

## **WARRINGTON JOINT STRATEGIC NEEDS ASSESSMENT: JSNA 2011/12 OVERVIEW AND PRIORITIES REPORT**

### **1. BACKGROUND TO THE JSNA**

In March 2007 the Department of Health published a “Commissioning Framework for Health and Wellbeing” which introduced the idea of a Joint Strategic Needs Assessment (JSNA) by which Primary Care Trusts and top tier Local Authorities would “describe the future health, care and wellbeing needs of local populations and strategic direction of service delivery to meet those needs”. This would then help to provide personalised services, promote health and wellbeing, prevent ill health and reduce health inequalities. In November 2007 the Local Government and Public Involvement in Health Act required the Director of Public Health, the Director of Children’s Services and the Director of Adult Services to work jointly to produce a JSNA. The Act also required Sustainable Community Strategies and Local Area Agreements to take account of the findings.

These strategies and agreements are no longer required but the rationale for a JSNA continues to exist and the Health and Social Care Bill currently before Parliament re-emphasises the importance of the JSNA as the starting point for strategy development and commissioning decisions. The Bill proposes the new statutory Health and Wellbeing Boards will have three required functions as follows:

1. To oversee the production of the Joint Strategic Needs Assessment.
2. To develop a Joint Health and Wellbeing Strategy (JHWS).
3. To develop joint commissioning intentions and ensure all commissioning intentions meet the needs identified by the JSNA and are in line with the JHWS.

This 2011/12 JSNA for Warrington is an overarching needs assessment. A wide range of information has been reviewed to identify key issues for our population. This will be used in planning, commissioning and providing programmes and services to meet identified needs.

The aim of the JSNA 2011/12 has been to provide an up to date picture of the current and likely future health and wellbeing needs of the people of Warrington. The areas included for analysis were decided upon following engagement with a range of stakeholders.

## **2. JSNA in 2011**

Although there has been a JSNA programme in place since 2008, for the 2011/12 programme a fundamentally different approach has been taken. The core data sets will be available on the DORIC website, which is a public facing shared data repository. (<http://www.doriconline.org.uk/>) The data will be accompanied by full topic specific commentaries collated in a standardised format which aim to make the information accessible and understandable. Additionally, this summary document is published to highlight the main findings and priorities for decision makers. An overview report will be produced on an annual basis in future and it is proposed that this will feed into an annual refresh of the Warrington Strategy.

The commentary directs people to data sources, and evidence of effective interventions. It describes what is working well in Warrington, and what has been achieved. The analysis summaries also identify areas where improvements could be made; where need is greater, and where data suggests needs may not be being fully met. In addition to identifying the gaps, the established evidence base has been used to provide suggestions of how these gaps can be addressed.

The analysis has covered a wide range of indicators. Analysis and commentaries have looked at individual lifestyle factors that impact on health and wellbeing, and assessed the local prevalence and impact of major diseases. Commentaries have also looked at many of the wider, social and economic determinants of health, such as housing, employment, education, transport and poverty. As we know, these factors have a substantial impact on health and health inequalities, and improvements in these areas extend far beyond the scope of the health service, so a collaborative, strategic approach is needed if we are to effect long-term change.

The approach adopted for the JSNA in 2011/12 is one of continuous evolution and improvement. We have set four clear objectives which aim to ensure that the JSNA:

- Results in an annual report which summarises analysis findings into intelligence upon which strategic priorities and commissioning intentions can be drawn
- Is a continuous process; having regular data updates released throughout the year, with interested stakeholders notified of these updates;
- Includes a process of engagement through which stakeholders are involved in the development of the JSNA and in agreeing what the priorities are;
- Is linked to the themes of the Marmot Review into Health Inequalities in order to ensure the issue of tackling health inequalities is firmly embedded.

To achieve this, a process has been established this year which consists of:

- Engagement with a wider range of stakeholders throughout the process. This included eliciting partners' perceptions of the JSNA, and developing actions to help improve how people regard and use the JSNA.
- Allocation of specific topic areas to the most appropriate service manager or Commissioner, who is able to provide meaningful commentary on key issues. Using this 'key author' approach has meant active engagement with those directly concerned in implementing the changes necessary to address need and improve outcomes.

