

STOCKPORT METROPOLITAN BOROUGH COUNCIL

Stockport Primary Care Trust NHS

Stockport JSNA

joint strategic needs assessment

JSNA First Data Report Part One and Two Introducing Stockport

November 2007

Contents

1 Introduction

1.1 Background

What is a Joint Strategic Needs Assessment?

The Department for Health consultation document *Commissioning Frameworks for Health and Wellbeing* signposts an expectation that Councils and PCTs work together in partnership to undertake a regular 'Joint Strategic Needs Assessment' (JSNA) of the community, to ensure current and future services are planned as effectively as possible to meet identified needs. There is an expectation that a JSNA will effectively harness public health intelligence to coherently influence appropriate commissioning changes to health and social care services, as well as the commissioning of preventative services to support the broader health and wellbeing of local communities. The JSNA will also contribute to the underpinning intelligence for the wider Community Strategy and Local Area Agreements.

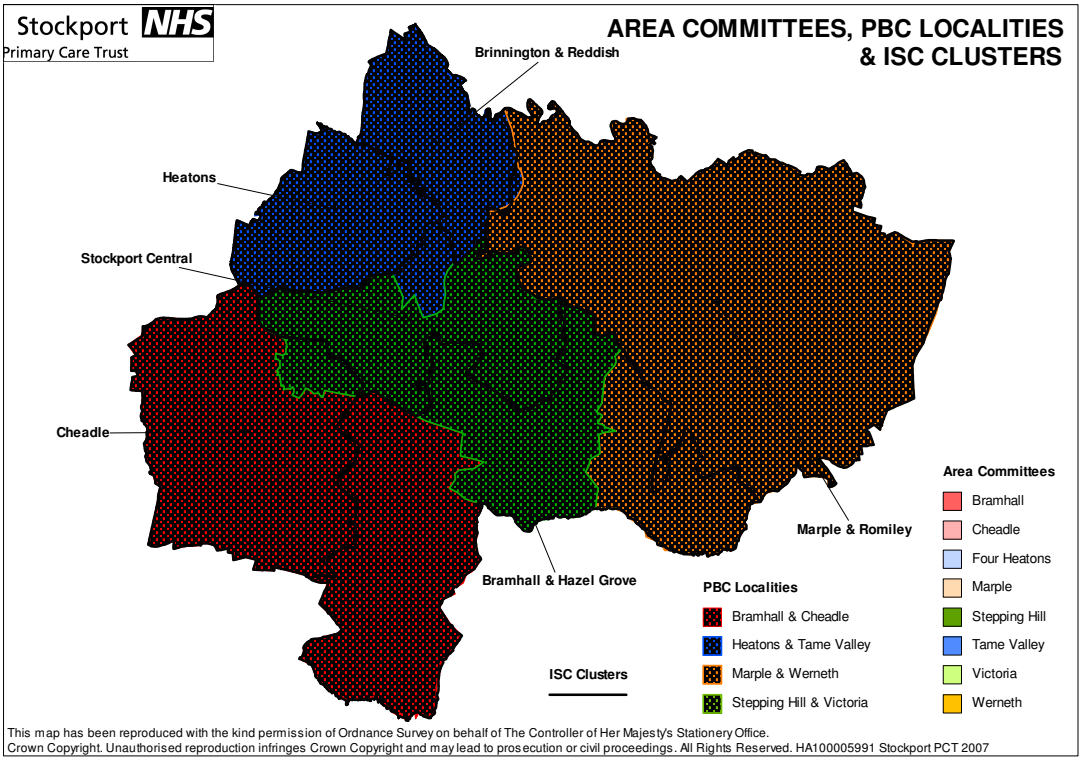
This Executive Summary represents a first draft analysis of the suggested minimum data set held at 'Annexe A' of the *Commissioning Frameworks for Health and Wellbeing* document, plus other appropriate locally identified data. This data has been collected in a short period of time from a range of providers, and caveats are, therefore, generally suggested with regard to key messages and wider circulation at this stage.

What happens next?

Given that a JSNA covers all age groups in the community and needs to encompass health and social care commissioning as well as broader health and well-being, it is clear the JSNA will need wide ownership and engagement across a variety of local planning and delivery structures if it is to deliver, as envisaged, nationally. This analysis is the first product arising from the process; however, it is recognised a sustainable and longer-term work-stream is needed to ensure JSNA becomes an embedded process, ensuring engagement, understanding and ownership from commissioners and wider stakeholders as appropriate. A project plan will be subsequently circulated to a range of stakeholders to articulate the longer-term aims and objectives of the JSNA process in Stockport.

1.2 Format of reports

The report is presented at PBC area level.



PBC Locality	Approx Ward	Deprived Areas (Priority 1 in bold)
Bramhall & Cheadle	Bramhall North Bramhall South Cheadle Cheadle Hulme North Cheadle Hulme South Heald Green	North Park Road (Bramhall Green) Queen's Gardens (Cheadle)
Heatons & Tame Valley	Brinnington & Central Heatons North Heatons South Reddish North Reddish South	**Brinnington** **Heaton Norris & Lancashire Hill** Mottram Street (Town Centre) North & South Reddish Craig Road (Heaton Mersey) School Lane (Heaton Chapel)
Marple & Werneth	Bredbury & Woodley Bredbury Green & Romiley Marple North Marple South	Cross Lane (Marple) Cherry Tree (Romiley) Barrack Hill (Bredbury) Woodley Precinct
Stepping Hill & Victoria	Davenport & Cale Green Edgeley & Cheadle Heath Hazel Grove Manor Offerton Stepping Hill	**Adswood & Bridgehall** Cheadle Heath & Edgeley Cale Green & Shaw Heath Councillor Lane Offerton Estate Victoria Park (Offerton)

The Data Profile is a comprehensive report covering a range of indicators that are currently available at Practice-Based Commissioning Area level (see the map above). This document sits alongside the:

- Executive Summary- a mid-size document summarising the main issues for Stockport that have emerged from the Data Profile, and
- Digests- A number of short reports that apply projected population change to demographic and service data related to specific age groups and groups in the population with specific and complex needs. These documents are the basis for identifying prioritising aspects of health and social care for drilling down into the data in the form of a service review.

This report is organised into chapters with chapter two giving an overview of the key characteristics of the whole population. Each subsequent chapter focuses on a different age group; 0-15, 16-24, 25-64 and 65+. Each chapter contains a number of sections breaking the information down into:

- Population
- Social and environmental context
- Health and social care
- Lifestyles and wellbeing

Each section is further broken-down into groups of related information. Each group of indicators are presented in the same format. First, the reason for collecting and analysing each group of indicators is stated in the rationale. The rationale is followed by the data (in table or map format), an analysis of the data and lastly any initial conclusions, in terms of directing services, setting policy or the need for further investigation.

1.3 Content of the report

The data collected in this report is based on the data-list given in Annex A of the commissioning framework for health and wellbeing with the incorporation of the data-list developed by Bury MBC, who have been developing their vision of JSNA over the last two years. The data list for Stockport has been further developed with input from the PCT and Local Authority. A list of all the indicators in Annex A and Bury list can be found in Appendix i. Appendix ii is a list of all the indicators available in this document cross referenced against Annex A and the list that Bury MBC proposed.

The DH consultation document signposts an expectation that community views are used to identify needs in the JSNA. Sections five and six of Annex A relate to suggested sources of information on patient/Service user voice and public demands respectively. The use of this data aims to put people at the centre of commissioning. There is already a wealth of information that can feed into the JSNA and the incorporation of this information. Stockport will need to develop an agreed and robust long-term process, ensuring engagement, understanding and ownership from all key stakeholders. The development of a process for JSNA that systematically involves the community will be developed through piloting a proposed process where existing information is pulled together and then challenged and developed through on-going public involvement. Detailed focus groups are being held to support the 'drilled-down' approach for the older people's client group, and as the JSNA proceeds it may become necessary to commission further consultation with other client groups. In doing so we will gain a level of understanding of i) which groups are be involved in contributing to health and social care planning and decision-making, ii) how they are involved and iii) how systematic or successful that involvement is. If successful a long-term

plan is required to develop this process across client/service user groups. Appendix iii sets out the main stages and milestones required to achieve this.

1.4 Way forward

This report is not the end of a piece of work, but rather the start of an on-going process of developing a shared understanding and vision for how health and social care in Stockport can promote health and wellbeing in the borough.

The JSNA as a wider process will develop from this report in a number of ways.

1.4.1 Further documentation

- The Executive Summary
- The Digests
  (see 1.2 for description)

1.4.2 Engagement and improving our information base

- Outcomes and priorities- through the communication of agreed outcomes and priorities. The process for prioritisation needs to be developed and made explicit, making a clear link between the JNSA and decision making. This will include initial consultation with commissioners and policy leads regarding emerging high level statements of need
- Public feedback – we need to fully understand, support and develop continuous feedback mechanisms that allow information and flow to and from the community. The public need to know about health and wellbeing in their area.
- Telling the Stockport Story – the development of a story that tells us the health and wellbeing needs of people in Stockport. This needs to balance and integrate qualitative and quantitative data from a range of sources to produce a robust assessment.
- Service review- Using outcomes identified in the early stages of work to inform the programme of further analysis of services

1.4.3 Improving analysis and information

We need to look at the data requirements of the JSNA process has produced a wealth of data. Hosting of data and analysis in a format that can be easily accessed and shared – this is likely to be a website.

Further data analysis will be on-going and it is hoped that the data will eventually be shared electronically in a way that can enable people to view data in the way most relevant to them. Work will concentrate on developing a number of aspects of data.

- Geographical coverage. Further collection of indicators, where possible, broken down by:
  - PBC
  - ISC
  - Ward
  - LSOA

- Equalities' groups
    - Age
    - Gender
    - Ethnicity
    - Disability
- Over time – we are looking to collect data, where possible, from 2001 and develop a consistent way of presenting and analysing trends. There is also the need to understand service requirement and forecast levels of demand in 5, 10 and 15 years time. This will be achieved through modelling service data trends and projected population changes in addition to known changes in demand and expectation.
- Patient voice and demand- we are looking at developing what we know about user demand and patient voice to increase the systematic incorporation of knowledge into the JSNA process.

2 Introducing Stockport (All Ages)

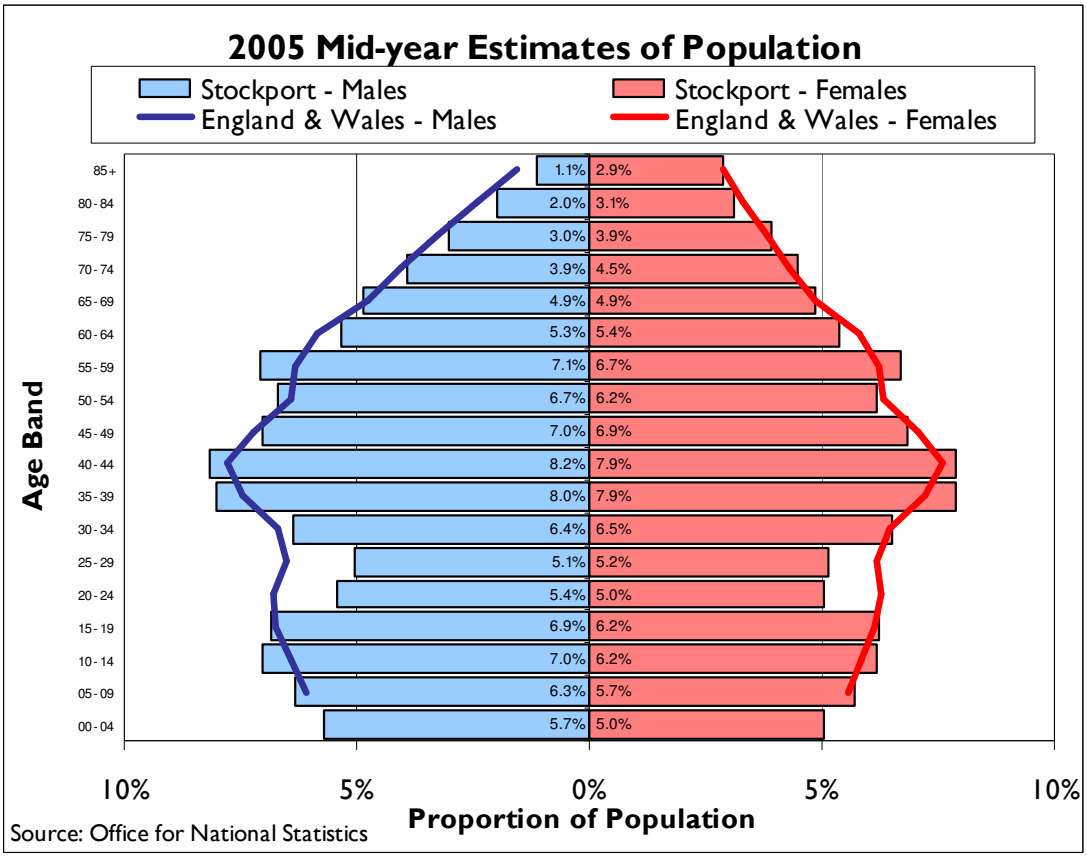
2.1 Population

2.1.1 Age Structure

Rationale

- Age structure is key to understanding basic demographic patterns, including size of population, age profile and, therefore, likely demands on service.

Data



Source: Office for National Statistics

STOCKPORT RESIDENTS REGISTERED WITH ANY GP 30-06-2007 – RESIDENT IN:						2006 mid-year estimate England & Wales
Age Band	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	
00-04	3,734	4,024	2,504	5,411	15,673	3,115,628
05-14	9,050	8,320	5,901	10,565	33,836	6,411,849
15-24	8,962	9,476	6,122	11,645	36,205	7,094,592
25-64	41,046	39,740	28,602	50,405	159,793	28,496,139
65-74	7,812	5,083	5,705	7,066	25,666	4,443,803
75-84	5,313	3,629	3,726	4,709	17,377	3,045,174
85 +	1,836	1,347	1,397	1,725	6,305	1,121,645
TOTAL	77,753	71,619	53,957	91,526	294,855	53,728,830
00-24	27.9%	30.4%	26.8%	30.1%	29.1%	30.9%
25-64	52.8%	55.5%	53.0%	55.1%	54.2%	53.0%
65+	19.2%	14.1%	20.1%	14.7%	16.7%	16.0%

Source: Exeter Patient Registration System

Analysis

- Stockport as a whole has a slightly older age profile than the national average. This is mainly due to the loss of young adults between the ages of 20-29, anecdotally because of the lack of university and new graduate jobs.
- Within Stockport PBC, localities are not of similar sizes; Marple & Werneth Around 25% smaller, Stepping Hill & Victoria is around 25% bigger
- Heatons & Tame Valley and Stepping Hill & Victoria have younger age profiles. Young people especially concentrate in wards of Davenport & Cale Green, Brinnington & Central and Reddish North. Marple South has particularly low levels of young people.
- Bramhall & Cheadle and Marple & Werneth have older age profile, though it's worth noting that Stepping Hill & Victoria, due do its larger size actually has more 65+ people than Marple & Werneth. Older people especially concentrate in wards of Marple South and Bramhall South.
- Analysis of the population pyramid clearly demonstrates that those aged under 34 represent smaller five-year birth cohorts than those aged 35 and above. The 20-24 and 25-29 age groups were particularly small birth cohorts representing the baby bust of the early 1970s when the birth rates were exceptionally low. These age groups are also the ones most likely to be affected by movements of students to attend higher education.
- The post war baby boom is also clearly evident in the 55-59 age group, and similarly the baby boom of the 1960's can also be seen in the 35-44 age group.

