

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

NHS
Stockport

Stockport LINk

Stockport JSNA

joint strategic needs assessment

Priorities and Key Findings

Stockport JSNA 2011
& 20th Annual Public Health Report

April 2011

Contents

1. Foreword

There are three long term trends affecting the health of the people of Stockport.

First there is a trend which has been under way since the early 1990s of steady year on year improvement in health especially with regard to heart disease and lung cancer. Not only is health improving but it is improving most in the most deprived sections of the community so that inequalities are narrowing. It is on that basis that **we recommend the continuation of the public health strategies, such as tobacco control, which have produced, and are still achieving, this steady improvement.**

Secondly there is a trend which has been under way for the last ten years of increasing mortality rate in diseases related to alcohol, especially in younger age groups. This trend was initially present most of all in deprived areas so that it undermined improvements in health inequality. However recently this picture has been less consistent – it is clearly spreading into affluent areas as well and some manifestations of it (such as the increase in cancer deaths that has occurred in the last two years) affect affluent areas more. This trend is obvious not only in relation to mortality but also in relation to health service utilisation – alcohol-related admissions are one of the largest elements of increasing hospital admissions which in turn is one of the greatest pressures on NHS resources.

The balance between these two trends varies by age cohorts. In younger age groups the alcohol effect predominates and health is deteriorating. In older age groups health continues to improve. Therefore indicators which attach a heavy weighting to deaths at younger age groups (such as the 2010 index of multiple deprivation [published after the JSNA analysis was complete] which uses years of life lost as its indicator) already show health in Stockport worsening and inequalities widening. However indicators which attach less of an age-weighting to a death, such as age-standardised mortality, still show Stockport with steadily improving health and narrowing inequalities. For the future if the relationship with age is a true age-related impact then this situation will continue. If, however, it is a birth cohort effect (such as the drinking culture of a particular generation) then it will spread upwards in age as that cohort ages and in doing so will cause more deaths as it starts to affect age groups in which more people die. This is the basis of our prediction that unless the alcohol epidemic is successfully addressed there will come a point (which we are attempting to calculate) at which life expectancy in Stockport will start to fall**.**

The best known previous example of deteriorating life expectancy in a developed country as a result of alcohol during a period of economic crisis was in Russia and other Soviet-bloc countries during the decline of the Soviet Union. The work of McKee has shown that in that epidemic the strength of civil society was an important protector so that in communities where membership of clubs and societies was above 46% the deterioration was not seen. On this basis we **recommend that our response to the alcohol epidemic should include a strong community development component.** The Russian epidemic also shows the difficulty in eradicating such an alcohol problem once it has taken a firm hold and on this basis we **recommend that, despite financial difficulties, funds be invested in addressing the alcohol epidemic as soon as possible, that it be seen as a high priority for all agencies and that it be seen as a false economy to allow this problem to worsen.**

Alongside these two contradictory trends in overall health is a third trend – that of an ageing population. It is often said that this is the result of medical advances and that it will lead to an

increased demand for healthcare as old people make more use of health services. However both these statements are only partly true. It is true that increasing life expectancy contributes to an ageing population but a much bigger contribution is made by demographic factors – in the 1970s, 1980s and 1990s the coming into old age of the last generation of Victorian large families, in the 1990s and 2000s the coming into old age of the first generation of men to have lived their entire adult life in peacetime, and from this year onwards the coming into old age, and then the ageing, of the postwar baby boom. It is also true that older people have greater health needs. However what determines the extent of that burden is not the number of old people but their state of health and dependency. It is the difference between healthy life expectancy and life expectancy which matters, not life expectancy alone. It is on that basis that **we recommend the pursuit of a strategy of active healthy ageing as the best way to make care of the elderly affordable.** There will undoubtedly be pressure on health services and adult social care as a result of an ageing population – an active healthy ageing strategy could have a real impact on the extent of this pressure.

These trends will all affect the way in which the population of Stockport will use and interact with health care, social care and children's services, and all services need to plan for the implications of these trends. There are however particular areas of priority which should be the focus for each of the main statutory sectors.

For adult social care is a trend of increasing longevity for younger adults with complex needs, including those with learning, physical and sensory disabilities. This increase in life expectancy has led to an increase in demand for social care services during a period of shrinking public sector funding. The impact of this trend, along with the ageing population trend, is also likely to increase the pressure on those family and friends who provide unpaid care. We know that unpaid carers provide invaluable support, however carers themselves can become isolated and vulnerable and suffer poor health and wellbeing as a consequence. On this basis **we recommend the recognition of the value of carers and the need they have for support.** In addition adult social care are experiencing the impacts of the ageing population directly in increased demands on services, on this basis **we recommend the development of preventative interventions to support healthy ageing.**

For children's services we recognise the vital importance of early years prevention for improving health and reducing health inequalities at all ages. The 2007 JSNA noted an emerging trend of an increasing birth rate, the 2011 JSNA shows that this trend has now stabilised but that birth levels remain at the higher level. Birth rates are highest in our most deprived areas and early years outcomes such as smoking in pregnancy and breastfeeding are not improving in these areas. It is on this basis **we recommend a focus on prevention in the early years.**

For health services evidence states that we should be shifting from treatment to early detection and prevention, especially in deprived areas. The introduction of screening programmes for cancer and other conditions moves towards this vision, however trends show that it is those who are most in need who are least likely to take up these services. A community development approach is again best placed to address these trends. On this basis **we recommend health services work with communities to identify early undiagnosed long term conditions.**

Dr Stephen J Watkins

Director of Public Health

April 2011

2. Executive Summary

2.1. Background

This report presents the key findings and priorities identified by the Stockport 2011 JSNA. It should be seen as the continuation of an on-going process of developing a shared understanding and vision for health and social care in Stockport, and how we can best improve health and wellbeing in the borough and reduce inequalities. The 2011 JSNA will underpin the development of the local Health and Wellbeing Strategy, will inform the health elements of other corporate strategies and will directly influence the commissioning of health, social care and preventative services.

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

2.2. Key Findings

There has been an overall improvement in the health of the population as measured by mortality and life expectancy since the 2007 JSNA and Stockport remains one of the healthier places in the North West and average in national terms for most health indicators. Indications are however emerging that Stockport is deteriorating in relative terms compared to other areas. Health inequalities endure and outcomes in the most deprived areas are significantly lower than average.

There is evidence that current interventions are improving the situation for smoking as rates continue to fall. This has in part contributed to the dramatic fall in the number of early deaths from circulatory disease in deprived areas; cancer is now the leading cause of early (under 75) deaths in all areas.

Alcohol is emerging as the next priority for action and the impact of unhealthy drinking behaviours is seen in the lack of progress in reducing mortality from cancer and in the rapid increase in admissions to hospital due to alcohol related harm. The increase in admissions is more significant in the most deprived areas, but is evident in all areas of the borough.

New local evidence is available showing the strong association between mental wellbeing and physical health and lifestyle as well as with work, education, relationships and life satisfaction. Mental wellbeing is a strong theme throughout community and commissioner engagement and is an issue for all lifestages although people in deprived areas and those in the 40-49 year age range are more likely to experience below average wellbeing.

Different patterns of birth rates between deprived and affluent areas mean that more children are living in areas of deprivation than did three years ago. Early indicators of child and family health are deteriorating; rates of smoking in pregnancy are rising and significant inequalities remain in breastfeeding rates.

Evidence from children and young people suggest that the recession has made a significant impact on the priorities for this age group; the areas of highest concern for young people are the need for opportunities, a purpose in life and employment to improve wellbeing.

The ageing population is still a major demographic trend; by 2019 20.3% of the population could be aged 65+; an additional 9,200 people. Recent research shows that older people highlight issues of social contact, mobility and independence as being the most important influences on their ongoing wellbeing.

Challenges are emerging from rising numbers of people at all ages with complex care needs, highlighted particularly by commissioners but also by the public. Areas of particular concern are CAMHs (Child and Adolescent Mental Health), ADHD (Attention Deficit Hyperactivity Disorder) and autism in children and young people and autism and learning, physical and sensory disabilities for adults.

Carers are a significant priority for the local residents of Stockport. Carers are a valuable resource for the health and wellbeing economy of Stockport, but being a carer can have adverse effects on mental wellbeing and financial stability.

Stockport is increasingly ethnically diverse and services need to be aware of the needs of BME and other cultural groups.

2.3. Priorities

The overarching objectives for health and wellbeing in Stockport are to **improve life expectancy and healthy life expectancy** and to **reduce health inequalities**.

The priorities identified by the 2011 JSNA to help us achieve these objectives are to:

- **Reduce the consumption of and harm relating to alcohol**
- **Improve and promote mental wellbeing & resilience at all ages**
- **Reduce health inequalities**
- **Assess and respond to the increasing future need for complex packages of care at all ages**
- **Recognise the value of and support carers**

These priorities are supported by specific priorities for each lifestage, priorities for the wider partnership and priorities for ways of working. A comprehensive set of these priorities can be found in section 5, pages 14 and 15.

For all these priorities a **focus on prevention for children and young people and healthy ageing for older people is crucial**.

2.4. Next Steps

The JSNA is both a product and a process. This high-level needs analysis is a specific JSNA output, and it should not be seen as the 'completed' JSNA, but rather as a starting point for ongoing scrutiny of particular issues of agreed strategic local importance.

A key test of JSNAs is to assess not what they contain, or how well written they are but to see how they are used and what the impact of the analysis has been in terms of real changes in commissioning. In order to assess the utilisation of the JSNA some tests of the degree to which the Stockport JSNA has influenced commissioning will be developed and implemented.

In Stockport we have made progress towards a position where going forward the JSNA, and the analytical team supporting its development, will work with strategic commissioners in health and social care to develop more in-depth analyses to answer particular commissioning questions.

There are challenges to delivering comprehensive needs assessments for every commissioning area, and therefore priority will be given to further analysis over the period 2011-2014 to support commissioning for the 2011 JSNA priority areas.

Stockport's longstanding interest in community development and our current emphasis on mental well being and community empowerment has led to our involvement in a North West regional pilot project on the use of asset-based approaches and the creation of a Joint Strategic Assets Assessment (JSAA).

JSAAs will provide a greater understanding of local communities and will enable a richer perspective to be offered about ways in which improvements in health and wellbeing can be made into the strategic planning process. The aim is to eventually create a systematic, area-wide approach to asset mapping and embed the JSAA firmly within the JSNA. As a first step a JSAA will be produced for the pilot area of Lancashire Hill and Heaton Norris.

3. Background

3.1. What is a Joint Strategic Needs Assessment?

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

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

As a needs assessment the JSNA necessarily has a "deficit model" perspective, in other words it concentrates on issues that need improvement rather than highlighting issues where performance is already good or services are already meeting local needs.