### **3. HEADLINE FINDINGS**

**Encouraging findings:** Analysis has highlighted a number of areas in which Warrington is doing well.

In relation to health outcomes and the impact of major diseases:

- Life Expectancy is increasing for Warrington residents, and the gap between Warrington and England has reduced for males
- The internal inequalities gap in life expectancy associated with deprivation has also reduced for males in the town.
- The overall gap in death rates between the more deprived and more affluent areas of Warrington has reduced.
- The rate of new cancers in Warrington is lower than the average for England
- Cancer death rates locally are reducing and are in keeping with England

Looking at health related behaviours and individual lifestyle factors:

- Smoking rates have decreased and are similar to the average for England
- Emergency admissions to hospital for alcohol specific conditions decreased in 2010/11. This follows previous year on year increases and is likely to be in response to the focussed work in A&E.
- The percentage of mothers smoking during pregnancy is low in Warrington
- The number of people cycling in Warrington has increased since 2004

The educational achievements, participation in exercise and the health of children and young people in Warrington are generally good, and:

- Warrington has higher uptake rates for most childhood immunisations than nationally
- Participation in the National Child Measurement Programme is very high
- Obesity levels amongst Year 6 children are significantly lower than England
- Although teenage conception rates in Warrington increased in 2009, the long-term trend shows a substantial reduction. In fact, measured on a 3-year rolling basis, the percentage decrease in Warrington is significantly better than England.
- The proportion of local young people attempting to buy alcohol illegally has fallen.

In relation to some of the wider determinants of health:

- The percentage of non-decent homes within Warrington is lower than the average for England
- Levels of Fuel Poverty in Warrington are substantially lower than the North West.
- Levels of worklessness in Warrington are lower than nationally and regionally
- Warrington has lower rates of claimants for all out of work benefits.
- In Warrington the numbers of road traffic accidents are falling.
- The proportion of emissions generated by transport within Warrington is lower than the national average, and
- Reductions in CO2 emissions per capita within Warrington have fallen at a greater rate than nationally and regionally.

## **4. ANALYSIS SUMMARIES AND EMERGING PRIORITIES**

Summarised below are some of the key points which have come from the more detailed commentary within the topic specific chapters. Priorities have emerged from this analysis, based on areas where Warrington is not faring as well as might be expected, or where specific needs of local population groups appear not to be being fully met. The emerging priorities have been grouped into themes; these are described more fully in section 5.

### **4.1 DEMOGRAPHIC AND ENVIRONMENTAL CONTEXT**

In addition to providing information on current population numbers and structure and on projected change, this section of the JSNA refresh looks at the wider social and economic context. The individual chapters written focus on some of the main social determinants of health and wellbeing. A major misconception is that health and ill-health is primarily the business of the health sector. Certainly, the health sector has a vital role to play in tackling the misdistribution of services and access to them (the so-called 'inverse care law') as this is one of the social determinants of health. But the key drivers that account for people's poor health in the main lie in the 'conditions in which people are born, grow, live, work, and age'. We know that healthy places grow healthy people, and that factors such as fair employment and decent working conditions contribute to health and well-being.

**4.1a) Population:** The current population of Warrington is estimated at 198,900, with an estimated 85,500 households. In 2010, the average household size was 2.3. The population comprises 49.5% males, and 50.5% females.

#### **Currently Warrington has:**

- A **higher proportion** of people aged **0 to 15**; 19.1% compared to 18.7% regionally and nationally, a **similar proportion aged 16 to 64**; 64.8% compared to 64.6% regionally and 64.7% nationally, and a **lower proportion aged 65 or over**; 16.1% compared to 16.6% nationally.
- There is considerable variation within Warrington, with the Stronger Together area having a higher proportion of children than other neighbourhoods, and South Warrington having the highest proportion of older residents (aged 65 & over).
- The fertility rate in 2009 was below replacement level, and 12% of births in 2009 were to non-UK born mothers; this is likely to have implications for maternity services, with potential language barriers for people accessing services.
- Approximately 900 school children educated in Warrington (3.3% of the total), whose first language is not English. This is likely to increase given the rising number of births to non-UK born women.
- An estimated 652 long-term international migrants arrived in Warrington during 2009/10, with an estimated net inflow of long-term international migrants of 71.
- A small but increasing black or minority ethnic (BME) population. With estimates suggesting that 6.9% of the resident population belong to an ethnic minority group compared to 11.6% regionally and 17.2% in England.