Conclusion

- All areas need to be aware of their population size and age structure. Areas to the south and east need to pay particular attention to the needs of older people while areas to the north and west need to pay particular attention to the needs of children.

2.1.2 Gender

Rationale

- Gender is a key factor in the likely risks of certain diseases and is key to understanding further breakdowns of data

Data

STOCKPORT RESIDENTS REGISTERED WITH ANY GP 30-06-2007 – RESIDENT IN:						2006 mid-year estimate England & Wales
Gender	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	
Males	38,046	35,704	26,490	45,238	145,478	26,371,156
Females	39,707	35,915	27,467	46,288	149,377	27,357,674
TOTAL	77,753	71,619	53,957	91,526	294,855	53,728,830
Males	48.9%	49.9%	49.1%	49.4%	49.3%	49.1%
Females	51.1%	50.1%	50.9%	50.6%	50.7%	50.9%

Source: Exeter Patient Registration System

Analysis

- The population pyramid in section 2.1.1 shows marked difference in the genders in the older age groups. Women outnumber men after age of 24.
- There's not much difference in overall balance of gender between areas, though as older populations tend to have more females, rates are slightly higher in Bramhall & Cheadle and Marple & Werneth.

Conclusion

- Stockport's gender split mirrors national figures and is relatively even across the Borough. Gender needs to be considered when designing services for older people especially as this is where imbalances exist.

2.1.3 Ethnicity

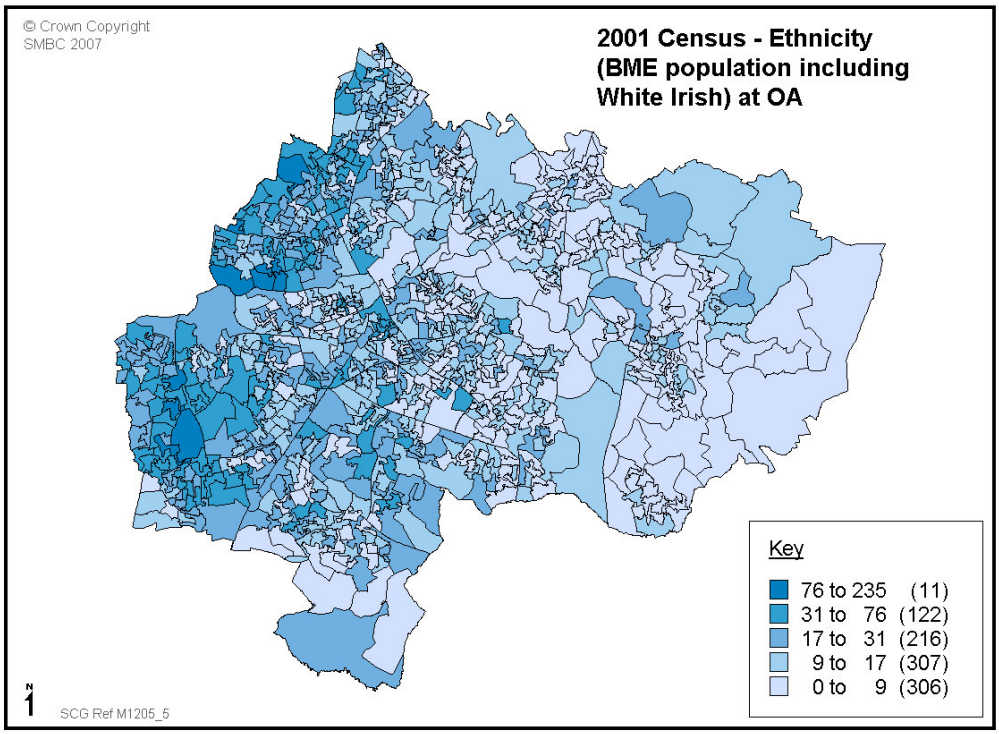
Rationale

- Ethnicity is a key profiling tool as populations from BME ancestries have distinct patterns of health conditions and different lifestyle-related risk factor behaviours.
- Residents from ethnic minority populations may experience barriers to services and information arising from differential treatment and/or language barriers.
- Research has shown that residents from ethnic minorities have different expectations of the health service and their own health and may be less likely to demand services or present with illnesses.

Data

2001 CENSUS ETHNIC GROUP OF POPULATION – RESIDENT IN:							
Ethnic Group		Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England & Wales
White	British	66,817	61,377	50,771	85,314	264,279	45,533,741
	Irish	882	1,838	419	1,016	4,155	641,804
	Other	1,295	954	512	1,035	3,796	1,345,321
	TOTAL	68,994	64,169	51,702	87,365	272,230	47,520,866
Mixed	White & Black C'bean	200	329	137	287	953	237,420
	White & Black African	83	152	42	136	413	78,911
	White & Asian	311	290	113	201	915	189,015
	Other	210	233	94	208	745	155,688
	TOTAL	804	1,004	386	832	3,026	661,034
Asian or Asian British	Indian	1,030	459	96	282	1,867	1,036,807
	Pakistani	1,337	957	44	611	2,949	714,826
	Bangladeshi	132	116	18	87	353	280,830
	Other	370	244	51	133	798	241,274
	TOTAL	2,869	1,776	209	1,113	5,967	2,273,737
Black or Black British	Black Caribbean	162	302	58	137	659	563,843
	Black African	94	121	33	104	352	479,665
	Other	24	61	11	74	170	96,069
	TOTAL	280	484	102	315	1,181	1,139,577
Other Ethnic Group	Chinese	478	411	89	337	1,315	226,948
	Other	329	232	48	200	809	219,754
	TOTAL	807	643	137	537	2,124	446,702
ALL PEOPLE		73,754	68,076	52,536	90,162	284,528	52,041,916
White		93.5%	94.3%	98.4%	96.9%	95.7%	91.3%
Mixed		1.1%	1.5%	0.7%	0.9%	1.1%	1.3%
Asian or Asian British		3.9%	2.6%	0.4%	1.2%	2.1%	4.4%
Black or Black British		0.4%	0.7%	0.2%	0.3%	0.4%	2.2%
Other Ethnic Group		1.1%	0.9%	0.3%	0.6%	0.7%	0.9%

Source: Office of National Statistics



Source: 2001 Census key statistics

Analysis

- Stockport, compared to the national average, is not very ethnically diverse.
- Bramhall & Cheadle has high rates of BME, primarily those of Pakistani and Indian ethnicity and concentrating in wards of Heald Green and Gatley.
- Heatons & Tame Valley also has high rates of people of Pakistani ancestry, particularly in the ward of Heatons South
- BME populations tend to have a younger age profile, particularly those of mixed ancestry. However, it is likely in the next 10 years that the first significant BME populations will be reaching the age of 65.
- Evidence based on the analysis of the country of birth of patients registered with Stockport GPs suggests that, since the 2001 Census, BME populations are likely to have increased. Data shows particular increases in populations originating from Asia (most notably Pakistan and Iran) and Poland.

Conclusion

- Stockport's ethnic diversity is thought to be increasing and therefore BME needs must be considered in the future planning of services and the prediction of the likely health and social care needs.

2.1.3.1 Ethnicity: Immigrants and Refugees

Number of Immigrants and Refugees by Country of Origin (Proxy by Translation Services)					
Country	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	TOTAL
Afghanistan		2	1	2	5
Angola		1		2	3
China (Peoples Republic of China)		4		2	6
Colombia		1			1
Congo		2			2
Congo Democratic Republic (Formerly Zaire)		3			3
Eritrea		1			1
Ethiopia				2	2
Guinea		1			1
Iran	3	6		3	12
Iraq		7	1	5	13
Jamaica		1			1
Lebanon		1			1
Libya (Arab Republic)		1			1
Malawi		2			2
Mongolia		1			1
Pakistan		7		2	9
Palestine		2			2
Sierra Leone				1	1
Somalia		1			1
South Africa		1			1
Sri Lanka		1			1
Sudan		4			4
Tanzania		1			1
Turkey				1	1
Uzbekistan		1			1
Zimbabwe		2		1	3
TOTAL	3	54	2	21	80

Source: Stockport Homes

Number of Immigrants and Refugees by support received	
	TOTAL
Number of applicants in Private Provider Accommodation	72
Number of applicants in NASS accommodation (Support we provide)	114
Number of applicants who only receive Subsistence (cash allowance)	8
Total in Stockport	194
Region total	7,645

Source: Stockport Homes

2.1.4 Population Trends – Past

Rationale

- Past trends are important to understand as they give an indication of direction of travel and future trends

STOCKPORT RESIDENTS REGISTERED WITH ANY GP – RESIDENT IN:						
	Age Band	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
30-06-2001	00 – 14	13,482	13,663	9,112	17,624	53,881
	15 – 64	50,584	47,482	35,208	60,442	193,716
	65 – 74	7,705	5,438	5,212	7,120	25,475
	75 – 84	4,711	3,752	3,495	4,827	16,785
	85+	1,571	1,325	1,218	1,620	5,734
	TOTAL	78,053	71,660	54,245	91,633	295,591
30-06-2007	00 – 14	12,784	12,344	8,405	15,976	49,509
	15 – 64	50,008	49,216	34,724	62,050	195,998
	65 – 74	7,812	5,083	5,705	7,066	25,666
	75 – 84	5,313	3,629	3,726	4,709	17,377
	85+	1,836	1,347	1,397	1,725	6,305
	TOTAL	77,753	71,619	53,957	91,526	294,855
% Difference	00 – 14	94.8%	90.3%	92.2%	90.6%	91.9%
	15 – 64	98.9%	103.7%	98.6%	102.7%	101.2%
	65 – 74	101.4%	93.5%	109.5%	99.2%	100.7%
	75 – 84	112.8%	96.7%	106.6%	97.6%	103.5%
	85+	116.9%	101.7%	114.7%	106.5%	110.0%
	TOTAL	99.6%	99.9%	99.5%	99.9%	99.8%

Source: Exeter Patient Registration System

Analysis

- Total population size was stable across all areas between 2001 and 2006.
- The numbers of children are falling in all areas, and fastest in the areas with higher proportions (Heatons & Tame Valley and Stepping Hill & Victoria).
- 85+ populations have increased the most, by 10% (600 people); rates of change have been greatest in Bramhall & Cheadle and Marple & Werneth.
- Like the rest of England & Wales, Stockport's population is ageing markedly. Between 1991 and 2001 in Stockport the number of people aged 65 and over rose by over 3.6%, the number aged 75 and over by 9%; and the number aged 85 and over by 30.6%. After Knowsley and Sefton, Stockport has seen the biggest increase of people of retirement age in the North West.

Conclusion

- Trend data show a relatively stable population size, although changes in the age profile are significant and need to be built into future planning.

2.1.5 Population Trends – Future

Rationale

- Population projections allow services to anticipate likely demand for services and identify early on the changes in population structure

Data

Note: Data not available at PBC Locality Level

2004 BASED POPULATION PROJECTIONS - STOCKPORT									
	Age Band	2005	2006	2007	2008	2009	2010	2015	2020
Persons	00-14	50,747	49,778	48,988	48,457	47,865	47,478	46,069	46,482
	15-64	183,001	183,631	183,990	183,868	183,842	183,587	180,739	179,538
	65-74	25,520	25,346	25,334	25,654	25,938	26,299	29,586	30,426
	75-84	17,025	17,043	17,042	17,068	17,157	17,289	18,391	19,660
	85+	5,685	5,926	6,162	6,296	6,434	6,543	7,277	8,182
	TOTAL	281,978	281,724	281,516	281,343	281,236	281,196	282,062	284,288
%Change '05	00-14	-	98.1%	96.5%	95.5%	94.3%	93.6%	90.8%	91.6%
	15-64	-	100.3%	100.5%	100.5%	100.5%	100.3%	98.8%	98.1%
	65-74	-	99.3%	99.3%	100.5%	101.6%	103.1%	115.9%	119.2%
	75-84	-	100.1%	100.1%	100.3%	100.8%	101.6%	108.0%	115.5%
	85+	-	104.2%	108.4%	110.7%	113.2%	115.1%	128.0%	143.9%
	TOTAL	-	99.9%	99.8%	99.8%	99.7%	99.7%	100.0%	100.8%
Proportion	00-14	18.0%	17.7%	17.4%	17.2%	17.0%	16.9%	16.3%	16.4%
	15-64	64.9%	65.2%	65.4%	65.4%	65.4%	65.3%	64.1%	63.2%
	65-74	9.1%	9.0%	9.0%	9.1%	9.2%	9.4%	10.5%	10.7%
	75-84	6.0%	6.0%	6.1%	6.1%	6.1%	6.1%	6.5%	6.9%
	85+	2.0%	2.1%	2.2%	2.2%	2.3%	2.3%	2.6%	2.9%

Source: Office for National Statistics

Analysis

- Total population size is likely to remain stable until 2015.
- 65+ population expected to increase by 21% and the 85+ population is expected to increase by 50%.
- The increases in the age group 65+ are accompanied by a 13.9% decrease in the population aged 24 and under, although it should be noted that in the last 2 – 3 years the birth rate in Stockport has increased slightly.
- Analysis of population pyramids (see section 2.1.1) suggests that, over the next five years, two significant five-year birth cohorts, those aged 55-59 and those aged 60-64, will swell the numbers of those aged over 60 considerably. This group represents the post-war baby boom. In ten years' time they will swell the population aged over 70; in twenty years' time they will swell the population aged over 80, and in thirty years' time they will swell the number aged over 90.

After they age or die, to be replaced by a smaller cohort, the older population will enter a cyclical pattern in which the number of younger old people (60-75) will be falling in numbers when the numbers of older people (over 75) will be rising and then when the next baby boom (1960s the children of the first baby boom) reaches old age the situation will reverse again.

Conclusion

- Demand for older people services are likely to grow significantly. The demand for services for the very elderly is increasing faster than those for early old age. Cycles of birth 'booms and bust' are significant for understanding future population change.

2.2 Social & Environmental Context

2.2.1 Deprivation

Rationale

- Deprivation is a short-hand measure that combines indicators on a range of socio-economic topics to show areas where people are at a high risk of social and economic disadvantage and are, therefore, more likely to experience poor health and barriers to accessing services.

