



**STOCKPORT**  
METROPOLITAN BOROUGH COUNCIL

# 23<sup>rd</sup> Annual Public Health Report for Stockport 2016/17

## SECTION A

### The Health of the People



The Council's public health duties are part of the comprehensive health service established under the National Health Service Acts

# 23rd Annual Public Health Report for Stockport - 2016/17

## SECTION A: The Health of the People

### Contents

The report is broken down in to levels and sections.

There are six sections:

- **Section A** describes and considers an overview of the health of the people of Stockport.
- **Section B** covers the diseases which cause death and disability in Stockport.
- **Section C** explores the major risk factors for disease, death and disability so we understand how we can address the issues described in section B
- **Section D** looks at these issues as part of the life-cycle, considering the health of children through to healthier aging.
- **Section E** summarises our response; how we are addressing the causes of ill-health and reducing health inequalities for the people of Stockport.
- **Section F** contains recommendations

**This report presents Section A of the report**

Within each section there are five levels:

- [Level 1](#) are a series of tweets sent by @stockportdph over the autumn of 2015.
- [Level 2](#) is an overview in which each chapter of the report is summarised in a paragraph.
- [Level 3](#) gives key messages where each chapter is summarised in one or two pages.
- [Level 4](#) contains the full report and analysis.
- [Level 5](#) provides links to additional reports and analysis where needed

A full content list follows, and you can access any level of this section of the report by clicking the chapter name in the content list. Each page contains a “return to contents” button to enable you to return to this list and navigate to other levels and sections of the report easily.

Contents.....	2
LEVEL 1 (TWEETS) SECTION A: THE HEALTH OF THE PEOPLE .....	6
A1.1. ILL HEALTH IN BRITAIN AND STOCKPORT .....	6
A1.2. INEQUALITIES.....	6
A1.3. HEALTH OF STOCKPORT COMMUNITIES.....	6
LEVEL 2 (OVERVIEW) SECTION A: THE HEALTH OF THE PEOPLE.....	10
A2.1. ILL HEALTH IN BRITAIN AND STOCKPORT .....	10
A2.2. INEQUALITIES.....	10
A2.3. HEALTH OF STOCKPORT COMMUNITIES .....	10
LEVEL 3 (KEY MESSAGES) SECTION A: THE HEALTH OF THE PEOPLE .....	13
A3.1. ILL HEALTH IN BRITAIN AND STOCKPORT .....	13
A3.2. INEQUALITIES.....	14
A3.3. THE HEALTH OF STOCKPORT COMMUNITIES .....	15
LEVEL 4 (FULL ANALYSIS) SECTION A: THE HEALTH OF THE PEOPLE .....	19
A4.1. ILL HEALTH IN BRITAIN AND STOCKPORT .....	19
A4.2. INEQUALITIES.....	26
A4.3. THE HEALTH OF STOCKPORT COMMUNITIES .....	30
LEVEL 5 (ADDITIONAL ANALYSIS) SECTION A: THE HEALTH OF THE PEOPLE.....	47
A5.1. ILL HEALTH IN BRITAIN AND STOCKPORT .....	47
A5.2. INEQUALITIES.....	47
A5.3. HEALTH OF STOCKPORT COMMUNITIES.....	47



**23rd Annual Public Health Report for  
Stockport - 2016/17**

**SECTION A: The Health of the People**

**LEVEL 1**

**Tweets**

## LEVEL 1 (TWEETS) SECTION A: THE HEALTH OF THE PEOPLE

The following tweets were sent by @stockportdph over the autumn of 2015.

### A1.1 ILL HEALTH IN BRITAIN AND STOCKPORT

- Life expectancy in #Stockport is similar to the country as a whole but with marked differences across the Borough [overview](#)
- The main causes of death in #Stockport like most places are heart disease, cancer and respiratory disease
- Important to look at years of life lost in #Stockport rather than no. of deaths as this shows #injuries in younger people as a major cause
- The main causes of #disability in #Stockport are mental illness, sight & hearing impairments & conditions involving muscles and bones
- For further information on today's three #Stockport #publichealth tweets go to [overview](#)

### A1.2 INEQUALITIES

- #Stockport has the third highest #affluence gap in England between our most deprived & least deprived small areas [overview](#)
- #Life expectancy in #Bramhall better than any country in world but #Brinnington's is on a par with Serbia or Malaysia [overview](#)
- #Health differences between the North and the rest of England have been examined in the #Due North report <http://www.cles.org.uk/publications/due-north-report-of-the-inquiry-on-health-equity-for-the-north/>

### A1.3 HEALTH OF STOCKPORT COMMUNITIES

- Today's tweets address the #health of #Stockport's various areas using mortality data, NHS data & lifestyle surveys [overview](#)
- #Bramhall & #Cheadle are healthy, make greater use of #health services but have low physical activity levels [overview](#)
- #Heatons is healthier than average for #Stockport except for slightly more #mental health and #alcohol problems [overview](#)
- Compared to the rest of #Stockport, #Marple is healthier except for high risk #alcohol use & low physical activity [overview](#)
- #Werneth life expectancy slightly ↓ than #Stockport as a whole as are most lifestyle factors except physical activity [overview](#)
- Compared to #Stockport - #Reddish, #Offerton & Central Area lifestyles r generally less healthy xcept 4 exercise [overview](#)
- Central, #Offerton & #Reddish suffered alcohol related ill health early this century but life expectancy now improving [overview](#)

- #Offerton, Central & #Reddish, due to poor health receive the most healthcare in #Stockport, but should get more [overview](#)
- #Stepping Hill (except Offerton) compared to SK hve ↑well being, ↑ life, ↓alcohol use, worse diet & exercise, ↑NHS use [overview](#)



**23rd Annual Public Health Report for  
Stockport - 2016/17**

**SECTION A: The Health of the People**

**LEVEL 2**

**Overview**

## LEVEL 2 (OVERVIEW) SECTION A: THE HEALTH OF THE PEOPLE

### A2.1 ILL HEALTH IN BRITAIN AND STOCKPORT

Life expectancy in Stockport is similar to that in the country as a whole but with marked differences across the Borough, life expectancy in Bramhall South being 13.4 years greater for men and 10.0 years greater for women than life expectancy in Brinnington & Central. Cancer and heart disease are the main causes of death, with respiratory disease coming third if we consider numbers of death but accidents coming third if we consider years of life lost (this is because accidents are the main cause of death in young people). These main three causes of death account for three quarters of all deaths. The main causes of disability are mental health, sight and hearing impairments and musculoskeletal conditions. Some would view the six main determinants of health as smoking; high blood pressure; obesity; physical activity; alcohol; and diet. Others put social relationships, social integration and wellbeing ahead of these six (with the more traditional six then following). Whilst there is scope for scientific debate, I am professionally convinced of the latter analysis, valuing social support and wellbeing.

Go to [key messages](#) or go to [full analysis](#)

### A2.2 INEQUALITIES

Stockport has an unusual diversity of affluence and deprivation in its population. We are the third most polarised local authority in England, which means we have the third greatest gap between our most deprived and least deprived LSOA. This isn't the result of any local failure of policy or services. It simply results from the fact that our boundaries embrace some of the most affluent areas in the country but also some of the most deprived areas. This context actually means that Stockport has a spread of affluence and deprivation similar to that of the country as a whole. Inequalities in health in Stockport improved dramatically in the 1990s but then the gap widened slightly before resuming a slower narrowing.

Go to [key messages](#) or go to [full analysis](#)

### A2.3 HEALTH OF STOCKPORT COMMUNITIES

Bramhall, Cheadle and Marple are healthy but make greater use of health services and have low physical activity levels. Heaton is healthier than the average for the borough except for alcohol consumption and some aspects of mental health. In Reddish, Offerton and Central Area lifestyles are generally less healthy than in the rest of the borough except for physical activity. Alcohol related harm has had a significant adverse effect on health in these areas in the early years of this century but life expectancy is now improving. Stepping Hill Area (excluding Offerton) shows better mental well being, life expectancy and alcohol consumption, but worse diet and physical activity. It has high levels of health service use. In Werneth life expectancy is slightly worse than in the borough as a whole as are most lifestyle factors except for physical activity.

Go to [key messages](#) or go to [full analysis](#)



**23rd Annual Public Health Report for  
Stockport - 2016/17**

**SECTION A: The Health of the People**

**LEVEL 3**

**Key messages**

## LEVEL 3 (KEY MESSAGES) SECTION A: THE HEALTH OF THE PEOPLE

### A3.1 ILL HEALTH IN BRITAIN AND STOCKPORT

One key measure of the general health of any population is the age that you can expect to live to, or life expectancy, for that area. Life expectancy in Stockport is 79.9 years for men and 83 years for women.

The life expectancy for men equates to that of Australia, Sweden, Canada, and Japan. That for women equates to that of Germany, Netherlands, and United Kingdom.

The overall high life expectancy does not tell the whole story for the general health of Stockport. Male life expectancy varies from 72.2 years in Brinnington & Central, equivalent to life expectancy in Iran/Malaysia/Serbia/Venezuela to 85.6 years in Bramhall South, better than that of any country in the world (the best national figure being 81 years for Iceland/Singapore/Switzerland). Bramhall South also has better life expectancy than any country in the world for women at 86.4 years (the best being Spain at 86 years) whilst Brinnington & Central at 76.4 years equates to the life expectancy of women in Iran/Malaysia/Albania.

When we consider what affects life expectancy, we need to understand the causes of death in the population. Heart disease and cancer account for almost 60% of all deaths. If respiratory disease is added these three causes account for three quarters of all deaths and adding dementia accounts for 80%. This is similar to the position in England and Wales and also in Europe (although in Europe respiratory disease is less prominent). Internationally the picture is similar except that infections account for 13% of all deaths in the world but only about 1% in Europe, England & Wales and Stockport.

If we focus on years of life lost, weighting the deaths of younger people instead of counting all deaths equally, injuries become a major contributor, moving from a small role (only 4%) up to third place, since they account for the greatest number of deaths in children, young people and young male adults.

We must be concerned not just with causes of death but also the causes of disability. The most significant causes of disability for high income countries relate to mental health (depression, alcohol dependence and dementia) hearing, sight and musculoskeletal conditions (osteoarthritis).

When it comes to determinants of health which cause those diseases, it's not entirely clear as to the extent of the contribution of different factors. We find scientific disagreement focussed mainly on how much high blood cholesterol is caused by diet and how much by stress.

Some would view the six main determinants of health as smoking; high blood pressure; obesity; physical activity; alcohol; and diet. Others put social relationships, social integration and wellbeing ahead of these six (with the more traditional six then following). Whilst there is scope for scientific debate, I am professionally convinced of the case for the latter analysis, valuing social support and wellbeing. We explore the contribution of all of these factors, in this report.

