection)

Life expectancy at 65



19.4 years in 2012-14

73.2 in most deprived areas

82.5 in least deprived areas



21.1 years in 2012-14

17.7 in most deprived areas

22.5 in least deprived areas

Healthy life expectancy at 65



10.3 years in 2011-13

5.6 in most deprived areas

12.7 in least deprived areas



10.7 years in 2011-13

6.5 in most deprived areas

12.8 in least deprived areas

Hospital admissions age 65+ (2012-13, directly age standardised per 100,000)



28,754 emergency hospital admissions

41,237 in most deprived areas
23,706 in least deprived areas



27,070 in 2012-13



2,748 injuries due to falls

3,896 in most deprived areas
2,351 in least deprived areas



2,367 in 2012-13



6,652 cancer admissions

6,133 in most deprived areas
6,645 in least deprived areas



6,073 in 2012-13

Excess winter deaths



65.5 (9.5%) age 65+

100.5 (12.7%) all ages

7.2% in 40% most deprived areas (65+)
14.5% in 40% most deprived areas (aa)

11.6% England and Wales (all age)

Health and wellbeing



2,700 with dementia



20% with 2 or more long term conditions



33% living alone



42% cannot do at least 1 domestic task



14% provide unpaid care



50% with a long term health problem or disability

Social Care



775.7 Permanent admissions to care homes (65+ per 100,000)
731.4 National average



86.6% Older people at home 91 days after leaving hospital
83.7% England average

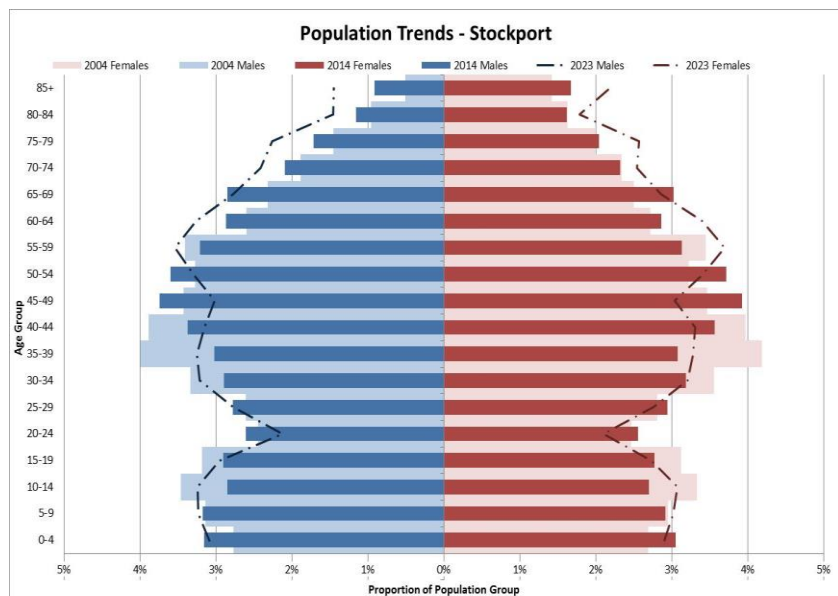


89.2% people using adult social care who received self-directed support
59.9% England average

Key Findings - Demographics



 **286,800**



Projected Population

Age group	2014	2017	2020	% increase 2014-2020
0-17	61,500	62,050	63,750	+4%
18-64	169,600	169,650	169,600	-
65-74	29,500	30,850	31,300	+6% ↑
75-84	18,750	19,200	20,550	+10% ↑
85+	7,400	8,300	9,200	+24% ↑
TOTAL	286,750	290,050	294,400	+3%
Total 65+	55,650	58,350	61,050	+10%

- The population of Stockport is now expected to grow, previously it was expected to be stable:
 - There are currently more births than deaths
 - The population is living longer
 - There are significant planned housing and economic developments
- The population is likely to be needier:
 - Birth rates and numbers have grown most rapidly in deprived areas, where there are more children at risk
 - Ageing population, with more health needs
 - More people living in one person or lone parent households
- Stockport had seen a trend of population growth being more rapid in deprived areas over the last decade, this may change as there are some planned large scale housing developments in the less deprived areas
- The population of Stockport continues to become more ethnically diverse, especially in younger populations to the west of the borough. Immigration rates in Stockport are lower than national averages.

Key Findings – Service Locations

- Health services within Stockport are well distributed - with concentrations in the town centre and main district centres;
- The vast majority of Stockport residents are within easy reach of a GP surgery and a pharmacy;
- The net effect of people travelling to access GP services is that Stockport imports around 2,700 patients;
- People who live to the west of Stockport are more likely to use hospital provision outside of Stockport;
- Care homes and specialist housing provision for older people are spread throughout the borough, regular reviews of the capacity for our ageing population will need to be undertaken
- There are a range of independent providers of health and care services in Stockport, including private hospitals, hospices, voluntary organisations and local providers of home based care. A comprehensive assessment of the full range of these services has not yet been undertaken.



Stockport has...



47 GP Practices



69 Pharmacies



48 Dental Practices



38 Opticians



67 care homes



170 housing schemes



12 council direct centres

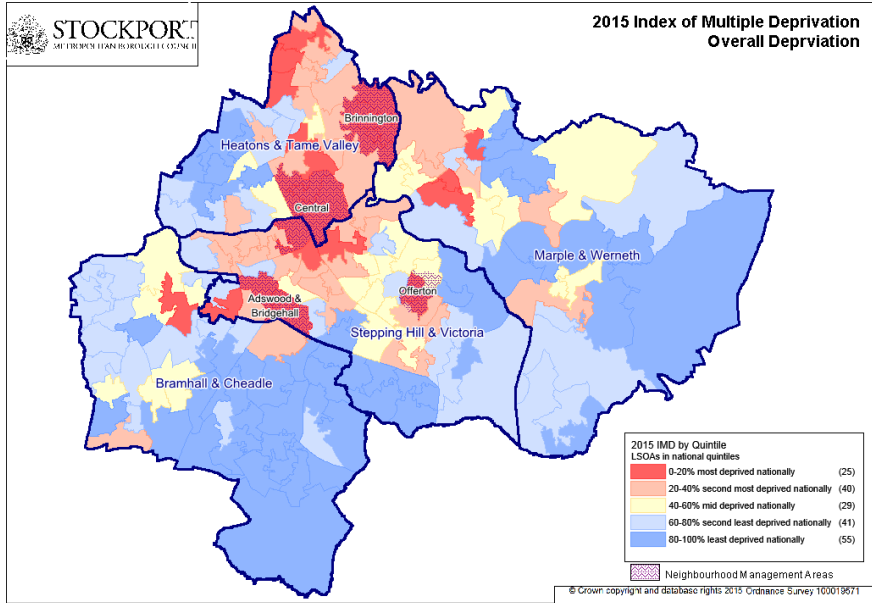


1 hospital provider

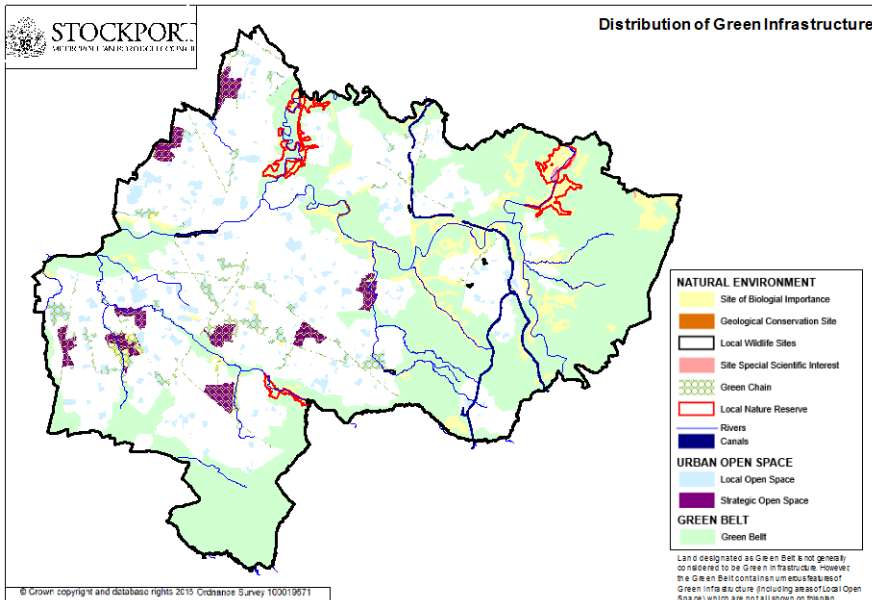


1 mental health provider

Key Findings – Socio-economic



- Stockport has pockets of severe deprivation, but that deprivation is not particularly widespread
 - 14% of the population lives in the nationally ranked 20% most deprived areas, 28% in the least deprived
 - Brinnington and Lancashire Hill are the most deprived areas in the borough, ranking within the 2% most deprived nationally; areas of social housing concentrate in these areas
 - There are pockets of deprivation across most parts of Stockport
- 85% of working age people who claim out of work benefit do so because of ill health or disability – half of which relate to mental health
 - 13,800 working age people in Stockport are claiming disability related benefit – numbers have been stable since 2005
 - 2,200 people in Stockport are claiming Job Seekers Allowance – this has fallen in recent years from a high of 6,000 in 2009
- There are an estimated 30,000 low income households in Stockport
 - On average household incomes in Brinnington are 50% lower than in Bramhall
- There are an estimated 36,400 people living in poverty:
 - 10,400 older people living in poverty
 - 8,500 children living in poverty
- Educational attainment shows a deprivation gap which isn't evident at birth, which develops and continues to widen as children grow up, so that by age 16 25% of children in Brinnington & Central achieve 5 A*-C GCSEs
- Housing and assets such as greenspace and leisure facilities have a significant impact on both physical and mental wellbeing. Stockport has a good range of assets however provision varies across the borough.



Key Findings – Vulnerable and at risk groups

At some point in our lives we are all likely need some support, be that from family, friends, the NHS or social care services. Some groups are more likely to require support than others.

There are people within our community who are more likely to be vulnerable or at risk due to their personal circumstances.