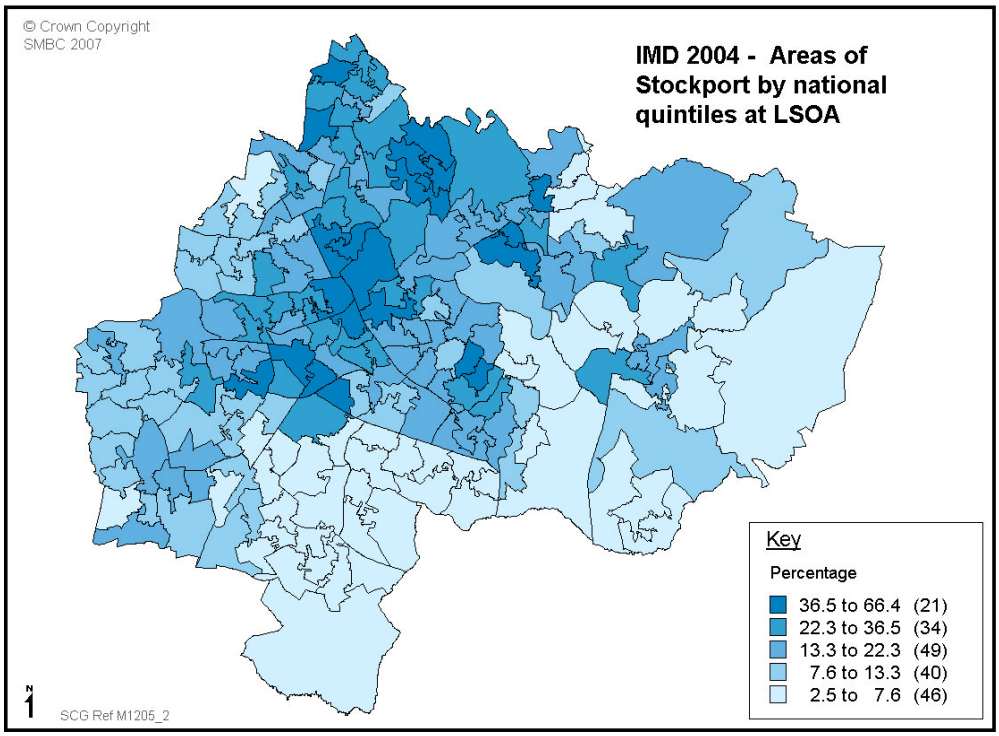
Conclusion

- Demand for older people services are likely to grow significantly. The demand for services for the very elderly is increasing faster than those for early old age. Cycles of birth 'booms and bust' are significant for understanding future population change.

Data

STOCKPORT RESIDENTS REGISTERED WITH ANY GP 30-06-2007 – RESIDENT IN:					
Areas Ranking in National Quintiles of Deprivation:	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Most deprived 20%	0	15,904	4,620	13,847	34,371
Second most deprived 20%	3,169	23,352	6,123	22,285	54,929
Mid deprived 20%	9,818	13,142	15,505	29,593	68,058
Second least deprived 20%	25,654	11,272	6,205	10,441	53,572
Least deprived 20%	39,112	7,949	21,504	15,360	83,925
ALL AREAS	77,753	71,619	53,957	91,526	294,855
Most deprived 20%	0.0%	22.2%	8.6%	15.1%	11.7%
Second most deprived 20%	4.1%	32.6%	11.3%	24.3%	18.6%
Mid deprived 20%	12.6%	18.3%	28.7%	32.3%	23.1%
Second least deprived 20%	33.0%	15.7%	11.5%	11.4%	18.2%
Least deprived 20%	50.3%	11.1%	39.9%	16.8%	28.5%

Source: Office of the Deputy Prime Minister



Source: Index of multiple Deprivation 2001

Analysis

- Heatons & Tame Valley most deprived, especially ward Brinnington & Central and, to a lesser extent Reddish
- Other significant areas of deprivation are Stepping Hill & Victoria, with Davenport & Cale Green and Edgeley & Cheadle Heath contributing in this locality.
- There are smaller pockets of deprivation in Bramhall & Cheadle and Marple & Werneth that are masked by analysis at this level.

Conclusion

- The Index of Deprivation shows that a relatively small proportion of the Borough (11.7%) is very deprived, however, analysis at lower geographies shows pockets of deprivation all across the Borough.
- Services should ensure that areas of deprivation are well served and that barriers to access are minimised through appropriate service design catering to the particular needs of deprived residents, however there is a need to recognise that individual residents in areas not recognised as deprived may still themselves be deprived.
- Services should work to ensure that any issues relating to low expectations and lack of demand for appropriate care from people living deprived areas are minimised.

2.2.2 Income

Rationale

- Income has a direct effect on an individual's ability to make housing, food, and lifestyle choices. It also affects what health care you can choose and whether preventative measures are taken
- The number of postcode units in the Borough that are classed as poor has been calculated. The method uses a national recognised threshold of those areas with an average household income of less than 60% of the national median household income.
- The ranking of Output Areas (OAs) has been used to indicate the extent to which the poorest and richest OAs in the Borough are located. The average ranking indicates the spread of ranking within each PBC area.

Data

AVERAGE INCOMES AT POSTCODE UNIT* LEVEL					
Median Income (£)	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Average median household income at postcode unit level	£35,644	£25,402	£30,071	£26,744	£28,500
Median household income of the lowest income PC unit in the PBC area	£10,100	£10,300	£8,800	£11,600	£8,800
Median household income of the lowest income PC unit** in the PBC area	£63,400	£59,700	£57,000	£58,600	£63,400

Source: CACI
* A postcode unit is the full postcode e.g. SK1 3XE
**Average household income at postcode unit level and the number and proportion of postcode units with a median household income below 60% of the median income of England & Wales (Poverty measure)

HOUSEHOLDS IN 'POOR' POSTCODE UNITS*					
Household below postcode unit level	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Not poor** postcode units	2,041	2,172	1,477	2,162	7,852
Poor** postcode units	7	175	17	74	273
Not poor** postcode units as percentage of all postcodes in PBC area	99.7%	92.5%	98.9%	96.7%	96.6%
Poor** postcode units as a percentage of all postcodes in PBC unit	0.3%	7.5%	1.1%	3.3%	3.4%
Percentage of the boroughs 'Poor' postcode units	3%	64%	6%	27%	100%

Source: CACI
* A postcode unit is the full postcode e.g. SK1 3XE
**Average household income at postcode unit level and the number and proportion of postcode units with a median household income below 60% of the median income of England & Wales (Poverty measure)

RANKING OF AVERAGE INCOMES AT OUTPUT AREA LEVEL					
Average household income at OA level (£)	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Average at OA level of median household income	£35,103	£26,779	£29,457	£26,990	£29,398
Average rank of OAs in PBC area	677	388	488	399	481
Highest* ranking OA in PBC area	11	2	1	4	1
Lowest* ranking OA in PBC area	961	959	953	962	962

Source: CACI
* The highest ranked area is the OA with the lowest average household income in Stockport.

Analysis

- Heatons & Tame Valley has lowest median income, followed by Stepping Hill & Victoria.
- Areas in Stockport with the lowest incomes are also those with the youngest populations.
- Marple & Werneth have the area with the lowest income, in Romiley where a significant cluster of older people dependent on pensions skew the results.
- Bramhall & Cheadle have highest incomes.
- Each PBC has affluent and poor areas; however, the average rank for each PBC reveals that the similarity in the extreme ranking in each area masks large

differences. The average rank for Bramhall & Cheadle is almost twice the average ranking of both Heatons & Tame Valley and Stepping Hill & Victoria.

Conclusion

- Low income is concentrated in small areas and initiatives related to affordability should direct services to Heatons & Tame Valley in the first instance and then Stepping Hill & Victoria.
- Services must bear in mind the ability of older people on low incomes to make choices about their health care.

2.2.3 Environment

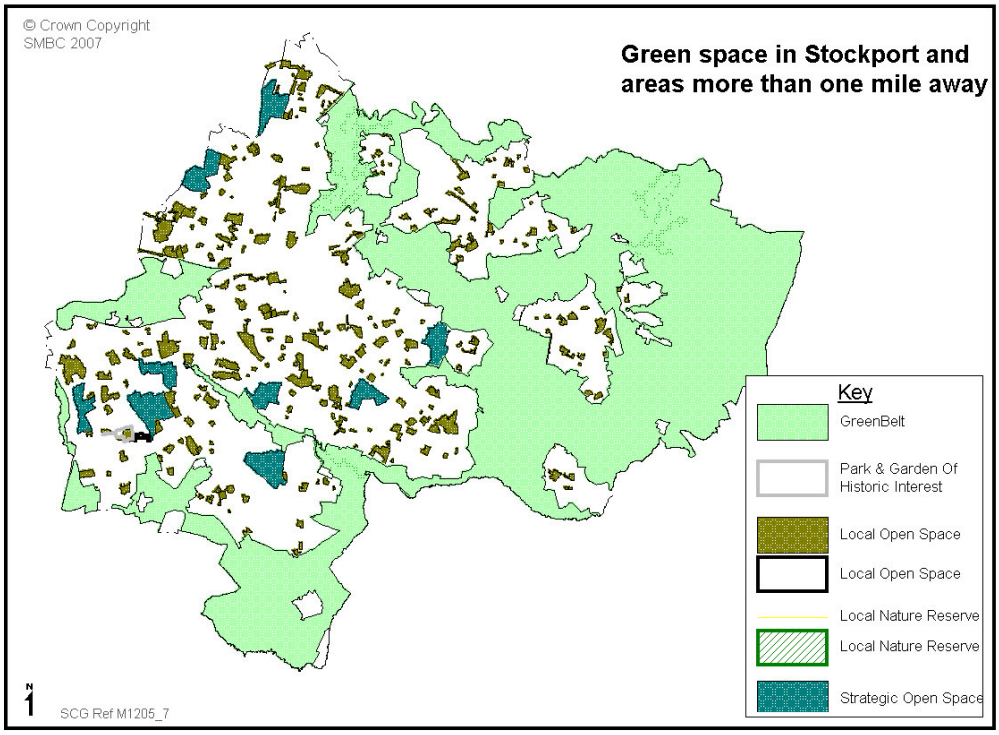
Rationale

- The proportion of the Borough classified as urban or rural can be used as a proxy for measuring the opportunity residents have to access green space, which is important for both physical activity and mental wellbeing.

Data

2001 CENSUS – URBAN OR RURAL CLASSIFICATION					
Postcode Classification	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Urban	100.0%	100.0%	87.5%	99.9%	97.6%
Rural	0.0%	0.0%	12.5%	0.1%	2.4%

Source: Office of National Statistics



Source: Stockport Council SCG group, Environment and Economy Directorate, 2007
*no areas of Stockport are more than one mile from an area of greenspace

Analysis

- Stockport is mainly urban, Marple & Werneth most rural.
- There are pockets of green space in all areas of Stockport which are not identified in the first analysis but which can be seen on the map.
- Evidence from the 1995-1997 Director of Public Health's Annual Report suggests that a very small minority of people living in Stockport will live more than ½ mile from countryside or a large park – the majority of whom live in Stepping Hill & Victoria.

Conclusion

- Stockport should preserve the quantity and quality of its green space, particularly those areas serving communities where people may lack other recreational opportunities or where population is dense.
- Transport opportunities for those areas not within walking distance of green space should be prioritised.

2.2.4 Housing

Rationale

- Research has shown that those in privately rented accommodation are the most likely to be living in non decent housing

- Social housing links closely to income and deprivation and indicates areas where services can be targeted at particular communities.
- Overcrowding is associated with higher rates of childhood accidents and mental stress. Lack of privacy can cause reduced life opportunities – for example by limiting the amount and quality of a child's home study

Data

2001 CENSUS – TENURE OF HOUSEHOLDS						
Tenure	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England
Owner Occupied	26,360	20,759	17,723	28,795	93,643	14,054,123
Rented - social landlord	1,914	6,436	2,911	5,785	17,057	3,940,730
Rented - private / other	1,664	3,440	1,455	3,201	9,756	2,456,573
TOTAL	29,938	30,635	22,089	37,781	120,456	20,451,426
Owner Occupied	88.0%	67.8%	80.2%	76.2%	77.7%	68.7%
Rented - social landlord	6.4%	21.0%	13.2%	15.3%	14.2%	19.3%
Rented - private / other	5.6%	11.2%	6.6%	8.5%	8.1%	12.0%

Source: Office of National Statistics

2001 CENSUS – OVERCROWDED HOUSEHOLDS						
Overcrowded (-1 occupancy) households	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England
Overcrowded Households	859	2,022	799	1,777	5,438	1,457,512
As % of total	2.9%	6.6%	3.6%	4.7%	4.5%	7.1%

Source: Office of National Statistics

2001 CENSUS – DEPENDENTS IN OVERCROWDED HOUSEHOLDS						
Dependent children in Over-occupied households by age	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England
-1 or less, 0-4	184	425	197	474	1,280	351,405
-1 or less, 5-7	131	224	107	275	737	197,315
-1 or less, 8-11	157	447	206	475	1,285	305,158
-1 or less, 12-15	227	496	209	536	1,468	336,848
-1 or less, 16-18	127	253	125	225	730	184,867
-1 or less, All children	826	1,845	844	1,985	5,500	1,375,590
-1 or less, 0-4	1.1%	2.6%	1.8%	2.3%	2%	3.2%
-1 or less, 5-7	0.8%	1.4%	1%	1.3%	1.1%	1.8%
-1 or less, 8-11	1%	2.7%	1.8%	2.3%	2%	2.8%
-1 or less, 12-15	1.4%	3%	1.9%	2.6%	2.3%	3.1%
-1 or less, 16-18	0.8%	1.5%	1.1%	1.1%	1.1%	1.7%
-1 or less, All children	5%	11.3%	7.5%	9.5%	8.5%	12.5%

Analysis

- Social housing concentrates in Heatons & Tame Valley, but both Stepping Hill & Victoria and Marple & Werneth also have significant numbers. Main estates are:
  - Brinnington
  - Lancashire Hill
  - Adswood & Bridgehall
  - Mottram Street
  - Covent Garden
  - Offerton Estate
  - Cherry Tree Estate
  - Councillor Lane
- Private rented accommodation also concentrated in Heatons & Tame Valley.
- Highest rate of over occupancy is in Heatons & Tame Valley
- Brinnington & Central has highest rate at 9.1%.

Conclusion

- There is the opportunity to target services to areas in both Heatons & Tame Valley And Stepping Hill & Victoria as these have the highest numbers of both social and private landlords
- Service related to easing the impact of overcrowding should also be targeted to areas within Heatons & Tame Valley And Stepping Hill & Victoria

2.3.5 Education

Rationale

- Directly correlates with income and disadvantage as the lack of educational qualifications is a barrier to work and also limits future earning potential.
- Education is important in providing individuals with basic skills relating to literacy and numeracy, skills which enable people to take control of, and manage their lives. These skills are also vital in empowering people to make change, e.g. act on health advice and information.
- 1yr of education beyond the age of sixteen adds 1.5 years to life expectancy.