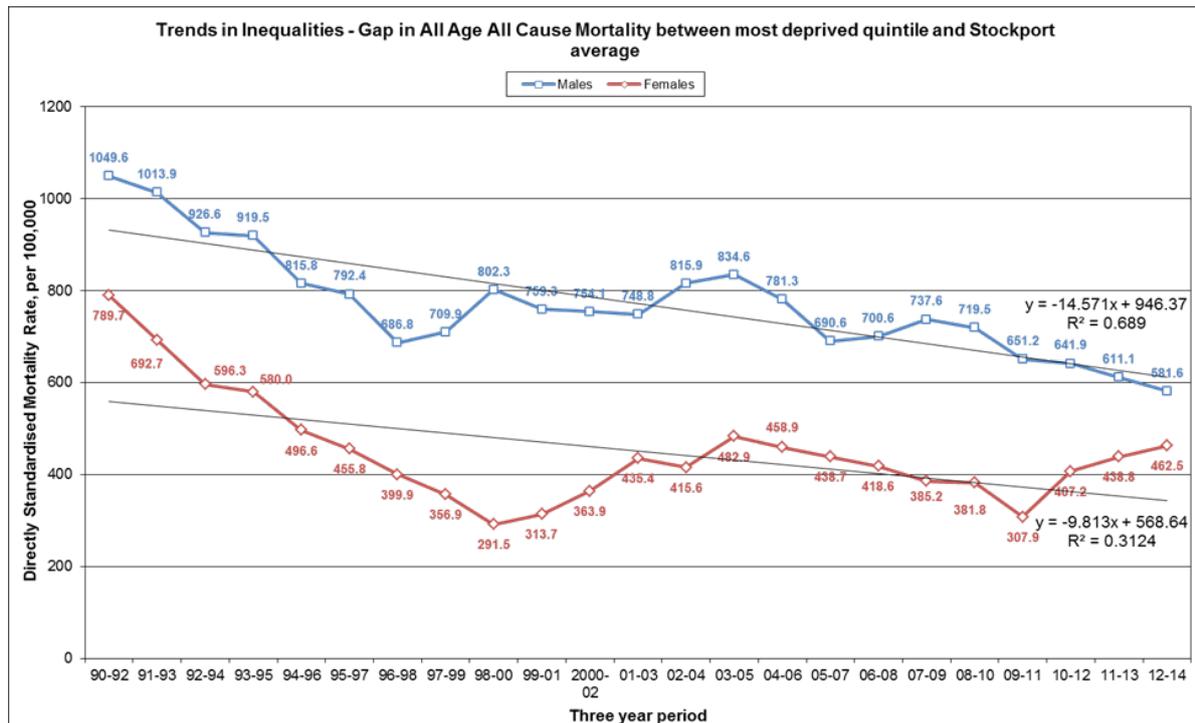
Go to [overview](#) or go to [full analysis](#)

## A3.2 INEQUALITIES

Chapter A3.1 shows us that death rates in Bramhall are better than those in highest countries and those in Brinnington & Central are more like those of mid ranking countries such as Iran, Malaysia, Serbia or Venezuela.

Stockport has an unusual diversity of affluence and deprivation in its population. In 2007 we were the third most polarised local authority in England, which means we have the third greatest gap between our most deprived and least deprived LSOA. This isn't the result of any local failure of policy or services. It simply results from the fact that our boundaries embrace some of the most affluent areas in the Country but also some of the most deprived areas. This context actually means that Stockport has a spread of affluence and deprivation similar to that of the country as a whole.

**Figure A1**



As you can see from the graph above, the gap in death rates between the most deprived areas and the average for all of Stockport is narrowing over time for men. Yet we saw a worrying reversal of this trend in the early part of this century, and it appears that trends for females may be worsening again. We need to consider why did the gaps stop narrowing?

There are a few possible explanations. It could be a natural cycle, which might be the case if the changes were due to cohort effects. Alternatively, it may be explained by loss of drive behind various programmes (such as those made as part of the Stockport Health Promise) when they were mainstreamed. This is the hypothesis that underpins our plans to pilot a return to the 90s initiatives.

We also consider that as heart disease is not causing the same number of deaths, the narrowing of inequalities seen in heart disease have been outweighed by other diseases (especially cancer and gastrointestinal/liver diseases). Finally, the alcohol epidemic may offer explanation, as impact of cancer and gastrointestinal diseases suggest alcohol as a factor.

Go to [overview](#) or go to [full analysis](#)

### A3.3 THE HEALTH OF STOCKPORT COMMUNITIES

**Bramhall** is healthy. Its use of health service resources is disproportionately large when account is taken of its general good health; however this may be explained by the older population profile. It is also noticeable that the percentage of people who are not physically active is higher than in Stockport as a whole. Given the attractive footpath network of the area and the availability both of Bramhall Park and of the Ladybrook Valley this is disappointing.

**Cheadle** is adversely affected by aircraft noise. In much of the Area the natural patient flow is towards Wythenshawe Hospital rather than Stepping Hill. The large social housing areas of Councillor Lane and Brookfield are within the nationally most deprived quintile but not within the most deprived decile. Overall its health is slightly better than the borough as a whole and its lifestyles slightly healthier but it makes slightly more use of health services and less than a quarter of its population are physically active.

**Heatons** is a mixed area bordering Manchester. Its health is somewhat better than the Stockport average, apart from mental wellbeing which is slightly worse perhaps due to the age of the population as Mental Wellbeing is lowest for those in middle age. It makes less use of health services than the Borough as a whole and lifestyles are generally healthier apart from drinking which is very slightly worse.

**Brinnington & Central Ward** has markedly lower life expectancy, markedly worse lifestyles and markedly worse health than Stockport as a whole. Brinnington is an attractive community with good facilities and ample greenspace set close to the town centre but still amidst countryside and with strong community spirit. It is possible that the health indicators are affected by the inclusion of the Town Centre within the ward and by the use of some housing in Brinnington for short term housing.

**Reddish** also shows worse life expectancy, health and lifestyles, especially in the North of the township, but to a much less marked extent than in Brinnington

**Victoria** is the other major deprived area of the borough. Life expectancy is intermediate between that of Brinnington and Reddish. It has one of the best levels of physical activity in the borough and low levels of high risk drinking. Its proportions of people with multiple risks are only slightly worse than the affluent areas.

Life expectancy and self-reported health are slightly better in **Stepping Hill** Area than in the borough as a whole. Mental wellbeing is slightly better except in Offerton where it is markedly worse. Physical activity is better in Offerton and markedly worse in Hazel Grove. Diet is slightly worse, the alcohol epidemic slightly better. Use of health services is high, perhaps reflecting the proximity of Stepping Hill Hospital.

Life expectancy is better in **Marple** than in the Borough as a whole. Self-reported health is very slightly better. Smoking, diet and physical activity levels are better but levels of high risk drinking are markedly worse and the levels of physical activity are not as high as might be expected from the excellent walking opportunities in the area. Use of health services is lower.

In **Werneth** life expectancy, self-reported health and mental wellbeing are slightly worse than in the borough as a whole. Rates of problem drinking are high. Rates of smoking, obesity and unhealthy diets are slightly higher than in the borough as a whole. Physical activity rates are slightly better.

Neighbourhood management teams were developed to work on the four most deprived areas of Stockport. The following graphs show trends in life expectancy in the neighbourhood management areas.

**Figure A2: Trend in Life Expectancy – by Neighbourhood Management Area**



In neighbourhood management areas lifestyles are generally less healthy than in the rest of the borough except for physical activity. Alcohol related harm has had a significant adverse effect on health in these areas in the early years of this century.

Go to [overview](#) or go to [full analysis](#)



**23rd Annual Public Health Report for  
Stockport - 2016/17**

**SECTION A: The Health of the People**

**LEVEL 4**

**Full Analyses**

## LEVEL 4 (FULL ANALYSIS) SECTION A: THE HEALTH OF THE PEOPLE

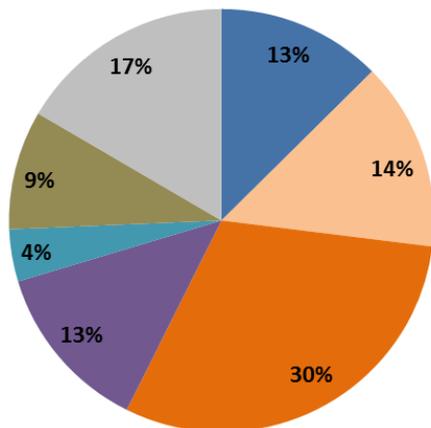
### A4.1 ILL HEALTH IN BRITAIN AND STOCKPORT

Stockport Wards	2013-15	Nearest matching country 2015	2015
<b>Table A1 Life Expectancy for Men</b>			
Bramhall North	82.6	Switzerland/Iceland/Australia	81
Bramhall South	84.3	Switzerland/Iceland/Australia	81
Bredbury & Woodley	79.1	United Kingdom/Austria	79
Bredbury Green & Romiley	81.7	Switzerland/Iceland/Australia	81
Brinnington & Central	72.8	Malaysia/Argentina/Serbia	73
Cheadle & Gatley	82.0	Switzerland/Iceland/Australia	81
Cheadle Hulme North	80.7	Switzerland/Iceland/Australia	81
Cheadle Hulme South	82.4	Switzerland/Iceland/Australia	81
Davenport & Cale Green	74.8	Croatia/Albania/China	75
Edgeley & Cheadle Heath	76.2	Czech Republic/United Arab Emirates	76
Hazel Grove	80.6	Switzerland/Iceland/Australia	81
Heald Green	81.0	Switzerland/Iceland/Australia	81
Heatons North	77.9	Slovenia/Portugal/Greece	78
Heatons South	81.3	Switzerland/Iceland/Australia	81
Manor	78.9	United Kingdom/Austria	79
Marple North	81.8	Switzerland/Iceland/Australia	81
Marple South	81.6	Switzerland/Iceland/Australia	81
Offerton	81.0	Switzerland/Iceland/Australia	81
Reddish North	79.1	United Kingdom/Austria	79
Reddish South	78.7	United Kingdom/Austria	79
Stepping Hill	79.8	Netherlands/New Zealand/Norway	80
<b>STOCKPORT</b>	<b>79.8</b>	<b>Netherlands/New Zealand/Norway</b>	<b>80</b>
<b>Table A 2 – Life expectancy for women</b>			
Bramhall North	85.8	Singapore/Spain	86
Bramhall South	86.4	Singapore/Spain	86
Bredbury & Woodley	81.7	Czech Republic/Estonia/U.S.A	82
Bredbury Green & Romiley	83.1	United Kingdom/New Zealand/Germany	83
Brinnington & Central	76.6	Malaysia/Iran	77
Cheadle & Gatley	84.8	Italy/Australia/France	85
Cheadle Hulme North	83.8	Portugal/Netherlands/Greece	84
Cheadle Hulme South	84.9	Italy/Australia/France	85
Davenport & Cale Green	77.4	Malaysia/Iran	77
Edgeley & Cheadle Heath	80.1	Argentina/Slovakia/Qatar	80
Hazel Grove	85.5	Singapore/Spain	86
Heald Green	86.1	Singapore/Spain	86
Heatons North	82.9	United Kingdom/New Zealand/Germany	83
Heatons South	85.6	Singapore/Spain	86
Manor	83.4	United Kingdom/New Zealand/Germany	83
Marple North	83.9	Portugal/Netherlands/Greece	84
Marple South	83.8	Portugal/Netherlands/Greece	84
Offerton	82.5	United Kingdom/New Zealand/Germany	83
Reddish North	82.6	United Kingdom/New Zealand/Germany	83
Reddish South	83.3	United Kingdom/New Zealand/Germany	83
Stepping Hill	85.1	Italy/Australia/France	85
<b>STOCKPORT</b>	<b>83.1</b>	<b>United Kingdom/New Zealand/Germany</b>	<b>83</b>