The table shows a headline indicator for each risk characteristic, summarising the full available analysis.

The information comes from a range of sources, and in many cases is a best estimate based on either national prevalence or small local samples.

All numbers should therefore be treated as indicative.

When commissioning or planning services we need to consider the size of the population in need and the levels and type of additional support that may be needed by people with particular characteristics.



People with mental health problems	6,500 (benefit uptake) / 16,500 (depression) / 30,000 (low wellbeing)
People with learning disability	1,225 (adults with moderate or severe) / 5,250 (adults total)
People with autism	2,500 (modelled)
People with physical disability / sensory impairment	11,600 (benefit uptake) / 98 young people aged 0-25 receive continuing care
People with long term health conditions	124,000 with at least one condition (SHR)
Older people	55,600 aged 65+ (ONS)
People at risk of falls	1,300 admissions from falls aged 65+ (CMS)
People at risk of loneliness or social isolation	38,500 people living alone (Census)
Carers, including young carers	32,000 (Census)
Asylum seekers / refugees	100 asylum seeker households (benefit uptake)
BME communities: South Asian	10,000 (Census)
BME communities: Black Caribbean and Black African	2,000 (Census)
Gypsies & travellers	1,720 (modelled)
Immigrants (last 10 yrs)	6,400 resident in UK less than 10 years (Census)
LGBT	17,000 (modelled)
Domestic abuse victims	5,000 incidents in year (report to CLT) / 3,000 children domestic abuse referral
Child sexual exploitation	50 referrals to MASE per year
Looked after children – both resident and responsible	484 living in Stockport (Vulnerable Children's Team)
Care leavers	50 per year (EIS)
Teenage conceptions	150 per year (TPU) / 40% result in a birth
Children eligible for free school meals	5,179 children are eligible for free school meals
Children with SEN (special educational need)	6,874 with SEN (1,666 with statements)
Children in need	2,903 children assessed as being in need (2014/15)
Drugs / Substance misuse	900 adults in drug treatment (NDTMS) / An estimated 7,000-9,000 drug users
Alcohol misuse	60,000 adults unhealthy drinking (ALS)
Offenders	75 new young offenders, 800 probation clients
Homeless	500 households (Stockport Homes)
Workless	2,700 (benefit uptake), 410 NEET
Veterans	22,500 (modelled)

Key Findings – life expectancy



Wards	Male Life Expectancy at birth (2011-2013)	Female Life Expectancy at birth (2011-2013)
Bramhall North	84.5	85.0
Bramhall South & Woodford	84.9	86.6
Bredbury & Woodley	78.4	82.0
Bredbury Green & Romiley	79.8	81.9
Brinnington & Central	72.1	76.9
Cheadle & Gatley	81.2	84.8
Cheadle Hulme North	80.3	83.9
Cheadle Hulme South	82.1	86.2
Davenport & Cale Green	76.7	77.4
Edgeley & Cheadle Heath	75.7	81.7
Hazel Grove	81.4	86.5
Heald Green	81.8	86.6
Heatons North	79.4	83.0
Heatons South	81.5	83.8
Manor	79.3	82.0
Marple North	79.2	83.2
Marple South	79.5	84.0
Offerton	79.8	83.5
Reddish North	78.8	82.5
Reddish South	78.6	83.6
Stepping Hill	81.1	82.9
STOCKPORT	79.7	83.0
Gap between highest and lowest	12.8	9.8

Highest ward

Lowest ward

Life expectancy at birth has increased by 10% over the last 20 years. **Males in Stockport are now expected to live to age 79.7 and females to age 83.0 years** which is similar to the national average

The gap between the genders has narrowed as male life expectancy has grown more quickly than female life expectancy.

There are **clear deprivation profiles in life expectancy** with males in the least deprived areas (as measured by quintile of deprivation) are expected to live 9.7 years longer, and females 7.4 years longer, than in the most deprived areas.

The inequality gap in life expectancy has not narrowed over the last 10 years.

The main causes of death responsible for the inequality in life expectancy are cancer, circulatory disease and respiratory disease for males and cancer for females, causes of death that are linked to lifestyles.

The main contributing age group to life expectancy inequality is those dying between the ages of 50 and 69.

Early mortality is **largely preventable**.

Key Findings – healthy life expectancy at birth

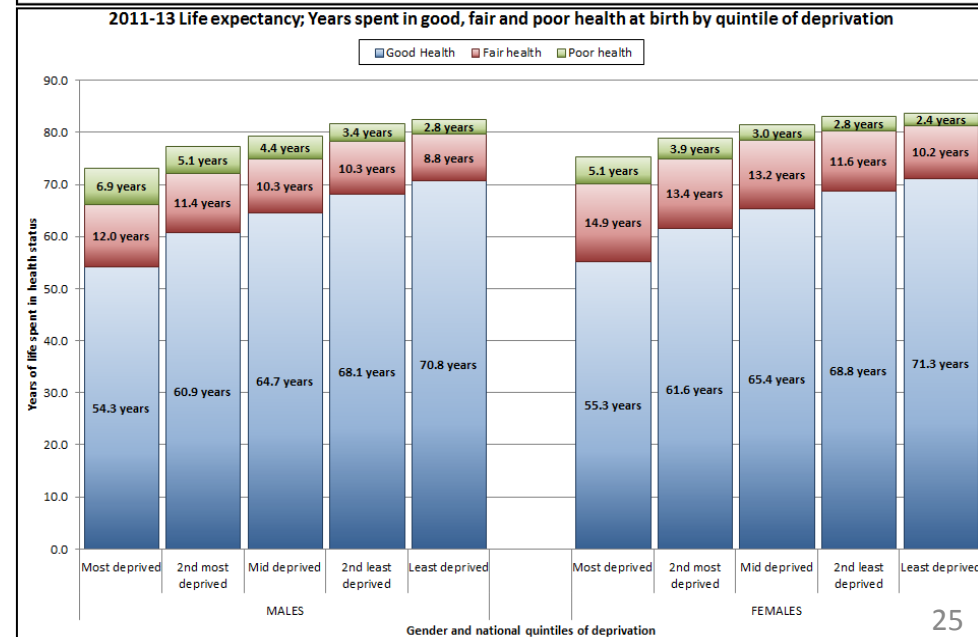
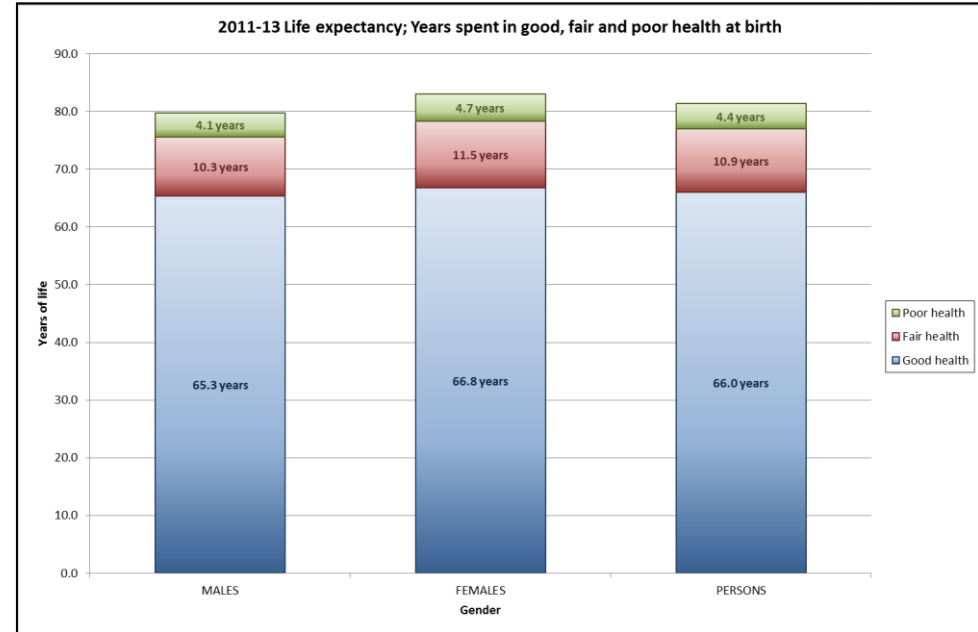
Healthy life expectancy is a new measure.

18% (males) and 20% (females) of a typical Stockport resident's life will be spent in fair or poor health; 5-6% will be spent in poor health.

An inequality gap exists in the healthy life expectancy of both male and females

- In the most deprived areas men will on average have 7 years (9.4% of life) poor health compared to 3 years (3.4%) in the most affluent areas.
- In the most deprived areas women will on average have 5 years (6.8%) poor health compared to 2 years (2.9%) in the most affluent areas.
- In the most deprived areas men will on average have 19 years (25.8%) fair or poor health compared to 12 years (14.1%) in the most affluent areas.
- In the most deprived areas women will on average have 20 years (26.6%) fair or poor health compared to 13 years (15.0%) in the most affluent areas.

In the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas.