Data

2001 CENSUS – QUALIFICATIONS OF PEOPLE AGED 16 TO 74 YEARS						
Number and percentage who have at least:		Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
All Ages-Persons	Degree or equivalent	15,629	9,864	8,221	11,480	45,194
	2+ A Levels or equivalent	20,203	13,108	10,987	16,072	60,370
	5+ GCSEs or equivalent	31,920	22,420	18,993	29,674	103,007
	1+ GCSE or equivalent	39,834	30,833	25,390	42,006	138,063
	No qualifications	10,382	14,767	9,539	18,142	52,830
	Level unknown	3,320	3,117	3,019	4,640	14,096
% All Ages	Degree or equivalent	29.2%	20.2%	21.7%	17.7%	22.0%
	2+ A Levels or equivalent	37.7%	26.9%	29.0%	24.8%	29.4%
	5+ GCSEs or equivalent	59.6%	46.0%	50.1%	45.8%	50.2%
	1+ GCSE or equivalent	74.4%	63.3%	67.0%	64.8%	67.3%
	No qualifications	19.4%	30.3%	25.1%	28.0%	25.8%
	Level unknown	6.2%	6.4%	8.0%	7.2%	6.9%
% 16 -24	Degree or equivalent	13.1%	10.7%	10.0%	9.9%	10.9%
	2+ A Levels or equivalent	19.3%	15.6%	17.1%	16.3%	17.0%
	5+ GCSEs or equivalent	72.9%	63.5%	68.0%	65.0%	67.1%
	1+ GCSE or equivalent	85.5%	81.4%	83.8%	82.6%	83.2%
	No qualifications	13.2%	17.2%	15.2%	16.0%	15.5%
	Level unknown	1.3%	1.5%	1.0%	1.4%	1.3%

2001 CENSUS – QUALIFICATIONS OF PEOPLE AGED 16 TO 74 YEARS continued						
Number and percentage who have at least:		Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
% 25-49	Degree or equivalent	36.9%	26.2%	26.4%	22.8%	27.6%
	2+ A Levels or equivalent	46.1%	33.1%	34.4%	30.1%	35.4%
	5+ GCSEs or equivalent	68.6%	54.2%	58.0%	53.6%	58.0%
	1+ GCSE or equivalent	87.6%	76.7%	81.6%	79.1%	80.9%
	No qualifications	9.1%	18.5%	13.7%	16.0%	14.6%
	Level unknown	3.3%	4.8%	4.8%	5.0%	4.5%
% 50 – pension age	Degree or equivalent	28.7%	17.5%	22.4%	14.7%	21.0%
	2+ A Levels or equivalent	34.2%	20.5%	26.6%	18.4%	25.2%
	5+ GCSEs or equivalent	49.8%	29.6%	39.8%	28.6%	37.4%
	1+ GCSE or equivalent	64.0%	41.4%	52.9%	41.3%	50.4%
	No qualifications	23.8%	45.6%	31.5%	43.1%	35.6%
	Level unknown	12.2%	13.0%	15.6%	15.6%	14.0%
% Pension age – 74	Degree or equivalent	21.3%	10.9%	16.7%	10.8%	15.2%
	2+ A Levels or equivalent	25.0%	13.2%	19.8%	12.9%	18.1%
	5+ GCSEs or equivalent	41.4%	21.8%	32.4%	22.4%	30.1%
	1+ GCSE or equivalent	47.8%	26.6%	38.3%	27.5%	35.7%
	No qualifications	43.4%	65.7%	51.6%	63.2%	55.4%
	Level unknown	8.8%	7.7%	10.0%	9.2%	8.9%

Source: Office of National Statistics

2001 CENSUS- LEVEL OF QUALIFICATION- ACCUMULATIVE PROPORTIONS				
Percentage who have at least:	Bramhall Area	Cheadle Area	Four Heatons Area	Marple Area
Degree or equivalent	32.1%	25%	33.9%	28.1%
2+ A Levels or equivalent	41.1%	33.1%	42%	36.2%
5+ GCSEs or equivalent	63.3%	54.2%	61%	57.3%
1+ GCSE or equivalent	77.6%	70.1%	74.7%	72.1%
No qualifications	16.4%	23.3%	19.8%	20.5%
Level unknown	6.1%	6.5%	5.4%	7.4%

Source: Office of National Statistics

2001 CENSUS- LEVEL OF QUALIFICATION- ACCUMULATIVE PROPORTIONS				
Percentage who have at least:	Stepping Hill Area	Tame Valley Area	Victoria Area	Werneth Partnership
Degree or equivalent	20.1%	11%	15.8%	16%
2+ A Levels or equivalent	27.5%	16.8%	22.6%	22.6%
5+ GCSEs or equivalent	49%	36%	43.3%	43.7%
1+ GCSE or equivalent	67.4%	55.7%	62.9%	62.4%
No qualifications	24.8%	37.5%	30.3%	29.2%
Level unknown	7.8%	6.9%	6.7%	8.4%

Source: Office of National Statistics

Analysis

- A fifth of people have degree or equivalent, and the highest rate is in Bramhall & Cheadle (29%).
- A quarter of people have no formal qualifications, and the rates are highest in Heatons & Tame Valley (30%).
- 55% of people aged above pensionable age have no qualifications and 36% of those aged 50 to pensionable age have no qualifications, only 16% of people aged 16 – 24 years have no qualification.
- Younger adults are also more likely to have higher qualifications, with 28% of 25-49 year holds holding a degree or equivalent.
- Stop points at GCSE and Degree, i.e. relatively few people gain A level equivalents and do not go on to gain degree or equivalent.

Conclusion

- People without literacy skills either need support in improving their reading or are likely to need information in appropriate alternative forms. Evidence is that the majority of these individuals are likely to live in Heatons & Tame Valley.
- Those aged between 50 and pensionable age are more likely to not hold any formal qualifications, which may affect their ability to gain employment and maximise income. Employers need to be encouraged to recognise less formal qualification and valuable life and work experience held by this age group.
- Evidence suggests that, to improve rates of higher qualifications efforts are best concentrated at getting people to gain A level or equivalent qualifications as these are highly likely to progress to higher education.
- It is important to recognise that older people [who have gained the majority of their life experience in previous generations] may not adapt easily to changes in service delivery or ethos. They may experience difficulties in engagement with health professionals, especially as doctor-patient relationships become less formal and may have lower expectations or demand less than younger adults.
- Although statistics relating to computer literacy are not available, it is important to recognise that there will be some people who are unfamiliar with computers and will need support with, or alternatives to, new technologies.

2.2.6 Crime

Rationale

- Crime is the most commonly reported issue in people's neighbourhoods, with three quarters viewing it as a problem, and a quarter viewing it as a serious problem, many regard it as the key issue affecting local quality of life.
- Domestic violence is a crime which particularly impacts on self-esteem and mental wellbeing, both of the victim and any other family members.
- Alcohol related offences are strongly related with late night A&E attendances.

Data

2006/07 RECORDED CRIME – NUMBERS AND RATE PER 1,000 POPULATION*						
Offence Type	Bramhall & Cheadle	Heatons & Tame Valley		Marple & Werneth	Stepping Hill & Victoria	Stockport
		Heatons & Tame Valley	Town centre*			
Anti-social behaviour	5,079	7580	922	3,782	8,012	25,375
Alcohol Related Offences	117	222	96	119	332	886
Drugs Offences	192	219	80	105	207	803
Rate per 1,000 population						
Anti-social behaviour	65.3	102.6	81.9	70.1	87.5	86.1
Alcohol Related Offences	1.5	3.0	8.5	2.2	3.6	3.0
Drug Offences	2.5	3.0	7.1	1.9	2.3	2.7

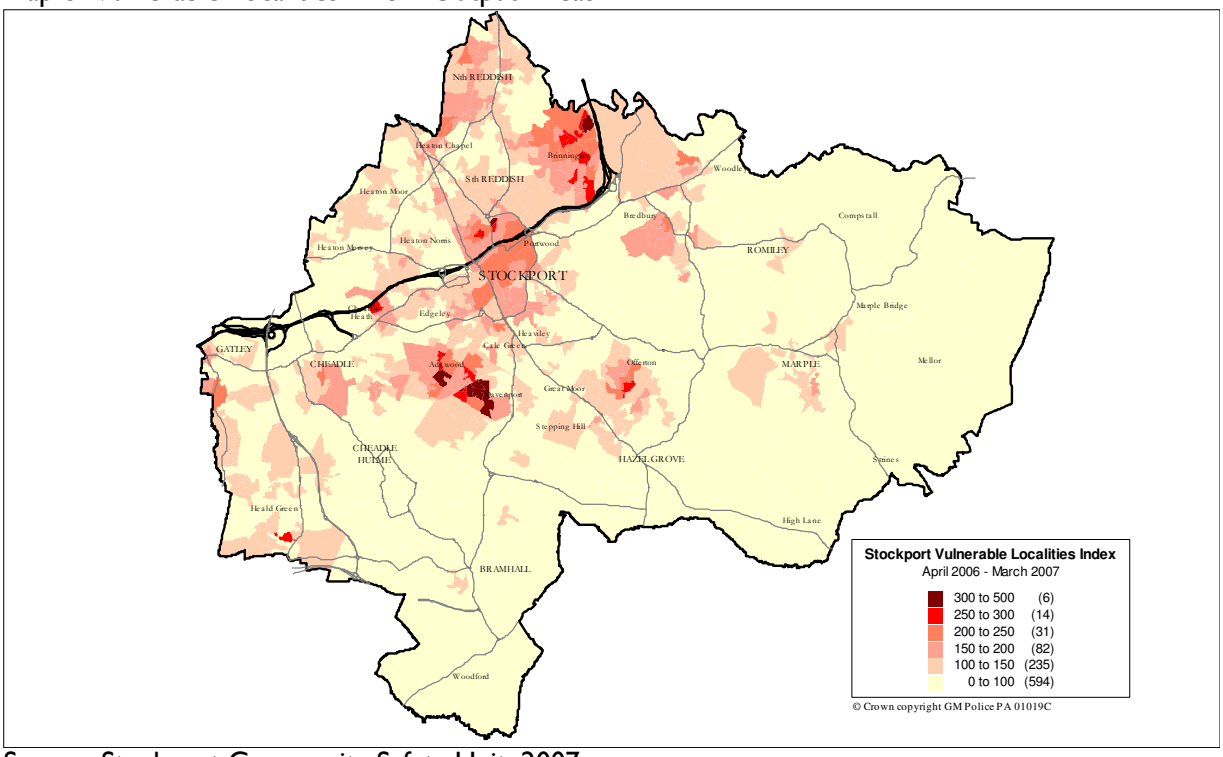
Source:
* Town centre rates are based on daytime population rather than resident population to reflect the proportion of incidents relative to the numbers of people at risk

The Vulnerable Localities Index (VLI)

The Vulnerable Localities Index (VLI) was developed as a tool to aid the identification of neighbourhoods that may be more at risk to suffering from crime, disorder and community tension. If the score is 200, then the area has been rated as twice as vulnerable as the Stockport average.

VULNERABLE LOCALITIES INDEX- OUTPUT AREA SCORES		
VLI Score	**Number of Output areas**	**% of Output areas (out of 962 in Stockport)**
0-50	97	10%
50-100	497	52%
100-150	235	24%
150-200	82	9%
200+	51	5%
Total	962	100%

Map of Vulnerable Localities Index- Output Areas



Source: Stockport Community Safety Unit, 2007

Analysis

- Rates of anti-social behaviour offences are almost twice as high in Heatons & Tame Valley as in Bramhall & Cheadle.
- Rates of alcohol related offences are higher in Heatons & Tame Valley and Stepping Hill & Victoria.
- Rates of drugs related offences are higher in Heatons & Tame Valley and lower in Marple & Werneth. Interestingly rates in Bramhall & Cheadle are as high as rates in Stepping Hill & Victoria.
- Rates of domestic violence offences are higher in Heatons & Tame Valley and Stepping Hill & Victoria.
- The map shows Stockport (mapped by census output area) and the most recent VLI score available (April 2006 – March 2007). Areas marked in dark red or brown are the areas with the highest VLI scores of 250 and above. This means these communities are potentially twice as vulnerable as the Stockport average.

- The six highest VLI output areas (each with a VLI score of 300 or more) were in Adswood, Brinnington, Bridgehall and Lancashire Hill. These areas, using the VLI as a guide, are 3 times more vulnerable as the Stockport average.

Conclusion

- If anti-social behaviour is a proxy for quality of life then services targeted at improving social cohesion should be targeted at Heatons & Tame Valley.
- Generally any crime reduction strategy should also be targeted in this area.
- The areas identified in the VLI should be used to act as a pointer or guide to supplement or direct further analysis.

2.3 Health & Social Care

2.3.1 Life Expectancy

Rationale

- Life expectancy is a summary measure of mortality which calculates the average age to which babies born today would live if there is no change throughout their life in the age-specific mortality rates currently being experienced by the present population. As such, it is the key measure of health status of the population.
- It's worth noting that there may be future changes in mortality during the lifetimes of those babies, as there have been past changes in mortality during the lifetime of those now alive, and so it does not correspond to any actual average age of death. It is a summary predictor if the current situation were to continue.

Data

2003/05 LIFE EXPECTANCY AT BIRTH						
Gender	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England & Wales
VALUE						
Males	79.7	74.9	78.2	75.1	76.8	76.8
Females	84.0	79.6	82.4	79.8	81.3	81.1
GAP TO STOCKPORT						
Males	+2.9	**-1.9**	+1.3	**-1.7**	-	0.0
Females	+2.7	**-1.7**	+1.1	**-1.5**	-	**-0.2**
GAP TO ENGLAND & WALES						
Males	+2.9	**-1.9**	+1.4	**-1.7**	+0.0	-
Females	+2.9	**-1.5**	+1.3	**-1.3**	+0.2	-

Source: Public Health Mortality File & Stockport PCT

Analysis

- Life expectancy is higher for females than for males and is similar to the national average.
- Heatons & Tame Valley and Stepping Hill & Victoria have lower than average levels compared to other areas.

- Life expectancy follows patterns of deprivation: in-depth analysis shows that, across small areas, the gap in life expectancy is up to 10 years.
- National trend analysis shows that life expectancy at birth since 1940 has improved by about 15 years for both men and women, with a particularly large increase in the post war decade but also a steady increase throughout the period. Much of this improvement in life expectancy results from the fact that fewer people die young. Life expectancy at age 65 over the same period has also improved; by about five years for women and about four years for men. This is obviously less than the corresponding increase at birth, but proportionately greater in terms of years of life remaining.

- Locally, it can be seen that life expectancy in Stockport is better than that in the North West as a whole, but only about the same as England & Wales. In the 1990s it improved faster than in the country as a whole but around the turn of the century this improvement faltered. For women, the gains were retained and life expectancy remains greater than that of the country as a whole. For men, however, the rest of the country caught up.

Conclusion

- Life expectancy is improving in all areas, however, the gap in life expectancy between areas within Stockport are one of the key priorities for action; people in the most deprived areas die up to 10 years earlier than people in the most affluent areas.