The tables show life expectancy for men and women by ward linked to comparator countries across the world. The most affluent wards have male life expectancies greater than the highest country

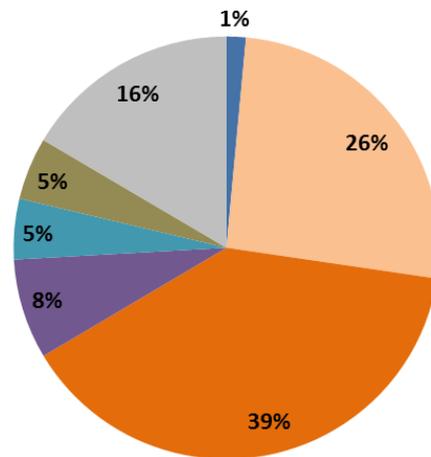
(Switzerland) whilst females in these areas are below only Japan; life expectancy in the most deprived areas of Stockport is better than the life expectancy of more than half of the world's countries. With a life expectancy of 79.8 years, Stockport males are similar to counterparts in the Netherlands, New Zealand and Norway. For women the life expectancy of 83.1 is similar to Germany, New Zealand, and United Kingdom.

**Figure A3 – Causes of death – World**



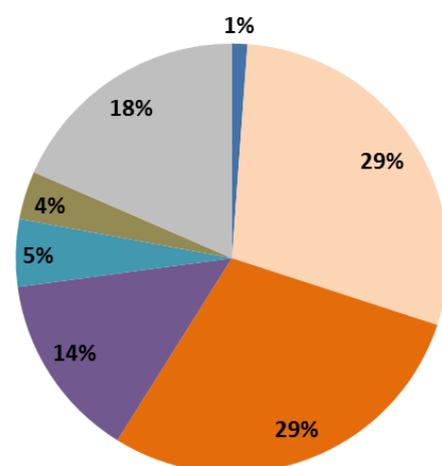
Data for 2011 Source: WHO

**Figure A4 – Causes of death – European Union**



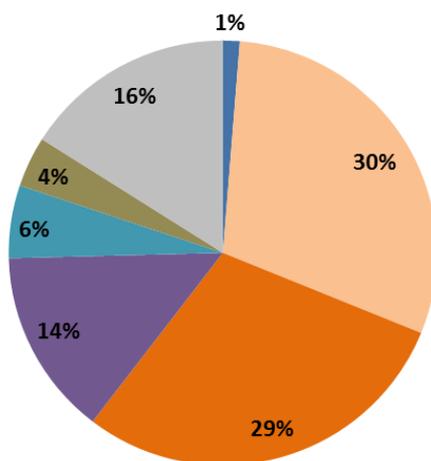
Data for 2010 Source: Eurostat

**Figure A5 – Causes of death – England & Wales**



Data for 2011 Source: Vital Statistics

**Figure A6 – Causes of death – Stockport**



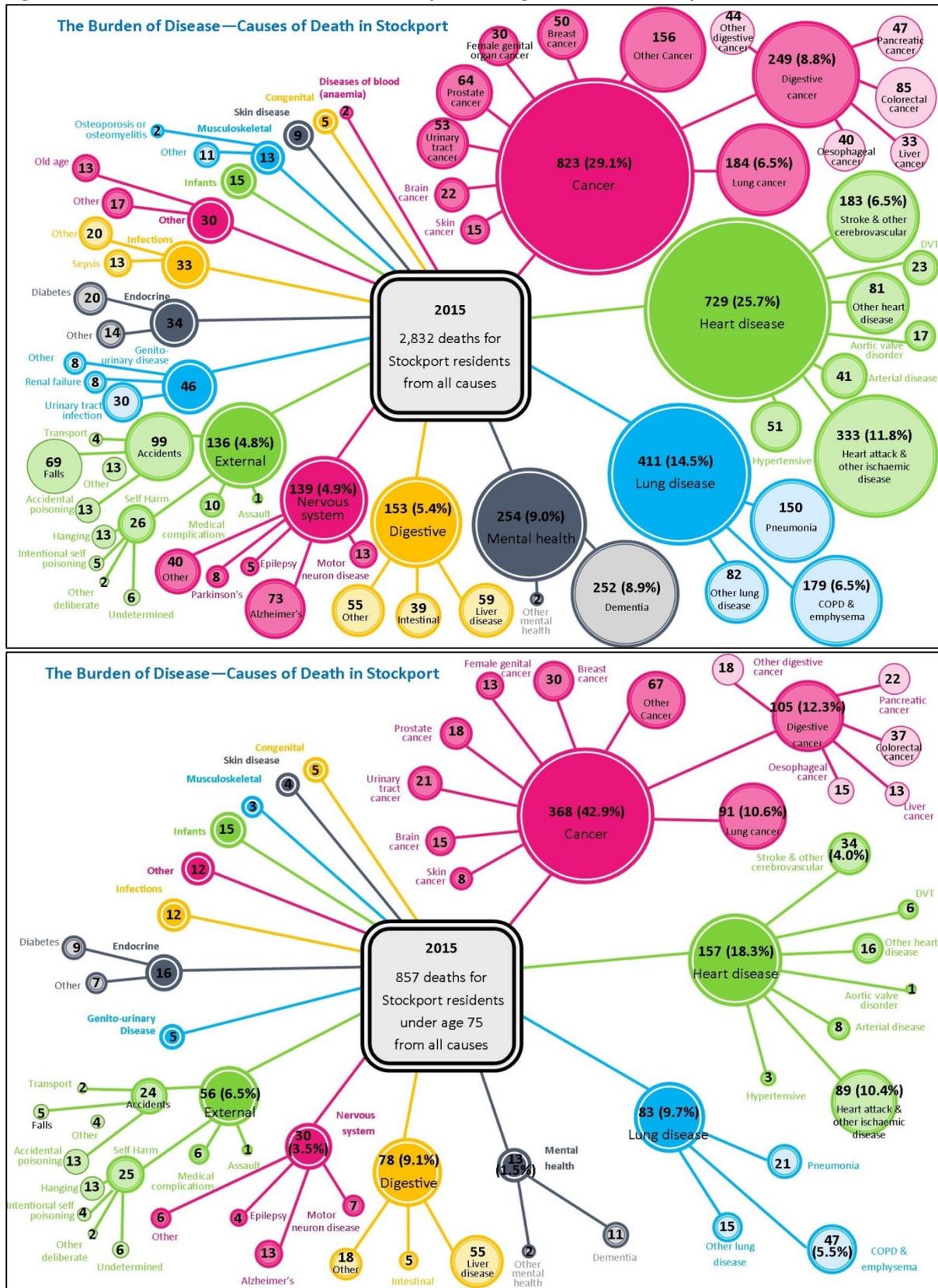
Data for 2011 Source: Vital Statistics

■ Infectious and parasitic diseases	■ Cancer	■ Respiratory	■ Injury
■ Circulatory	■ Digestive	■ All other causes	

Charts A3-A6 show that causes of death in Stockport are almost exactly comparable with the pattern across England and Wales; however there are difference between the national pattern and international patters. While infectious diseases are a major cause of death on a global scale, prevention and treatment have virtually eradicated these as a cause of death in Europe (including England and Wales). Injuries and respiratory causes also account for a far lower proportion of deaths in Europe than they do worldwide, however while England and Wales follows European patterns for injuries, the proportion of deaths from respiratory causes nationally is much more similar to the

global rather than European trend. Conversely England and Wales has a far lower proportion of deaths from circulatory disease than the European average; heart disease and cancer are the main causes of death in Stockport.

**Figure A7 – Detailed causes of death in Stockport, all ages and under 75 years**



Charts A7 and A8 show a more detailed analysis of the causes of death in Stockport for 2015, for all ages and for early deaths. They show that cancer, heart disease, lung disease and dementia are the largest causes of death overall, together accounting for around 80% of all deaths. Cancer is by far the largest cause of early deaths, and while heart disease and lung disease remain significant, both accidental deaths and digestive disease are also major issues. Further analysis of all these diseases is presented in section B of this report.

The above analysis could also be expressed instead in terms years of life lost, rather than just a proportional count. The measure “years of life lost to age 75” would count a person who died at 74 as having lost one year of life but a person who died at 55 as having lost 20 years of life. When we consider years of life lost, rather than just number of deaths, injuries join cancer and heart disease as major killers in Europe as well as internationally. This is because injuries are the commonest cause of death in young people.

**Table A3- Prevalence rate per billion of moderate and severe disability, by leading health condition associated with disability, and by age and income status of countries**

Health condition (b, c)	High-income countries (a)			Low and middle-income countries			World		
	0–59	60+	All	0–59	60+	All	0–59	60+	All
	years	years	ages	years	years	ages	years	Years	ages
Hearing loss (d)	9.4	96.9	26.5	10.9	93.8	18.0	10.7	94.7	19.3
Refractive errors (e)	9.8	33.5	14.4	13.7	85.0	19.8	13.1	70.1	18.9
Depression	20.1	2.6	16.7	15.6	10.3	15.1	16.2	8.0	15.3
Cataracts	0.6	5.8	1.6	4.2	67.1	9.6	3.7	49.3	8.4
Unintentional injuries	3.6	5.8	4.0	7.1	12.2	7.5	6.6	10.3	7.0
Osteoarthritis	2.4	42.4	10.2	2.8	41.5	6.1	2.8	41.7	6.7
Alcohol dependence & problem use	9.3	2.1	7.9	6.2	3.8	6.0	6.6	3.3	6.3
Infertility (unsafe abortion & maternal sepsis)	1.0	0.0	0.8	6.5	0.0	6.0	5.8	0.0	5.2
Macular degeneration (f)	2.3	31.4	8.0	1.8	32.3	4.4	1.9	32.0	5.0
Chronic obstructive pulmonary disease	4.1	23.6	7.9	2.2	17.1	3.5	2.4	19.0	4.1
Ischaemic heart disease	1.3	11.5	3.3	1.6	25.4	3.7	1.6	21.4	3.6
Bipolar disorder	4.2	2.1	3.8	3.5	1.7	3.4	3.6	1.8	3.4
Asthma	3.7	2.6	3.5	3.0	1.9	2.9	3.1	2.1	3.0
Schizophrenia	2.8	2.1	2.7	2.6	2.1	2.6	2.6	2.1	2.6
Glaucoma	0.5	7.9	1.9	1.1	16.9	2.5	1.1	14.3	2.4
Alzheimer and other dementias	0.5	32.5	6.7	0.3	15.0	1.5	0.3	20.0	2.3
Panic disorder	2.4	0.5	2.0	2.3	0.6	2.1	2.3	0.6	2.1
Cerebrovascular disease	1.8	11.5	3.7	0.8	10.5	1.6	0.9	10.8	2.0
Rheumatoid arthritis	1.7	8.9	3.1	1.2	6.4	1.6	1.2	7.1	1.8
Drug dependence & problem use	4.7	0.5	3.9	1.6	0.2	1.5	2.0	0.3	1.8

Notes: Source: The Global Burden of Disease, 2004 update. Geneva, World Health Organization, 2008.

a. High-income countries have 2004 Gross National Income per capita of US\$ 10 066 or more in 2004 per the World Bank (5).

b. GBD disability classes III and above.

c. Disease and injury associated with disability. Conditions are listed in descending order by global all-age prevalence.

d. Includes adult onset hearing loss, excluding that due to infectious causes; adjusted for availability of hearing aids.

e. Includes presenting refractive errors; adjusted for availability of glasses and other devices for correction.

f. Includes other age-related causes of vision loss apart from glaucoma, cataracts and refractive errors.