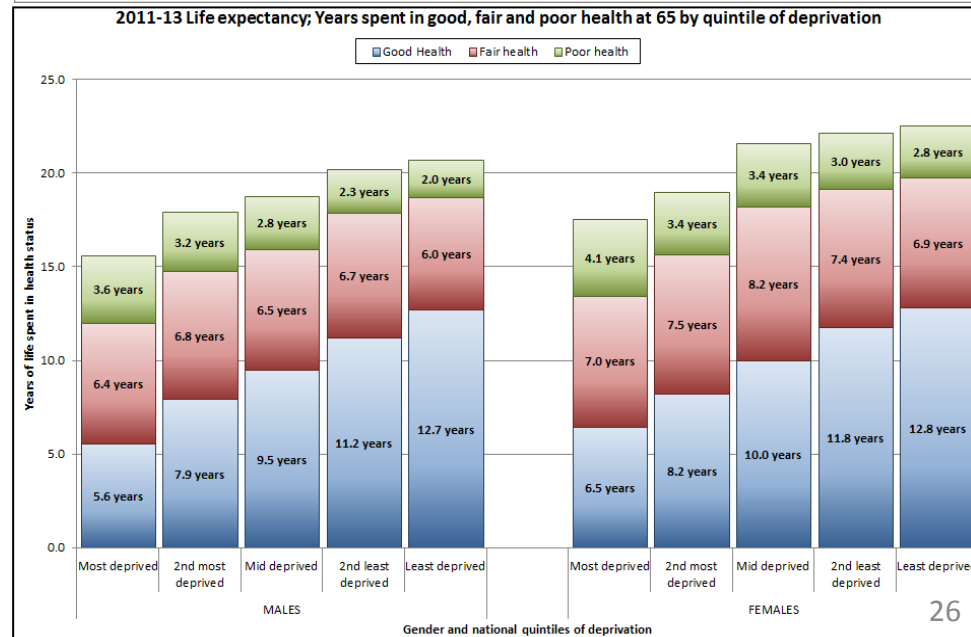
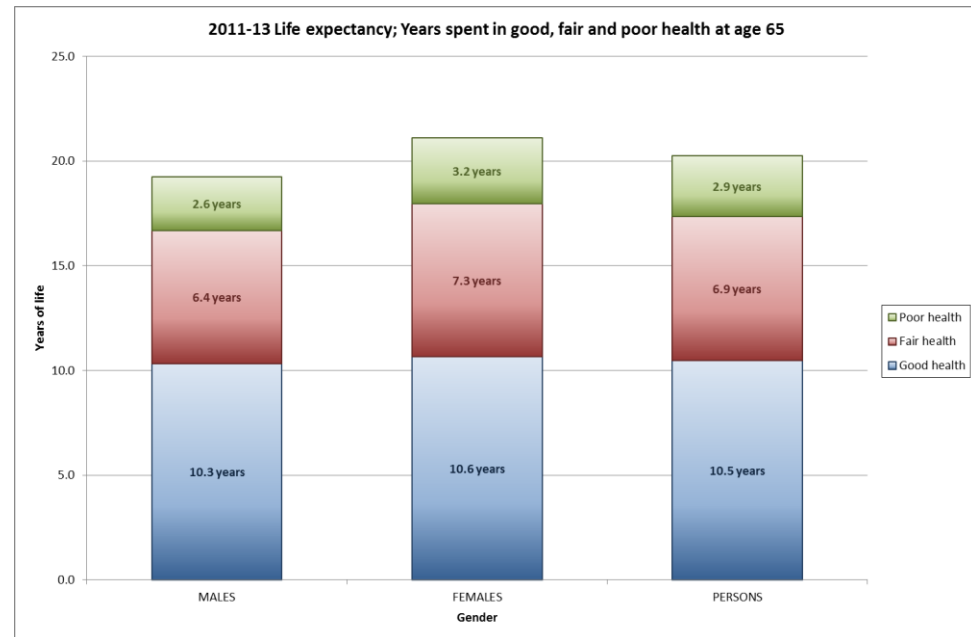


Key Findings – healthy life expectancy at age 65

At age 65, 46% (males) and 50% (females) of a typical Stockport resident's remaining life will be spent in not good health; 13-15% will be spent in poor health

At age 65 the inequality gap is in the number of years lived in good health and in poor health rather than the years lived in fair health

- Males and females at age 65 living in the two most deprived areas will spend more than 50% of their remaining years in fair or poor health.
- In the most deprived areas men will on average have 4 years (23.1%) poor health compared to 2 years (9.7%) in the most affluent areas.
- In the most deprived areas women will on average have 4 years (23.3%) poor health compared to 3 years (12.5%) in the most affluent areas.
- Men live 7 years longer in good health in the least deprived areas compared to the most deprived
- Females live 6 years longer in good health in the least deprived areas compared to the most deprived



Key Findings – long term conditions



Condition	Number (Aug 15)	Gender pattern	Age trend	Deprivation
Hypertension	43,589		Highest 45+	Increase with dep
Anxiety	40,114	Higher in F.	Highest 40-59	Increase with dep
Depression (18+)	26,088	Higher in F.	Highest 40-54	Increase with dep
Obesity (16+)	20,544*			Increase with dep
Asthma	19,933			Increase with dep
Diabetes	14,816		Highest 45+	Increase with dep
Coronary Heart Disease (CHD)	12,304	Higher in M.	Highest 45+	Increase with dep
History of Fall	11,433	Higher in F.	Highest 75+	Increase with dep
Cancer	7,992			Decrease with dep
Chronic Kidney Disease (CKD)	7,698		Highest 50+	Increase with dep
Chronic Obstructive Pulmonary Disease (COPD)	6,959		Highest 45+	Increase with dep
Stroke or Transient Ischaemic Attack (TIA)	6,224		Highest 45+	Increase with dep
Self harm	6,054*	Higher in F.		Increase with dep
Atrial Fibrillation (AF)	5,903		Highest 50+	
Heart Failure (HF)	2,812		Highest 55+	Increase with dep
Dementia	2,695	Higher in F.	Highest 65+	Increase with dep
Glaucoma	2,504		Highest 55+	
Severe mental health	2,434			Increase with dep
Epilepsy	2,389			Increase with dep
Peripheral Arterial Disease (PAD)	2,233	Higher in M.	Highest 55+	Increase with dep
Rickets	1,570	Higher in F.		
Learning disability	1,495	Higher in M.		Increase with dep
Rheumatoid Arthritis (16+)	1,482	Higher in F.	Highest 45+	
Acute Macular Degeneration (AMD)	1,428*	Higher in F.	Highest 75+	Decrease with dep
Autism	927*	Higher in M.		
Cerebral palsy	275*			
Downs Syndrome	234	Higher in M.		

Information about the number of people in Stockport with certain illnesses or disabilities has been analysed from Stockport GP practice registers - this excludes acute health needs, for example infections, so is not a measure of all needs and demands.

- Overall, **41% (124,000) of the people registered with Stockport GPs have one or more of the conditions analysed**
- It is important to note that the 59% of people not in this analysis may have undiagnosed conditions or have poor health generally, and equally the people with long-term conditions may be healthy and well self-managed.
- The proportion with at least one condition increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over
- **By age 55, half of the people in Stockport have one or more of these conditions.**
- **Asthma** is the major condition affecting **school aged children** in the borough (more than 2,000 cases aged 5-14) , **anxiety** affect those **aged 15-24** in particular (more than 2,700 cases).

Key Findings – multiple long term conditions

In addition to looking at each of the conditions individually it is also useful to understand trends in the number of conditions people are living with, and how this varies over the life course – as this gives some measure of the complexity of issues, co-morbidities and treatments patients and health carers may be dealing with. Analysis focussed on 8 groups of diagnoses, excluding some conditions where data quality is lower or where people may not need clinical management permanently.

9% (26,250) of the population have two or more of 8 key long term conditions

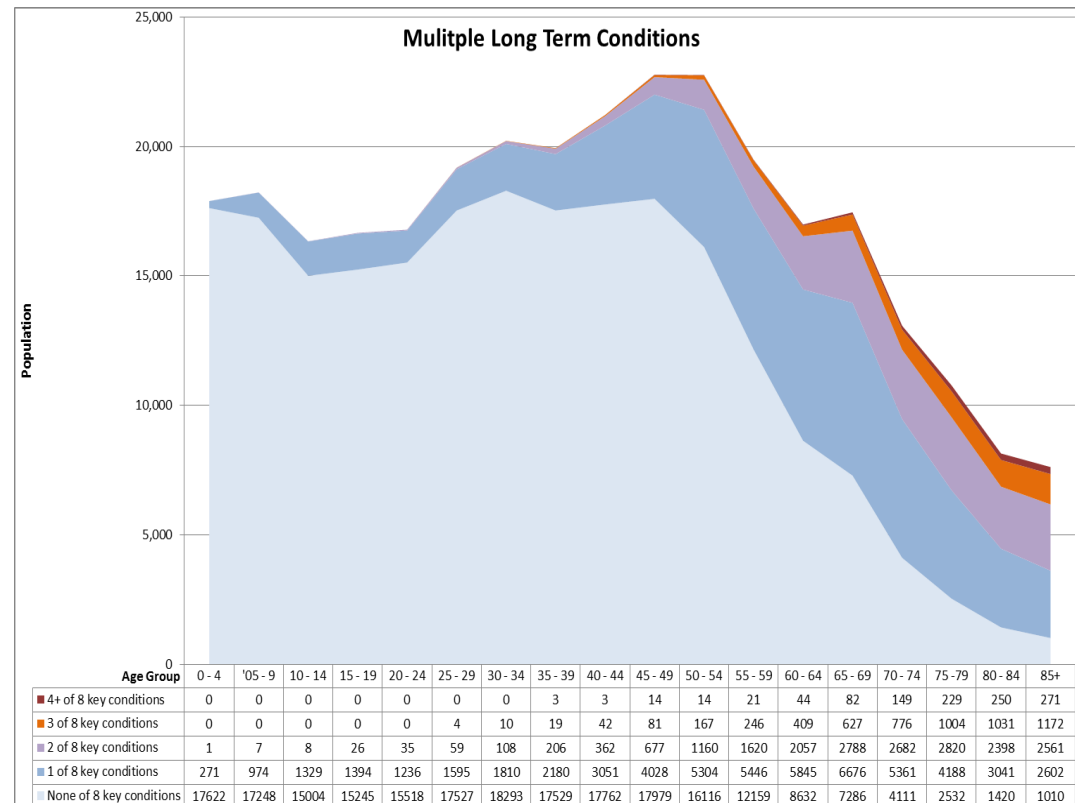
These key conditions are strongly age related.