2.3.2 Causes in Inequalities in Life Expectancy

Rationale

- As life expectancy is the key summary measure of health, and inequalities one of the key priorities for action, then understanding the causes of inequalities in life expectancy is vital to finding the drivers of differentials in health. Improving the health of the least healthy is the most important way in which the health of the whole population of Stockport can be improved.

Data

Note: Data not available at PBC locality level

2003/05 Life Expectancy Inequalities between the deprived areas in Stockport* and Stockport average by component cause	
Cause of Death	**Contribution to LE Gap**
Infant death	**7.3%**
Accidental poisoning	9.1%
Violence	2.0%
Self-harm	3.0%
Other external causes	5.4%
COPD	3.9%
Other respiratory causes	3.6%
CHD	19.0%
Stroke	1.9%
Other circulatory causes	7.6%
Lung cancer	9.7%
Breast or prostate cancer	0.0%
Colorectal cancer	1.1%
Mouth and throat cancer	0.6%
Other cancers	3.6%
Digestive	15.1%
Diabetes	1.0%
Other causes	7.2%

Source: Stockport PCT
* ranking in the 20% most deprived nationally IMD 2004

Analysis

- In depth analysis has shown that:
  - Stockport has the greatest health differences between its most affluent quintile and its most deprived quintile of any PCT in Greater Manchester and the gap is widening.
  - Although life expectancy in Stockport has gradually increased in all areas, it has not done so at a uniform rate throughout the district and there are large differences in the average life expectancies for different communities within the Borough. There is a powerful relationship between the gap in life expectancy and local measures of deprivation.
  - The lowest life expectancies are to be found in the most deprived fifth of areas nationally: in Stockport the areas in the centre and north of the Borough such as Brinnington, Adswood and South Reddish, and people living in these areas can expect to live on average 4 to 6 years less than the Stockport and England average.
  - Major drivers in differences in life expectancy are currently: circulatory disease (28%); cancer (16%); digestive disease (15%); and with smaller contributions made by accidental poisoning (9%); and respiratory conditions (8%) – mainly conditions that are strongly associated with smoking and alcohol misuse.
  - Trend analysis shows that causes of death where the life expectancy gap is reducing are those attributable wholly or in part to the consequences of

smoking. Conversely the increasing impact of alcohol upon life expectancy is cause for concern.

Conclusion

- Conditions that are strongly associated with smoking and alcohol misuse are the most important drivers for inequalities. There is evidence that current interventions are improving the situation in terms of smoking, however, alcohol is emerging as the next priority for action. Policies must maintain and build on the recent good progress for smoking as it is still a major cause of inequality and services should also think about how they can contribute to tackling problems associated with alcohol.

2.3.3 Numbers of Deaths and SMRs (all ages)

Rationale

- SMRs are again a summary measure of health, showing the patterns of mortality experience by different populations compared to the national average. They allow analysis of the rates of deaths for different major causes of death.
- The statistic controls for differences in the age and sex structure of the population and, therefore, differences in the ratio are taken to relate to the different qualities of life, health experience and health behaviours of the population.
- England & Wales average is 100, a figure above 100 suggests that mortality rates are higher than average.

Data

2003-2005 NUMBERS OF DEATHS – ALL AGES – RESIDENT IN:					
	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
All Circulatory Disease	757	826	661	1,084	3,328
CHD	379	430	329	550	1,688
Stroke	169	155	123	215	662
Cancer	565	536	448	694	2,243
Lung Cancer	123	129	80	165	497
Breast Cancer	46	42	42	60	190
Respiratory Disease	251	274	220	399	1,144
Digestive	77	128	77	140	422
Accidents	45	66	46	68	225
Suicides & open verdict	13	21	12	26	72
All Causes	1,930	2,165	1,658	2,768	8,521

Source: Stockport PCT

2003-2005 STANDARDISED MORTALITY RATIOS (SMR) – ALL AGES – RESIDENT IN:										
	Bramhall & Cheadle		Heatons & Tame Valley		Marple & Werneth		Stepping Hill & Victoria		Stockport	
	SMR	Sig.	SMR	Sig.	SMR	Sig.	SMR	Sig.	SMR	Sig.
All Circulatory Disease	80.9	Low	116.3	High	96.1		118.7	High	102.5	
CHD	83.0	Low	125.6	High	98.5		124.5	High	107.2	High
Stroke	84.5	Low	100.9		83.1	Low	109.0		94.7	
Cancer	84.0	Low	108.2		92.6		107.5		97.7	
Lung Cancer	85.4		124.2	High	77.6	Low	121.2	High	102.0	
Breast Cancer	84.4		101.3		107.3		110.6		100.3	
Respiratory Disease	72.3	Low	103.7		85.8	Low	117.9	High	94.8	
Digestive	63.4	Low	136.1	High	87.3		115.7		99.4	
Accidents	86.8		149.2	High	122.5		121.6		118.7	High
Suicides &open verdict	60.7		105.2		80.1		103.6		88.4	
All Causes	76.5	Low	112.4	High	89.9	Low	111.6	High	97.1	Low

Source: Stockport PCT
Note: England & Wales average = 100 for all categories

Analysis

- Around 3,000 people in Stockport die a year. The most common cause of death is circulatory disease (around a third of deaths), followed by cancer and respiratory disease.
- Fewer than 100 people a year die as a result of an accident, but rates in Stockport are higher than the national average. Research has shown that this is due to the different approach the local coroner takes to elderly falls compared to coroners elsewhere, which has led to a higher rate of identification in Stockport.
- There are around 20 deaths from suicide and deaths of undetermined intent a year, a low number but a cause that should be preventable.
- Heatons & Tame Valley has significantly higher SMRs for circulatory disease (especially CHD), lung cancer lung and digestive disease. All causes strongly linked to smoking and alcohol. Accidental deaths are also more likely.
- Stepping Hill & Victoria has significantly higher SMRs for circulatory disease (especially CHD), lung cancer and respiratory disease; causes strongly linked to smoking.

Conclusion

- Circulatory disease is the biggest single cause of death, followed by cancer and respiratory disease. Initiatives focusing on preventing death should focus on these causes.
- Mortality rates are highest in deprived areas, especially for causes of death associated with smoking and alcohol. Again if inequalities are to be reduced work must focus on these key lifestyle behaviours.

2.3.4 General health (all ages)

Rationale

- As an overall indicator of current health status (rather than mortality), one of the few comprehensively available is one of the general health questions which ask survey respondents to assess their own health. Self-reported health has been shown to be generally reliable and correlates to health outcomes.

Data

2001 CENSUS – ALL AGES – RESIDENT IN:						
General health in year preceding 2001 Census	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England & Wales
Good Health	53,397	46,199	35,909	61,471	196,976	-
Fairly good health	14,829	14,981	11,758	20,140	61,708	-
Not good health	5,531	6,898	4,870	8,545	25,844	-
Good Health	72.4%	67.9%	68.3%	68.2%	69.2%	68.6%
Fairly good health	20.1%	22.0%	22.4%	22.3%	21.7%	22.2%
Not good health	7.5%	10.1%	9.3%	9.5%	9.1%	9.2%

Source: 2001 Census

Analysis

- 26,000 (1 in 10) people in Stockport reported not having good health over the year preceding the Census; a rate very similar to the national average.
- Rates of poor health increase with age (see subsequent chapters).
- Rates of poor health are highest in Heatons & Tame Valley and lowest in Bramhall & Cheadle, despite the fact that Bramhall & Cheadle has the older population.

Conclusion

- 26,000 people in Stockport reported not having good health. This gives one indication of the size of the health 'problem'.
- There are significant numbers of people with poor health in all areas, so although rates are highest in deprived areas we must not neglect those in other areas.

2.3.5 Limiting long-term illness (all ages)

Rationale

- Limiting long-term illness from the Census is, again, one of the few comprehensively available estimates of the prevalence of long-term conditions which impact on daily life in the population.
- Evidence suggests that the measure underestimates the total with long-term conditions, as many conditions – for example asthma, once managed, do not necessarily impede on the day-to-day activities of individuals and, therefore, may be excluded from this analysis.

Data

2001 CENSUS – ALL AGES – RESIDENT IN:						
Limiting Long-term Illness (LLTI)	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England & Wales
Number with LLTI	11,734	12,698	9,778	16,088	50,298	-
Percentage with LLTI	15.9%	18.7%	18.6%	17.8%	17.7%	18.2%

Source: 2001 Census

2001 Census – LIMITING LONG-TERM ILNESS BY ETHNICITY					
People with LLTI by ethnicity	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
All people	11,645	13,031	9,731	15,848	50,255
White British	11,020	12,331	9,565	15,351	48,267
BME(including white Irish)	625	700	166	497	1,988
Percentages					
All people	15.8%	19.1%	18.5%	17.6%	17.7%
White British	16.3%	19.5%	18.7%	17.8%	18.0%
BME(including white Irish)	10.3%	14.4%	12.3%	13.0%	12.4%

Source: Office of National Statistics, 2001

Analysis

- 18% of Stockport's population stated that they have an illness or condition which limits their day-to-day activities; a rate slightly below the national average.
- Rates of LLTI increase with age (see subsequent chapters).
- Rates of LLTI are highest in Heatons & Tame Valley and Marple & Werneth and lowest in Bramhall & Cheadle, again despite the fact that Bramhall & Cheadle has the older population.
- In depth analysis has shown that, unsurprisingly rates are much higher for those in communal establishments (87.2%) as compared to household residents (17.1%), although only around 2,000 of the total population are reported to live in these institutions
- People in Stockport from BME ancestries are less likely to have reported having a limiting long-term illness.

Conclusion

- At least 50,000 people have a limiting long-term illness affecting their daily life. This gives one indication of the size of the health 'problem'.
- There are significant numbers of people with LLTI in all areas so, although rates are highest in deprived areas, we must not neglect those in other areas.
- Further work is required to understand whether residents from the BME community are less likely to experience limiting long-term illness or are less likely to perceive or report themselves as being limited by their illness.

2.3.6 Uptake of disability related benefits (all ages)

Rationale

- The government provides financial assistance for people who meet the criteria for certain types of disability related benefits.
- In the absence of up-to-date or comprehensive data regarding the number of people in Stockport with disabilities this information provides a proxy.

Data

DISABILITY BENEFIT UPTAKE - AUGUST 2006 - NUMBERS					
	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Incapacity benefit / severe disablement allowance *					
- 16-24	110	235	100	260	705
- 25-49	765	1,920	920	1,965	5,570
- 50-59	705	1,245	780	1,410	4,140
- 60-64 and over	250	425	325	560	1,560
TOTAL	1,830	3,825	2,125	4,195	11,975
Disability Living Allowance ^					
- <16	305	435	235	570	1,545
- 16-24	145	210	120	280	755
- 25-49	485	960	570	1,260	3,275
- 50-59	415	730	450	855	2,450
- 60-69	575	840	565	1,025	3,005
- 70+	320	415	300	565	1,600
TOTAL	2,245	3,590	2,240	4,555	12,630

Source: Office for National Statistics
* Incapacity Benefit is available to adults under state pension age who become incapable of work because of illness or disability.
^ Disability living allowance is a benefit for children and adults aged under 65 years who need help with personal care or have walking difficulties because they are physically or mentally disabled.

DISABILITY BENEFIT UPTAKE - AUGUST 2006 – RATES PER 1,000					
	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Incapacity benefit / severe disablement allowance *					
- 16-24	14.0	27.6	18.6	25.0	21.9
- 25-49	30.1	69.8	52.8	57.1	53.2
- 50-59	66.5	142.9	105.7	128.3	109.9
- 60-64 and over	49.5	120.2	85.6	112.5	89.8
TOTAL	37.4	79.3	62.5	69.0	62.4
Disability Living Allowance ^					
- <16	21.9	32.7	25.7	33.1	28.8
- 16-24	18.5	24.7	22.3	27.0	23.5
- 25-49	19.1	34.9	32.7	36.6	31.3
- 50-59	39.2	83.8	61.0	77.8	65.0
- 60-69	63.3	134.3	81.8	116.6	96.8
- 70+	29.3	56.5	38.8	58.3	44.8
TOTAL	28.9	50.1	41.5	49.8	42.8

Source: Office for National Statistics

Analysis

- There are currently 11,975 claimants of working age for incapacity benefit or severe disablement allowance in Stockport (these benefits are available to those who become incapable of work due to illness or disability). Almost a half (44%) of these claims are due to mental health problems and 15% are due to problems with the musculoskeletal system; rates of claim are highest in the over 50's where more than 10% of people are in receipt of these benefits.
- There are also 12,630 claimants of disability living allowance in Stockport (this benefit is available to those who need help with personal care or walking as a result of physical or mental disability). Rates of claim are highest for those in their 60's, where again nearly 10% of the population are in receipt of this benefit.
- Heatons & Tame Valley has the highest uptake rate for both benefit types across most age groups while Bramhall & Cheadle has the lowest rates, rates which are up to a half lower.

Conclusion

- There are significant levels of uptake for disability related benefits in Stockport with almost 25,000 people claiming. Rates of uptake are strongly associated with deprivation.

2.3.7 Caring (all ages)

2.3.7.1 All Carers

Rationale

- A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability

- Unpaid caring provides a large and invaluable resource input into health and social care services.
- Taking on a caring role can mean facing a life of poverty, isolation, frustration, ill health and depression. Many carers give up an income, future employment prospects and pension rights to become a carer. Many carers also work outside the home and are trying to juggle jobs with their caring responsibilities.

Data

2001 CENSUS – ALL AGES – RESIDENT IN:						
Hours of unpaid care given per week:	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport	England & Wales
None	65,302	61,374	46,543	81,124	254,343	49,236,232
1-19	6,341	4,585	4,412	6,240	21,578	3,347,530
20-49	813	685	548	926	2,972	530,797
50+	1,301	1,434	1,034	1,866	5,635	998,732
None	88.5%	90.2%	88.6%	90.0%	89.4%	90.0%
1-19	8.6%	6.7%	8.4%	6.9%	7.6%	6.8%
20-49	1.1%	1.0%	1.0%	1.0%	1.0%	1.1%
50+	1.8%	2.1%	2.0%	2.1%	2.0%	2.1%

Source: 2001 Census

Analysis

- 10% of Stockport's population provides some unpaid care in an average week, a rate slightly higher than the national average.
- Around 8,500 people provide more than 20 hours a week.
- Rates are highest in Bramhall & Cheadle and Marple & Werneth despite the fact that these areas have lower levels of limiting long-term illness and poor general health.

Conclusion

- We need to acknowledge that there are a significant number of unpaid carers in Stockport and a small but significant proportion of these people are providing very intensive care. Policies need to ensure that the needs of these carers are considered along with the needs of those receiving care.

2.3.7.2 Carer's Assessments of Social Care

Rationale

- Stockport has a statutory obligation to monitor and report on the provision of assessments and services to carers of clients.
- Additional support provided to carers of social care clients can prevent deterioration in a person's circumstances, improve their outcomes, and reflect Central Government's agenda to support carers.