It is a DH requirement that Councils and PCTs work together in partnership to undertake regular JSNAs (at least once every three years) and this requirement has been restated by the coalition government as a responsibility for local councils in the recent NHS white paper, '*Equity and Excellence – Liberating the NHS*'. The White paper places JSNA at the very centre of Council, GPCC and joint commissioning arrangements through the Health and Wellbeing Board.

3.2. JSNA in Stockport

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

The Stockport JSNA has now been refreshed to see whether the priorities identified three years ago have altered. This report presents the summary of the process undertaken in 2010/11, the key findings of the analysis and most importantly the new priorities identified.

It is important to note however that the JSNA is not only a one off piece of analysis conducted every three years and the intention is that, in the years between the full refreshes, more in-depth analysis are undertaken to inform particular priority areas. Between 2007/2008 and 2010/11 pieces of work were undertaken in certain commissioning areas, including older people, dementia and CAMHS (Children and Adolescents with Mental Health). Information about plans for the Stockport JSNA for the next three years are also included in the report.

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

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

4. Stockport JSNA 2011 Process

Stockport's JSNA 2011 is built on three different strands of intelligence, namely the analysis of:

- quantative service, outcome and contextual data – presented in sections 6 and 7 (data analysis).
- qualitative information and feedback from patients and the public – presented in section 8 (patient and public voice).
- knowledge of professionals and commissioners working in the borough - presented in section 9 (professional and commissioner perspectives).

The finding from each of these three strands have been brought together and discussed by a wide range of partnership bodies, professionals, commissioners, analysts and the general public. The final priorities have been determined following the examination of all the evidence and the interpretation through these discussions.

4.1. Process – Data Analysis

Over the summer and autumn of 2010 the JSNA project team analysed a large body of data, based on information included in the JSNA 2007 data set but with the addition of new analyses and data sources that emerged in the subsequent years.

The data analysed includes:

- demographic trends, including age structures, ethnicity, geographic distribution and projections for the future,
- contextual data about social and economic trends, including deprivation, poverty, educational attainment, housing, crime and vulnerable groups
- health and social care data, including information on mortality, disease prevalence, hospital admissions, early years health and packages of social care
- lifestyle data, including smoking, alcohol use and mental wellbeing.

A full list of data sets used in the Stockport JSNA 2011 is included in appendix 1.

A lifecourse approach to the analysis was taken, examining trends across four broad age cohorts (0-15 years, 16-24 years, 25-64 years and 65+ years) as well as for the whole population.

Data was analysed by 2004 electoral ward boundaries and Priority 1 neighbourhoods, and where possible national trends were added to enable benchmarking. Trend analysis to examine changes since the JSNA 2007 was also included where possible.

Benchmarking was also conducted using a "spine chart" methodology, where key information for each lifestage is shown in terms of the relative position of Stockport to other local areas. Areas of poorer performance can be quickly highlighted in this way.

The full analysis is presented on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/ in a series of detailed data reports; a summary of the key findings are presented in this report (see sections 6 and 7).

The data has also been added to the Profiling Stockport Live data hub where possible so that commissioners and other users can access the most up to date data and also undertake analysis by other geographies if needed.

4.2. Process – Patient and Public Voice

In undertaking the JSNA both the Council and the PCT need to work together to ensure that local community views help shape services. In the 2007 JSNA priorities were determined by the data analysis and then adopted by the strategic partnership, and it was only after this adoption that they were tested with the public. This was recognised as an area that should be improved in the 2011 JSNA, as voice should be incorporated before priorities are determined.

This, however, did not mean that we needed to conduct lots more consultations and increase the burden on an already consultation weary public. Instead we have brought together the views that people are already expressing to us in many different ways; for example through Stockport LINk (Local Involvement Network), existing consultations and customer satisfaction surveys; to form a comprehensive and coherent understanding of the views of the public. A series of meetings held over the winter enabled community engagement leads from NHS Stockport, Adult Social Care, Children and Young People and LINk to meet with the JSNA team to begin to collate the findings of many different consultations. The preliminary summary findings of this collation of voice are presented in section 8 and a full report will be available on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/ once it has been finalised.

One specific consultation was run to explicitly give local residents the opportunity to influence the JSNA. A day event was hosted by the Stockport LINk in conjunction with the Stockport Health and Wellbeing Partnership in September 2010. Members of the public, the LINk and partnership organisations, including Stockport Council, NHS Stockport and the voluntary sector, were invited to attend; and more than 150 people did so, and in addition 30 young people from Stockport College joined the afternoon discussion sessions. The summary findings of this event are also presented in section 8 and a full report can be found on the JSNA hub.

4.3. Process – Professional and Commissioner Perspectives

When JSNAs were first introduced as a statutory requirement in 2007, their purpose was to create a systematic method of reviewing the health and wellbeing needs of the local population, leading to agreed commissioning priorities. However, in subsequent reviews DH recognised that whilst the needs assessments took various forms across the country, the element that was almost universally least well-developed was the link with local commissioning. The Stockport 2011 JSNA aimed to rectify this by strengthening the link between the JSNA and commissioning.

The third strand to the 2011 Stockport JSNA therefore has been the explicit inclusion of the knowledge and views of professionals and commissioners who work in Stockport and the engagement of them in the process. This has been achieved in a number of ways including:

- A joint visioning workshop attended by local joint commissioners and senior management of NHS Stockport and Adult Social Care, held in June 2010
- A full two day workshop attended by analysts, commissioners and Public Health professionals from NHS Stockport, Adult Social Care and Children and Young People to examine the data report and to identify the initial key findings, held in August 2010
- A series of meetings held with commissioners (and key providers with relevant knowledge) with responsibilities for commissioning to explicitly engage them in the JSNA refresh process. Meetings were held for the areas of children and young

people, mental health and wellbeing, adults with disabilities, older people, alcohol and drugs, housing and a final group looking specifically at issues of inequality and diversity. The commissioners were asked to sense-check the JSNA findings against their own specialist knowledge and expertise and to identify any issues for which more in-depth knowledge or insight may be needed to inform effective local commissioning and service delivery. These took place from November to March 2011.

The summary findings of this process are presented in section 9.2 and a full report will be published on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

The engagement of Public Health, and specifically the Director of Public Health, is also a vital to the JSNA process. The 2011 Stockport JSNA therefore amalgamates the JSNA and the Annual Public Health Report (APHR) into a single system of analysis and recommendations. The Director of Public Health has made some explicit recommendations for Health and Wellbeing in the foreword of this report, based on the combined findings of the JSNA and previous analysis undertaken for the APHR. The summary findings of this joint JSNA / APHR are presented in section 9.1 and a full copy of the APHR report can be found on the JSNA hub.

4.4. Process – Determining Priorities

The first draft priorities were identified during the initial data discussion described above (see section 4.3). The priorities were divided into two broad groups, those that are the direct responsibility of the Health and Wellbeing partnership and those which are the responsibility of other partnerships, but still have a significant impact on health and wellbeing.

To be sure that the priorities drawn from the data were the right ones however, they also needed to be discussed, tested and challenged by the local population and the partnership organisations; using their own experience and knowledge to add to the discussion.

The draft properties have therefore been presented, discussed and amended by:

- partnership boards, including Health and Wellbeing Integrated Partnership Board, Health and Wellbeing Partnership, NHS Stockport Board and Health Scrutiny Committee - September and October 2010
- The general public and other professionals at the JSNA LINk event in September 2010 (see section 4.2)
- Commissioners at the JSNA & Commissioning meetings - November 2010 to March 2011 (see section 4.3)

Only once the priorities were amended to reflect the views of the local population, partnership organisations and decision makers have they been finalised.

During these discussions it became clear that there was a need to also articulate the strategic principles that will be used to frame commissioning for health and wellbeing, in other words to express the priorities for the **how** as well as the **what**. These views were raised both by commissioners and also by the public. The 2011 JSNA priorities therefore also include a section titled "ways of working" which have been generated from joint engagement with senior commissioning managers at the council and NHS (see section 4.3) as well as findings from Voice (see section 4.2).

5. Priorities for Health and Social Care 2011-2014

5.1. Priorities for Health and Wellbeing

The overarching objectives for health and wellbeing in Stockport are to:

- Improve life expectancy and healthy life expectancy
- Reduce health inequalities

The priorities identified by the 2011 JSNA to help us achieve these objectives are to:

- **Reduce the consumption of and harm relating to alcohol**
- **Improve and promote mental wellbeing & resilience at all ages**
- **Reduce health inequalities**
- **Assess and respond to the increasing future need for complex packages of care at all ages**
- **Recognise the value of and support carers**

The first four of these objectives have been assessed using the lifecourse approach, and specific priorities for each age group have been identified, for example for alcohol there is a need to focus on reducing the consumption of alcohol for those who drink risky volumes in the 25-64 age group, but for the younger adults the focus should be on binge drinking. For children and young people the 2011 JSNA recommends that reducing smoking in pregnancy and child accidents and increasing breastfeeding as actions to deliver reductions in health inequalities, while for older people focus on healthy ageing, maintaining independence and social networks will improve mental wellbeing.

The final priority is the same for all ages and does not have specific sub priorities associated with it.

In addition further priorities relevant to only one lifecourse cohort have been identified:

- Reducing levels of child obesity, by focusing on healthy eating and physical activity
- Promoting effective sexual health in young adulthood
- Assess changes in trends for the use of illegal substances for young adults
- Reduce levels of obesity in adulthood
- Promote a planned and patient centred approach towards the end of life for older people
- Prevent falls in older people

The full list of priorities is shown in the table on pages 14.

For all these priorities **a focus on prevention for children and young people and healthy ageing for older people is vital**.

5.2. Priorities for the Wider Partnership to Support Health and Wellbeing

Priorities for health and wellbeing for other partnerships have also been identified, following the system wide approach recommended by Marmott. These priorities will enable colleagues in other partnerships to focus their attention on areas which can create the conditions needed to promote and improve health. Again a lifecourse approach has been taken to give priorities for each age group, at all ages the following priorities have been recommended:

- Focus on the wider determinants of health, especially deprivation & social exclusion
- Promote positive social networks and norms to challenge lifestyle culture
- Provide an environment which encourages healthy living
- Reduce the reliance on unscheduled health care

Again more specific priorities have been given for each lifecourse cohort; ranging from increasing educational attainment in deprived areas for children to providing accessible and affordable transport for older people.

The full list of priorities is shown in the table on pages 15.