- By age 65, 58% of the population have at least one of the key conditions, with 20% having two or more.
- In the **oldest age group**, 87% have at least one condition, with **53% having two or more of the conditions**

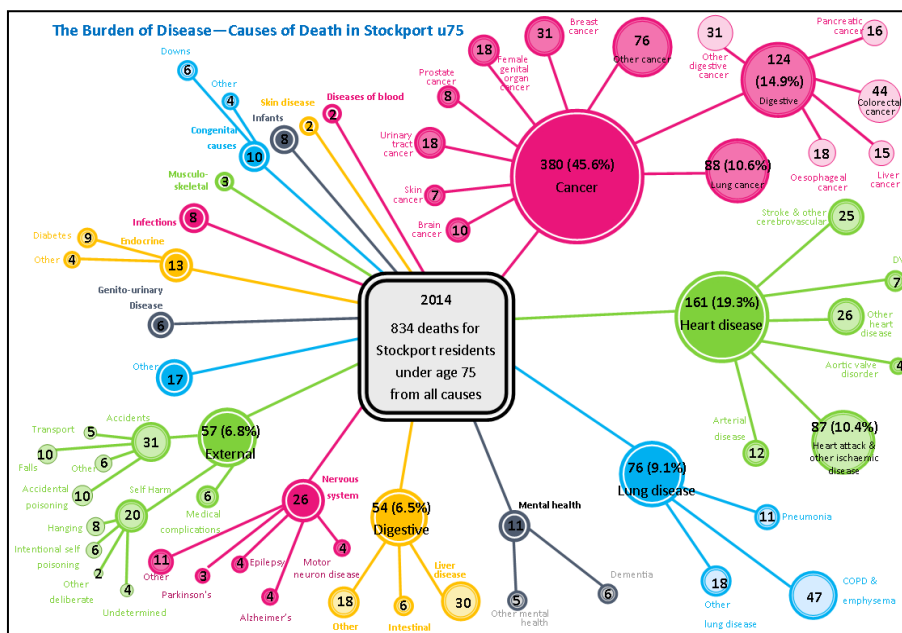
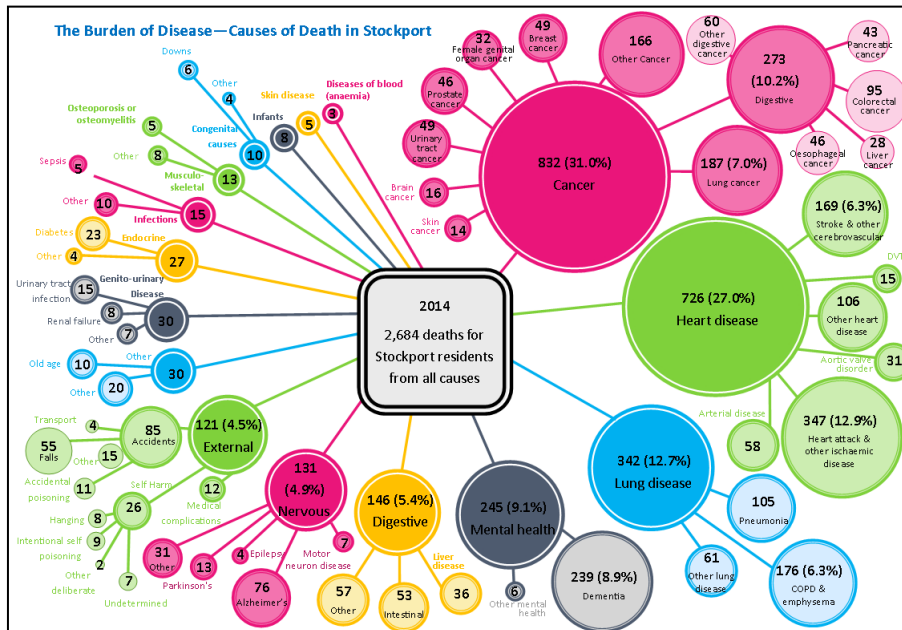
The rates of these key conditions show a strong deprivation profile. As the number of conditions increase, the deprivation profile becomes more pronounced.



Number of key conditions	Number of people	% of people
0	222,993	73.0%
1	56,331	18.4%
2	19,575	6.4%
3	5,588	1.8%
4	984	0.3%
5+	96	<0.1%



Key Findings – causes of death



Between 1995 and 2013 overall mortality rates fell by 25%, and the number of deaths a year fell by 10%. Rates for early deaths have fallen even faster, by 33%.

- Inequalities have not narrowed, mortality rates in the most deprived areas are almost double those in the least deprived areas.

Cancer is now the single biggest cause of death in Stockport

- Cancer, heart disease and lung disease are the largest causes of death in Stockport at all ages.
- Cancer, heart disease and external causes (accidents or self harm) are the biggest causes of early death in Stockport.
- Cancer accounts for a far bigger share of early deaths than it does for deaths overall.
- Mortality rates for both cancer and heart disease are falling, but are falling faster for heart disease than cancer.
- Mortality rates have risen for dementia (mostly driven by coding changes) and liver disease.

Mortality rates are higher for men than women for all causes apart from dementia, this is because on average males die earlier than females.

All major causes of death show a deprivation profile with digestive mortality rates being the most inequitable in all ages and under 75's.

Around 550 deaths a year are from preventable causes.

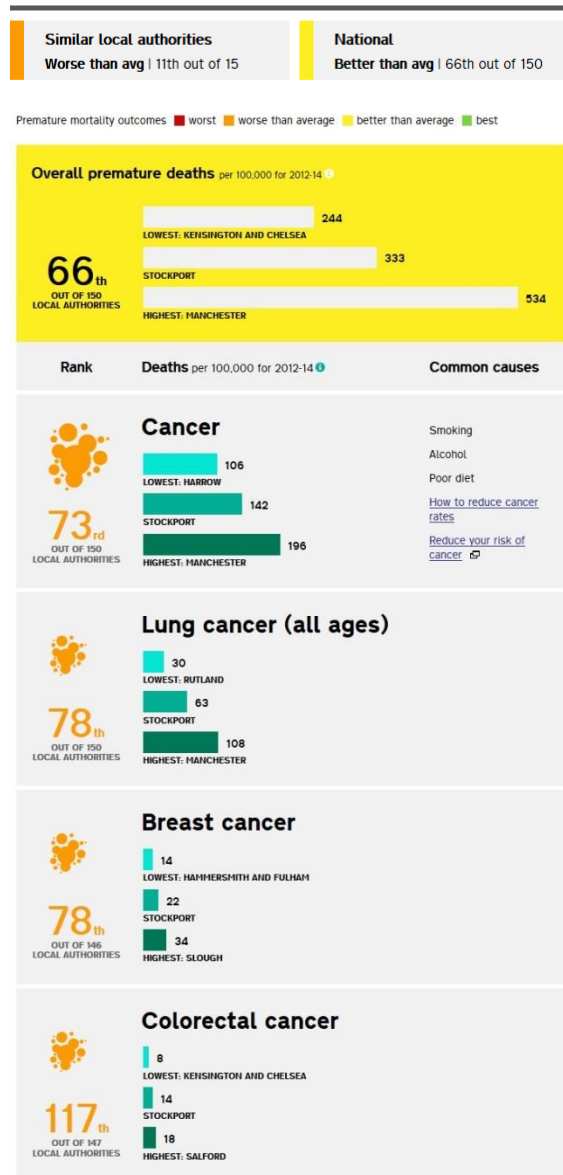
Rates of infant and child mortality are low and stable.

Key Findings – benchmarking premature death

- Stockport ranks significantly worse compared to similar local authorities for:
 - Liver disease (70 deaths a year)
- Stockport ranks worse for
 - Cancer (350 deaths a year)
 - despite over the same period having some of the best one year survival rates nationally, this is likely to be due to deaths that occurred more than one year after diagnosis
 - Injuries (35 deaths a year)
- Stockport ranks significantly better for:
 - Lung disease (65 deaths a year)
 - Heart disease and stroke combined (170 deaths a year)

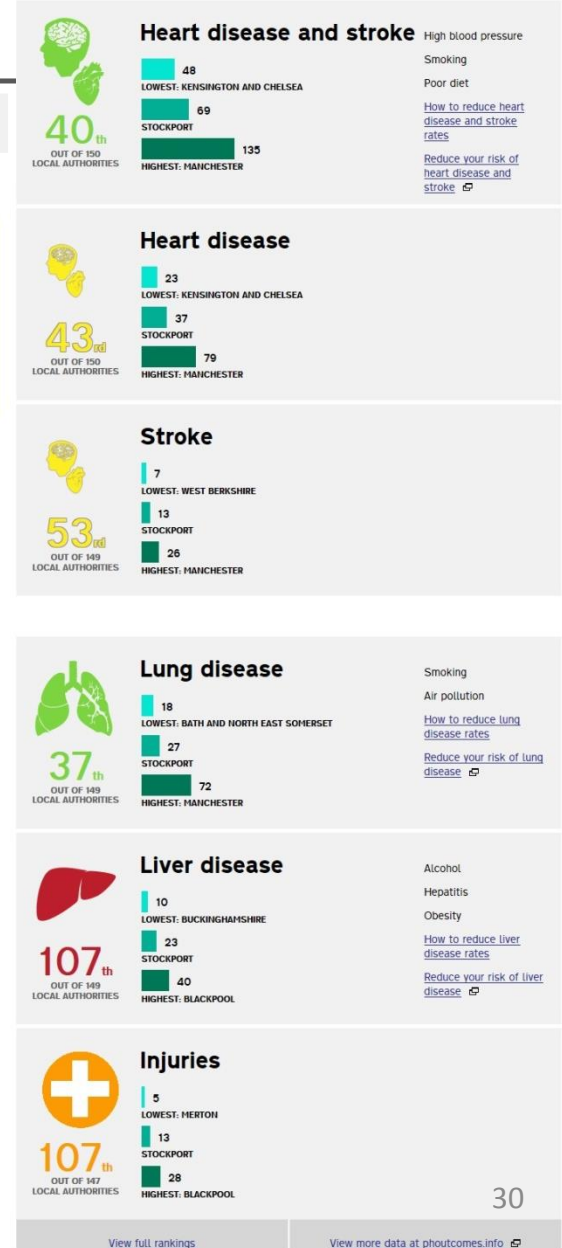


Stockport



Stockport JSNA

joint strategic needs assessment



Public Health England

<http://longerlives.phe.org.uk/>

Key Findings – focus on cancer



Prevention



cancers are preventable



19.4% of all new cancer cases due to tobacco



9.2% due to poor diet



5.5% due to excess weight

4 in 10 cancers can be prevented – the main preventable cause of cancer being smoking.