Data

CARERS OF CLIENTS ASSESSED & REVIEWED:						
	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	OOA / NFA / Unknown	Stockport Total
Under 18	1	3	1	2	0	7
18-64	443	529	383	568	43	1966
65-74	161	156	160	187	22	686
75 and over	175	135	150	154	16	630
Total	780	823	694	911	81	3289

Source: Adults & Communities Performance information unit, 2007

Analysis

- The data demonstrates that the majority of carers (59.8%) assessed are aged between 18 and 64
- There is, however, a significant section of carers assessed that are 65 and over: they are distributed fairly evenly across the Borough, with an overall average of 40% of all carers' assessments being carried out amongst this age group.
- Again, the data demonstrates a strong link between carers assessed and the areas of deprivation in Stockport in terms of volume.
- It's worth noting that, in the more affluent areas of Marple & Werneth and Bramhall & Cheadle, the proportion of carers assessed aged 75 and over is much higher than in the 2 more socially deprived areas, i.e. average carers assessed for Marple & Werneth and Bramhall & Cheadle aged 75 and over was 22%, compared with an average of 16.7% for Heatons & Tame Valley and Stepping Hill & Victoria. This needs to be matched to the profile of the areas.

Conclusion

- There appears to be a definite difference in terms of age profile for carers dependent on which PBC area the carer is located. Further work should be done to establish the reasons behind this and whether they are due to the local population profiles or a difference in approach by local services towards carers.

2.3.7.3 Intensive Home Care for Clients (18+)

Rationale

- Intensive home care is defined as someone receiving more than 10 hours of home care a week and 6 or more visits a week.
- One of the key preventative strategies in place to prevent outcomes such as permanent residential admissions or secondary health admissions is to offer clients intensive support in their own homes. In most instances, this is the preferred option for people.
- Intensive home care can also enable clients to return home more quickly after an acute admission to Hospital, which in turn reduces demand for short term residential and nursing resources.

Data

CLIENTS GETTING INTENSIVE HOME CARE PACKAGES BY CLIENT GROUP:						
Primary client type	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	NFA/ OOA/ Unknown	Stockport
Physical disability, frailty and sensory impairment	71	95	77	114	5	362
Mental health (total)	7	2	5	4	0	18
Vulnerable People	2	0	0	4	0	6
Learning Disability	14	44	17	76	2	153
Substance Misuse	0	0	0	1	0	1
Total	94	141	99	199	7	540

CLIENTS GETTING INTENSIVE HOME CARE PACKAGES BY AGE:						
	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	NFA/OOA/ Unknown	Stockport
18-64	24	60	34	106	2	226
65-74	12	14	5	34	1	66
75-84	17	33	24	28	4	106
85+	41	34	36	31	0	142
Total	94	141	99	199	7	540

Analysis

- For clients receiving intensive home care, the majority of them, 67%, will have a primary client category of physical disability. The next most significant client group is learning disability, at 28% of the whole.
- Again, we can see that the pattern of intensive home care clients reflects other information presented in terms of it being focused very much around the 2 areas of deprivation.
- There are significant differences in the distribution of the age groups between the areas. For the 2 socially deprived areas of Heatons & Tame Valley and Stepping Hill & Victoria, the average intensive home care clients are mainly aged 18-64 (average across both is 47% of all clients are aged 18-64). This is significantly different in the more affluent areas of Marple & Werneth and Bramhall & Cheadle, where 70.1% of all intensive home care clients are aged 65+.
- Bramhall stands out as having an extremely high number of intensive home care clients that are in the 85+ age category, at 43.6% of all clients. This compares with an average of just 25.4% for the three other PCB areas.

Conclusion

- In terms of intensive home care packages, although the data reflects differences in terms of volume by PCB area, there are significant differences in the age distribution of those clients receiving an intensive home care package.

2.3.8 Inpatient Activity (all ages)

2.3.8.1 Age Structure (all ages)

Rationale

- Inpatient admissions are some of the highest cost and most invasive health care interventions, often disempowering for the patient. A key policy drive is to minimise these episodes and shift towards care in a community setting, where possible.
- Analysis of admissions can give indications of the patterns of illness and disease and also demonstrates the use of health services.
- Age is the key profiling tool used later in the document to segment populations.

Data

2006/07 INPATIENT ADMISSIONS – NUMBERS AND RATE PER 1,000 POPULATION					
Inpatient Admissions by age	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
00-15 – numbers	2,404	2,987	1,878	4,375	11,644
16-24 – numbers	1,096	1,861	1,023	2,395	6,375
25-64 – numbers	7,746	9,377	6,247	12,071	35,441
65+ – numbers	7,343	5,243	5,221	7,076	24,883
All Admissions	18,589	19,468	14,369	25,917	78,343
75+ – numbers	2,993	2,182	2,179	2,875	10,229
85+ – numbers	1,237	843	871	1,234	4,185
00-15 – rate	172.9	224.4	205.4	253.8	217.3
16-24 – rate	139.7	218.8	190.1	230.6	198.5
25-64 – rate	188.7	236.0	218.4	239.5	221.8
65+ – rate	490.8	521.2	482.2	524.1	504.2
All Admissions – rate	239.1	271.8	266.3	283.2	265.7

Source: Stockport PCT

Analysis

- There are around 78,000 inpatient admissions made by Stockport residents each year.
- Rate of use is lowest for those aged 16 – 24 years and highest for those aged 65+, where the rate is more than doubled.
- Overall rates of admission are highest in Stepping Hill & Victoria and lowest in Bramhall & Cheadle.

Conclusion

- Significant use is made of the available secondary care services in Stockport.
- Older people are more likely to be inpatients and therefore any strategies targeted at hospital services need to account for the needs of this vulnerable group.

2.3.8.2 Admission Type (all ages)

Rationale

- Inpatient admissions are some of the highest cost and most invasive health care interventions, often disempowering for the patient. Key policy drive is to minimise these episodes and shift towards care in a community setting where possible.
- Analysis of admissions can give indications of the patterns of illness and disease and also demonstrates the use of health services.
- Admission type allows us to discriminate between planned care - where patients are referred through health care pathways and which are likely to be the most appropriate – and emergency admissions – which are more likely to result from lack of early presentation and diagnosis.

Data

2006/07 INPATIENT ADMISSIONS – NUMBERS AND PROPORTIONS					
Inpatient Admissions by Admission Type	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Planned Admissions	9,745	8,339	6,648	11,098	35,830
Emergency Admissions	6,824	7,953	5,773	10,536	31,086
Maternity / Birth Adm.	1,812	2,877	1,711	3,888	10,288
Other Admissions	208	299	237	395	1,139
All Admissions	18,589	19,468	14,369	25,917	78,343
Planned Admissions	52.4%	42.8%	46.3%	42.8%	45.7%
Emergency Admissions	36.7%	40.9%	40.2%	40.7%	39.7%
Maternity / Birth Adm.	9.7%	14.8%	11.9%	15.0%	13.1%
Other Admissions	1.1%	1.5%	1.6%	1.5%	1.5%

Source: Stockport PCT

Analysis

- Almost a half of the total admissions are planned and two-fifths are emergencies.
- Rates of emergency admissions are similar across Heatons & Tame Valley, Stepping Hill & Victoria and Marple & Werneth but are much lower in Bramhall & Cheadle.
- Planned admissions are highest in Bramhall & Cheadle, and lowest in Heatons & Tame Valley and Stepping Hill & Victoria.

Conclusion

- Patterns of admission types relate to deprivation, with areas of deprivation having higher rates of emergency admissions. This suggests that work may need to be targeted here to improve rates of presentation and identification and to ensure care pathways are implemented.

2.3.8.3 Provider of Care (all ages)

Rationale

- Inpatient admissions are some of the highest cost, and most invasive health care interventions, often disempowering for the patient. Key policy drive is to minimise these episodes and shift towards care in a community setting, where possible.
- Analysis of admissions can give indications of the patterns of illness and disease and also demonstrates the use of health services.
- Analysis by provider gives an indication of which providers commissioners in each area need to engage with.

Data

2006/07 INPATIENT ADMISSIONS – NUMBERS AND PROPORTIONS					
Inpatient Admissions by NHS Trust	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Stockport Foundation	9,636	13,898	11,249	20,713	55,496
South Manchester Univ.	5,185	1,194	710	1,556	8,645
Central Manchester	1,356	2,308	863	1,502	6,029
Christie Hospital (Cancer)	1,080	693	554	674	3,001
Pennine Care (MH)	367	505	294	543	1,709
Other Greater Manchester	525	584	440	515	2,064
Non-Greater Manchester	440	286	259	414	1,399
All Admissions	18,589	19,468	14,369	25,917	78,343
Stockport Foundation	51.8%	71.4%	78.3%	79.9%	70.8%
South Manchester Univ.	27.9%	6.1%	4.9%	6.0%	11.0%
Central Manchester	7.3%	11.9%	6.0%	5.8%	7.7%
Christie Hospital (Cancer)	5.8%	3.6%	3.9%	2.6%	3.8%
Pennine Care (MH)	2.0%	2.6%	2.0%	2.1%	2.2%
Other Greater Manchester	2.8%	3.0%	3.1%	2.0%	2.6%
Non-Greater Manchester	2.4%	1.5%	1.8%	1.6%	1.8%

Source: Stockport PCT

Analysis

- Stockport Foundation Trust provides the majority of inpatient admissions for Stockport residents, with other local trusts providing care in descending order of proximity.
- Rates of attendance at each provider varies between areas, depending on their proximity to each trust, only half of the inpatient admissions from Bramhall & Cheadle are made in Stockport and more than a quarter are made at Wythenshawe as this provider is close to the Cheadle border.

- Specialist care for cancer and mental health are provided by Christies and Pennine Care respectively.

Conclusion

- Commissioners in all areas need to work with the trusts that provide care for their patients, for general admissions in the main this will be Stockport Foundation; however those in Bramhall & Cheadle especially need to also work closely with the Manchester trusts.

2.3.8.4 Length of Stay (all ages)

Rationale

- Inpatient admissions are some of the highest cost and most invasive health care interventions, often disempowering for the patient. Key policy drive is to minimise these episodes and shift towards care in a community setting where possible.
- Analysis of admissions can give indications of the patterns of illness and disease and also demonstrates the use of health service.
- Length of stay is used as a proxy measure for efficiency; ideally a short length of stay as possible is desirable, although obviously a 0 or 1 day length of stay is not appropriate in all cases.
- On the other end of the scale there is emerging evidence that very short length of stay admissions may not be entirely appropriate and care best given in an alternative, community, setting.

Data

2006/07 INPATIENT ADMISSIONS – NUMBERS AND PROPORTIONS					
Inpatient Admissions by Length of Stay	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
0 day	8,957	8,868	6,537	12,094	36,456
1 day	3,132	3,654	2,534	4,934	14,254
2 days	1,459	1,551	1,069	1,959	6,038
3-4 days	1,551	1,697	1,224	2,166	6,638
5-7 days	1,238	1,252	1,005	1,673	5,168
8 -14 days	1,045	1,102	921	1,442	4,510
15-28 days	590	626	555	812	2,583
29 + days	526	666	502	789	2,483
Unknown / unfinished	91	52	22	48	213
All Admissions	18,589	19,468	14,369	25,917	78,343
0 day	48.2%	45.6%	45.5%	46.7%	46.5%
1 day	16.8%	18.8%	17.6%	19.0%	18.2%
2 days	7.8%	8.0%	7.4%	7.6%	7.7%
3-4 days	8.3%	8.7%	8.5%	8.4%	8.5%
5-7 days	6.7%	6.4%	7.0%	6.5%	6.6%
8 -14 days	5.6%	5.7%	6.4%	5.6%	5.8%
15-28 days	3.2%	3.2%	3.9%	3.1%	3.3%
29 + days	2.8%	3.4%	3.5%	3.0%	3.2%
Unknown / unfinished	0.5%	0.3%	0.2%	0.2%	0.3%
2006/07 INPATIENT ADMISSIONS – AVERAGE LENGTH OF STAY					
Mean	4.07	4.60	4.76	4.90	4.60
Median	0.09	0.23	0.25	0.17	0.18

Source: Stockport PCT

Analysis

- The majority (65%) of inpatient admissions are associated with a length of stay of 0 or 1 day, and for all areas the modal average and median average approximate to 0.
- There are significant numbers (around 2,500) of outliers with length of stays beyond 4 weeks, some of whom have been inpatients for more than a year. These skew the mean average length of stay to 4.6.
- Patterns of length of stay are broadly similar across areas.

Conclusion

- In line with the national strategy, the majority of hospital stays are for a day or shorter, however, policy makers need to ensure that these individuals are appropriately admitted and discharged.
- For those with long length of stay, consideration needs to be given to appropriate settings and support for facilitating either a move back to independence or towards a less medicalised supported living.

2.3.8.5 Cause of Admission (all ages)

Rationale

- Inpatient admissions are some of the highest cost and most invasive health care interventions, often disempowering for the patient. Key policy drive is to minimise these episodes and shift towards care in a community setting where possible.
- Analysis of admissions can give indications of the patterns of illness and disease and also demonstrates the use of health services.
- Analysing the cause of admissions give indications of the type of conditions people in Stockport are receiving treatment for.

Data

2006/07 INPATIENT ADMISSIONS – PROPORTIONS					
Inpatient Admissions by Healthcare Reference Group Chapter (HRG)	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Nervous System	3.3%	3.2%	3.3%	3.0%	3.2%
Eyes & Periorbita	4.6%	3.9%	4.1%	3.6%	4.0%
Mouth, Head, Neck & Ears	4.7%	5.0%	4.1%	4.6%	4.6%
Respiratory System	4.0%	4.3%	4.6%	4.5%	4.4%
Cardiac Surgery & Primary Cardiac Conditions	7.9%	7.6%	8.3%	7.3%	7.7%
Digestive System	15.2%	13.9%	16.9%	15.0%	15.1%
Hepato-biliary & Pancreatic Sys.	1.7%	1.6%	1.6%	1.4%	1.6%
Musculoskeletal System	9.9%	9.0%	10.4%	9.1%	9.5%
Skin, Breast & Burns	4.4%	4.3%	4.3%	4.4%	4.3%
Endocrine & Metabolic System	1.0%	1.0%	0.8%	0.8%	0.9%
Urinary Tract & Male Reproductive System	7.0%	4.6%	5.3%	4.3%	5.2%
Female Reproductive System	5.0%	4.9%	4.5%	5.2%	5.0%
Obstetrics & Neonatal Care	9.7%	14.9%	11.9%	15.2%	13.2%
Diseases of Childhood	5.3%	6.3%	5.4%	7.3%	6.2%
Vascular System	0.9%	0.9%	0.9%	0.8%	0.9%
Spinal Surgery & Primary Spinal Conditions	0.9%	1.0%	1.0%	0.9%	0.9%
Haematology, Infectious Disease, Poisoning & Non-specific Groups	11.6%	10.0%	9.9%	9.8%	10.3%
Mental Health	1.8%	3.1%	2.0%	2.3%	2.3%
Undefined Groups	1.1%	0.6%	0.6%	0.6%	0.7%

Source: Stockport PCT

Analysis

- Conditions relating to the digestive system, obstetrics & neonatal care, 'haematology, infectious disease, poisoning & non-specific groups' and musculoskeletal system are the most common cause of admission in all areas.
- Over half the digestive system admissions are for either 'diagnostic procedures' relating to the oesophagus and stomach or 'endoscopic or intermediate procedures' relating to the large intestine
- Obstetrics & neonatal care admissions relate to more than 3,000 births occurring a year, each with a minimum of two admissions – one for the mother and one for the baby at delivery but many with earlier admissions relating to monitoring or screening.
- 'Haematology, infectious disease, poisoning & non-specific groups' include large numbers of admissions (under 'non-specific') relating to 'examination, follow up and special screening', 'planned procedures not carried out' and respite care, as well as a significant number of admissions for 'malignant disorder of the lymphatic / haematological systems'.