5.3. Priorities for the Ways of Working

As discussed in section 4.4 the 2011 JSNA priorities also include a section titled "ways of working" which have been generated from joint engagement with senior commissioning managers at the council and NHS (see section 4.3) as well as findings from Voice (see section 4.2). Again a lifecourse approach has been taken to give priorities for each age group, at all ages the following strategic principals have been recommended:

- Focus on prevention, engage with individuals and the community to find the causes of issues and potential solutions, using social marketing approaches
- Work with individuals and families in a holistic way, so they are fully involved in decisions about their care
- Support communities to help themselves
- Ensure that the needs of vulnerable groups are fully acknowledged

Further specific priorities have been given for each lifecourse cohort; ranging from ensuring that prevention work for young adulthood is undertaken before they reach the age of 16, and therefore to be delivered in schools, to moving towards the provision of personal budgets to empower people to make decisions about their own care.

The full list of priorities is shown in the table on pages 15.

2011 Stockport JSNA for Health and Wellbeing – Priorities for Health and Wellbeing					
	Our objective is to:	• **Improve life expectancy and healthy life expectancy** • **Reduce health inequalities**			
	All Ages	**Childhood (0 - 15)**	**Young adulthood (16 - 24)**	**Healthy adulthood (25 - 64)**	**Older people (65+)**
Priorities for Health & Wellbeing	**Reducing the consumption of and harm relating to alcohol**	Safeguarding vulnerable children in families affected by alcohol	Reducing alcohol consumption, focusing on binge drinking	Reducing alcohol consumption, focusing on increasing and high risk drinking	Reduce the impact alcohol consumption has on older people.
	Improving and promoting mental wellbeing & resilience at all ages	Promoting and supporting good parenting	Supporting service users in the transition from youth to adult mental health services	Promoting mental wellbeing in middle age Ensuring mental health services are culturally sensitive	Promoting independence and healthy ageing Maintaining social networks, targeting the most isolated
	Reducing health inequalities	Reducing levels of smoking in pregnancy, especially in deprived areas Increasing rates of breastfeeding, especially in deprived areas Reducing the number of childhood accidents, especially in deprived areas	Reducing the number and rate of teenage conceptions, especially in deprived areas Supporting vulnerable young families to have positive health Reducing the number of young people who start to smoke, especially in deprived areas and minority groups	Preventing or detecting cancer early, especially in deprived areas and minority groups Identifying patients with undiagnosed long term conditions, especially in deprived areas and minority groups	Preventing early deaths or disability from circulatory disease, especially in deprived areas Identifying patients with undiagnosed long term conditions, especially in deprived areas and minority groups
	Modelling and responding to increasing future need for complex packages of care at all ages	Model trends for the needs of children with long term and complex health needs, especially in CAMHS, ADHD and autism	Providing support towards becoming independent, especially at transitions	Model needs of adults with learning, physical and sensory disabilities, especially for mainstream services	Plan for an ageing population, especially frail elderly with complex needs, multiple conditions or elderly carers Promoting early detection and effective services for dementia
	Recognising the value of and supporting carers	Recognising the value of and supporting carers whatever their age or whatever the age of the cared for person.			
	Other priorities specific to lifestage:	Reducing levels of child obesity, by focusing on healthy eating and physical activity	Promoting effective sexual health Assess changes in trends for the use of illegal substances	Reducing levels of obesity, focusing on physical activity	Promoting a planned and patient centred approach towards the end of life Preventing falls

2011 Stockport JSNA for Health and Wellbeing – Priorities for the wider partnership and ways of working					
	All Ages	**Childhood (0 - 15)**	**Young adulthood (16 - 24)**	**Healthy adulthood (25 - 64)**	**Older people (65+)**
Priorities for wider partnership	Focusing on the wider determinants of health, especially deprivation & social exclusion Promoting positive social networks and norms to challenge lifestyle culture Providing an environment which encourages healthy living Reducing the reliance on unscheduled health care	Increasing educational attainment in deprived areas Reducing child poverty Health promoting schools and high quality PHSE	Providing opportunities to reduce the numbers who are not in education, employment or training Preventing crime Protecting victims of domestic violence	Providing opportunities for employment and skills Providing support to reduce dependence on disability and other benefits Exploiting the potential of the workplace as setting for health promotion	Promote and maintain social networks, targeting the most isolated Increasing housing quality and appropriately making adaptations. Maintain people in own homes or residence of choice. Reducing fuel poverty Provide accessible and affordable transport
Ways of working	Focusing on prevention, engage with individuals and the community to find the causes of issues and potential solutions, using social marketing approaches Working with individuals and families in a holistic way, so are fully involved in decisions about their care Supporting communities to help themselves Ensuring that the needs of vulnerable groups are fully acknowledged	Focus especially on the early years Focus on families and parenting Involve children and young people in planning their health and social care. Ensure that staff working with these age group are fully trained in the specialist skills needed	Prevention for this age group needs to start early, school setting is key Continue focus on families and parenting Promote social responsibility Provision of affordable and popular activities Use of peer education, role models and real life examples	Provide fair and appropriate access to services Move towards the provision of personal budgets to empower people to make decisions about their own care Focusing on prevention and early detection of lower level health and social care needs Ensuring services are culturally appropriate Ensuring services are accessible and co-ordinated	Promoting independence and choice Empowerment of the vulnerable, maintain confidence by promoting activity and safety early Work with private sector care organisations to give excellent quality service Flexibility in services, designed for the individual not one size fits all
	Key focus through lifecourse	**PREVENTION**		**HEALTHY AGEING**	

5.4. Changes since 2007

The 2011 JSNA priorities have developed significantly from those identified by the 2007 JSNA; major changes include:

Reducing the number of headline priorities from 10 to 5, this provides more clarity about what the key issues are currently, rather than trying to express a priority for all needs.

Using the lifecourse framework to develop priorities for each specific age cohort. This enables different teams within the Council, NHS and voluntary organisations to identify how each key priority relates to particular age group, for example for mental wellbeing children's services can focus on parenting while older peoples services and Age UK can focus on maintaining social networks.

Becoming more focussed so that there are some clear ways forward to tackle the overall priority. For example reducing health inequalities remains a priority, but there are now some key sub-priorities under this heading to steer action, such as increasing breastfeeding, improving identification of disease and supporting vulnerable young families.

Reflecting changing trends, for example alcohol is the key lifestyle priority now rather than smoking. This is not to say that smoking is not still a major threat to health, but the data shows that smoking's impact on early death is reducing and levels of smoking in the general population are declining. Smoking is still however a major issue in deprived areas, and therefore has been identified within the lifecourse framework as a sub-priority for tackling health inequalities.

More balanced as overall priorities are less public health dominated than in 2007, and represent the priorities for Adult Social Care and Children's services as well. The priorities also more fully relate to other parts of the NHS, including primary and secondary care.

Being informed by voice and derived in partnership these priorities have been developed by talking to professionals, commissioners and the public as well as assessing the data and evidence base. This is especially important in themes where data is less robust such as complex care packages or carers.

Include way of working, by doing this the priorities include not only what issues are most important but also suggest how commissioners should go about delivering change.

6. Key Findings – Data Analysis – Demographics and Context Setting

Section 6 describes the summary findings of the analysis of demographic and socio-economic trends and initial discussion of these and there implications between analysts, commissioners and Public Health. A copy of the full data analysis is held on the JSNA Hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

6.1. Population Trends

The total population of Stockport is currently 283,650 (ONS 2009), a figure which has been relatively stable over the last 10 years.

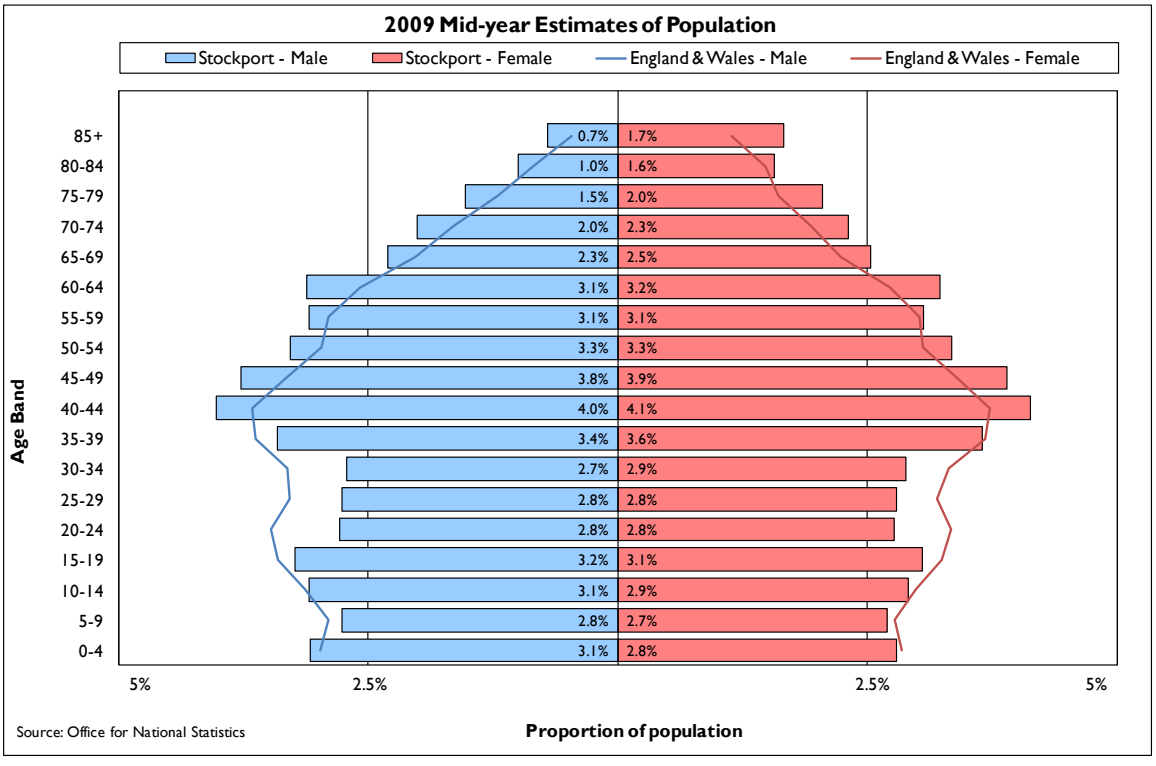
- 18.6% of the population are aged 0-15 years, a total of 52,700 people
- 10.6% of the population are aged 16-24 years. a total of 30,000 people
- 17.7% of the population are aged 65+ years, a total of 50,100 people

The age structure of the borough's population is older than the national average and has significantly lower than average proportions of 20-34 year olds (see figure 6.1). This fall in younger adults has been linked to university and new graduate job provision.