In the years 2011-13 over 5,000 new cases of cancer were diagnosed amongst Stockport residents. Lung, colorectal, breast and prostate cancer made up over 54% of these new cases

In Stockport cancer is the biggest cause of death, responsible for 30% all age (811) and 45% under 75 (377) deaths in 2014. Lung, colorectal, breast and prostate are the largest causes of cancer deaths

Those living in the most deprived areas suffer the greater burden of all cancer, and particularly lung cancer

In the two years between 2013-14 and 2014-15 there were 1,135 operations to remove major cancers. In 2014-15 initial oncological outpatient appointments where a follow up was required totalled 1,812.

Stockport has better 1 year survival rates in all cancers and three cancers combined (female breast, colorectal and lung) than England and Greater Manchester – however despite this overall mortality rates in Stockport are not better than national average.

Screening uptake for both bowel and breast cancer are lower in Stockport than the national average

Incidence



5,102 new cancers 2011-13



757 female breast cancer



729 lung cancer



688 colorectal cancer



610 prostate cancer

Mortality



2,326 cancers deaths 2012-14



531 lung cancer



249 colorectal cancer



172 female breast cancer



144 prostate cancer

Key Findings – focus on liver disease

Liver disease mortality is one of the few causes of death that has risen over the last 20 years and is also one of the few causes where rates in Stockport are significantly higher than the national average.

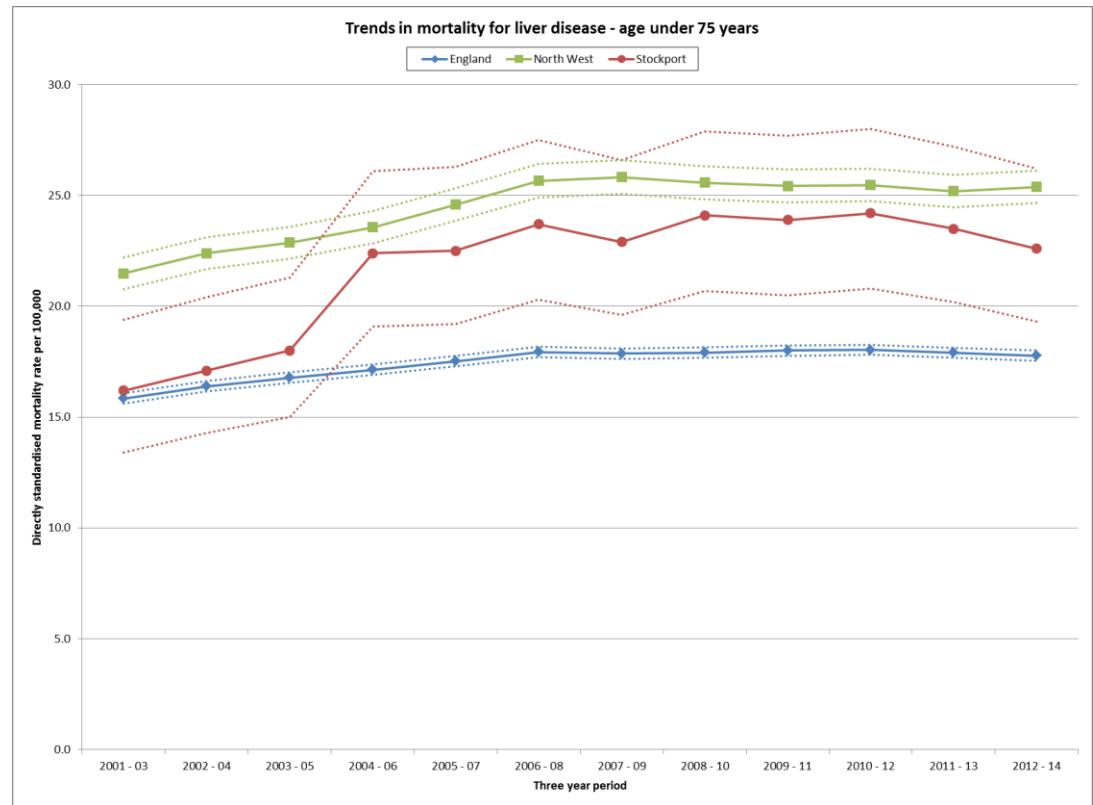
Trend analysis shows that this rise occurred in the middle of the last decade – when the number of annual deaths increased from 40 up to 60. This increase was in both cancers of the liver and in alcoholic liver disease.

Since then rates have levelled out, but have maintained the gap to the national average. Similar trends occurred in Rochdale and Bury, but not in all areas.

Early indications from 2012-14 suggests that rates may be falling, however Stockport is still well above national average.

The majority of these deaths occur for people aged 45-69 and there is a close link to **alcohol and obesity**.

90% of these deaths are defined as preventable if lifestyle issues were addressed.



Key Findings – adult lifestyles



32% of adults have three or more lifestyle risk factors



18% of adults smoke – rates are falling



26% of adults drink unhealthily – rates are stable



7,000-9,000 Stockport residents use illegal drugs – rates for opiates are falling



0.9% of adults have tried New Psychoactive Substances (legal highs)



74% of adults are not active enough – rates are stable



25% of adults are obese – rates are stable



Smoking, poor diets, low activity, alcohol and obesity are a major underlying cause of disease and disability.

Smoking is the biggest single cause of poor health – however rates in most areas of Stockport are falling – priorities for smoking therefore **focus on inequalities**, as rates in deprived areas and certain vulnerable groups (such as those with mental health problems) remain **more than twice the average**.

Alcohol also remains a key concern, although rates of consumption are no longer rising the impacts on health are still significant and are felt disproportionately in the most deprived areas. Stockport has especially **poor outcomes for liver disease**, caused by both alcohol and obesity.

A key priority for Stockport is **physical activity**, the burden of disease study highlights activity / inactivity on it's own as having a significant impact on health, aside from the indirect impact through weight management and blood pressure. **More than 200** deaths a year in Stockport could be saved if every adult met the target of 5 x 30 minutes moderate activity a week.

Obesity is also of increasing concern with more than 25% of adults being obese, and being a significant cause of liver disease, heart disease and diabetes.

Adult lifestyle behaviours also **impacts on children**:

- 40% of adults receiving drug and alcohol treatment live with children either some or all of the time;
- Generally people who live with children some of the time have poorer lifestyles than those who live with children all of the time.

Key Findings – impact of lifestyles



Analysis from the Global Burden of Disease Study 2010 (published in The Lancet in 2012) shows that the underlying risk drivers of **early disease and disability are largely preventable**.

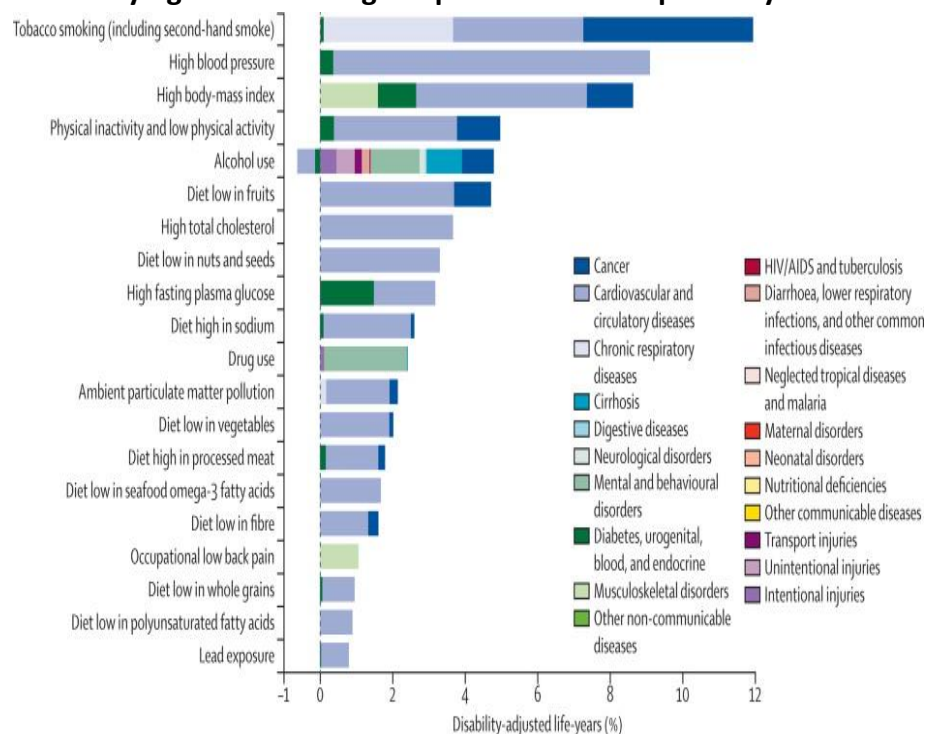
Smoking, poor diets, low activity, and alcohol are a major underlying causes of disease and disability and the **most significant driver of health inequalities**.

Further analysis by PHE has shown how these **risks vary by deprivation, tobacco is the biggest underlying cause in the three most deprived quintiles in the North West**.

In the **two least deprived quintiles** however **dietary risks** (including low fruit, nuts and seeds, vegetables) are the most significant cause of disease and disability.

Obesity and high blood pressure are the third and fourth most significant drivers.

Underlying causes driving inequalities in life expectancy



Rank of risk impact by deprivation (1=most deprived) in NW

	NW England	NW England Lev1	NW England Lev2	NW England Lev3	NW England Lev4	NW England Lev5
Tobacco	1	1	1	1	2	2
Dietary risks	2	2	2	2	1	1
High body-mass index	3	3	3	3	3	3
High blood pressure	4	4	4	4	4	4
Alcohol & drug use	5	5	5	5	5	6
High fasting plasma glucose	6	6	6	6	6	5

Key Findings – mental health wellbeing



There are approximately **28,000 over 18's** (12%) in Stockport with **below average mental wellbeing**.