Conclusion

- The fact that many of the most common causes of admission relate to diagnostics and screening is a point worth noting. These, perhaps, should be the focus of efforts for moves to community based services and further work is needed to detail the reasons for admission in each of these areas.
- Commissioners need to ensure that these individuals are only admitted if necessary and that alternatives to admission exist on the care pathways.

2.3.8.6 Ambulatory Care Sensitive Conditions (all ages)

Rationale

- Inpatient admissions are some of the highest cost and most invasive health care interventions, often disempowering for the patient. A key policy drive is to minimise these episodes and shift towards care in a community setting where possible.
- Analysis of admissions can give indications of the patterns of illness and disease and also demonstrates the use of health service.
- The 19 Ambulatory Care Sensitive (ACS) Conditions are long-term health conditions that can often be managed with timely and effective treatment in the community without hospitalisation, implying that a proportion of ACS admissions - though of course not all - could be prevented.
- Data is presented for the numbers of emergency admissions each of the 19 conditions.

Data

2006/07 INPATIENT ADMISSIONS – EMERGENCY ADMISSIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS – NUMBERS AND RATES						
		Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Acute	Cellulitis	107	92	77	139	415
	Convulsions & epilepsy	68	140	87	173	468
	Dehydration & gastroenteritis	76	73	62	116	327
	Dental conditions	13	15	10	19	57
	Ear, nose & throat infections	114	142	77	221	554
	Gangrene	2	5	2	8	17
	Pelvic inflammatory disease	5	9	4	11	29
	Perforated / bleeding ulcer	2	7	7	8	24
	Pyelonephritis	14	13	8	19	54
	Ruptured appendix	9	11	7	16	43
	TOTAL	410	507	341	730	1,988
Chronic	Angina	106	137	112	190	545
	Asthma	80	96	59	128	363
	COPD	94	174	130	248	646
	Congestive heart failure	66	66	89	109	330
	Diabetes complications	19	31	7	31	88
	Hypertension	7	7	3	8	25
	Iron deficiency anaemia	12	17	25	20	74
	Nutritional deficiencies		1			1
	TOTAL	384	529	425	734	2,072
Vaccine	Influenza and pneumonia	94	117	103	162	476
	Other vaccine preventable		1		3	4
	TOTAL	94	118	103	165	480
TOTAL ACS Conditions		888	1,154	869	1,629	4,540
Rate – Acute		5.3	7.1	6.3	8.0	6.7
Rate – Chronic		4.9	7.4	7.9	8.0	7.0
Rate – Vaccine Preventable		1.2	1.6	1.9	1.8	1.6
Rate - Total ACS Conditions		11.4	16.1	16.1	17.8	15.4

Source: Stockport PCT

Analysis

- Ambulatory Care Sensitive Conditions accounted for around 14.6% of the total numbers of emergency admissions for Stockport residents in 2006/07, at a total crude rate of 15.4 admissions per 1,000 population.
- Approximately 45% of the ACS condition emergency admissions were for chronic conditions and 45% were for acute conditions with the remaining 10% being for vaccine preventable conditions.
- The most common causes of admission for chronic conditions were for respiratory problems (49% were for asthma or COPD) and heart conditions (43% were for angina, congestive heart failure or hypertension). Around 4% were due to diabetes complications and a further 4% due to iron deficiency anaemia.
- The most common causes of admission for acute conditions were for ear, nose & throat problems (28%), convulsions & epilepsy (24%), cellulitis (21%) and dehydration & gastroenteritis (16%).
- The vast majority (99%) of admissions for vaccine preventable conditions related to influenza and pneumonia.
- Rates of admission were highest in S&V and lowest in B&C. M&W had high rates for chronic and vaccine preventable conditions through rates in the area were lower for acute conditions – suggesting that acute conditions might be those most strongly associated with deprivation.

Conclusion

- A total of 4,500 emergency admissions were made for Ambulatory Care Sensitive Conditions in 2006/07 – admissions that should be preventable. Commissioners need to examine pathways, especially for respiratory and heart conditions, to ensure that patients are supported to manage their conditions and to avoid hospital whenever possible.

2.3.9 Accident & Emergency Activity (all ages)

2.3.9.1 Age Structure (all ages)

Rationale

- A&E attendances give evidence as to the acute demands for health care.
- Analysis of attendance can give indications of the patterns of illness and of injuries and also demonstrates the use of the health service.
- Note that this dataset is severely limited as it does not include attendances at other providers. The PBC locality of Bramhall & Cheadle will be particularly affected due to the proximity of Wythenshawe Hospital's A&E service to its boundary. Work is underway to obtain data from other providers and improve the quality of this analysis.
- Age is the key profiling tool used later in the document to segment populations.

Data

2006/07 A&E ATTENDENCES AT STEPPING HILL HOSPITAL – ALL AGES – NUMBERS AND RATE PER 1,000 POPULATION					
Inpatient Admissions by age	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
0-15 years – numbers	2,182	3,359	2,457	5,655	13,653
16-24 years – numbers	1,433	2,903	1,773	4,229	10,338
25-64 years – numbers	4,059	7,869	5,409	12,032	29,369
65+ years – numbers	2,319	2,997	3,115	4,665	13,096
All Admissions	9,993	17,128	12,754	26,581	66,456
75+ years – numbers	1,523	1,927	2,014	2,965	8,429
85+ years – numbers	619	709	683	1,032	3,043
0-15 years – rate	157.0	252.3	268.7	328.1	254.7
16-24 years – rate	182.7	341.2	329.4	407.2	321.9
25-64 years – rate	98.9	198.0	189.1	238.7	183.8
65+ years – rate	155.0	297.9	287.7	345.6	265.4
All Admissions – rate	128.5	239.2	236.4	290.4	225.4

Source: Stockport PCT

Analysis

- There are around 66,500 A&E attendances made by Stockport residents at Stepping Hill Hospital each year.
- Rate of use is lowest for those aged 25-64 years and highest for those aged 16-24 years, where the rate is more than 50% higher. This is in marked contrast to the use of inpatient services where the 16-24 age group had the lowest use. As people reach retirement age their likelihood of attending A&E increases again.
- Overall rates of admission are highest in Stepping Hill & Victoria and lowest in Bramhall & Cheadle, though as noted in the rationale the figures for Bramhall & Cheadle will be artificially low.

Conclusion

- Significant use is made of the A&E service in Stockport.
- Young adults are more likely to attend A&E and therefore any strategies targeted at these services need to account for this group.

2.3.9.2 Cause of Admission (all ages)

Rationale

- A&E attendances give evidence as to the acute demands for health care.
- Analysis of attendance can give indications of the patterns of illness and of injuries and also demonstrates the use of health services.
- Note that this dataset is severely limited as it does not include attendances at other providers. The PBC locality of Bramhall & Cheadle will be particularly affected due to the proximity of Wythenshawe Hospital's A&E service to its boundary.
- Analysing the cause of admissions give indications of the type of conditions people in Stockport are demanding treatment for.

Data

2006/07 A&E ATTENDENCES AT STEPPING HILL HOSPITAL – ALL AGES – PROPORTION						
Primary Diagnosis following Attendance		Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Non-injury	Abdominal	4.1%	4.0%	4.3%	3.9%	4.0%
	Cardiovascular Sys.	1.5%	1.6%	1.7%	1.6%	1.6%
	Central Nervous Sys.	2.4%	2.7%	2.7%	2.5%	2.6%
	Endocrine System	0.2%	0.3%	0.2%	0.2%	0.2%
	Gynaecological	0.7%	1.0%	0.7%	1.0%	0.9%
	Infection	4.0%	4.0%	3.4%	4.3%	4.0%
	Miscellaneous	7.5%	7.8%	7.5%	7.9%	7.7%
	Psychiatry	1.5%	2.8%	1.9%	2.2%	2.2%
	Respiratory System	1.5%	1.9%	2.1%	1.8%	1.9%
	TOTAL Non-injury	*23.3%*	*26.0%*	*24.5%*	*25.4%*	*25.1%*
Injury	Fracture / Dislocation	7.8%	6.9%	7.3%	6.5%	6.9%
	Head Injury	4.4%	4.8%	4.2%	4.5%	4.5%
	Soft Tissue Injury	20.0%	18.7%	19.9%	19.9%	19.6%
	Sprain / Strain	8.1%	7.4%	7.8%	8.0%	7.8%
	Other Injury	8.1%	7.1%	7.5%	7.8%	7.6%
	TOTAL Injury	*48.4%*	*44.9%*	*46.7%*	*46.7%*	*46.5%*
Other	Alcohol related	0.2%	0.6%	0.3%	0.4%	0.4%
	No diagnosis	28.0%	28.5%	28.4%	27.5%	28.0%

Source: Stockport PCT

Analysis

- A quarter of all attendances result in a diagnosis of illness, whereas almost a half relate to injuries.
- The most common injuries in descending order are soft tissue injuries (including lacerations and bruising), sprains & strains, fractures and head injuries.
- The most common illnesses are classified as 'miscellaneous', with abdominal and infection the next most common.
- Interestingly, over a quarter of all attendances do not result in any diagnosis, perhaps suggesting that the attendance might have been inappropriate.
- Only 250 attendances were identified as 'alcohol related' however it is hypothesised that many more attendances than this are alcohol related.
- Patterns across areas are broadly similar.

Conclusion

- There is a need for better quality data as a quarter of admissions have no diagnosis and almost a tenth are coded as 'miscellaneous'.

- Evidence does suggest that minor injuries account for many attendances, and work may need to be undertaken to assess whether A&E is the most efficient setting for the treatment of these.
- Work also needs to be conducted so that people with an illness choose to present to primary care in the first instance, rather than A&E.

2.3.9.3 Location of Incident (all ages)

Rationale

- A&E attendances give evidence as to the acute demands for health care.
- Analysis of attendance can give indications of the patterns of illness and of injuries and also demonstrates the use of health services.
- Note that this dataset is severely limited as it does not include attendances at other providers. The PBC locality of Bramhall & Cheadle will be particularly affected due to the proximity of Wythenshawe hospital's A&E service to its boundary.
- Analysing the location of the incident give indications of the type of settings children in Stockport are either getting injured or ill at.

Data

2006/07 A&E ATTENDENCES AT STEPPING HILL HOSPITAL – ALL AGES PROPORTION					
Inpatient Admissions by age	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Home	51.4%	51.1%	52.8%	50.5%	51.2%
Public Place	10.6%	12.6%	11.2%	11.6%	11.7%
Work	3.8%	5.0%	5.2%	6.0%	5.2%
Sporting	6.5%	4.8%	5.4%	4.7%	5.1%
Road Traffic Accident	3.0%	3.0%	3.1%	3.1%	3.1%
Educational Establishment	3.7%	2.9%	2.8%	3.1%	3.1%
Holiday	1.1%	0.7%	0.8%	0.8%	0.8%
Assault	0.6%	0.9%	0.7%	0.9%	0.8%
Other	19.3%	19.0%	18.1%	19.4%	19.0%

Source: Stockport PCT

Analysis

- More than a half (51%) of all incidents occur in the home, a pattern which is similar across all PBC localities.
- 12% occur in public places and 19% in 'other' locations.

Conclusion

- There is a need for better quality data as almost a fifth of attendances are from 'other' locations.
- Evidence does suggest that homes are the most likely place for an incident to occur and, therefore, accident prevention schemes should target these locations.

2.4 Lifestyles & wellbeing (aged 18+)

2.4.1 Smoking (aged 18+)

Rationale

- Smoking is a direct cause of premature mortality, heart disease, cancer and lung disease. 1 in 4 smokers will die as a result of a smoking related disease.
- Adults born before 1956 were more likely to become smokers but rates of quitting were relatively high. Adults born after 1956 are less likely to begin smoking but are also less likely to give up; rates of quitting are especially low for manual workers.

Data

2006 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
Smoking	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Current Smoker	10.7%	21.5%	14.0%	18.7%	16.2%
Ex-smoker	41.3%	37.6%	38.3%	37.7%	38.7%
Never Smoked	48.1%	40.9%	47.7%	43.6%	45.1%
Sample Size	2,385	1,795	1,588	2,392	8,525

Source: Stockport PCT

PRIORITY 1 LOCAL AREA SURVEYS – ADULTS RESIDENT IN:			
Smoking	Adswood & Bridgehall	Brinnington	Heaton Norris & Lancashire Hill
Current Smoker	45.8%	51.8%	49.3%
Ex-smoker	18.6%	11.0%	16.0%
Never Smoked	35.4%	37.2%	34.7%
Sample Size	500	600	369

Source: Neighbourhood Renewal, Stockport MBC

Analysis

- The Stockport Health Survey reveals an overall smoking prevalence of 16.2% amongst respondents. This rate is significantly lower than that for England, 25% (2004-5). More men (19.1%) than women (14.8%) reported being current smokers. It should be noted that these prevalences are likely to be lower than the true smoking prevalence in Stockport owing to a higher proportion of the survey respondents being older and more affluent than in the Stockport population as per the 2001 Census.

- Smoking is closely associated with deprivation nationally, and this picture is mirrored by the PBC data, showing smoking prevalence increasing with deprivation, with a prevalence of 21.5% in Heatons & Tame Valley and a prevalence of just 10.7% in Bramhall & Cheadle.
- Further evidence from the Neighbourhood Renewal team shows that rates of smoking are particularly high in the three priority 1 areas, with around a half of

adults in Brinnington and Heaton Norris & Lancashire Hill reporting that they smoked.

Conclusion

- This analysis supports previous evidence on the drivers of health inequalities and should focus the attention of smoking services on the most deprived areas of the Borough.

2.4.2 Alcohol (aged 18+)

Rationale

- The ideal pattern of alcohol consumption is to drink a small amount on most days and to have at least one alcohol free day a week, so as to gain the benefits of its cardioprotective effects without the damage that comes from alcohol excess. Safety margins are small – the first two units a day are beneficial, the next two cancel out any benefit and thereafter any alcohol consumed is harmful.
- The pattern of beneficial alcohol consumption is, however, not the norm and concern about the negative impacts of alcohol is on the increase. The effects of alcohol misuse in relation to liver cirrhosis are well-known, but its impacts are far wider than this, as it increases a multitude of health and social problems.