Trends show that over the last decade the age structure of population of Stockport has changed significantly and that the population is ageing, in 1999 16.4% of the population was aged 65+.

The more deprived areas of Stockport (see section 6.2) have a younger age profile than average, whereas the least deprived areas have an older age profile.

Figure 6.1: Population Pyramid



Projections to up to 2019 suggest that the total population of Stockport will rise slightly, perhaps up to a total around 290,000.

The significant changes in the age structure are anticipated to continue; by 2019 20.3% of the population could be aged 65+.

By 2014 there are projected to be ***an additional*** 5,400 people aged 65+ (an 11% increase) and an additional 900 people aged 85+ (a 13% increase). By 2019 there will be a further 3,800 people aged 65+ and a further 1,400 people aged 85+; an increase of 18% and 25% respectively in the 10 years between 2009 and 2019 .

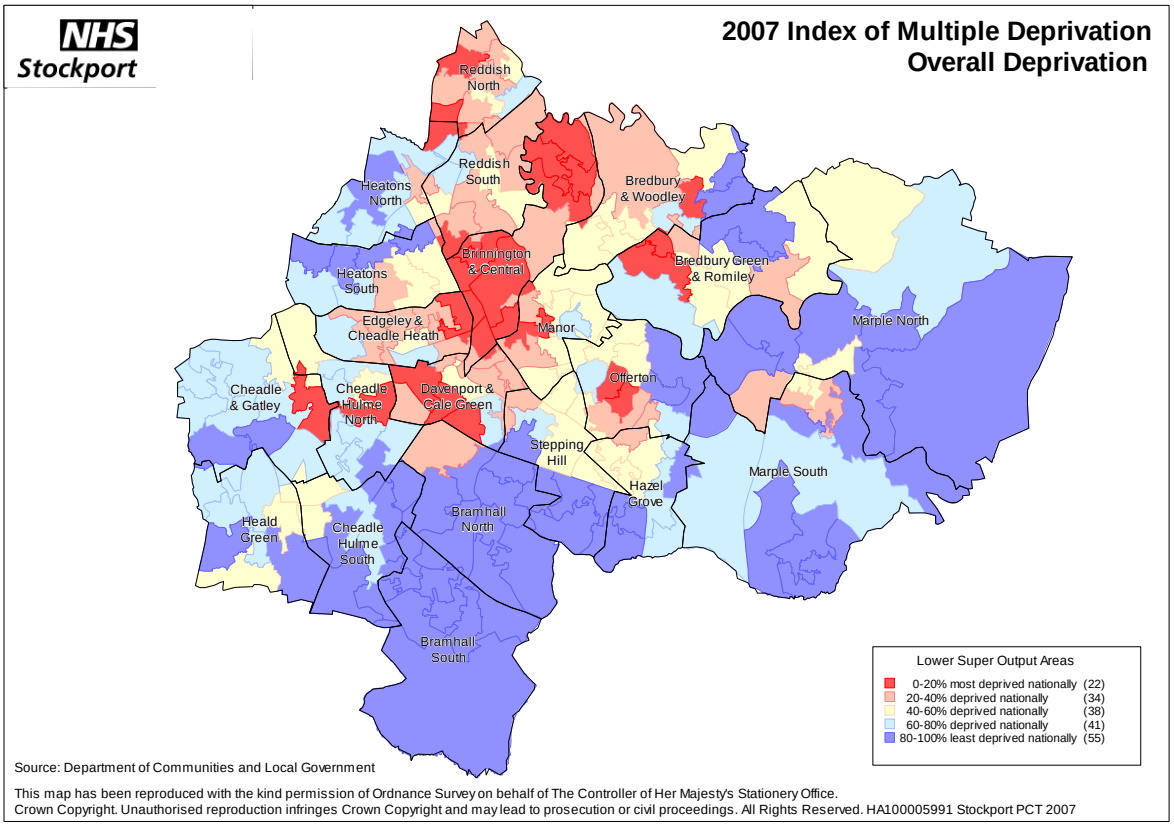
The increase in older populations is due to two major factors, first the post-war baby boomers moving into the 65-75 age group and secondly, increased life expectancy. Demand for older peoples services in the future is therefore likely to grow significantly.

6.2. Deprivation Trends

At a borough level deprivation in Stockport is unremarkable with the area ranking 159th out of 354 boroughs in England.

Internal differences show marked polarisation with small areas that rank within the 2% most ***and*** 2% least deprived in England.

Figure 6.2: Multiple Deprivation



11% of the boroughs population live in one of 22 small areas that fall within the top 20% most deprived in England (see figure 6.2). The most deprived areas have been designated as "Priority One" areas and include Brinnington, Lancashire Hill & Heaton Norris, Adswood & Bridgehall and the Town Centre.

Deprivation measures include income, employment, health, education, crime, the environment and access to housing & services; low income and poor educational attainment cluster in areas of multiple deprivation.

Overall average household income has risen slightly over the past few years; however the proportion of poor postcodes has increased which suggests that the inequalities of income between areas in Stockport are increasing. This is likely in part to have resulted from the unequal impact of the recession on different communities within Stockport.

6.3. Lifecourse Trends

6.3.1. Early Years and Childhood (0-15)

18.6% of the population of Stockport are aged 0-15 years, a total of 52,700 people. The numbers of 0-15 year olds in Stockport had steadily decreased over the last decade; however this trend is projected to now cease and the population is set to stabilise.

The more deprived areas of Stockport (see section 6.2) have a younger age profile than average, a quarter of the population in Brinnington and Adswood & Bridgehall priority 1 areas are aged under 16 years. Over the last decade the most deprived areas have not experienced a significant fall in the 0-15 population, unlike other areas of the borough, and in the future the younger population in these areas could grow.

Stockport's birth rate had decreased steadily to 2003; however since then the rate has increased. Projections suggest that in the future the numbers of births in Stockport will stabilise at the higher level.

Birth rates are highest in the most deprived areas, in the Brinnington priority 1 area fertility rates are 50% higher than average; and in BME communities.

The 0-15 age group is the most ethnically diverse; and analysis of birth and school census data suggests that this trend is increasing. Areas to the west of the borough have the highest proportions of younger population from BME ancestries; in Cheadle & Gatley ward a third of births where ethnicity is known were for babies of a BME ancestry.

Almost 5,000 (8.6%) dependent children in Stockport live in households dependent on income support. This is a significant increase from the 2007 JSNA when the figure was 3,000; this is a reflection of the change in economic circumstances due to the recession. Almost a third of children in the Brinnington priority 1 areas live in households dependent on income support.

On average only 19% of the children from Brinnington priority 1 area attain 5 or more A*-C grades at GCSE level compared to a borough average of almost 56%. Stockport rates compare favourably with the national average of 49%. Educational attainment across all areas in the borough is much closer at younger ages but the attainment gap widens as children grow older, and children from areas of deprivation fall behind.

6.3.2. Young Adulthood (16-24)

10.6% of the population of Stockport are aged 16-24 years, a total of 30,000 people. The numbers of 16-24 year olds in Stockport had risen slightly over the last decade, as those born in the early 1990's reach this age. However this trend is projected to reverse and population levels to fall over the next decade, so that by 2019 this age group form only 9% of the total population.

The young adult population follows the trends seen for children and young people, so that areas of higher deprivation are more likely to have more residents in this young adult age compared to more affluent areas and that this population is more ethnically diverse than older groups.

Almost 750 (7.1%) young adults aged 16-18 years are not in education, employment or training (NEET) a key risk factor in falling into poverty later in life. This number is broadly similar to that seen in 2007, despite the impact of the recession, although rates are higher in Stockport than both the national and comparator averages. More than 1 in 5 16-18 year olds are NEET in the Priority 1 areas and this rises to 2 in 5 in the Town Centre.

Youth unemployment is most marked in Brinnington; 1 in 5 16-24 year olds are unemployed and claiming Job Seekers Allowance. Rates of youth unemployment across Stockport are higher than the average for all ages.

There are 625 youth offenders known in Stockport, a third of all known youth offenders in Stockport live in the three most deprived wards. The proportion of people aged 16-25 experiencing domestic violence as both victim and offender in Stockport are high compared with other age groups.

6.3.3. Healthy Adulthood (25-64)

53.2% of the population of Stockport are aged 25-64 years, a total of 150,800 people. The numbers aged 25-44 years Stockport had fallen over the last decade, whereas the numbers aged 45-64 have risen as those born in previous baby booms age; so although the over number of people has remained static services will have experienced a change in the internal age structure. This population group is projected to fall in number over the next decade, as the first post war baby boomers move into the 65+ age group.

Unemployment levels have increased since the 2007 JSNA as a result of the recession, although levels in Stockport are below the national average. There is a significant gender divide with the male unemployment rate being more than twice that for females. There are high concentrations of unemployment in the deprived areas.

Around 1 in 20 households in Stockport are claiming Housing Benefit or Council Tax Benefit as well as Job Seekers Allowance or Income Support; this rises to 1 in 4 households in Brinnington and Central ward and 1 in 10 households in Davenport and Cale Green, Edgeley and Cheadle Heath and Reddish North.

Demand for advice and information, particularly regarding debt and benefits, has risen due to the effects of the recession. The highest demand on advice and information service during the last year has been from the most deprived areas.

6.3.4. Older People (65+)

17.7% of the population are aged 65+ years, a total of 50,100 people; of these 6,700 people are aged 85+ years. The numbers aged 65+ years in Stockport had risen significantly over the last decade, from 16.4% of the population in 1999. The most significant rise has been in the 85+ age group, which has increased by17.6% over the 10 year period. The significant changes in the age structure are anticipated to continue; by 2019 20.3% of the population could be aged 65+.

By 2014 there are projected to be ***an additional*** 5,400 people aged 65+ (an 11% increase) and an additional 900 people aged 85+ (a 13% increase). By 2019 there will be a further 3,800 people aged 65+ and a further 1,400 people aged 85+; an increase of 18% and 25% respectively in 10 years between 2009 and 2019 .

Every area of Stockport is experiencing this trend, and there are significant numbers of older people in each ward. However the most affluent areas of the borough have the largest older population both in terms of actual numbers and as a proportion, more than 1 in 5 of the residents of Marple South and Bramhall South are aged 65+.

The 2001 Census showed that 18,500 older people in Stockport live on their own; with Brinnington, Cheadle and Marple having the greatest number of lone pensioners. Housing is a significant issue for many older people, in terms of affordability, suitability, conditions and fuel poverty.

The proportion of older people from a BME ancestry is very low compared to the rest of the population. However if 2001 Census cohorts age as expected we can estimate that 2.3% (740 people) of the 65-74 population will be from a non-white ancestry in 2011 compared to 1.3% in 2001. Older peoples services for the first time may therefore experience significant numbers of patients or clients who come from minority cultural backgrounds.