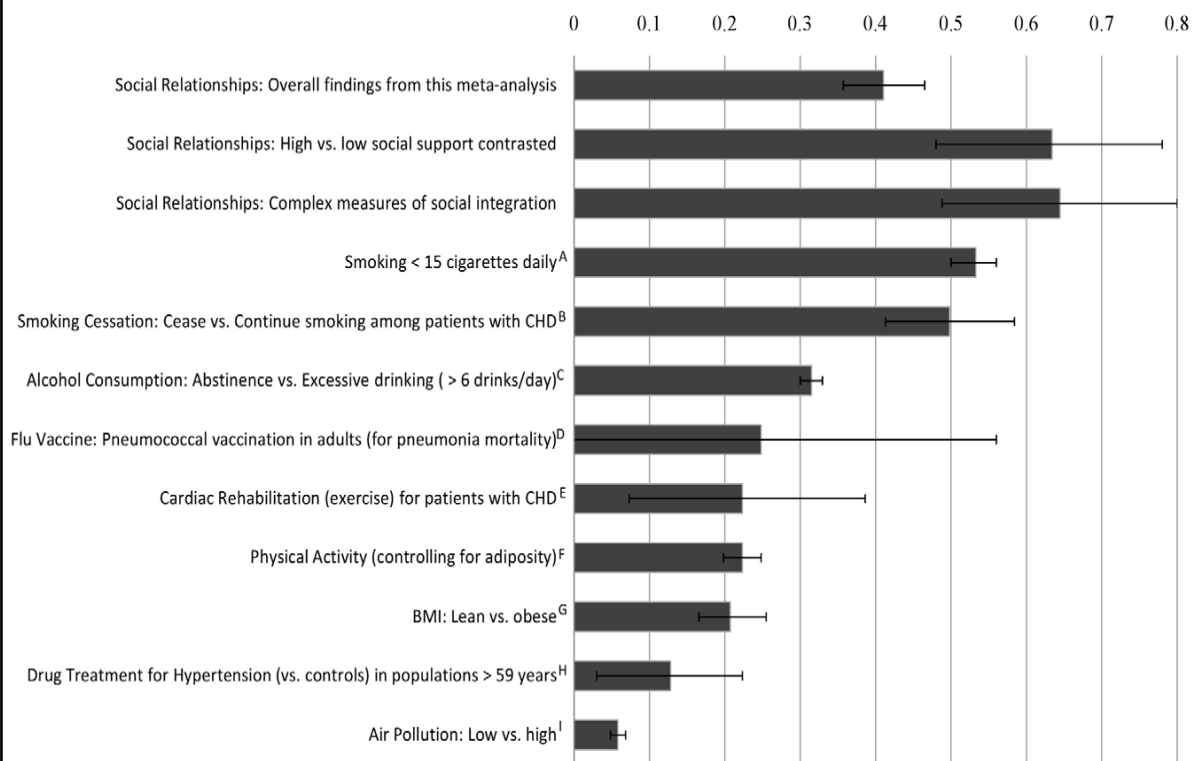
The risk of low mental wellbeing appears to be at the beginning of adulthood and at the very end of life. Wellbeing is highest in those aged 60-79 years.

There is a **clear deprivation profile for wellbeing**, with rates in the most deprived areas are more than double those in the least deprived.

Research shows that levels of **social support** can have as significant an impact on physical health as lifestyles such as smoking and alcohol.

The **Five Ways** to Wellbeing are a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population.

The relative value of social support/ social integration



Meta analysis: comparative odds of decreased mortality

Source: Holt-Lundstad et al 2010

Key Findings – mental health



1 in 4 adults in the UK will suffer from a mental health condition in any given year – in Stockport this equates to 56,300 adults. Over 60% of this population remain unidentified or not seeking treatment and any analysis of this group is difficult as they are unknown to services.

Depression and anxiety

- There are **26,000 people registered with a Stockport GP with a history of depression** and there are **40,000 people registered with a history of anxiety**
- Those aged 25-59 have the highest rates, **peaking for people in their 40s. Women** are nearly twice as likely to be diagnosed as men and there is also a clear **deprivation trend**.
- Around 5,000 people in Stockport claim Disability Living Allowance (DLA) because of a mental or behavioural disabling condition. This represents **half of all working age DLA claimants**.
- In Stockport the rate of referrals to IAPT **has almost doubled from 646 to 1,265 per 100,000** in under 2 years.

Serious mental illness

- There are over **2,400 people registered with a Stockport GP with a severe mental health disorder**, those in the **most deprived areas are over three times as likely to be experiencing a severe mental health problem** than those in the least deprived areas.
- The under 75 mortality rate for those with serious mental illness in Stockport is **almost four times higher** than that of the average for the borough. This is particularly driven by **high rates of smoking**—national research suggesting that 85% of the mortality gap is due to smoking.

Acute care and mortality

- Stepping Hill Emergency Department attendances with a psychiatric diagnosis have risen by 94% in seven years to 1,975 in 2014-15. Those aged under 45 are most likely to attend, especially those **aged 15-24 for self-harm**.
- Research being undertaken by Stockport HealthWatch shows that the physical health needs and especially **physical activity needs** of patients in inpatient psychiatric care are not being met – for this group the principle of the parity of esteem is key.
- There are 700 hospital admissions a year for deliberate self-harm predominantly from those aged 15-44, the inequality profile shows that rates in the **most deprived areas are more than four times higher than in least deprived areas**.
- Roughly **30 deaths a year occur due to suicide and deaths of undetermined intent** (open verdicts) with those aged 35-44 the key risk group.

Child and adolescent mental health

- Research suggests there are **4,000 5 to 16 year olds living in Stockport with a diagnosable mental health disorder**.
- In 2014-15 there were 2,348 referrals to tier 3 Children and Mental Health Services.
- Rates of admissions for mental health problems and self harm are higher in Stockport than the national average, and are especially high for **older teenage females** and for those who live in areas of **deprivation**.
- 50% of children with a Special Educational Needs Statement have social, emotional and mental health needs.

Key Findings – public opinion



In 2015 the people of Stockport said a good experience of health or care service would be:



Access to appointments - fast and easy access to primary care help when needed

Information & communication – more information and discussion with patients and families

Attitudes and listening – professionals taking time and treating people with respect

Integration – services that are joined up and making use of technology to share information

Community – services which are available locally, focusing on prevention so can stay in our own homes









LGBT Youth – to be treated with respect and listened to by health care staff

Key Findings – health and social care service use



The currency for activity varies across sectors, with Primary, community and mental health care dealing mainly in appointments, acute measuring staff time through admissions or bed days and social care using clients or care packages as a measure of activity. This can make it a challenge to compare.

- Overall the trends show a large volume of health and care activity takes place in Stockport each year across a range of settings, the majority of this is for older people.
- Volumes of service use are increasing, this increase is in excess of that predicted by the changing demographics.
- **Stockport benchmarks as a higher use authority nationally on a range of measures.**

	Volume	Trend	Key issue
Inpatient admissions	97,000	 36% in 10 years	<ul style="list-style-type: none"> • Rates rising, especially for older people • Significant inequalities profile
<i>Inpatients - emergency</i>	<i>39,700</i>	 47% in 10 years	<ul style="list-style-type: none"> • <i>Benchmark as high levels compared to national average and peers</i>
<i>Inpatients - Planned</i>	<i>46,300</i>	 25% in 10 years	<ul style="list-style-type: none"> • <i>Only 60% of activity at main provider</i>
A & E Attendances	94,000	 13% in 7 years	<ul style="list-style-type: none"> • Rise in demand • High levels of admission as result (30%)
Outpatients appointments attended	483,600	 11% in 3 years	<ul style="list-style-type: none"> • Rising demand • Benchmark high on follow up ratio
Community contacts	543,000 of which 245,600 DNursing	 District Nursing 13% in 2 years	<ul style="list-style-type: none"> • Rising activity for district nursing, linked to ageing • Demand will rise further with care planned outside of hospital in Stockport Together.
Mental health care – people in contact with services	11,000 5% as inpatients	 Non inpatient 39% in 6 years	<ul style="list-style-type: none"> • Physical health needs of people on psychiatric wards, especially facilities for physical activity
Adult Social Care	8,455		<ul style="list-style-type: none"> • Fall in levels of provision 2007-2011, now stable • Rise in dementia client group
Primary Care – contacts in practice	700,000+	?	<ul style="list-style-type: none"> • Prescribing volumes rising • Dental access better than average