Health is not simply a matter of the length of life and causes of death; it is also a matter of quality - hence the public health slogan “**add years to life and life to years**”

Table A3 shows the leading causes of moderate and severe disability across the world, in descending order of prevalence for the total global population. This evidence suggests that the most significant causes of disability for high income countries relate to mental health (depression, alcohol dependence and dementia) hearing, sight and musculoskeletal conditions (osteoarthritis).

Further analysis giving more detail of causes of death and disability in Stockport can be found on the JSNA hub (<http://www.stockportjsna.org.uk/>).

Ideally we would look not just at the diseases that cause death and disability but at the factors that cause those diseases. How much of the burden of disease is due to smoking, alcohol, mental well-being, section C of this report analyses these in more detail, however an important context to understand is that risk factors interact:

- Smoking and diet both cause both cancer and heart disease.
- Diet and stress both cause increased cholesterol which causes heart disease.
- Stress causes high blood pressure (which is a cause of heart disease) as does obesity which is contributed to by diet and physical inactivity.
- Stress and high blood pressure both cause heart disease.
- Stress causes a depressed immunity and physical activity counters this. The depressed immunity causes cancer and infections.
- Alcohol in excess can lead to heart disease and cancer but in moderation protects against heart disease.

This makes it difficult to attribute particular diseases to particular risk factors.

Some of the major interactions are shown in figure A8.

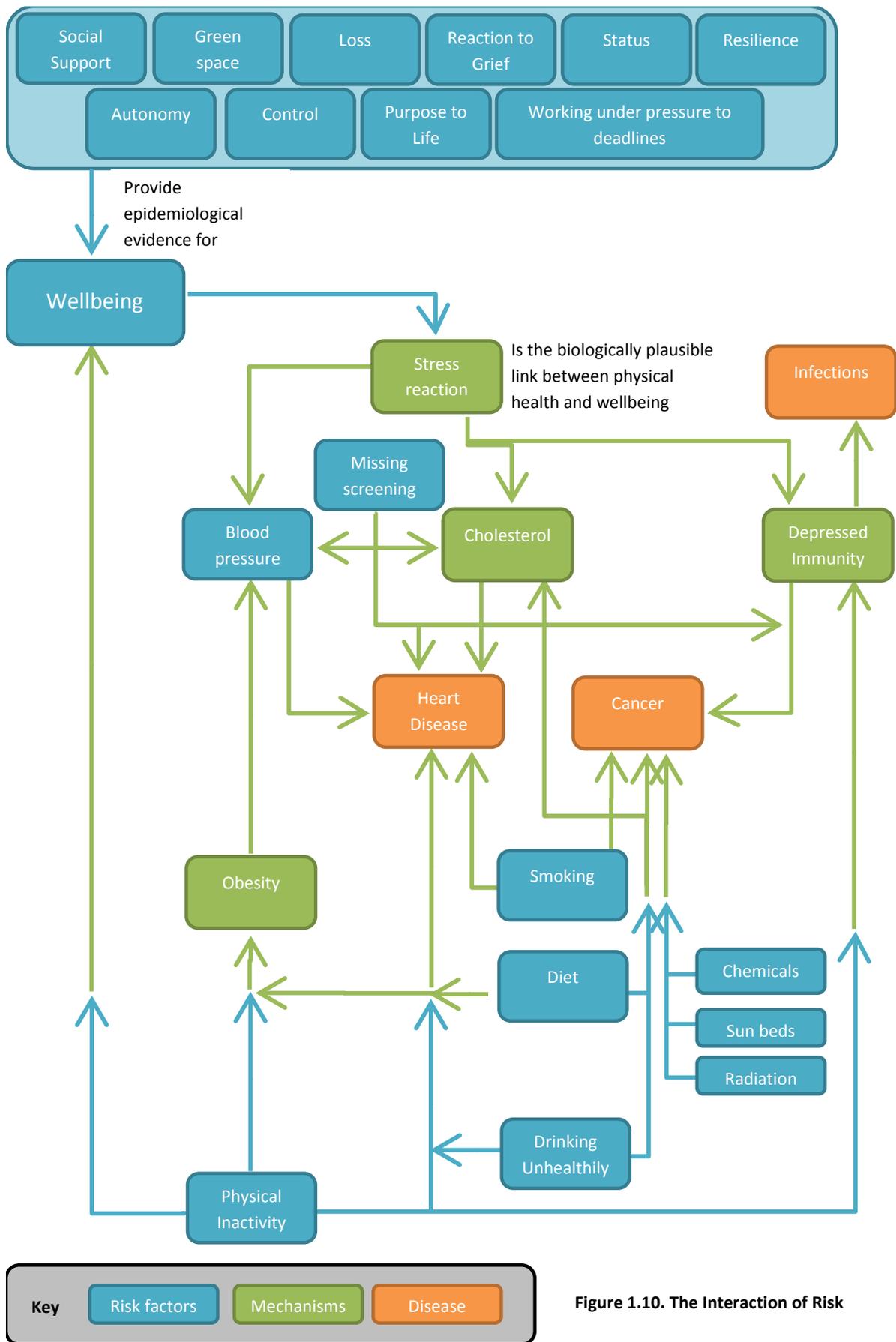
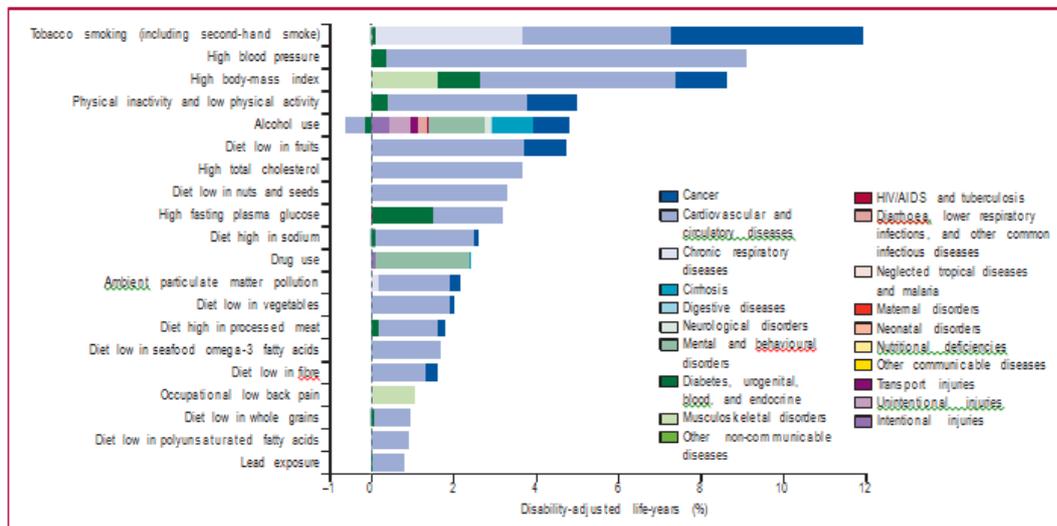


Figure 1.10. The Interaction of Risk

Also scientists disagree about which associations can be regarded as causal for example, how much raised blood cholesterol is due to stress or to diet. Consider the following two different analyses.

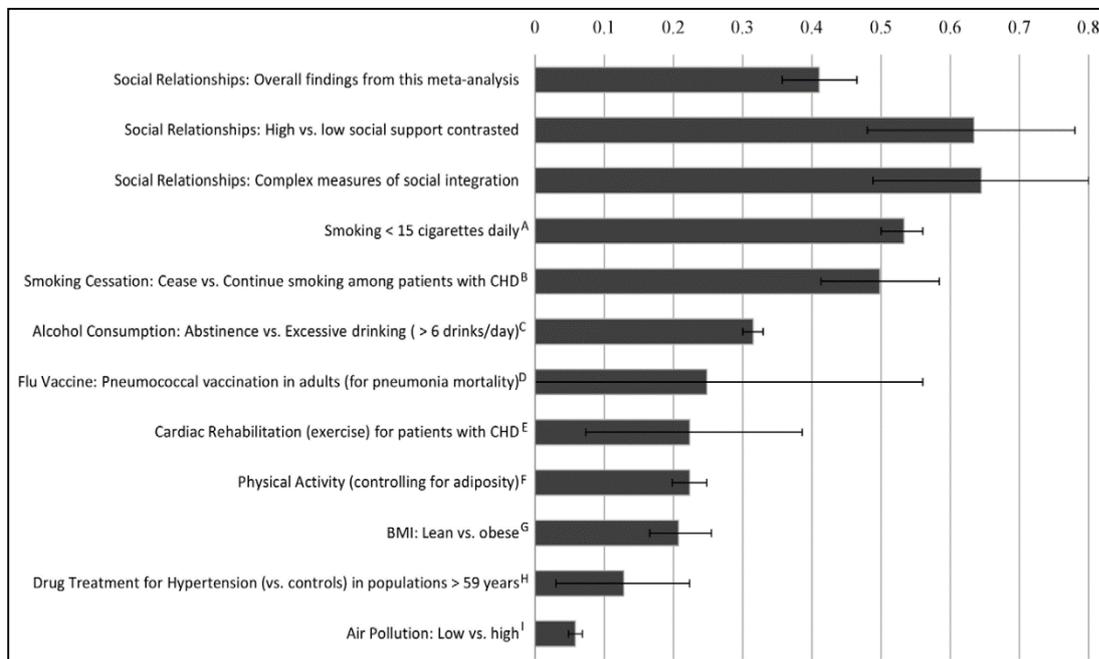
**Figure A9 – Burden of disease from UK risk factors – analyses by Murray et al**



**Figure 7:** Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years. The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

Source: Murray CJL, Richards MAR, Newton JN, Fenton KA, et al. UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet. 2013 March 5; [http://dx.doi.org/10.1016/S0140-6736\(13\)60355-4](http://dx.doi.org/10.1016/S0140-6736(13)60355-4), figure 7.