6.4. Ethnicity and Migration

Stockport is not particularly ethnically diverse compared to the nation as a whole. However ethnic diversity is increasing and services need to be aware of the needs of BME and other cultural groups. Areas in the west of Stockport, including Cheadle and Gatley, Heald Green and Heatons South have a higher than average portion of residents from Asian ancestries.

In particular older peoples services will start to notice increasing ethnic diversity as the people who belong to first large cohorts of immigration reach age 65. If 2001 Census trends continue we can expect that 2.3% (740 people) of the 65-74 population will be from a non-white ancestry in the 2011 data compared to 1.3% in 2001. Younger peoples services have experienced a long term trend of increasing ethnic diversity, and this is set to continue.

It is estimated that between 2001 and 2009, 6,132 people arrived from outside the UK to live in Stockport. During the same period, estimates show 6,470 people leaving Stockport to live outside the UK. Based on new NI Numbers issued, over 1,000 of the migrants came from Poland and almost 500 from Pakistan. At the end of 2009, it was estimated that around 10,000 non-UK nationals were resident in Stockport. This would be approximately 3% of the population. In March 2009, fewer than 200 asylum seekers were housed in Stockport.

7. Key findings – Data Analysis – Health and Wellbeing Needs

Section 7 describes the summary findings of the data analysis and initial discussions between analysts, commissioners and Public Health. A copy of the full data analysis is held on the JSNA Hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

7.1. Health and Wellbeing Needs – Trends 2007-2010

In summary the key trends noted since 2007 are:

- **An overall improvement in the health of the population as measured by mortality and life expectancy, but with health inequalities which endure.**

  Life expectancy has risen in Stockport by 0.9 years for men since 2004/06 and 0.7 years for women. Stockport remains one of the healthier places in the North West and is average in national terms for most health indicators.

  Life expectancy in Brinnington & Central has risen above 70 years for men for the first time, but the gap in life expectancy is being maintained. The new national slope indicator of inequalities (SII) shows that Stockport has one of the biggest internal gaps in life expectancy in the country, this is driven by the polarisation of deprivation of the local population.

  Cancer is now the leading cause of early (under 75) deaths in all areas, following the dramatic fall in the number of early deaths from circulatory disease in deprived areas. Cancer survival rates are lower in deprived areas, possibly as a result of late presentation; prevention and early detection of cancer are therefore key areas of focus.

- **There is evidence that current interventions are improving the situation for smoking, however, alcohol is emerging as the next priority for action**.

  The causes of death contributing to inequalities in life expectancy are changing although lifestyles remain the key driver. Heart disease remains a major, though decreasing, cause of inequalities but the impact of deaths from digestive disease and cancer, thought to be mainly driven by alcohol, are increasing.

  The impact of unhealthy drinking behaviours is also seen in the rapid increase in admissions to hospital due to alcohol related harm. This increase is more significant in the most deprived areas, but is evident in all areas of the borough.

  Findings from the Stockport Adult Lifestyle survey suggest that there are some small improvements in the rate of smoking (probably following trends similar to the national average of a 0.4% reduction in prevalence a year) and rates of physical activity (with fewer people being inactive, although similar low proportions achieve the recommended five 30 minute sessions per week).

  Inequalities in mortality are driven by early deaths between the aged of 40 and 60 years.

- **New data from the regional mental wellbeing survey observes the strong associations that high levels of mental wellbeing have with health and lifestyle as well as with work, education, relationships and life satisfaction.**

Local data from the Adult Lifestyle survey shows that people with lower mental well being are more likely to smoke, drink unhealthily, be obese, have lower physical activity levels and eat unhealthily; all of which contribute to lower life expectancy.

It is clear that behaviour change cannot be undertaken separately from improving mental wellbeing and self confidence. Holistic approaches to change, where both mental and physical wellbeing are addressed, are those most likely to succeed.

Within Stockport people in deprived areas and those in the 40-49 year age range are more likely to experience below average wellbeing.

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

- **Different patterns of fertility between deprived and affluent areas mean that more children are living in areas of deprivation than did three years ago.**

  Early indicators of child and family health are deteriorating; rates of smoking in pregnancy are rising and significant inequalities remain in breastfeeding rates.

  Attainment data shows that by the time they reach GCSE age children in the most deprived areas of Stockport have lower outcomes than children living in similar areas elsewhere in the County. This is in contrast to children in the more affluent areas of Stockport who outperform the national average for these areas.

  These patterns follow through into early adulthood with teenage conceptions and early motherhood concentrating in the more deprived areas; continuing the cycle.

  The impact of parental alcohol and substance misuse on children can be serious. Data from the Safeguarding team suggests that 60% of referrals are linked to parents with drug or alcohol problems.

- **The ageing population is still a major demographic trend. Some evidence is emerging from the JSNA to support the theoretical analysis of healthy aging contained within Annual Public Health Report (APHR), but further analysis is needed.**

  The theoretical analysis presented in the APHR shows that the cost of the aging population is directly related to the gap between healthy life expectancy and life expectancy, so that where the gap between the two measures is greatest the cost is highest. In Stockport the gaps are largest in the more deprived areas, where life expectancy is lowest, which leads to the paradoxical situation that the cost of aging falls disproportionately on areas where the population is least old.

  Population analysis undertaken by the Public Health team has supported this theoretical finding and early findings from the JSNA, for example the analysis of the distribution of complex packages of care, also seem to support the findings.

  Further analysis is need but if the predictions contained in the APHR are confirmed it will emphasise the importance of healthy aging for inequalities and as a medium term essential prerequisite for financial stability.

Dementia and end of life care remain areas of concern within the older population as does the support of unpaid carers.

- **Challenges are emerging from rising numbers of people at all ages with complex care needs**

  This is an area where further analysis is needed across a broad range of health and social care data. Increases in demand however can be demonstrated in certain areas and analysis and modelling will continue to assess the impact of this trend across the partnership.

  Areas of particular concern are CAMHs (Child and Adolescent Mental Health), ADHD (Attention Deficit Hyperactivity Disorder) and autism in children and young people and autism and learning, physical and sensory disabilities for adults.

  For older people this issue is a significant element of the challenge relating to the ageing population, especially with the increasing numbers of frail elderly with complex needs.

- **Challenges are also emerging in terms of the utilisation of health services.**

  There is increasing reliance on acute services, particularly unplanned admissions and attendances at Accident & Emergency. This is despite an overall healthier population and runs counter to the stated intention to change models towards care closer to home.

  Modelling work has identified certain long term conditions where there are significant gaps between the actual number of patients listed on GP disease registers and the expected population prevalence. Early identification and care planning remain a priority for managing long term conditions but the analysis suggests there is still a need for case finding approaches in local communities.

- **There is an increase in risk for health due to the economic downturn and increased instability and uncertainty for the future.**

  Unemployment has risen in all areas since the last JSNA, however the rise has been disproportionately large in deprived areas where the effects of longer term unemployment are also greater. The possibility of a double dip recession is causing uncertainty and instability for the future.

  Since the last JSNA the numbers receiving Disability Living Allowance have increased, particularly in the 50-59 age group. As in the previous JSNA these are driven by mental health conditions.

7.2. Health and Wellbeing Needs – Facts and Figures

Birth and Death

Life expectancy in Stockport is currently 77.9 years for males and 82.5 years for females and is steadily rising.

The gap in life expectancy between the lowest and highest wards is 13.6 years for men and 9.9 for women.

Around 2,700 people in Stockport die a year. The most common cause of death is circulatory disease (more than a third of deaths).

Cancer is the second most common cause of death overall (around a 700 deaths per year) and the most common cause of early death (i.e. under 75 years). Around 1,500 people in Stockport are diagnosed with cancer in each year. Survival rates vary significantly by the type of cancer (prostate and breast have the highest rates and lung the lowest) and by deprivation.

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

Around 3,200 live births occur in Stockport each year, fewer than 200 of which will be "low weight". On average 15 still births and 10 infant deaths occur each year.

Around 200 teenage conceptions (under 18 years) occur each year in Stockport, around half lead to a termination of pregnancy. In an average year 220 live births are to mothers aged under 20 years whilst 140 are to mothers aged 40 years and above.

Lifestyle

Responses to the 2009 Adult Lifestyle Survey are likely to underestimate the prevalence of lifestyle issues in Stockport, results (to be treated with caution) suggest that:

- 12.5% of the population have lower than average mental wellbeing (28,000-31,500 people if applied to the 18+ population)
- 15.8% currently smoke (35,500-39,500 people)
- 27.9% drink unhealthily(64,000-69,000 people)
- 15.8% are obese (35,500-39,500 people)
- 3.4% use illegal substances (7,000-9,000 people)

Other local data suggests that 6% of reception aged and 16% of year 6 aged children in Stockport are obese.

The proportion of women in Stockport smoking at the time of delivery is 17.8%.

Health and Disability

One in 10 people in Stockport reported not having good health over the year preceding the 2001Census; a rate very similar to the national average. 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.

Hypertension (41,200 people), CHD (12,200), asthma (19,200), diabetes (12,500) and depression (30,300) are the most common long-term conditions diagnosed by GPs in Stockport.

900 people aged 18 and over at Stockport GP practices have been identified as having learning disabilities; 430 children living in Stockport ages 0-17 years are registered on the children's disability database as having a moderate learning disability while 70 are registered as having a severe learning disability.

221 children living in Stockport ages 0-17 years are registered on the children's disability database as having a physical disability and 40 with a sensory disability. Numbers for adults have yet to be established.

Overall in Stockport the uptake of disability related benefits is lower than the national average, with 9,900 claiming Incapacity Benefit/Severe Disablement Allowance (IB/SDA) and 14,400 claiming Disability Living Allowance (DLA). Mental health is the most significant condition leading to benefit uptake.

Health and Social Care

At the 2001 Census more than 8,500 people in Stockport reported that they provided more than 20 hours of unpaid care a week, a rate slightly lower than the national average. In 2009/10, 2,500 people were identified as carers for adult clients by Stockport Social Services.

There are around 81,000 inpatient admissions and around 86,000 A&E attendances made by Stockport residents each year. NHS Community Services makes around 375,000 patient contacts each year.

There are just over 13,000 referrals to Adult Social Care services for people aged 18+ a year, at the end of March 2010 5,300 people were receiving Social Care and of these around 700 adults were in receipt of intensive home support packages.

7.3. Health and Wellbeing Needs – Spine Chart Analysis

As part of the development of the JSNA, local data has been analysed against national, regional and peer authority trends and presented in spine charts. This enables areas where Stockport is an outlier to be clearly identified.