Key Findings – health and social care service workforce



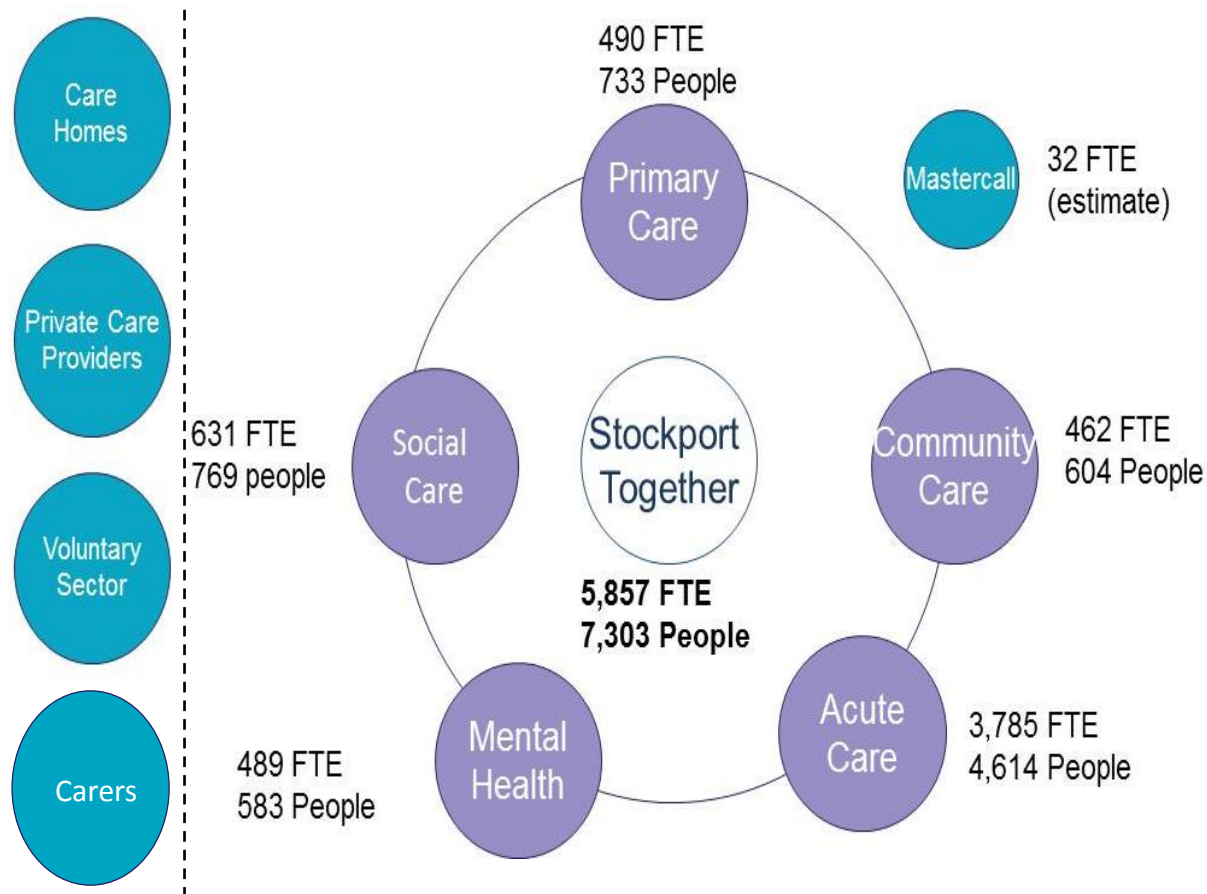
Stockport Together Workforce

The vast majority of Health and Social Care staff in Stockport are employed by the Stockport NHS Foundation Trust (72.5%), of which almost 65% work in the hospital (acute care).

Social Care is the next biggest element of the workforce – although this figure does not include staff in private companies delivering social care, either funded by Stockport Council or self-funded support.

Primary Care, Mental Health and Community services each constitute around 8% of the workforce – which explains the reactive system and need to change to enable a sustainable, preventative approach. Primary Care has particularly high levels of part-time working.

The average age of staff is in the 50s, highlighting a need for workforce continuity planning.



It has not been possible to estimate the size of the workforce in care homes, private care providers (ranging from large hospitals to small independent care organisations and individuals) or the voluntary sector; although these are all important parts of the health and care system.

The 2011 Census showed there are **31,982 unpaid carers** in Stockport (11% of population), over 20% of people aged 50-64 are carers.

Key Findings – carers



Carers – key trends

The 2011 Census showed there are **31,982 unpaid carers** in Stockport (11% of population),

- **66%** (21,091) provide 1-19 hours of care a week
- **12%** (3,921) provide 20-49 hours per week
- **22%** (6,970) provide 50+ hours of care per week.

Signpost for Carers estimate that the total value of unpaid care in Stockport is **£570 million** a year.

There are unpaid carers at all ages, but caring is most common for people aged 50-64, where 20% are carers

- 2,115 carers are under 25 years old
- 22,593 carers are aged 25-64
- 7,274 carers are aged 65+

Older carers are more likely to spend more hours per week caring:

- 38% of carers 65+ provide 50+ hours per week
- 19% of carers 25-49 provide 50+ hours per week

Carers are more likely to be female (58%) than male (42%).

Caring can lead to major health problems for the carer both physically and mentally and impacts on employment and educational opportunities.

- **2,056 (6.4%)** carers report their own health as bad or very bad;
- **6,439 (20.1%)** report their health as fair (rather than good)

Carers UK has highlighted the impact on family finances of giving up work or cutting working hours – including the risk of financial hardship and debt and the long-term damage to carers' careers and pensions.

Cared for – key trends

Most adult carers provide care for a **frail/older** person (62%), people with a physical disability (30%) or someone with a mental health problem (14%) – note the cared for can have more than one issue.

Young carers are more likely than adult carers to be providing care to people with **mental health problems** (38%), learning difficulty (18%), terminal illness (18%) and drug or alcohol problems (13%).

- 28% of young carers provide care for a sibling
- 72% provide care for a parent (Signpost for carers)

Some carers care for more than one person at the same time, and situations range from short term but very intensive caring responsibilities to caring that spans the lifetime of a child or sibling.

Carers – key needs

When carers are well-supported, they provide better care to the person they care for (Ablitt, Jones and Muers, 2009) and report better well-being outcomes themselves (Schoenmakers, 2010).

The needs of the carer are inextricably linked to the person being cared for. However many support services are provided separately by a range of different health, social care and voluntary sector organisations often leaving carers to bring together the different strands of support both for themselves and the person they care for. Carers want joined up, flexible and responsive services.

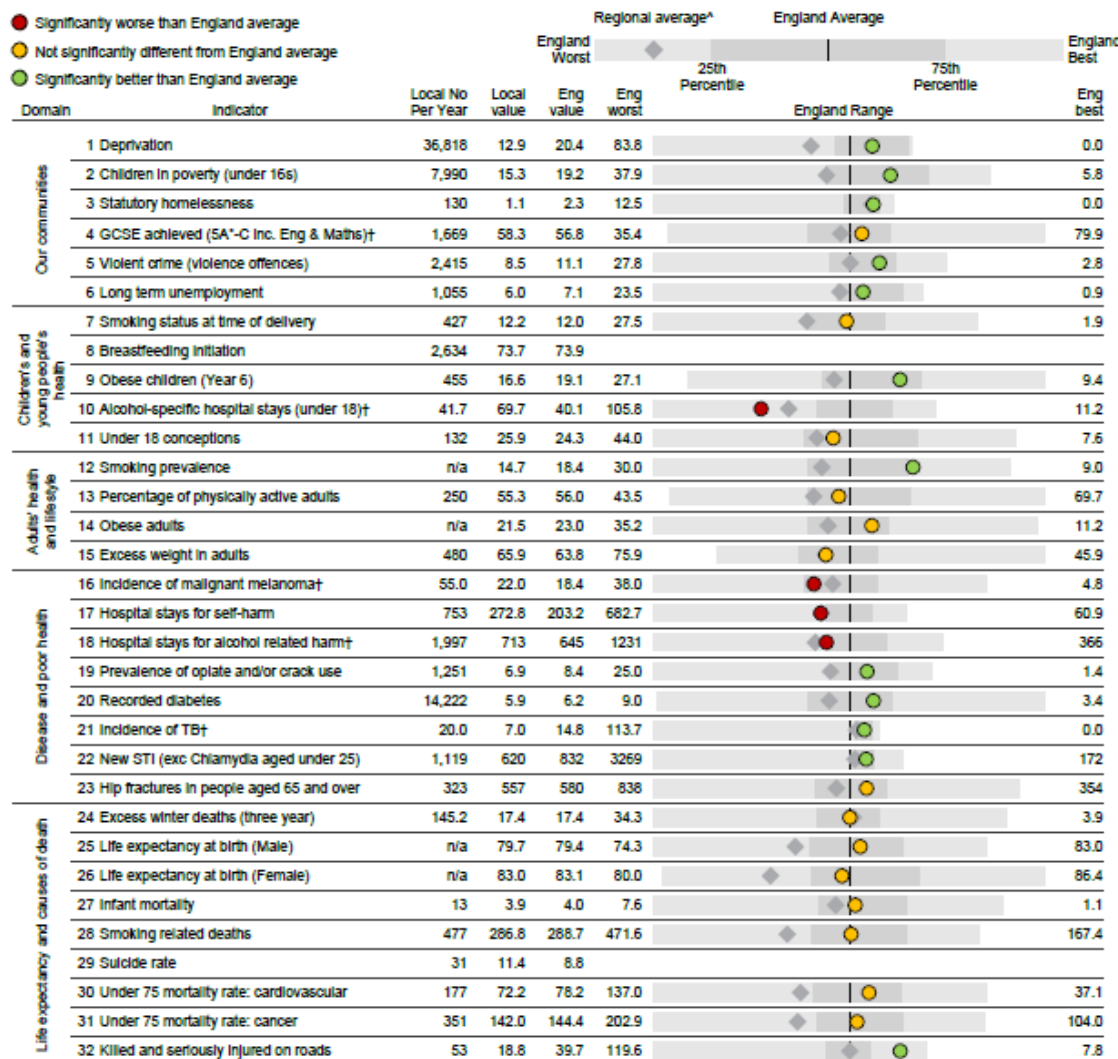
GPs and hospitals play a vital role in the early identification of carers and referral into support services for carers, the majority of carers need relatively simple support to help them.

Key Findings – outcomes frameworks



Health summary for Stockport

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.



There are a number of key national outcome frameworks for Stockport which highlight areas of good practice and areas of concern.

- CCG / NHS Outcomes Framework
<http://ccgtools.england.nhs.uk/ccgoutcomes/flash/atlas.html>
- Public Health Outcomes Framework
<http://www.phoutcomes.info/>
- Adult Social Care Outcomes Framework
<http://fingertips.phe.org.uk/profile/adultsocialcare>

A consistent theme across all frameworks are that outcomes where Stockport performs poorly relate to **alcohol and liver disease** and indicators which are based on **emergency or unplanned admissions to hospital**. Although melanoma incidence is high in Stockport, outcomes are not poorer.

A national outcome framework for the health and wellbeing of children has yet to be developed, but there are indicators within the Public Health Outcome Framework which are specifically targeted at these groups.