**Figure A10 – The relative value of social support/ social integration; a meta-analysis: comparative odds of decreased mortality**



Source: Holt-Lundstad et al 2010

One would focus attention on hypertension and traditional lifestyle factors, the other on aspects of wellbeing. Both have scientific validity; they differ because of genuine scientific differences about stress. It is my personal professional scientific conclusion that figure A8 is the more valid. But there is scope for legitimate scientific debate on that.

## A4.2 INEQUALITIES

In tables A1 and A2 we looked at life expectancy in various countries of the world and the various wards of Stockport. We saw how death rates in Bramhall are better than those in highest countries (Iceland/Singapore/Switzerland) and those in Brinnington & Central are more like those of mid ranking Countries such as Iran/Malaysia/Serbia/Venezuela.

Stockport has an unusual diversity of affluence and deprivation in its population. In 2007 we were third most polarised local authority in England, which means we have the third greatest gap between our most deprived and least deprived LSOA (Lower Super Output Areas). This isn't the result of any local failure of policy or services. It simply results from the fact that our boundaries embrace some of the most affluent areas in the Country (three of the 190 LSOAs in Stockport rank in the 2% most affluent nationally) but also some of the most deprived areas (three of the 190 LSOAs in Stockport rank in the 2% most deprived nationally). Our polarisation measure is a context not an outcome.

It actually means that Stockport has a spread of affluence and deprivation similar to that of the country as a whole.

**Table A4: Proportion of population by deciles of deprivation**

Decile of deprivation	Stockport	Greater Manchester	North West	North	England
0-10% most deprived	9.7%	21.8%	19.8%	18.7%	10.1%
10-20%	4.3%	14.5%	12.2%	11.7%	10.2%
20-30%	7.4%	11.7%	10.1%	10.5%	10.2%
30-40%	13.7%	10.5%	9.2%	9.2%	10.2%
40-50% mid deprived	5.2%	7.3%	8.2%	8.6%	10.0%
50-60% mid deprived	9.9%	7.2%	8.2%	8.2%	10.0%
60-70%	11.8%	5.6%	7.6%	8.5%	9.9%
70-80%	10.0%	8.2%	9.2%	9.0%	9.8%
80-90%	12.6%	7.5%	8.7%	8.6%	9.8%
90-100% least deprived	15.4%	5.7%	6.8%	6.9%	9.8%

Source: ONS MYE 2014, DCLG IMD 2015

Table A4 shows that the deprivation profile of Greater Manchester, the North West and North are more deprived than the national average; the profile of Stockport however is less skewed and is similar to the national average.

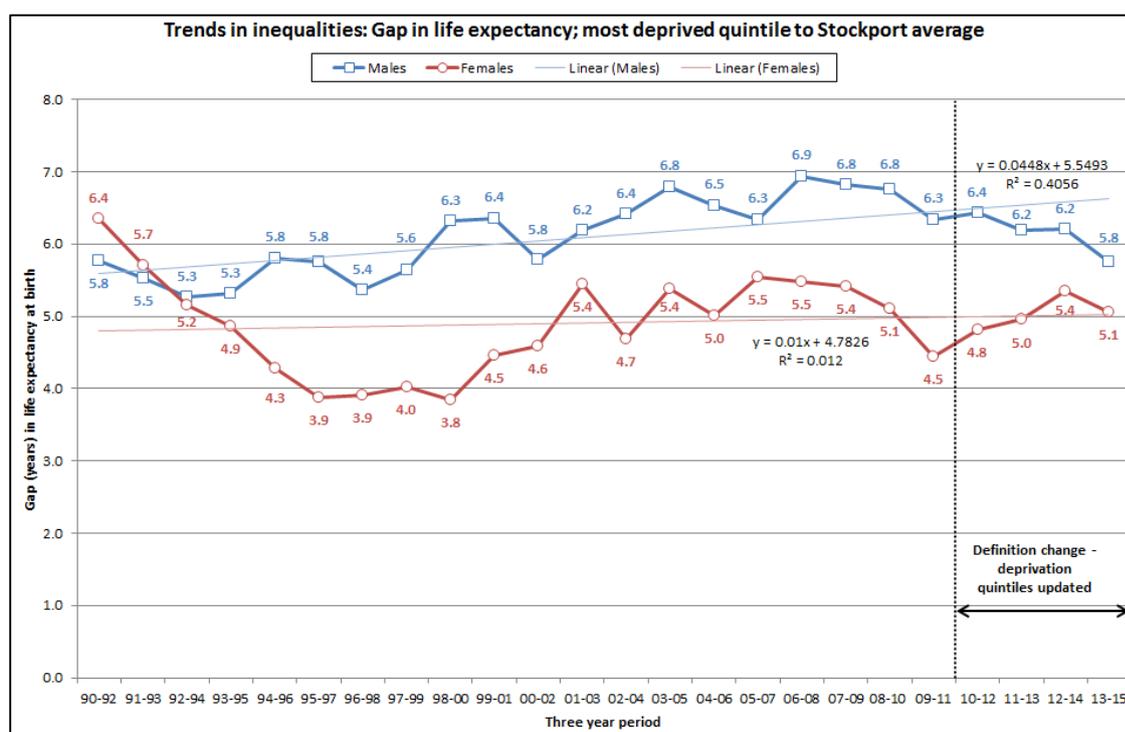
Life expectancy has improved in all wards in Stockport over the last 20 years (see table A5). The question is whether they have improved faster in deprived areas, narrowing inequalities, or whether they have diverged further.

There is evidence for Brinnington & Central, the most deprived ward improving more than the average for the whole borough, however the patterns are not clear as larger improvements were seen in other, more affluent wards including Bramhall North for males and Hazel Grove for women. If we look more closely at when these improvements occurred, it has not been consistent.

Table A5 Life expectancies in Stockport wards 1990/92 and 2012/14

	Males			Females		
	1990-92	2013-15	Change	1990-92	2013-15	Change
Bramhall North	75.7	82.6	+6.9	81.8	85.8	+3.9
Bramhall South	80.2	84.3	+4.1	85.5	86.4	+0.9
Bredbury & Woodley	72.7	79.1	+6.3	80.2	81.7	+1.5
Bredbury Green & Romiley	74.4	81.7	+7.3	79.6	83.1	+3.6
Brinnington & Central	64.1	72.8	+8.7	70.3	76.6	+6.3
Cheadle & Gatley	76.4	82.0	+5.6	82.4	84.8	+2.4
Cheadle Hulme North	74.0	80.7	+6.7	81.5	83.8	+2.3
Cheadle Hulme South	75.8	82.4	+6.6	80.0	84.9	+4.9
Davenport & Cale Green	70.1	74.8	+4.7	76.3	77.4	+1.0
Edgeley & Cheadle Heath	70.0	76.2	+6.3	76.9	80.1	+3.2
Hazel Grove	75.5	80.6	+5.1	78.6	85.5	+6.9
Heald Green	76.9	81.0	+4.2	83.6	86.1	+2.6
Heatons North	73.1	77.9	+4.9	78.9	82.9	+4.0
Heatons South	74.7	81.3	+6.7	81.0	85.6	+4.6
Manor	74.0	78.9	+4.9	77.8	83.4	+5.6
Marple North	76.9	81.8	+4.8	80.9	83.9	+3.0
Marple South	74.4	81.6	+7.2	81.2	83.8	+2.7
Offerton	73.3	81.0	+7.7	78.5	82.5	+4.0
Reddish North	71.6	79.1	+7.5	78.8	82.6	+3.9
Reddish South	71.6	78.7	+7.1	78.5	83.3	+4.8
Stepping Hill	70.9	79.8	+8.9	78.2	85.1	+6.9
Stockport	<b>73.3</b>	<b>79.8</b>	<b>+6.5</b>	<b>79.1</b>	<b>83.1</b>	<b>+3.9</b>

Figure A11 Trends in the gap in Life Expectancy



By plotting the trends in the gap in life expectancy between the most deprived quintile and the Stockport average (figure A11) it can be seen that the gap narrowed in the 1990s for women but has since risen and then remained fairly steady with some fluctuations, and overall there has been no significant change (R=0.0); for men the gap has risen (R=0.4) again with some fluctuations over the period.

A more detailed paper analysing these trends and the possible causes of these can be found on the JSNA hub (<http://www.stockportjsna.org.uk/>) or obtained in paper form on request.

It can be seen however from the above graph that there was a considerable reduction in inequalities for women in the 1990s, followed by worsening of the situation in the first three years of the new century losing about two thirds of the gain, then a levelling off with an improving trend restoring itself from about 2008 but then increasing since 2010. For men the 1990s improvement did not occur and the gap has widened into this century although it has started to level off.

There was a great deal of new public health activity in Stockport in the 1990s, focussed on community development, cardiovascular risk factor screening, neighbourhood health strategies and the Stockport Health Promise (a series of commitments to take specific health-improving steps by a range of organisations). It may be that the reduction in the gap resulted from that activity and that the initiative simply ran out of steam around the turn of the century. Or it may be that there was some other cause for the narrowing of the gap, perhaps even a cohort effect of something that happened some years previously.