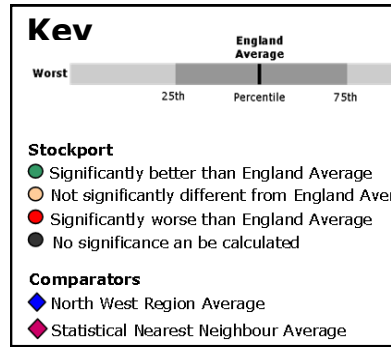
These spine charts have been developed based on the national health profiles produced by the Association of Public Health Observatories (APHO). Initially the APHO profile has been reproduced using local data and our statistical peers to give an overview. Further spine charts have been developed for each of the life stages; children, adults and older people.

The chart for all ages is presented here; a copy of the full analysis for each lifestage and including data sources is held on the JSNA Hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

The spine chart analysis has been used to test the priorities, in this chart it is possible to see that Stockport performs significantly worse than the national average for smoking in pregnancy, physical activity, binge drinking, cancer, mental health and alcohol – all issues included in the 2011 JSNA.

The only issue identified in the spine chart analysis that has not been identified in the 2011 JSNA is tooth decay in children, further analysis of trends shows that the levels of tooth decay have fallen rapidly since 1995, from and average of 2.1 decayed, missing or filled teeth in 5 years olds to 1.2. Therefore although performance is still above average, the trend is moving in the right direction.

		Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Communities	Deprivation	33642	12.0	19.9	89.2		0.0
2		Children in Poverty	8509	15.6	22.4	66.5		6.0
3		Statutory Homelessness	128	1.1	2.5	9.8		0.0
4		GCSE Achievement (5A*-C inc. Eng & Maths)	1681	55.2	50.9	32.1		76.1
5		Violent Crime	3094	11.0	16.4	36.6		4.8
6		Carbon Emissions	1628	5.8	6.8	14.4		4.1
7	Children	Smoking in Pregnancy	555	16.9	14.6	33.5		3.8
8		Breast Feeding Initiation	2391	73.0	72.5	39.7		92.7
9		Physically Active Children	16099	48.4	49.6	24.6		79.1
10		Obese Children	168	6.1	9.6	14.7		4.7
11		Tooth Decay in Children Aged 5	n/a	1.2	1.1	2.5		0.2
12		Teenage Pregnancy (Under 18)	218	38.5	40.9	74.8		14.9
13	Adults	Adults Who Smoke	n/a	18.7	22.2	35.2		10.2
14		Binge Drinking Adults	n/a	24.3	20.1	33.2		4.6
15		Healthy Eating Adults	n/a	28.8	28.7	18.3		48.1
16		Phsyically Active Adults	n/a	8.4	11.2	5.4		16.6
17		Obese Adults	n/a	21.9	26.1	32.8		13.2
18	Disease	Incidence of Malignant Melanoma	48	16.8	12.6	27.3		3.7
19		Incapacity Benefits for Mental Illness	5172	30.3	27.6	58.5		9.0
20		Hospital Stays for Alcohol Related Harm	5779	1760.0	1580.0	2860.0		784.0
21		People Diagnosed with Diabetes	11768	4.2	4.3	6.7		2.7
22		New Cases of TB	21	7.0	15.0	110.0		0.0
23		Hip Fracture in Over 65s	313	489.9	479.2	643.5		273.6
24	Life Expectancy	Excess Winter Deaths	151	17.8	15.6	26.3		2.3
25		Life Expectancy - male	n/a	77.9	77.9	76.3		84.3
26		Life Expectancy - female	n/a	82.5	82.0	78.8		88.9
27		Infant Deaths	13	3.9	4.8	8.7		1.1
28		Deaths from Smoking	460	204.7	206.8	360.3		118.7
29		Early Deaths: heart disease & stroke	248	76.9	74.8	125.0		40.1
30		Early Deaths: cancer	369	116.3	114.0	164.3		70.5
31		Road Injuries & Deaths	79	28.0	51.3	167.0		14.6



8. Key findings – Patient and Public Voice

8.1. Findings from the LINk and Health and Wellbeing Partnership Joint Event

Section 4.2 describes the event hosted by the Stockport LINk in conjunction with the Stockport Health and Wellbeing Partnership held to discuss the JSNA 2011. Summary findings are presented here and a copy of the full event report is held on the JSNA Hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

The feedback from delegates supported the identified draft priorities; they were all felt to be important issues for Health and Wellbeing in Stockport. Discussions at the event raised some important qualifications however which led to a number of the existing priorities being reworded; for example "reducing levels of child obesity" was been developed by adding "by focusing on healthy eating and physical activity".

Some additional priorities were identified by delegates too. A priority regarding **carers** was incorporated immediately into the JSNA template as this was recognised by a number of workshops. This was felt to be an issue that affected all lifestages.

Other additional potential priorities require further investigation before being accepted by the partnership. These included trends in the number of children with complex or long term health or mental health needs, drug use in young adulthood and adults with learning, physical and sensory disabilities. These themes were tested further through the commissioner engagement meetings held during the autumn.

Additional priorities for the wider partnership were also highlighted including accessible transport for older people, a health promoting environment and high quality Personal Social and Health Education in schools.

Delegates also provided a wealth of ideas about the ways in which some of these issues could be tackled. General themes were raised around focusing on prevention as early as possible (so for example prevention for the priorities for young adulthood should begin at secondary school) and about actively engaging with individuals and families.

In fact so many suggestions were made that an additional field was added to the JSNA priority template to identify the **ways of working** which should be used to deliver improvements in health and wellbeing.

The findings from this feedback have been incorporated into the revised set of priorities shown in section 5 and represented a significant development from the draft priorities presented during the course of the day.

Delegates were also asked to give each draft priority a score in terms of its relative importance to them, they could give each priority a score between 1 (lowest priority) and 10 (highest priority). These were collected individually on anonymous feedback sheets.

The priorities with the highest score were those in the healthy adulthood age range; promoting mental wellbeing, preventing or detecting early cancer, reducing alcohol consumption – particularly focusing on hazardous drinking – and reducing levels of obesity in this age group were the top 4 responses. Amongst delegates responding to this task there was a clear mandate to focus first on the 25-64 year age group and secondly on the 65+ year age group.

8.2. NHS Touchstone Tests

Over the summer 2008 Stockport PCT commissioned a public consultation as part of the local Darzi work and for development of the PCT Strategic Plan. The results of this consultation have been summarised into "Eight Touchstone Tests" which have implications for any services we commission or provide to the public.

The eight touchstone tests are listed below and are not in any order of priority. These touchstones are expressed from the perspective of a typical member of the public and they are based on the key themes that the public told us about during the patient consultation. Further information on the tests, including further elaboration about how patients would know if test were met is available on the JSNA Hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

1. I will receive clear and appropriate information at the point of contact about my condition.
2. The clinic I attend will have an environment which is suitable for the service provided.
3. I will be aware of the full range of services available to me.
4. I will be listened to and treated with respect by staff.
5. The service I receive will be individually tailored and personalised.
6. The discharge process I experience will be well explained, efficient and timely.
7. Health care will be provided at times and locations that I can attend.
8. Services for mental health services will be easy to access and personalised.

8.3. Health and Wellbeing Consultation Collation

As section 4.2 describes, the ambition for the 2011 Stockport JSNA is to comprehensively include patient and public voice as one of the three strands of evidence on which to base the priorities for health and wellbeing. As well as the event described in section 8.1 the 2011 JSNA has also brought together the views that people have already expressed to the partnership in many different ways; for example through Stockport LINk, existing consultations and customer satisfaction surveys. A series of meetings held over the winter enabled community engagement leads from NHS Stockport, Adult Social Care, Children and Young People and Stockport LINk to meet with the JSNA team to begin to collate the findings of these consultations.

The work on this collation is ongoing, and this section therefore presents the preliminary findings of this workstream. The final findings of this collation of voice will be published when complete in full on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

Evidence from local consultations supports in particular the priorities of improving mental wellbeing and supporting carers.

Evidence from older people suggested that mental wellbeing can be best maintained and improved by ensuring that activity levels are maintained (Anticipating Future Needs Study, April 2009). Loss of social contacts and / or mobility are the most significant triggers for poor wellbeing in later life, therefore priorities for independence and social networks have been added to this domain and accessible and affordable transport have been highlighted as an issue for the wider partnership.

Evidence from children and young people suggest that the recession has made a significant impact on the priorities for this age group. In the past issues of peer pressure, bullying and crime have dominated feedback. More recent feedback however suggests that the areas of highest concern for young people are the need for opportunities, a purpose in life and employment to improve wellbeing, and again this has been added to the template as a priority for the wider partnership. Poverty, education, training, mental wellbeing and substance misuse are seen as significant issues by this age group.

Evidence from carers suggests that currently they feel lonely and isolated, as the time and energy they have for their own social life is reduced and that there is a lack of understanding from employers which can lead to financial pressures through loss of income or work. Carers express a need for practical, emotional and financial support to help them in their role, and have a preference for peer support and more flexible but co-ordinated support across agencies.

Access to health services, especially primary care, remains a key issue and concerns about waiting times are raised regularly both to NHS Stockport and Stockport LINk. Stockport LINk has a number of ongoing projects to use their collective voice to recommend improvements in certain services. Priorities about accessibility have been added to the ways of working theme.

Key customer insights from local social marketing research in disadvantaged areas suggest that new service models could provide breakthroughs in behaviour change if they address root causes and are designed with, rather than, for the target groups; examples of lifestyle change from local neighbours are those most likely to prove inspirational rather than professional recommendations. Services should be aware that 'one size doesn't fit all' and should work to ensure that they are flexible, supportive and responsive to individuals.

9. Key findings – Professional and Commissioner Perspectives

9.1. Annual Report of the Director of Public Health

This section presents a summary of the 2010 Annual Report of the Director of Public Health (APHR). The full report (and chapters referred to in this summary) is available on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

9.1.1. The Strategic Context

The strategy adopted in 2006 and set out in the document called Volume 1 of the 16th to 20th Annual Public Health Reports for Stockport remains valid. This document is reproduced as chapter A2 of the APHR (available on the hub).

The strategy identified 10 outcomes to be pursued and it set 29 goals as the method of achieving them. From these, five priorities were identified, specifically for tackling health inequalities – major killers, obesity, sexual health, tobacco, alcohol; later a sixth was added – mental well being.

We were concerned in 2006 about the need to create a Smoke Free Stockport. Our priority was legislation to ban smoking in public places. That legislation is now in place and smoking rates have declined. It is however clear that we are now tackling a problem of users who have become addicted and find it very difficult to give up. There is also an ongoing uptake of smoking amongst young people who see it as part of the transition to adulthood. Our priorities must now develop to tackle smoking cultures. California has achieved success partly by being willing to attack the legitimacy of the tobacco trade, labelling it as the commercial exploitation of a death-bringing substance in extremely hard-hitting advertisements and partly by reaching out to young people as prospective adults rather than as children.