The total population within Warrington has increased by 3%, between 2005 and 2010. This is higher than regional growth of 1.4% but lower than national; 3.4%. The older

population (ages 65 & over) has increased by 10.3%, over the same period; higher than the regional and national averages of 5% and 6.9% respectively.

**Longer term** it is projected that between 2008 and 2033 the population within Warrington will continue to grow, reaching an estimated **221,500 by 2033**; an increase of 12.9% from 2008 compared to 17.7% nationally.

The **largest increases** are projected to be in the **65+ age groups**. This age group is projected to rise to 54,100, an increase of 79.7% from 2008 compared to 65% nationally. Locally, however, the population aged **16-64** is projected to rise by **only 0.3%** over the same period, this compares with a projected increase of 7.4% nationally.

**Populations with Disabilities:** In November 2010, there were 11,120 claimants of Disability Living Allowance. This accounted for 5.6% of the total population, slightly above the national average of 5.2%. This proportion has increased slightly from 5.3% in November 2006.

**4.1b) Deprivation** is a major determinant of health. With more deprived populations experiencing higher levels of ill-health and premature mortality.

Overall deprivation appears to have worsened very slightly. Warrington's new average score is 18.5 this compares with 17.9 in 2007.

- Analysis confirms that extreme deprivation affects a concentrated section of the population in Warrington and levels are not evenly spread across the borough.
- Although the absolute numbers of people in Warrington experiencing Income and Employment deprivation have increased, there have been small relative improvements in national ranking on the Income and Employment measures since 2007.
- Warrington now has more local areas (LSOAs) ranked within the most deprived quintile in England: In terms of overall deprivation 20 Warrington LSOAs now fall in the most deprived 20% in England (Quintile 1); this compares with 18 in 2007.
- Looking at more severe deprivation, the 11 LSOAs that fell within the most deprived 10% nationally (i.e. The Closing the Gap definition for targeted inequalities work) in 2007 remain the same.
- The proportion of Warrington LSOAs ranking within the most deprived 20% of areas nationally has increased for all but one of the individual domains of deprivation: Crime is the only domain in which there has been a decrease in the number of local LSOAs included within the most deprived 20% nationally.
- At Neighbourhood level, for all domains except accessibility, the Central Neighbourhood has by far the highest proportion of LSOAs ranked within the most deprived areas nationally.

**4.1c Housing:** The relationship between housing and health is complex owing to the many other factors which impact on health such as income and lifestyle, which in turn are often associated with poor quality living conditions. There is evidence that the quality and accessibility of housing has an impact on individual's health and wellbeing. Some of the main findings in relation to housing are:

- The percentage of non-decent homes within Warrington is lower than the average for England
- There is an association between non-decent homes and household income levels with lower income households more likely to live in a non-decent home.
- The majority (76%) of Warrington households are owner occupied, the social rented sector makes up 16%, and private rented just over 7%.
- The supply of new homes has been buoyant in recent years, and the Local Development Framework (LDF) is seeking to encourage an average of 500 net new homes per annum within the Borough between 2006 and 2027.
- In keeping with national trends, average house prices in Warrington grew strongly between 2002 and 2007. The current average is £141,988, lower than the national average of £163,049.
- Affordability appears to be an issue in Warrington, for lower quartile incomes, the average price is between 5 and 6 times income. Coupled with higher required deposits many households are likely to have difficulty in accessing the owner-occupied market
- Based on the numbers of those on the housing waiting list, it appears that affordable housing supply cannot keep pace with demand. The same appears to be true of private rented sector.

**4.1d) Fuel Poverty** is related in part to the quality of housing. Fuel poverty has damaging effects on health and quality of life. Research identifies that certain groups are particularly vulnerable with regards to fuel poverty and the adverse effects of cold housing; these include older people, particularly those living on their own, lone parents, young children, disabled people and families where adult members are either unemployed or working on a low income. Cold housing is a health risk. There are numerous health effects of cold damp homes including hypothermia, heart disease, respiratory illnesses, and falls (due to a reduction in mobility). Cold is believed to be the main explanation for the 'excess winter deaths' occurring between December and March. Excess winter deaths caused by the cold can be prevented.