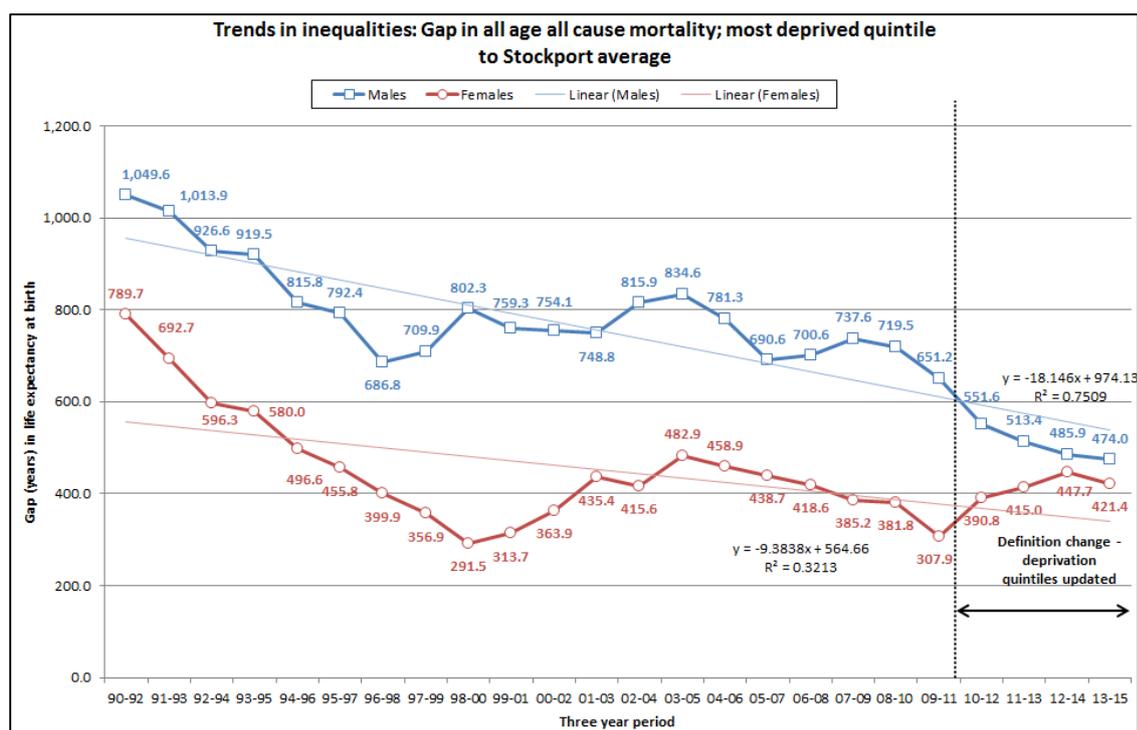
We therefore propose to see what the effect will be of reviving the Stockport Health Promise and revitalising the community development, screening uptake and neighbourhood projects. As we do this we will have to start in selected parts of the borough and comparison of those neighbourhoods with the rest of the inner city areas will help us see whether we are having an effect.

The worse trends for men will be addressed by programmes directed at healthy work.

A similar graph for directly standardised mortality shows a similar picture but with less loss of ground in the first few years of this century and with reduced inequalities in the 1990s extending to men as well as to women.

The main difference between life expectancy and directly standardised mortality is that the former places a greater weighting on deaths of younger people.

Figure A12 Alternative Trends in the gap in Life Expectancy



Why did the gaps stop narrowing? Several hypotheses have been considered:

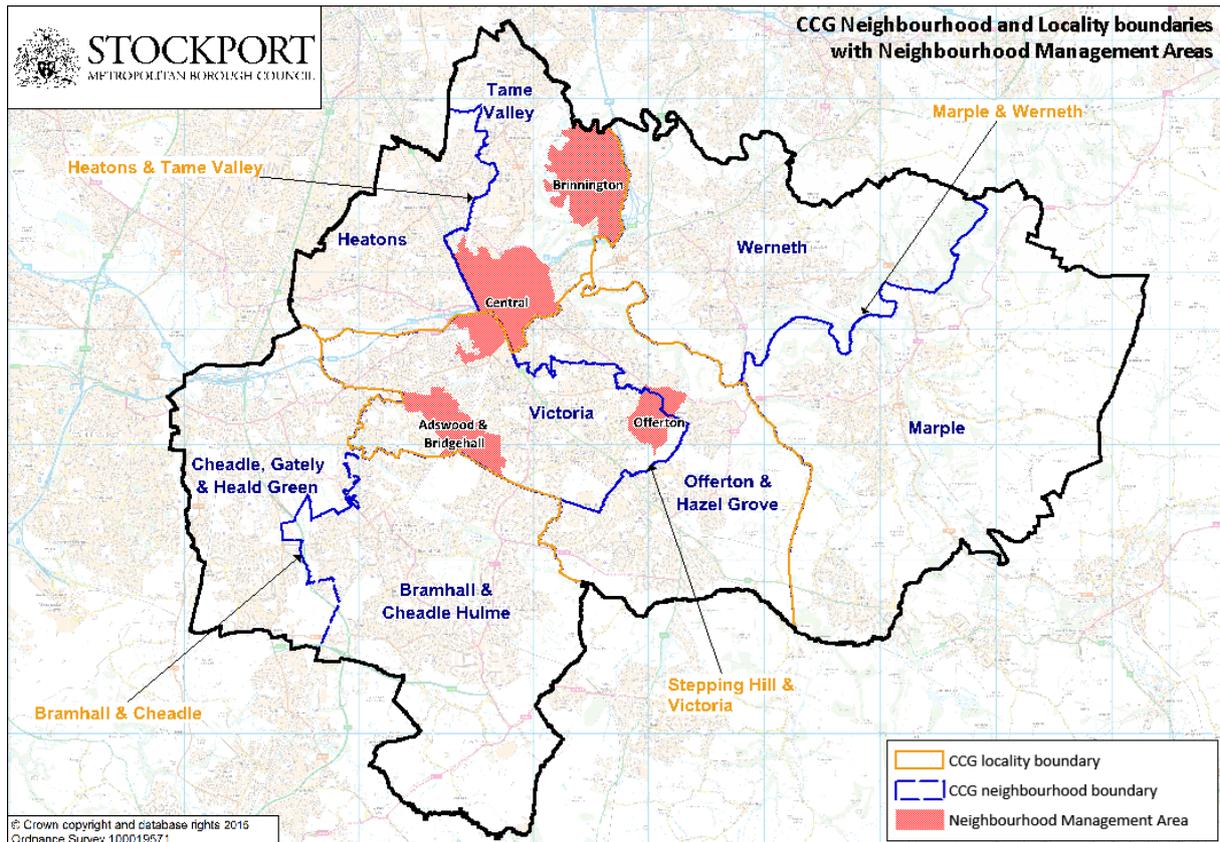
- Natural cycle – this might be the case if the changes were due to cohort effects,
- Loss of drive behind various programmes (such as those made as part of the Stockport Health Promise) when they were mainstreamed. This is the hypothesis that underpins the plans described above for piloting a reassertion of the 1990s initiatives.
- Heart disease becoming less of a driver for mortality, with less impact on overall mortality. Analysing inequalities in particular diseases those in heart disease continue to narrow but have been outweighed by other diseases especially cancer and gastrointestinal/liver diseases
- Deprived “Spearhead” PCTs funded to pursue intense inequalities programmes also had quick short term impact that were not sustained – explained as exhausting “health gain”
- The alcohol epidemic – the difference between life expectancy and directly standardised mortality and impact of cancer and gastrointestinal diseases suggest alcohol as a factor.

### A4.3 THE HEALTH OF STOCKPORT COMMUNITIES

#### The Health of the Council Areas and the CCG Localities

A CCG Locality consists of two CCG neighbourhoods and there are four neighbourhood management areas, a cluster of small areas ranked in the 20% most deprived nationally. The map below illustrates the breakdown of the various Stockport geographies and the links on the following pages lead to data for the eight CCG neighbourhoods.

Figure A13 CCG and Neighbourhood Management area maps



## **The Health of Bramhall and Cheadle Hulme**

Bramhall Area consists of the villages of Bramhall, Woodford and Cheadle Hulme. Bramhall is an area in which layers of housing and open space make up an attractive mix of village and country. Woodford is a rural village to the south of Bramhall where a planned major expansion of the village on a former aerodrome with a new garden village will more than double the size of the population over the next decade. This may help sustain village facilities but it will be especially important that the separation of Woodford and Bramhall is then maintained to avoid both being absorbed into urban sprawl.

The area is healthy. Its use of health service resources is disproportionately large when account is taken of its general good health; however this may be explained by the older population profile. It is also noticeable that the percentage of people who are not physically active is higher than in Stockport as a whole. Given the attractive footpath network of the area and the availability both of Bramhall Park and of the Ladybrook Valley this is disappointing.

[Bramhall and Cheadle Hulme CCG neighbourhood profile](#)

## **The Health of Cheadle, Gatley and Heald Green**

Cheadle, Gatley and Heald Green is generally quite affluent but includes some relatively deprived areas around Brookfield Road.

The area is adversely affected by aircraft noise from Manchester Airport.

In much of the area the natural patient flow is towards Wythenshawe Hospital rather than Stepping Hill.

The large social housing areas around Brookfield Road are within the nationally most deprived quintile but not within the most deprived decile.

Overall its health is slightly better than the borough as a whole and its lifestyles slightly healthier but it makes slightly more use of health services and less than a quarter of its population are physically active.

[Cheadle, Gatley and Heald Green CCG neighbourhood profile](#)

## **The Health of Heatons**

Heatons is a mixed area bordering Manchester.

Its health is somewhat better than the Stockport average, apart from mental well-being which is slightly worse, perhaps due to the age of the population as Mental Wellbeing is lowest for those in middle age.

It makes less use of health services than the Borough as a whole and lifestyles are generally healthier apart from drinking which is very slightly worse.

[Heatons CCG neighbourhood profile](#)

## **The Health of Tame Valley**

Tame Valley covers Reddish, Brinnington and the Town Centre area.

Brinnington & Central Ward has markedly lower life expectancy, markedly worse lifestyles and markedly worse health than Stockport as a whole. Brinnington is an attractive community with good facilities and ample greenspace set close to the town centre but still amidst countryside and with strong community spirit. It is possible that the health indicators are affected by the inclusion of the Town Centre within the ward (which is borne out by analysis of data for neighbourhood management areas – showing Brinnington itself as having improving health but not the Central Area) and by the use of some housing in Brinnington for short term housing.

Reddish also shows worse health and lifestyles, especially in the North of the township, but to a much less marked extent than in Brinnington.

[Tame Valley CCG neighbourhood profile](#)

## **The Health of Victoria**

Victoria is a relatively deprived area including Edgeley, Cheadle Heath, Adswood and Bridgehall.

Victoria is the other major deprived area of the borough. Life expectancy is intermediate between that of Brinnington and Reddish. It has one of the best levels of physical activity in the borough and low levels of high risk drinking. Its proportions of people with multiple risks are only slightly worse than the affluent areas.

[Victoria CCG neighbourhood profile](#)

### **The Health of Stepping Hill (Hazel Grove and Offerton)**

Stepping Hill is a mixed area stretching out to the east of the Borough and including Offerton, and Hazel Grove.

Life expectancy and self-reported health are slightly better than in the borough as a whole. Mental wellbeing is slightly better except in Offerton where it is markedly worse. Physical activity is better in Offerton and markedly worse in Hazel Grove. Diet is slightly worse, the alcohol epidemic slightly better.

Use of health services is high, perhaps reflecting the proximity of Stepping Hill Hospital.

[Hazel Grove and Offerton CCG neighbourhood profile](#)

## **The Health of Marple**

Marple consists of the township of Marple and the surrounding villages of Compstall, Mellor, Strines, and High Lane.

Life expectancy is better in Marple than in the Borough as a whole, the increase noted in the last report having proved to be a passing blip. Self-reported health is very slightly better. Smoking, diet and physical activity levels are better than in the rest of the borough but levels of high risk drinking are markedly worse and the levels of physical activity are not as high as might be expected from the excellent walking opportunities in the area. Use of health services is lower.