We were concerned in 2006 about the question of whether an ageing population would age healthily or would give added years of ill health. In 2008 we wrote a special report on this subject. By that time the 2004 data for healthy life expectancy had emerged and we knew that in the first part of this century the gap between healthy life expectancy and life expectancy had narrowed. In the Special Report we drew attention to the importance of healthy ageing in reducing the care costs of an ageing population. We advocated that the NHS should be careful not to consign people prematurely to the label "old" and that we should aim to create expectations of a healthy old age. This report is reproduced as chapter A3.

We were concerned in 2006 that inequalities had ceased to narrow. We looked into this and discovered that inequalities in age-standardised mortality had narrowed but inequalities in life expectancy had not. This could only mean that there was an increasing cause of death in young people. In our report to tackling this subject in 2008 we perceived this as being partly a blip in infant mortality and partly the emergence of the alcohol and obesity epidemics. This report is reproduced as chapter A4. For reasons which will become clear in the next few paragraphs we would now place more emphasis on alcohol.

We wrote about the obesity epidemic in 2007 and reproduce this in chapter A5. Obesity is a systems problem. It is due to an imbalance between energy intake in food and energy output in physical activity. The present epidemic has been brought about by declining physical activity. Active travel (walking and cycling for short journeys) is a potential solution.

Our perception of the alcohol problem has emerged strongly over the last five years. In our analysis of causes of inequality in 2006 we saw alcohol as one of the factors undermining our success in closing the gap in life expectancy. By 2008 we saw it as one of the factors affecting the adverse movements in mortality in young women. In chapter A6 we reproduce the 2006 special report on alcohol followed by a postscript indicating the various analyses that have led our thinking to develop since. We now see alcohol as an established epidemic which, if it is not tackled, could lead to a public health disaster with falling life expectancy, children dying younger than their parents and, by about 2040, the huge cost burden of two generations entering dependency at the same time.

As well as data on trends in health it is also necessary to have regard to evidence of what works in terms of making a difference. The 19th Annual Public Health report was devoted to this subject and is retained here as chapter A7.

Decisions need to be made against the background of the severe financial difficulties facing Stockport Council and the NHS. A strategy for resource utilisation in the NHS was included in the 18th Annual Public Health report and is retained as chapter A8.

The problems of recession have emerged since the last JSNA. The report that was written in response as part of the 18th Annual Public Health Report is retained here as chapter A9. In the 19th report attention is drawn to the evidence that the strength of civil society plays an important role in mitigating the impact of economic dislocation on health.

This brings into sharp focus the issue of mental well-being, and the special report on the subject in the 18th Annual Public Health report is retained here as chapter A10.1 with an earlier report on empowerment forming chapter A10.2

Climate change is an important overall threat to public health – indeed to the survival of our species.

The current JSNA takes our understanding of our people and their health further forward in a number of ways including:

- Reinforcing the focus on alcohol, mental wellbeing and health inequalities. New evidence has emerged for all these priorities, for example new data shows that 60% of our most vulnerable children (those with Child Protection arrangements) are from families where alcohol is an issue.
- Highlighting the increasing levels of demand from those with complex care needs. This is an issue for all age cohorts, and is due in part to improved life expectancy for those with complex needs and improved diagnosis. More analysis is needed to give a full estimate of the possible future levels of demand.
- Indentifying carers as being a significant priority for the local residents of Stockport. Carers are a valuable resource for the health and wellbeing economy of Stockport, but being a carer can have adverse effects on mental wellbeing and financial stability.
- Confirming the continuation of the ageing population trend, thereby reiterating healthy ageing as a key priority. Preliminary evidence has emerged in the 2011JSNA to support the theoretical analysis of healthy aging contained within Annual Public Health Report (APHR), but further analysis is needed. There is also new evidence linking the healthy ageing priority to the overall priority of mental wellbeing, as local

consultation has shown that maintaining social networks and activity are the best ways to maintain or improve mental wellbeing for older people.

9.1.2. The Updated Strategic Vision

Alcohol is an established epidemic carrying the potential for a public health disaster in the future. It requires urgent and effective action.

Other major public health priorities include:

- Mental well being (especially the promotion of strong, empowered communities)
- Obesity (especially the promotion of physical activity)
- Poverty (especially ways to help people escape from poverty or its consequences)
- Improving uptake of screening and early diagnosis (especially in deprived areas and men)
- Parenting and early years
- Tobacco control (especially work focussed on smoking cultures in deprived areas and in young people undergoing transition to adulthood)

Other major social care priorities include:

- Complex packages of care (especially work to understand and respond to increasing demands from frail elderly, dementia and adults with disabilities)
- Promoting healthy ageing and preventative support (especially independence and social networks)
- Supporting carers
- Providing choice and personalisation

Other major priorities for education and children's services include:

- Child obesity (especially focusing on families and physical activity)
- Prevention of poor lifestyle habits in early adulthood
- Educational attainment in deprived areas
- Safeguarding and supporting vulnerable young families

Other major priorities for the NHS include:

- Identifying those with undiagnosed long term conditions
- End of life care
- Reducing the reliance on unscheduled care

9.2. Health and Social Care Commissioners

9.2.1. Context

This section of the Stockport JSNA 2011 draws on a number of sources, both internal to the contributing organisations to the local JSNA process and external to it. The full report is currently being finalised, and will be published with associated documents when complete on the hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/.

When JSNAs were first introduced as a statutory requirement in 2007, their purpose was to create a systematic method of reviewing the health and wellbeing needs of the local population, leading to agreed commissioning priorities that would improve health and wellbeing generally and specifically reduce health inequalities. However, in subsequent reviews DH recognised that whilst the needs assessments took various forms across the country, the element that was almost universally least well-developed was the link with local commissioning. The Stockport 2011 JSNA aimed to rectify this by strengthening the link between the JSNA and commissioning.

As a result a series of engagement events and meetings with commissioners of health and wellbeing services in the areas of children and young people, mental health and wellbeing, adults with disabilities, older people, alcohol and drugs were held. Additional events were also held looking specifically at issues of inequality and diversity and the strategic commissioning process (for more detail see section 4.3).

The purpose of meeting with commissioning colleagues was to engage them in the JSNA process at a point where they were able to test the findings of the data analysis and shape the emerging priorities.

9.2.2. Findings

In the main, all colleagues recognised the issues relating to their particular commissioning interests and have helped significantly to refine the life-course summary priorities, but many also recognised the impact of wider factors.

Without exception, **mental wellbeing** was mentioned as an influential factor in each of the commissioning themes. Poor mental wellbeing, often low-level in nature, was seen as a significant contributory factor in the issues faced by children, patients and service users and if unrecognised and unsupported can lead to a potentially preventable point of crisis. Links with many other health and wellbeing issues were identified, but there was recognition that mental health and wellbeing problems are dispersed and require a population and prevention focussed commissioning approach.

Like mental wellbeing, the effects of **alcohol** misuse were acknowledged as a major theme at all ages in the meetings with commissioning colleagues. There was a recognised need for a proportionate approach to alcohol misuse commissioning which targets high-risk groups and geographies, whilst also reflecting the widespread nature of alcohol misuse

Packages of care for individual children and adults with disabilities can be some of the most complex and high-intensity that are seen by social care and health, although the number of care packages is relatively low. Demographic trends and medical developments are leading to greater demand for services over an extended period of time.

The expectations of **carers and families**, especially of those for younger adults with a disability, often exceed what it is possible to provide. People with care needs but who do not meet eligibility criteria for social care support, represent a need which often met by carers, however this need is not measured in routine data. An assessment is needed so that the value of carers is properly understood. Low-level preventative services could support these vulnerable but 'ineligible' groups to avoid a potentially preventable crisis situation at a later date.

The priorities for **children and young people** are similar to those for all ages, with alcohol, mental wellbeing and inequalities all being highlighted as major issues. For this age group however the focus should be on a cultural change towards **preventative activity**, and family focused interventions. Early prevention is the best way to improve the health of younger adults in particular.

In terms of social care and health need, **older people** form the largest population group requiring services and this population is set to increase significantly in the coming years. Colleagues responsible for commissioning for older people pointed particularly towards the early diagnosis and proactive management of issues relating to long-term conditions associated with ageing and an ageing population. Promoting independence and maintaining people in their own homes or residence of their choice were identified as being particularly important.

The main priority for **equality** going forward is to ensure that commissioned services offer appropriate accessibility, flexibility and sensitivity to be able to effectively support people from all different backgrounds. In particular the stigma attached by some groups to mental health problems means that these services need to be particularly culturally sensitive.

Socio-economic deprivation and **inequality** is a strong indicator of poorer health and wellbeing manifested in a variety of different ways within the health and social care system. Disadvantaged Stockport residents are more likely to be exposed to the risks associated with poor health and wellbeing and suffer higher levels of poor health and wellbeing within their lifetimes.

Commissioners also referred to the values that should underpin local commissioning, whether joint or by a single organisation. At a joint management session between Adult Social Care and NHS Stockport managers in June 2010, the following 5 shared key principles and values were identified:

- Achieving value for money
- Targeting resources to greatest need
- A single, shared local vision for the Stockport health and social care system
- Personalisation – quality, control and choice
- Prevention

10. Stockport JSNA 2011-2013

10.1. Strategic future

From April 2013 JSNAs are likely to be the joint responsibility of the Council and the local GPCC, and both organisations will be required to take proper account of the JSNA and the high-level Joint Health and Wellbeing Strategy arising from it, which will be 'owned' by the statutory Health and Wellbeing Board. This has given the JSNA a much stronger profile and place in the commissioning process.

A key test of JSNAs is to assess not what they contain, or how well written they are but to see how they are used and what the impact of the analysis has been in terms of real change. In order to assess the utilisation of the JSNA in future, the Stockport HWB may choose to develop some basic tests of the degree to which the Stockport JSNA has influenced commissioning within the local economy e.g.

- What services have been commissioned / decommissioned as a result of the JSNA or subsequent analyses?
- What has the impact been on managing demand for complex / high-intensity packages of care?
- What has the impact been on reducing health inequalities?
- What has the impact been on the prevention / treatment ratio?

10.2. Future of Joint Strategic Needs Assessment

The JSNA is both a product and a process. The first JSNAs were viewed as a single product by many boroughs, and the statutory requirement to complete them by a certain date and repeat this on a 3-year cycle, lent itself to this view.