Data

2003 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
Annual alcohol consumption pattern	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Not at all	15.3%	15.5%	14.6%	13.7%	14.7%
1-2 days a year	3.5%	5.7%	5.2%	5.9%	5.0%
1 day every couple of months	4.7%	6.5%	4.6%	6.9%	5.8%
1-2 days a month	12.8%	12.3%	11.8%	14.3%	13.0%
1-2 days a week	27.4%	30.3%	30.9%	31.0%	29.6%
3-4 days a week	17.7%	15.4%	16.4%	14.1%	15.7%
5-6 days a week	7.8%	5.2%	6.4%	5.5%	6.4%
Almost every day	10.8%	9.1%	10.2%	8.6%	9.8%
Sample size	2,428	1,853	1,611	2,421	8,687

Source: Stockport PCT

2003 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
For those who drink alcohol, the number of units drunk on the day drank most in preceding week	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Didn't drink alcohol last week	16.5%	20.1%	16.9%	19.2%	18.2%
Drank less than recommended daily limit	27.6%	21.5%	26.4%	24.7%	24.9%
Drank more than recommended daily limit but less than twice limit	20.3%	16.4%	20.2%	16.6%	18.3%
Binge drank (more than twice recommended daily limit)	35.6%	42.1%	36.5%	39.5%	38.5%
Binge drank (more than three times recommended daily limit)	*16.7%*	*23.9%*	*17.3%*	*22.5%*	*20.3%*
Sample size	2,060	1,551	1,388	2,099	7,405

Source: Stockport PCT

2003 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
For those who drink alcohol, the number of units drunk in preceding week	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Didn't drink alcohol last week	12.7%	15.7%	13.8%	15.1%	14.4%
Drank less than recommended weekly limit	59.5%	54.2%	60.1%	60.0%	58.3%
Drank more than recommended weekly limit but under 36/50 units	23.0%	24.0%	21.2%	19.7%	21.9%
Binge drank (more than 35 or 49 units)	4.9%	6.2%	4.9%	5.2%	5.4%
Sample size	2,060	1,551	1,388	2,099	7,405

Source: Stockport PCT

Analysis

- The Stockport Health Survey found that the average weekly consumption of alcohol for males was 20.7 units of alcohol which is just below the recommended weekly allowance of 21 units for males. For females the average consumption was 9.3, which is below the recommended weekly limit of 14 units. These calculations are based on the current average strength of alcoholic drinks (e.g. 2.4 units in 1 pint of normal strength beer, 2 units per glass of wine).

- Greater proportions of males than females consumed over the recommended safe limits for alcohol intake; interestingly it was found that the mean number of units reported to have been consumed in the preceding week increased with deprivation for males but fell with deprivation for females.

- 15% of respondents reported that they didn't drink any alcohol at all whereas 10% drank every day. Across the Borough the proportions drinking on at least 3 days a week were highest in the more affluent areas; 36% in Bramhall & Cheadle compared with 28% in Stepping Hill & Victoria or 30% in Heatons & Tame Valley.
- Binge drinking (i.e. drinking more than twice the daily recommended alcohol limit) was found to be more prevalent amongst the younger age groups, for men and women.
- The proportion consuming more than twice the safe daily limits increased with deprivation, with rates in Heatons & Tame Valley being the highest where 42% of drinkers binge drank in the preceding week.
- The proportion consuming more than 35 (females) or 49 (males) units of alcohol over the course of a week, i.e. drinking dangerously high levels, also increased with deprivation, with rates in Heatons & Tame Valley being the highest at 6.2%.
- Evidence from secondary care services shows that the number of inpatient stays and A&E attendance directly related to the effects of alcohol are increasing rapidly and are especially high in areas of deprivation. Alcohol related mortality is also demonstrating a worrying upward trend.

Conclusion

- People in affluent areas are more likely to drink alcohol frequently, however, people in deprived areas are more likely to binge drink, in other words, when people in deprived areas do drink alcohol they consume more. This trend means that people in deprived areas are more likely to be following unhealthy patterns of drinking.
- The current trends of unhealthy levels and patterns of drinking are having an increasing impact on many health and social care services. There are likely to be further increases in demand for direct health and social interventions due to the long-term effects of drinking on the health of individuals and there are also likely to be increases in demand for indirect services to tackle some of the alcohol associated problems of anti-social behaviour (especially violence) and social cohesion.

2.4.3 Obesity (aged 18+)

Rationale

- Obesity is responsible for more than 9,000 premature deaths per year in England and is an important risk factor for a number of chronic diseases such as heart disease, stroke, some cancers, and type 2 diabetes and is also associated with low self esteem and social isolation. The current expectation nationally is for rates of obesity to continue to increase.
- Conceptually we can view a person as:
    - ***overweight*** if their weight carries a risk of affecting their long-term health
    - ***obese*** if their weight causes some restriction in their current function
    - ***very obese*** if their weight seriously restricts their day to day life
    - ***morbidly obese*** if their weight causes immediate serious impact on their health and/or life expectancy (for example by restricting respiratory function)

- These functional definitions, however, cannot be applied statistically so, for analysis purposes we use a definition based on the Body Mass Index (BMI) in which people who are very overweight are defined as obese. The BMI is the ratio of weight to height squared, and a BMI of 25–30 is overweight and 30+ is obese (with 35+ classing as very obese and 40+ as morbidly obese). For statistical purposes these definitions are perfectly adequate, however, they do not necessarily describe the experience of each individual.

Data

2006 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
Obesity	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Not overweight or obese	54.7%	51.9%	53.8%	51.3%	52.9%
Overweight only	35.1%	33.7%	34.2%	34.7%	34.5%
Obese	10.3%	14.4%	11.9%	14.0%	12.6%
Sample Size	2,406	1,813	1,592	2,406	8,573

Source: Stockport PCT

2006/07 QOF PREVALENCE – ALL AGES – GP REGISTERED IN:					
On Register of Obesity	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Obesity – number	4,532	6,284	3,845	6,677	21,338
Obesity – rate per 1,000	53.6	79.3	70.1	87.7	72.4

Source: QMAS

Analysis

- The adult lifestyle survey indicated that 47.1% of adults in Stockport were overweight (i.e. with a BMI greater than 25) and 12.6% were obese (i.e. with a BMI greater than 30). Rates of obesity increase with age.
- For all ages the proportion of people who are overweight or obese increases with deprivation, a pattern which is mirrored by national data but which is less clear than for some of the other lifestyle factors such as smoking.
- Data from GP registers suggest that more than 21,000 people registered with a Stockport GP (wherever they live) have a BMI greater than 30, 7% of the total list, however, it is not known what the recording rate for BMI is so this figure is likely to be an underestimation.

Conclusion

- There are significant numbers of people who are obese in all ages, but policies should recognise that the impact of obesity is particularly linked with deprivation and should design initiative accordingly.

2.4.4 Diet (aged 18 +)

Rationale

- Diet has a known impact on health and the incidence of disease; including the major killers of cardiovascular disease and some cancers. A healthy eating pattern is low in fat, salt and sugar and high in nutrients and fibre and has controlled portion sizes.
- Fruits and vegetables are promoted as part of an overall healthy lifestyle, helping people to maintain this healthy eating pattern. These items are packed with vitamins and minerals and are an excellent source of fibre and antioxidants, they can help maintain a healthy weight and can help reduce the risk of heart disease, stroke and some cancers.
- The national recommendation is that people eat at least 5 portions of fruit and vegetables a day.

Data

2006 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
5-a-day	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
0 portions	1.0%	1.8%	1.5%	2.0%	1.6%
1 portion	8.1%	12.8%	10.0%	12.2%	10.8%
2 portions	17.8%	22.3%	17.7%	20.9%	19.8%
3 portions	27.2%	26.5%	27.3%	27.2%	27.1%
4 portions	23.8%	18.3%	22.8%	20.5%	21.4%
5+ portions	22.0%	18.3%	20.7%	17.2%	19.4%
Sample Size	2,400	1,819	1,602	2,394	8,575

Source: Stockport PCT

Analysis

- The percentage of respondents who reported eating the recommended five or more portions of fruit and vegetables per day was lower in Stockport (19%) than in England (25%). The most usual number of portions of fruit and vegetables to be consumed per day is three.
- More females than males eat five or more portions of fruit and vegetables per day. However, this still amounts to less than a quarter of females eating their 5-a-day. For both males and females, the age bracket with the greatest proportion of individuals consuming the recommended daily amount of fruit and vegetables was the 40 to 59 year olds.
- The proportion of individuals consuming five or more portions of fruit and vegetables per day increases with affluence.

Conclusion

- Less than 1 in 5 Stockport residents report eating 5 or more portions of fruit or vegetables a day, so there is much scope for improvement across the whole of Stockport and for all age groups. Policy makers need to bear in mind the affordability and accessibility of fruit and vegetables as evidence shows that people in deprived areas have even lower levels of consumption than elsewhere.

2.4.5 Exercise (aged 18+)

Rationale

- Evidence clearly demonstrates that an inactive lifestyle has a substantial negative impact on individual health. Adults who are physically active have 20-30% reduced risk of premature death, and up to 50% reduced risk of developing the major chronic diseases such as coronary heart disease, stroke, diabetes and cancers. Overall, physical activity levels are declining nationally.

- Since 1996 the Department of Health's advice for physical activity has been that adults should aim to take 30 minutes of at least moderate activity on at least five days a week.

Data

2006 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
Exercise – at least 30 minutes of moderate activity undertaken:	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Less than once a week	17.9%	19.7%	18.3%	20.4%	19.2%
1-2 times a week	29.2%	26.6%	27.2%	25.6%	26.9%
3-4 times a week	29.7%	27.2%	27.2%	28.4%	28.3%
5+ times a week	23.2%	26.5%	27.4%	25.7%	25.6%
Sample Size	2,390	1,817	1,594	2,377	8,538

Source: Stockport PCT

Analysis

- Approximately a quarter of respondents to the Stockport Health Survey reported that they undertake the recommended five or more 30 minute sessions of moderate physical activity each week, however, a fifth reported completing less than one session a week.
- Nationally, levels of walking have decreased as car dependency has increased.
- No clear distinction was apparent between the PBC localities in terms of the proportions of individuals in the sample undertaking physical activity.

Conclusion

- Three-quarters of people in Stockport do not undertake the recommended amount of physical activity a week. There is, therefore, large scope for improvement across all areas and all ages.

2.4.6 Mental wellbeing (aged 18+)

Rationale

- Complete mental wellbeing is both the absence of mental illness and the presence of positive mental health and well-being.

  The positive aspect of mental health encompasses how we think feel and relate giving people the resources to cope with life and the confidence to make the most

of any opportunities offered. Wellbeing can be encapsulated by the phrase 'feeling good and doing well'.

- Having positive mental health or wellbeing benefits physical health by: improving protection from heart disease; reducing stroke incidence (and promoting survival); minimising harmful health behaviours such as smoking and drug taking; and enhancing overall life time mortality rates and life expectancy.
- The risk factors for suffering mental ill health include: material and relative deprivation; low educational attainment; unemployment; environment; poor housing; poor resources; violence and crime; adverse life events and poor social networks. Improving mental health and wellbeing can make a contribution to reducing health inequalities.

Data

2006 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
Average MHI5 score (scale of 0 - 100, higher scores are better)	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
Average MHI5 Score	74.8	71.8	74.2	72.6	73.3
% with low* wellbeing score	32.0%	37.7%	32.8%	37.7%	35.2%
% with high* wellbeing score	68.0%	62.3%	67.2%	62.3%	64.8%
Sample Size	2,274	1,689	1,490	2,251	8,038

Source: Stockport PCT

* There is no gold standard definition for the classification of low / high wellbeing scores, however the consensus in the literature that a score of 72 and higher represents good mental wellbeing.

Analysis

- This survey measured mental health using five internationally validated questions. A higher score indicates better mental health.
- Almost two-thirds of respondents to the survey had scores that fell in the range of 'good' wellbeing, however, for both males and females the average score for the Stockport respondents was lower than those found in national surveys (i.e. they reported experiencing poorer mental health), with the exception of the 64 to 75 year olds who enjoyed better mental health than average for that age group.
- Both the average mental health score and the proportion of respondents with high scores increased (better mental health) with affluence, with rates being highest in Bramhall & Cheadle and lowest in Heatons & Tame Valley and Stepping Hill & Victoria.

Conclusion

- Although the majority of people have positive mental wellbeing there is a significant minority of people whose mental health status cannot be described as good. Mental wellbeing follows patterns of known deprivation and services should particularly target in these areas.

2.4.7 Multiple 'risk factors' (aged 18+)

Rationale

- The effects on health of smoking, alcohol misuse and obesity are well documented and they are often seen as the three most important priorities for modifying behaviour and promoting healthy lifestyles.
- Individually, each of these factors can have an enormous impact on the length and quality of a person's life. When a person shares in more than one of these behaviours the risk of poor health outcomes is enhanced.

Data

2006 ADULT LIFESTYLE SURVEY – AGED 18+ RESIDENT IN:					
Risk Behaviours	Bramhall & Cheadle	Heatons & Tame Valley	Marple & Werneth	Stepping Hill & Victoria	Stockport
No "risky" factors	57.2%	44.1%	51.7%	47.6%	50.4%
Binge drink only	22.8%	22.8%	23.1%	21.8%	22.6%
Obese only	6.6%	8.3%	7.8%	8.1%	7.6%
Smoke only	5.0%	9.5%	7.4%	8.6%	7.6%
Binge drink & smoke	4.5%	8.8%	5.7%	8.4%	6.8%
Binge drink & obese	2.8%	3.6%	3.1%	3.3%	3.2%
Smoke & obese	0.7%	1.7%	0.9%	1.0%	1.0%
Binge drink, obese & smoke	0.4%	1.1%	0.2%	1.1%	0.7%
Sample Size	2,278	1,686	1,496	2,258	8,044

Source: Stockport PCT

Analysis

- Analysis shows that around half of Stockport's population does not have one of the three key risk behaviours.
- 0.7% of the adult population does partake in all three risk behaviours, and if extrapolated to the total 18+ population this would indicate around 1,500 people who are most at risk of poor health because of their lifestyles. Analysis by PBC locality suggests that 85% of these people are likely to live in Heatons & Tame Valley or Stepping Hill & Victoria.
- Binge drinking only is the most widespread risk behaviour combination and is three times as common as the next three most frequent behaviour combinations of obese only, smoke only and both binge drinking and smoking.

Conclusion

- Any programmes that focus on modifying behaviour for all three risk factors should concentrate in Heatons & Tame Valley and Stepping Hill & Victoria as this is where evidence suggests the vast majority of people with the combination of smoking, alcohol misuse and obesity live.