[Marple CCG neighbourhood profile](#)

## **The Health of Werneth**

Werneth consists of the townships of Bredbury, Romiley and Woodley.

Self-reported health and mental well-being are slightly worse than in the borough as a whole. Rates of problem drinking are high. Rates of smoking, obesity and unhealthy diets are slightly higher than in the borough as a whole. Physical activity rates are slightly better.

[Werneth CCG neighbourhood profile](#)

## The Health of the Neighbourhood Management Areas

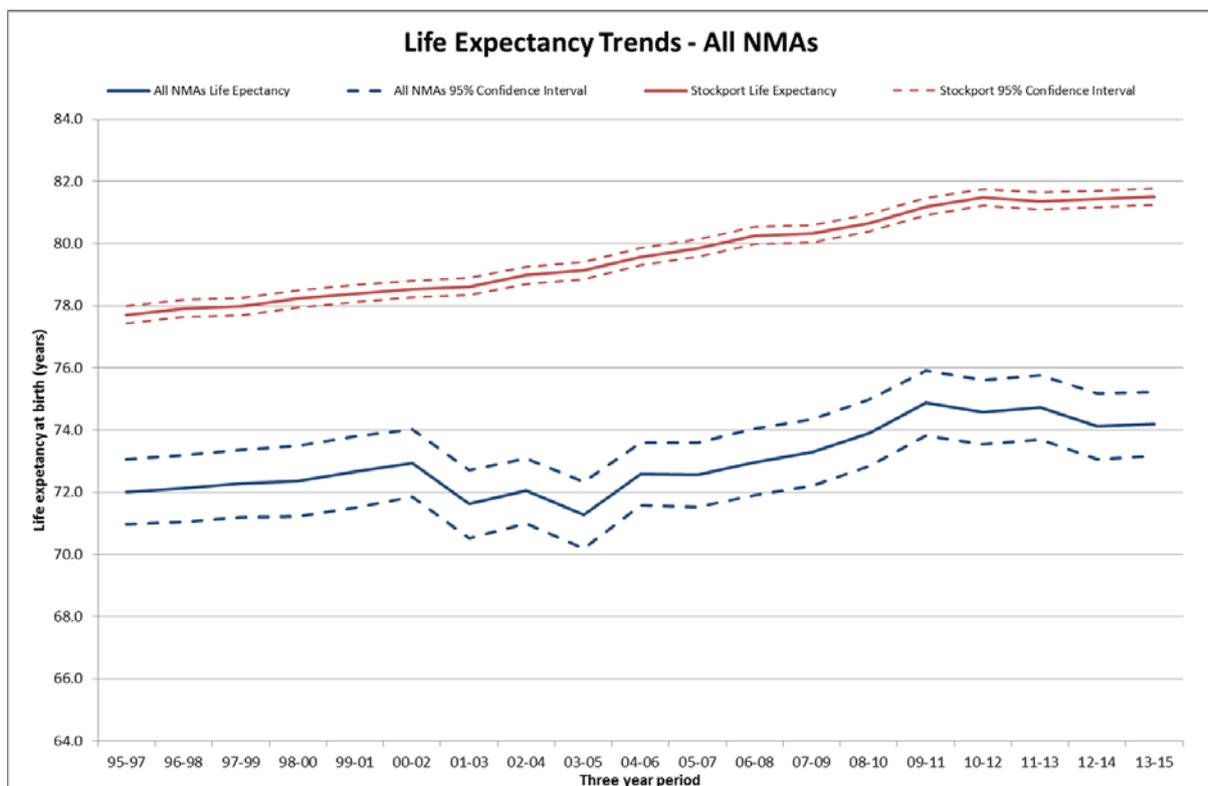
In the PCT public health gave special attention to the most deprived quintile of the population via a process of community development and targeted resources. The Council took a similar approach through the process of neighbourhood management. The four neighbourhood management areas (NMAs) cover approximately 60% of the population of the most deprived quintile. The areas comprise Adswold & Bridgehall, 5,400 population, Brinnington 7,100, Central 6,900 and Offerton 3,300 (30/06/15).

Since public health moved into the Council we are exploring how to reconcile these two approaches.

### Life expectancy

Trends in life expectancy for the NMAs can be seen in figure A14 and shows a general increase since 1995/97:

**Figure A14: Trend in Life Expectancy – all NMAs**



Source: PHMF, ONS & NHS Stockport

Trends suggest that during the early part of the last decade the rate of improvement stopped, and at this point the inequalities gap widened; in 2005/07 the improvement in life expectancy resumed and the gap narrowed, almost back to the level seen in the mid-nineties. Since 2009/11 however this improvement has halted and life expectancy for both Stockport and the NMAs has maintained rather than improved.

Trends in the inequalities gap in life expectancy have recently been re-examined and are discussed in chapter 4.2.

Life expectancy trends for each of the four NMAs individually need to be treated carefully, due to the small numbers involved, however key trends can be identified (see figure A3.11). Overall:

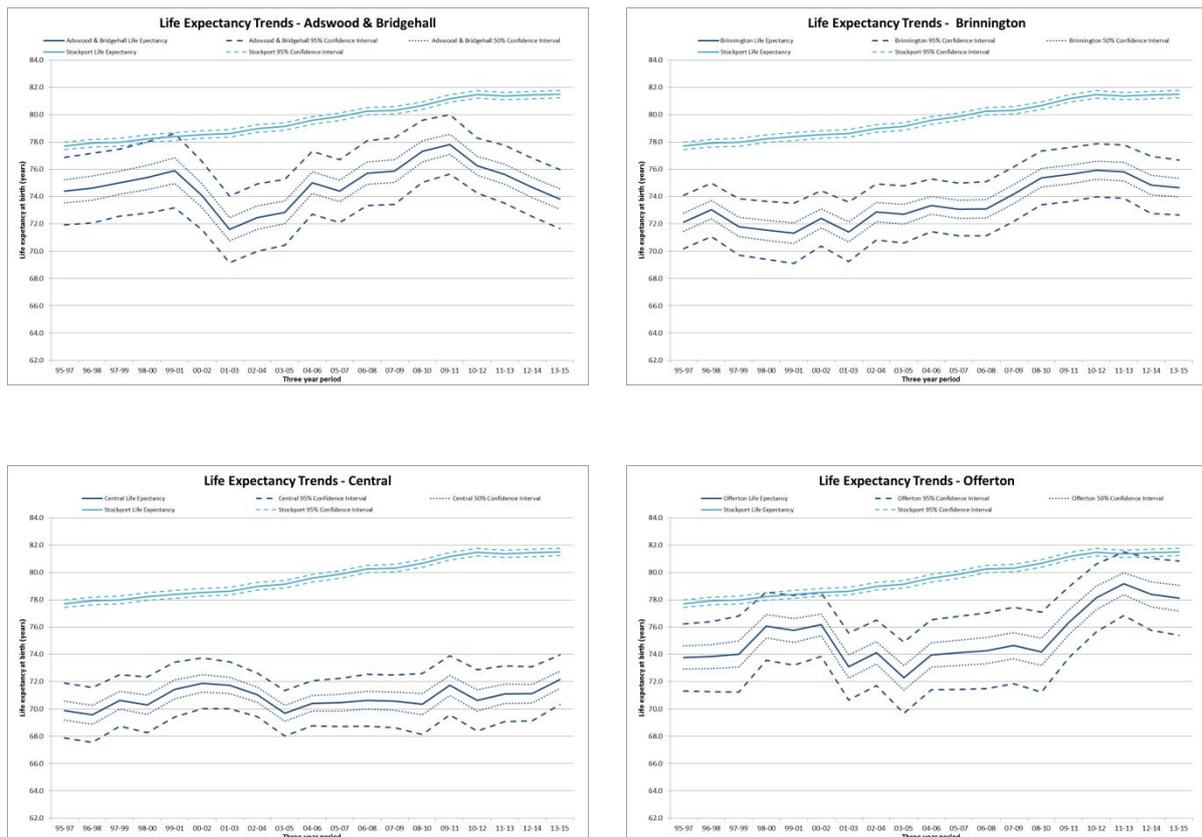
**Brinnington** had seen significant and consistent improvement in life expectancy rates since 1995/07 and until recently was the only NMA where a statistically significant increase could be shown. Over the period between 1995/97 and 2002/04 rates in this area remained relatively stable; since 2002/04 life expectancy increased by 3 years, but in more recent years has fallen.

**Central** neighbourhood management area saw little change between 1995/97 and 2010/12 but in recent years life expectancy has begun to rise. Rates in this area are lower than the other NMAs.

**Adswood & Bridgehall** had overall seen increases in life expectancy since 1995/97; but these could not be shown to be statistically significant. The area saw a drop in life expectancy between 2000/02 and 2003/05, then experienced an increase in life expectancy to 2010 and then rates have fallen so that rates have now fallen below 1995/97 levels.

**Offerton** has overall seen increases in life expectancy since 1995/97; the most significant increase from 2008/10 onwards. Rates have nonetheless mirrored all areas recently and stalled.

**Figure A15: Trend in Life Expectancy – by NMA**



Source: PHMF, ONS & NHS Stockport

**Table A6: Self-reported “good” or “very good” general health**

	2009 Adult Lifestyle Survey (18+)		2012 Adult Lifestyle Survey (18+)		2011 Census (all ages)	
	Sample size	Rate	Sample size	Rate	Sample size	Rate
Adswood & Bridgehall	94	64.9%	88	55.7%	5,088	76.5%
Brinnington	96	54.2%	104	56.7%	6,686	72.7%
Central	175	62.3%	123	58.5%	6,488	67.4%
Offerton	71	54.9%	64	68.8%	2,738	71.4%
<i>All NMAs</i>	<i>436</i>	<i>59.9%</i>	<i>379</i>	<i>59.1%</i>	<i>21,000</i>	<i>71.8%</i>
<i>Stockport</i>	<i>7,456</i>	<i>73.8%</i>	<i>6,668</i>	<i>74.2%</i>	<i>283,275</i>	<i>81.1%</i>

Source: 2012 Adult Lifestyle Survey, NHS Stockport

2011 Census data relating to the general health of the population is now available and shows that rates of general health in the NMA s are lower than the Stockport average; rates are lowest in Central and highest in Adswood & Bridgehall. Unsurprising the Census data for all ages shows a better picture of health than local surveys of adults; but this will be skewed by the inclusion of children.

## Alcohol

In depth analysis of local mortality data suggests that while smoking is still a major cause of early death some progress is being made in reducing prevalence; the impact of alcohol is however an emerging priority.