However, whilst the high-level needs analysis is a specific JSNA output, it should not be seen as the 'completed' JSNA, but rather as a starting point for ongoing scrutiny of particular issues of agreed strategic local importance.

A clear message from the NWJIP JSNA and commissioning review work of the 2007 JSNA was the underutilisation of the JSNA in commissioning processes, locally therefore we need to ensure that in 2011 the JSNAs also supports commissioning more directly. To do this the JSNA needs to be seen as an ongoing function and resource which can inform commissioning in its many forms and at different levels of the commissioning process, enabling strategic commissioning to more closely reflect needs and outcomes.

In Stockport we have made progress towards a position where the JSNA, and the analytical team supporting its development, will work with strategic commissioners in health and social care to develop more in-depth analyses to answer particular commissioning questions. The intention is to draw together additional disaggregated data from the JSNA with other information such as service usage data, service user experience, cost-benefit analyses, predictive modelling (taking into account the drivers behind demand and population shift), process mapping, programme budgeting, patient and service user journey mapping and examples of evidence based practice.

Discussions with commissioners suggest that analysis could usefully be undertaken in the following areas:

- Understanding demand and supply in a climate of an ageing population and reducing resources, which is essential for both commissioners and providers of services. Modelling future demands, estimating the resources needed to meet those demands and best use of those resources to manage demand are all crucial issues and are areas which are under-developed in the JSNAs;
- Understanding the triggers and or crises that lead to use of high-intensity services and how this information can be used by commissioners;
- Local health and social care systems working together to understand and address the drivers of 'early' need for health and social care services, repeat hospital admissions, high-intensity social care, regular attendees to A&E or GP surgeries;
- Active recognition in the JSNA and through commissioning of the market sectors where there already are / are likely to be particular problems in meeting demand e.g. dementia, stroke, younger people with profound and multiple disabilities, as well as the impact these groups have on carers;
- Having a process for reviewing unmet needs and how these might otherwise be met e.g. an individual with a learning disability falling short of eligibility criteria, people who are not identified in primary care as being at risk of disease or illness, late recognition of low-level mental health problems, numbers of self-funders in the social care system given the current economic climate and the degree to which long-life may lead to current self-funders becoming reliant on the state in very late life;
- There is considerable scope for additional analyses to inform prevention, early intervention, social capital, market development and assets approaches to meeting needs, be they low-level need, unmet need or essential health and social care provision;
- There is a currently untapped opportunity for the JSNA to support and inform the development of personalisation, choice and the development of the market;
- A clearer shared view, resource allocation approach and commissioning for health and wellbeing issues that have the most disproportionate impact on the lives of Stockport residents and the local health and social care system i.e. poor mental health, dementia, alcohol misuse, people with multiple complex needs etc;
- Inequality and diversity issues are highly relevant to all local health and social care commissioning and this is an area requiring local consideration and development.

There are challenges to delivering comprehensive needs assessments for every commissioning area, and therefore priority will be given to further analysis over the period 2011-2014 to support commissioning for the 2011 JSNA priority areas. The findings of such analysis will be published on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/, and indeed an in depth analysis for alcohol has already been undertaken (January 2011) and can be found on the hub.

10.3. Future of Joint Strategic Asset Assessments

As noted in section 3, one feature of the JSNA is that it is a deficit model of health needs. This is a necessary feature of a desk top analysis of needs, but is recognised as a limitation as it fails to take account of assets that exist within communities that could be used to help us bring about the improvements in health and wellbeing needed.

Stockport's longstanding interest in community development and our current emphasis on mental well being and community empowerment has led to our involvement in a North West regional pilot project on the use of asset-based approaches and the creation of a Joint Strategic Assets Assessment (JSAA).

JSAAs will provide a greater understanding of local communities and will enable a richer perspective to be offered about ways in which change can be delivered into the strategic planning process. The JSAA will substantially change the nature of the locality profiling so as to draw the existing statistical data together with locality pen pictures, lessons from appreciative enquiry, stories by individuals and assessments of physical and community assets in the area.

This approach is currently being piloted in the Lancashire Hill and Heaton Norris priority 1 area, particularly focusing on mental wellbeing. Findings of Stockport's pilot are expected towards the end of 2011 and results will be published on the JSNA hub at https://interactive.stockport.gov.uk/profile/hubs/JSNA/. The intention is also to embed JSAA into the in-depth analyses discussed in section 10.2 as a further way of piloting the approach.

These findings, along with those from other regional pilot areas will be used to develop plans for both JSNA and JSAA going forward in Stockport. The aim is to eventually create a systematic, area-wide approach to asset mapping and embed the JSAA firmly within the JSNA.

Appendix 1 – List of Data Sources Analysed

Population

- Population Estimates by Age and Gender (GP Registers, Stockport's Population Model, 2009)
- Population Estimates by Ethnicity (2001 Census, Stockport's Population Model 2009)
- Population Projections by Age, Gender and Ethnicity (Stockport's Population Model 2009)
- Past Population Trends (2001 Census, Stockport's Population Model 2009)
- Family Structure (2001 Census)
- Homelessness (Stockport Homes, 2010)
- Immigrants and refugees (2002-09)
- Births and Fertility (NHS Stockport, 1999-2009)
- Black and Minority Ethnic Pupils (School Census, 2010)
- Pupils with English as an Additional Language (School Census, 2010)

Social Context

- Index of Multiple Deprivation (Office of the Deputy Prime Minister, 2007)
- Child Poverty Index (Office of the Deputy Prime Minister, 2009)
- Older Persons Poverty Index (Office of the Deputy Prime Minister, 2009)
- Household Income (CACI, 2010)
- Environment Classification – Urban / Rural (ONS, 2004)
- Tenure of Households (2001 Census)
- Family Size (2001 Census)
- Overcrowding (2001 Census)
- Central Heating (2001 Census)
- Crime – Anti-social Behaviour, Domestic Violence, Alcohol-related (Community Safety, 2009/10)
- Youth Offenders (Stockport Youth Offending Team, 2008-10)
- Vulnerable Localities Index (Community Safety, 2010)
- Council Tax / Housing Benefits Claimants (Revenues and Benefits, 2009)
- Job Seekers Allowance Claimants (DWP, 2010)
- Income Support Claimants (DWP, 2010)
- Pension Credit Claimants (Revenues and Benefits, 2009)
- Young People Not in Education, Employment or Training (Connexions Stockport, 2010)
- Free School Meals (School Census, 2010)
- Mode of Travel to School (School Census, 2010)
- Access to Advice (Stockport Advice and Information Service, 2010)
- Active Library Membership & Computer Use (Stockport Libraries Service, 2010)
- Special Education Needs (School Census, 2010)
- Secondary School Absences (Children & Young People's Directorate, 2008-09)
- Secondary School Exclusions (Children & Young People's Directorate, 2008-09)
- Educational Attainment – Early Years, Key Stage 1,2,3 & 4 (Children & Young People's Directorate, 2008-09)
- Qualifications Held (2001 Census)

Health & Social Care

- Life Expectancy at Birth / 65 (NHS Stockport, 2007-09)
- Slope Index of Inequalities in Life Expectancy (NHS Stockport, 2001-09)

- Causes of Life Expectancy inequalities and age groups driving inequalities (NHS Stockport, 2001-09)
- Healthy Life Expectancy (NHS Stockport, 1981-2001)
- Standardised Mortality Ratios (NHS Stockport, 2006-08)
- Infant & Childhood Mortality (NHS Stockport, 2005-09)
- Young Adult Deaths (NHS Stockport, 2005-09)
- Mortality rates on key indicators (NHS Stockport, 2005-09)
- Place of death (NHS Stockport, 2009)
- Prevalence of Disease and comparison to models (Quality Outcomes Framework, NHS Stockport, 2009-10)
- Cancer incidence and mortality (NHS Stockport 2008)
- Cancer Screening (NHS Stockport, 2000-09)
- General Health (2001 Census)
- Limiting Long-term Illness (2001 Census)
- Disability Benefit Uptake (DWP, 2009)
- Unpaid Care (2001 Census)
- Stockport Carer's Survey (2010)
- Social Care Clients – Carers, Referrals, Home Care (Adult Social Care, 2009-10)
- Nursing and Residential Care Homes (2001 Census)
- Hospital Admissions by Age, Type, Provider, Cause and Length of Stay (NHS Stockport, 2008-09)
- Alcohol related hospital admissions (NHS Stockport 2008-09)
- A&E Attendances by Age, Provider, Primary Diagnosis and Location of Incident (NHS Stockport, 2008-09)
- Maternal Age (NHS Stockport, 2009)
- Low Weight Births & Still Births (NHS Stockport, 1998-2009)
- Smoking in Pregnancy (NHS Stockport, 2008-10)
- Breastfeeding Initiation & Continuation (NHS Stockport, 2008-10)
- Childhood Immunisation (NHS Stockport, 2005-10)
- Decayed, Missing & Filled Teeth at 5 Years Old (NHS Stockport, 2008)
- Childhood Accidents (NHS Stockport, 2004-10)
- Childhood Obesity (NHS Stockport, 2008-09)
- Childhood and Adolescent Mental Health Services (Pennine Care NHS Trust, 2004-09)
- Children with Learning / Communication Difficulties (Children's Disability Database, 2010)
- Children with Physical / Sensory Disabilities (Children's Disability Database, 2010)
- Respite Care for Children with a Disability (Children & Young People's Directorate)
- Looked After Children (School Census, 2010 and CareFirst, 2010 - C&YPD)
- Children with a Child Protection Plan (CareFirst, 2010 – C&YPD)
- Children in Need (Children & Young People's Directorate, 2009-10)
- Teenage Conceptions (NHS Stockport, 1998-2008)
- Terminations (NHS Stockport, 2005-08)
- Sexual Health (NHS Stockport, 2000-08)
- Flu Vaccinations (NHS Stockport, 2005-10)
- Excess Winter Deaths (NHS Stockport, 2004-09)

- Elderly falls (NHS Stockport, 2006-08)
- Community Health Stockport contacts (NHS Stockport, 2009-10)

Lifestyles and Well Being

- Adult Lifestyle Survey – Smoking, Drinking, Mental Well Being, Diet, Physical Activity and Drug Use (NHS Stockport, 2009)
- Smoking cessations (NHS Stockport, 2003-10)
- MOSAIC Drug and Alcohol Service (MOSAIC, 2008-10)
- Quality Outcomes Framework – Obesity (NHS Stockport, 2009-10)
- Young Person's Lifestyle Survey – Smoking, Drinking, Mental Well Being, Diet, Physical Activity, Drug Use and Sexual Activity (NHS Stockport, 2008)
- Physically Active Children (Annual PE & Sport Survey, 2008-09)