Key Findings – neighbourhoods



Populations

Resident Source: ONS Mid year estimates (LSOA based July 2013); Registered Source: Stockport Health Record (August 2015)

	RESIDENT	REGISTERED		RESIDENT	REGISTERED
Bramhall & Cheadle	74,636	89,206	Marple & Werneth	51,265	56,883
Bramhall & Cheadle Hulme	42,326	55,643	Marple	22,850	26,148
Cheadle, Gatley & Heald Green	32,310	33,563	Werneth	28,415	30,735
Heatons & Tame Valley	68,208	79,864	Stepping Hill & Victoria	90,923	79,646
Heatons	31,183	36,111	Hazel Grove & Offerton	36,072	32,908
Tame Valley	37,025	43,753	Victoria	54,851	46,738



Disease Prevalence

Source: Stockport Health Record

REGISTERED POPULATION	Hypertension	CHD	Stroke / TIA	Asthma	COPD	CKD	Diabetes	Epilepsy	Mental Health (QoF)	Depression	Anxiety	Dementia	Glaucoma	AMD	History of fall	Cancer diagnosed since 2003
Number of people - all ages																
Bramhall & Cheadle Hulme	7,871	2,079	1,143	3,359	845	1,254	2,430	382	346	4,528	6,361	456	644	368	1,988	1,490
Cheadle, Gatley & Heald Green	4,574	1,269	679	2,135	521	727	1,861	249	251	2,492	5,018	302	353	126	2,253	998
Heatons	4,658	1,098	604	2,475	665	901	1,419	249	316	2,647	3,767	342	227	137	1,015	922
Tame Valley	6,224	1,762	816	2,994	1,399	1,000	2,357	409	404	4,052	5,595	384	283	133	1,723	898
Marple	4,082	1,206	691	1,900	512	738	1,133	199	165	2,453	3,577	317	235	151	873	890
Werneth	4,834	1,377	701	1,473	843	875	1,504	215	243	2,145	3,943	255	220	152	825	795
Hazel Gove & Offerton	5,276	1,794	685	2,334	857	1,069	1,805	296	261	3,053	4,406	284	269	167	997	919
Victoria	6,070	1,719	905	3,263	1,317	1,134	2,307	390	448	4,848	7,447	355	273	194	1,759	1,080
Stockport	43,589	12,304	6,224	19,933	6,959	7,698	14,816	2,389	2,434	26,218	40,114	2,695	2,504	1,428	11,433	7,992

Number of people - aged 65+																
Bramhall & Cheadle Hulme	5,355	1,685	953	857	652	1,161	1,425	100	87	826	1,635	442	528	351	1,056	1,019
Cheadle, Gatley & Heald Green	2,986	985	548	481	390	662	1,064	64	67	512	1,380	295	302	123	1,095	648
Heatons	2,757	856	470	474	484	809	733	63	76	342	636	332	186	127	490	517
Tame Valley	3,603	1,249	591	560	851	874	1,217	76	73	475	1,038	370	230	129	653	566
Marple	2,916	1,011	586	565	406	682	740	63	59	552	1,022	302	213	147	492	603
Werneth	3,157	1,080	542	396	617	806	871	61	55	341	968	246	183	146	327	509
Hazel Gove & Offerton	3,304	1,210	537	518	596	962	1,026	81	45	440	922	276	221	160	507	596
Victoria	3,478	1,226	670	576	831	992	1,179	69	89	585	1,249	346	203	181	715	629
Stockport	27,556	9,302	4,897	4,427	4,827	6,948	8,255	577	551	4,073	8,850	2,609	2,066	1,364	5,335	5,087

Directly standardised rate per 100,000																
Bramhall & Cheadle Hulme	13,206.4	3,434.9	1,878.4	5,999.6	1,405.4	2,015.4	4,143.0	684.5	620.1	8,254.8	11,489.8	728.9	1,054.9	582.1	3,400.7	2,499.6
Cheadle, Gatley & Heald Green	13,630.2	3,719.6	1,973.7	6,445.7	1,551.5	2,062.3	5,594.6	753.8	769.0	7,564.9	15,194.6	835.4	1,031.4	357.0	6,662.1	2,991.9
Heatons	14,811.2	3,647.8	1,968.0	7,021.2	2,195.3	2,985.3	4,461.1	714.8	905.7	7,235.3	10,450.8	1,129.3	739.3	446.4	3,049.4	2,918.2
Tame Valley	16,857.3	4,936.9	2,298.0	7,055.0	3,837.3	2,878.6	6,278.7	973.1	964.7	9,365.3	13,275.4	1,127.9	801.8	381.2	4,306.3	2,450.7
Marple	12,679.9	3,638.0	2,101.3	7,126.3	1,562.2	2,196.6	3,602.2	723.4	601.3	9,410.4	13,371.8	944.4	702.1	446.3	2,979.9	2,804.9
Werneth	15,177.9	4,301.1	2,197.3	4,798.9	2,641.6	2,719.6	4,743.0	695.7	795.7	7,060.5	12,878.5	794.4	689.9	474.1	2,664.2	2,507.7
Hazel Gove & Offerton	16,118.8	5,490.3	2,115.2	7,143.3	2,619.8	3,277.3	5,514.9	904.6	796.3	9,241.8	13,362.6	881.5	829.9	509.2	3,033.2	2,811.3
Victoria	15,961.8	4,715.2	2,500.9	7,181.1	3,538.9	3,248.0	5,916.9	858.2	995.5	10,443.2	16,424.1	1,047.8	758.9	569.5	4,235.4	2,830.0
Stockport	14,730.6	4,180.2	2,114.7	6,589.2	2,366.9	2,602.7	4,996.7	790.4	807.7	8,643.0	13,275.7	913.1	849.4	481.0	3,801.4	2,705.4

Appendix – Legal context



The following section summaries the Department of Health's [Statutory Guidance on Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies](#) published in April 2012.

- The Health and Social Care Act 2012 has given local authorities (LAs) and clinical commissioning groups (CCGs) equal and joint duties to prepare a Joint Strategic Needs Assessment (JSNA) through the health and wellbeing board (HWB Board).
- The responsibility falls on the HWB Board as a whole.
- The HWB Board must involve the local Healthwatch and local community throughout the process, including those who are socially excluded, vulnerable or who have communication difficulties
- JSNAs are assessments of the **current and future health and social care needs of the community**, needs, often at the high-level, that could be met by the LA, CCG, or NHS England. JSNAs are unique to each area, and will reflect local ways of working; local areas are free to **undertake JSNAs in a way best suited to local circumstance**. JSNA outputs **must be published** and available to the local community to show what evidence has been considered and what priorities have been agreed and why.
- The purpose of the JSNA is to **improve the health and wellbeing of the local community and reduce inequalities for all ages**. They are not an end in themselves but a continuous process of strategic assessment and planning. The core aim is to develop local evidence based priorities for commissioning.
- The aim of the JSNA is to help HWB Boards to consider the factors that impact on the whole community's health and wellbeing, and **local assets** that can help to improve outcomes and reduce inequalities.
- The importance of JSNA lies in **how they are used locally**; plans for commissioning, including the joint Health and Wellbeing Strategy, are expected to be informed by the JSNA. The JSNA may also be used to inform and promote the integration of health and social care services by providing a joint evidence base and understanding
- JSNAs are continuous processes and are an integral part of CCG and local authority commissioning cycles. It is for boards to decide how and how often JSNAs are undertaken, but they will need to assure themselves that the evidence based priorities are up to date. To be transparent and to enable wider participation, board should be clear with their **partners and the community what their timing cycles are and when outputs will be published**.
- As JSNAs must consider the current and future health and social care needs of **the whole population, and ensure mental health receives equal priority to physical health**, JSNAs should have information that covers
 - Demographics – across the life course
 - Inequalities – disadvantaged areas and vulnerable groups
 - Wider social, environmental and economic factors
 - Health protection
 - Upstream prevention – reducing the need for acute and intensive health and care services
 - Residents and patients views, particularly through the involvement of Healthwatch
 - Assets within local communities

Appendix – Stockport process



Stockport Context 2007-2014

- 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 were 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 were agreed by the shadow Health and Wellbeing Board. The needs and priorities identified by the 2011 JSNA have underpinned the development of the Health and Wellbeing Strategy and also have informed 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 important to note however that the JSNA is not only a one off piece of analysis conducted every three years. In the years between the full refreshes, more in-depth analysis have been undertaken to inform particular priority areas. Between 2011 and 2013 these areas have included Alcohol, Healthy Weight, Autism and Learning Difficulties.
- Reports and findings from Stockport's JSNA are published via the Stockport JSNA Hub, currently hosted on My Stockport, at www.mystockport.org.uk/JSNA, although this site is to be decommissioned. The hub includes copies of the completed data reports, detailed topic analysis and consultation reports.
- A clear message from both national and North West reviews of the 2007 JSNA was the underutilisation of the JSNA in commissioning processes, locally therefore we tried to ensure that in 2011 the JSNA also supported commissioning more directly – reviews of which can be found in previous papers to the Health and Wellbeing Board.

2015 Stockport Process

- In 2014 planning for the next full Stockport JSNA began, with a revision to the **governance structure**. An initial proposal was agreed by the Stockport Health and Wellbeing Board, which has developed over the course of the project. The current project governance structure is illustrated on the next page.
- The scope and mandate of the 2015 JSNA was also agreed:
 - The **key audience** to be commissioners and strategic leaders of health and care in Stockport, along with Stockport HealthWatch and other interested parties
 - The **key functions** to be informing the refresh of the Health and Wellbeing Strategy and supporting major transformation and improvement programmes
 - The key outputs to be:
 - A revised set of priorities for Health and Wellbeing in Stockport
 - Analysis setting out key trends since 2011
 - Analysis to support the integration of health and social care
 - Analysis of vulnerable groups

Appendix – Stockport process



2015 Stockport Process (continued)

- The project leads group has met regularly and overseen the development of the 2015/16 JSNA. The steps undertaken to produce the JSNA have included:
 - A SWOT review of the 2011 JSNA
 - A review of the evidence to be used in the 2015/16 JSNA including a call for evidence to local provider and voluntary sector organisations in late 2014.
 - Commissioning of a specific public opinion report produced by Stockport HealthWatch and published as part of the JSNA.
 - Testing of presentational styles, which has resulted in the production of a series of topic briefings designed to be read and used as stand alone reports rather than the large data report produced in 2011.
 - Use of the CCGs online consultation platform to publish first drafts of each briefing to test the analysis and conclusions with key commissioners and to achieve a shared consensus on key issues.
- To develop the final summary report key findings from each of the briefings and the priorities arising from these were identified .
 - These were then tested and developed with in discussions with the project leads group, the Director and Deputy Directors of Public Health and Stockport HealthWatch.
 - Other key stakeholders were again consulted electronically before the priorities were finalised.

Governance Structure for the 2015/16 JSNA