**Table A7: 2012 Adult Lifestyle Survey – High and Increasing Risk Drinking**

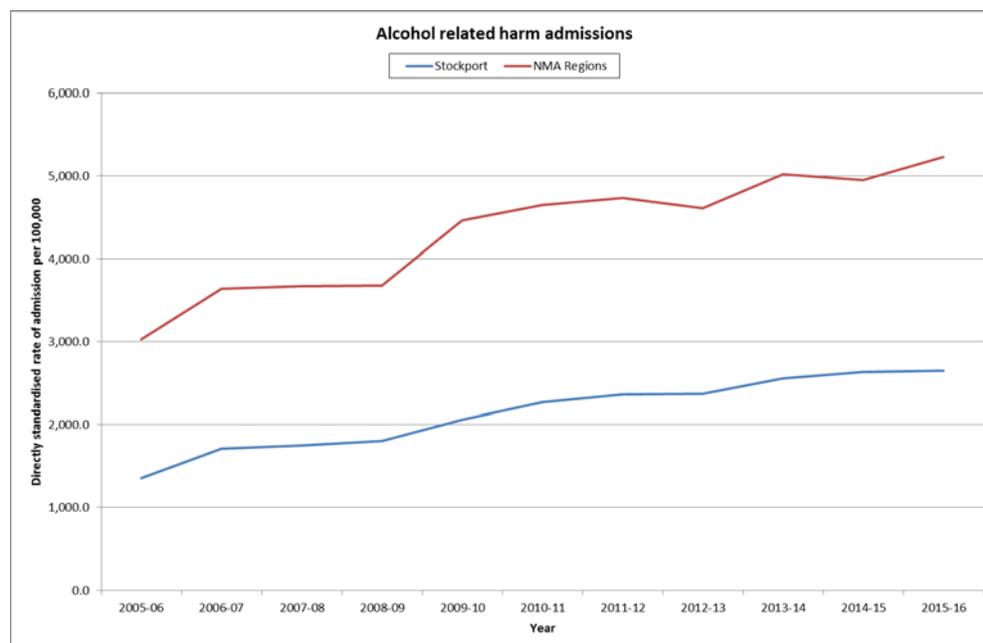
	Sample size	High risk	Increasing risk	Drank within weekly guideline	Didn't drink last week	Non drinker
<b>Adswood &amp; Bridgehall</b>	86	0.0%	12.8%	45.3%	9.3%	<b>32.6%<sup>H</sup></b>
<b>Brinnington</b>	103	<b>7.8%<sup>H</sup></b>	<b>4.9%<sup>L</sup></b>	47.6%	6.8%	<b>33.0%<sup>H</sup></b>
<b>Central</b>	121	5.8%	13.2%	<b>41.3%<sup>L</sup></b>	11.6%	28.1%
<b>Offerton</b>	63	1.6%	7.9%	60.3%	6.3%	23.8%
<i><b>All NMAs</b></i>	<i>373</i>	<i>4.3%</i>	<i>9.9%<sup>L</sup></i>	<i>47.2%</i>	<i>8.8%</i>	<i><b>29.8%<sup>H</sup></b></i>
<i><b>Stockport</b></i>	<i>6,635</i>	<i>2.9%</i>	<i>16.9%</i>	<i>52.0%</i>	<i>6.8%</i>	<i>21.4%</i>

Source: 2012 Adult Lifestyle Survey, NHS Stockport

Results from the 2012 Adult Lifestyle Survey (table A7) show that in both Adswood & Bridgehall and Brinnington there are significantly higher rate of adults reporting that they do not drink alcohol at all; further investigation suggests that these people tend to be older and in poorer health. Of those who do drink, Brinnington reported an especially high rate of drinking at high risk rates (35+ units for women and 50+ for men) and Central reported a lower proportion drinking within the weekly guidelines (14 units for women and 21 for men).

## Figure A16: Alcohol Related Harm Admissions

Source: SUS, NHS Stockport



The impact of the unhealthy levels of drinking can be seen in the trends in hospital admissions for alcohol related conditions (figure A16), which have increased markedly since 2005-06; especially in the NMA areas where rates are roughly double the Stockport average. In total around 1,000 alcohol related admissions are made each year from these areas and there is no real sign of a change in this trend.

### Other lifestyle issues

Data from the 2012 Adult Lifestyle Survey shows how other key health behaviours vary across the areas (table A3.15)

**Table A8: 2012 Adult Lifestyle Survey – Other key lifestyle issues**

	Low Mental Wellbeing	Current Smokers	Obesity	Not Physically Active	Unhealthy diet	Multiple Risks
<b>Adswood &amp; Bridgehall</b>	19.8%	<b>33.3%<sup>H</sup></b>	<b>27.7%<sup>H</sup></b>	74.4%	85.2%	38.8%
<b>Brinnington</b>	<b>20.8%<sup>H</sup></b>	<b>38.6%<sup>H</sup></b>	22.3%	83.5%	<b>93.3%<sup>H</sup></b>	<b>55.6%<sup>H</sup></b>
<b>Central</b>	<b>24.5%<sup>H</sup></b>	<b>28.9%<sup>H</sup></b>	23.1%	70.6%	<b>95.1%<sup>H</sup></b>	37.9%
<b>Offerton</b>	<b>29.3%<sup>H</sup></b>	<b>33.3%<sup>H</sup></b>	<b>35.0%<sup>H</sup></b>	65.5%	84.4%	<b>41.0%<sup>H</sup></b>
<b>All NMAs</b>	<b>23.1%<sup>H</sup></b>	<b>33.3%<sup>H</sup></b>	<b>26.0%<sup>H</sup></b>	74.1%	<b>90.5%<sup>H</sup></b>	<b>43.5%<sup>H</sup></b>
<b>Stockport</b>	12.2%	14.9%	16.2%	73.6%	82.1%	32.4%
<b>Ratio NMA: Stockport</b>	1.89x	2.23x	1.60x	1.01x	1.10x	1.34x

Source: 2012 Adult Lifestyle Survey, NHS Stockport

Smoking is the lifestyle behaviour with the steepest inequality gradient; rates of smoking in the NMAs are more than twice that of the Stockport average and are significantly higher in each of the four areas, but especially Brinnington. In 2011/12 275 people from NMAs were supported to quit

smoking; 14.4% of the total number of quitters (7.5% of the total population live in these areas) but a small figure when compared to the number of smokers (data from 2012/13 will be available at the end of June).

Mental wellbeing has the second steepest gradient; rates of poor mental wellbeing are 89% higher in the NMAs than in the rest of Stockport. Evidence suggests that mental wellbeing is a key determinant of health and underpins many poor health choices. Mental wellbeing is a priority of the Health and Wellbeing Strategy

Obesity rates are also significantly higher, with rates on average being 60% higher in the NMAs compared to the Stockport average. It should be noted that due to the self-reporting nature of this survey these rates are thought to be a significant underestimation of the issue (for example the Stockport average is thought to be 25% rather than 16%).

The only health behaviour which is not significantly worse across the NMAs as a whole is physical activity; where rates are similar to the Stockport average – however on average only 1 in 4 adults are active enough.

Over the last 2 years 295 residents of NMAs have been referred to the Stockport PARiS scheme (Physical Activity on Referral in Stockport).

In 2011/12 215 NMA residents received services from Stockport Health Trainers, who have now joined other lifestyle behaviour change services to become the Healthy Stockport Service. Over the last 2 years 25 frontline workers in the NMAs have undertaken Essential Public Health Training.

### Use of acute health services

The use of these services is another key indicator of health and health care in local areas (table 6.16).

**Table A9: Use of acute health services 2015-16**

	Number of			Crude rate per 1,000		
	ED attendances	inpatient admissions	emergency inpatient admissions	ED attendance	inpatient admissions all	emergency
<b>Adswood &amp; BH</b>	2,454	1,896	918	457.4	353.4	171.1
<b>Brinnington</b>	3,796	2,871	1,513	534.1	404.0	212.9
<b>Central</b>	3,762	3,042	1,607	542.7	438.8	231.8
<b>Offerton</b>	1,766	1,501	754	530.0	450.5	226.3
<b>All NMAs</b>	11,778	9,310	4,792	518.0	409.5	210.8
<b>Stockport</b>	97,464	94,835	39,954	337.6	328.5	138.4

Source: SUS, NHS Stockport

Rates of attendance at Emergency Departments (ED) and inpatient admissions are all higher in the NMAs than compared to the Stockport average; and are highest in the Central area for ED attendance and emergency admissions and in Offerton for all inpatient admissions.

## Health Services

These communities are less likely to use primary care services or access opportunities to check their health e.g. screening which can result in them using more intensive or crisis services such as the Emergency Department or receiving late diagnoses of conditions which make them more difficult to treat. Health inequalities also surface once people have been diagnosed with a condition, which may be due to people from a more disadvantaged background being less able to articulate their needs or be a confident self-advocate. NHS services are provided universally and the way they are provided and structured is generally not geared around socio-economic disadvantage, or a locality model of service provision. The development of processes to integrate health and social care, however, is leading to a locality model of provision. The CCG's priority to reduce health inequalities and establishment of locality footprint in addition to Stockport Health Promise and the proposed Health inequality pilot outlined elsewhere in this annual report may lead to increased proportion of resource directed towards more disadvantaged localities.

Most public health services are provided 'universally' to the whole of Stockport. The Healthy Stockport service combining the Health Trainer service, alcohol, smoking cessation and weight management is available to all Stockport residents but for residents living in the most disadvantaged parts of the borough more intensive contact and support is available. A number of community public health services focus on disadvantaged neighbourhoods or communities such as the Food and Health Team, the community stop smoking team; and the community development team. In addition a number of small schemes focus on the health and wider wellbeing of very vulnerable group including people who are homeless, people with alcohol addiction, refugee and asylum seekers, young people who are substance misusers, and vulnerable women / those at risk of domestic violence.



**23rd Annual Public Health Report for  
Stockport - 2016/17**

**SECTION A: The Health of the People**

**LEVEL 5**

**Additional Analysis**

## LEVEL 5 (ADDITIONAL ANALYSIS) SECTION A: THE HEALTH OF THE PEOPLE

More detailed analysis of demographic patterns, trends in mortality, health status and inequalities, and the possible causes of these can be found on the JSNA hub (<http://www.stockportjsna.org.uk/>).

The JSNA has recently been refreshed and the overall priorities and key objectives can be found here <http://www.stockportjsna.org.uk/2016-2019-priorities/>. If there are any questions arising from the JSNA analysis then please contact the public health intelligence team at [JSNA@stockport.gov.uk](mailto:JSNA@stockport.gov.uk).

### A5.1 ILL HEALTH IN BRITAIN AND STOCKPORT

- [JSNA briefing - Long term conditions](#)
- [JSNA briefing - Cancer](#)
- [JSNA briefing - Liver disease](#)
- [JSNA briefing - Health at a glance](#)

### A5.2 INEQUALITIES

Analysis undertaken in previous Stockport Annual Public Health Reports remains relevant and is available from the Public Health team on request, for inequalities this includes:

- Section 2 of the 14<sup>th</sup> report – Men’s Health
- [JSNA briefing - Socio-economic trends](#)
- [JSNA briefing - Mortality](#)

### A5.3 HEALTH OF STOCKPORT COMMUNITIES

- [JSNA briefing - Neighbourhood Profiles](#)