- There has been a substantial increase in fuel poverty in England; from 1.2 million households in 2003 to 4 million in 2009 (around 18.4% of all households). The increase is likely to continue, given the recent large increases in fuel prices.
- The percentage of households in fuel poverty in Warrington is slightly lower than the England average and quite a bit lower than the North West average.
- At a sub-Warrington level, fuel poverty appears scattered throughout the borough, including in some of the more affluent areas. However, when analysed by deprivation quintile, there is a strong association with deprivation.
- Local analysis has highlighted that Warrington has similar levels of Excess Winter Mortality to England and the North West. As is the case nationally, older people are at greater risk of winter mortality when compared to the rest of the population, especially older females.
- In Warrington the largest disease specific cause of excess winter death was respiratory disease, a pattern observed at national levels. Whilst the influenza virus is only partially associated with EWM ensuring high rates of annual influenza vaccine uptake amongst people aged over 65 years and those who are aged less than 65 years in at risk groups, such as asthmatics is an important public health measure.

- Older people are at greater risk of fuel poverty. Increases in older populations, coupled with rising fuel prices, and withdrawal of Government funding for Warm Front suggest that the prevalence and impact of fuel poverty may increase.

**4.1e) Worklessness** is a major determinant of people's health. Work improves mental health, reduces the likelihood of poverty, and enhances self-esteem. It is linked closely to both education achievement and skill base, but is very dependent of economic development. Tackling worklessness is not just about employment but it is about 'good' employment. Jobs need to be sustainable as well as be of good quality with regard to fair levels of pay, opportunities for development and be flexible to accommodate work and family life balance. Rates of unemployment tend to be highest amongst people with few qualifications, people with disabilities, carers, lone parents, older workers and ethnic minority groups. When in work these groups are likely to be further disadvantaged by being in low paid, poor quality jobs. Some of the main findings from the JSNA analysis include:

- Levels of worklessness in Warrington are lower than nationally and regionally: 20% of the Warrington working age population are economically inactive, this compares with 25.3% and 23.7% regionally and nationally.
- Warrington has lower rates of claimants for all out of work benefits individually, and in total (11.1% compared with 15.0% NW and 12.3% GB)
- Worklessness is an issue in Warrington, both because of its geographic concentration and as an indicator of wider disadvantage.
- The number of people claiming out of work benefits has increased from 9.9% in 2008 to 11.1% in 2011. The increase in out-of-work claimants was fuelled entirely by additional people claiming JSA.
- Worklessness has become entrenched in certain areas of the borough. Among these areas are the Closing the Gap (CtG) LSOAs. The gap between the CtG areas and the borough has remained largely unchanged since 2004. This shows that despite some attempts to target service delivery at areas with the highest levels of need, the outcomes for people living in these areas have not improved relative to the rest of the borough. This suggests that far greater targeting will be required to make a significant impact.

## 4.2 ADULT HEALTH AND LIFESTYLE

Individual lifestyle factors have an impact on health and wellbeing. This section of the JSNA looked at trends in some lifestyle and risk factors. Up to date analysis of local prevalence is limited as there is a need to update the comprehensive Health and Lifestyle Survey that was last undertaken locally in 2006.

**4.2a) Smoking** rates declined within Warrington between 2001 and 2006 and current prevalence is estimated to be 21.3%; similar to the average for England, however findings from the JSNA analysis highlight;

- Smoking attributable mortality in Warrington is significantly higher than the average for England.
- Both lung cancer mortality rates and the rate of new registrations for lung cancer are substantially higher in Warrington, than national averages.
- There is considerable variation in smoking prevalence rates across the borough and amongst different population groups. The overall pattern is consistent with deprivation.

- Trend analysis suggests that smoking prevalence is increasing amongst the most deprived populations locally.
- The numbers of Warrington people accessing Stop Smoking Services falls short of the NICE recommendation for services to aim to treat 5% of local smokers.

#### **4.2b) Alcohol and Substance Misuse:**

- Warrington has significantly higher rates of admission from alcohol *related* conditions when compared to England. Locally, as regionally and nationally, the rates are increasing year on year.
- Emergency admissions for alcohol *specific* conditions decreased slightly in 2010/11, likely to be in response to the focussed work in A&E.
- Hospital admission rates due to alcohol related harm are highest amongst more deprived populations.
- Admissions wholly attributable to alcohol have been increasing year on year in Warrington. Within Warrington, admission rates are significantly higher in the central wards when compared to Warrington overall.
- Women in Warrington have significantly higher mortality rates from Chronic Liver Disease compared to England.
- Hidden harm from alcohol is an issue which needs further work. Estimates suggest that there may be around 11,500 children in Warrington living with at least 1 binge drinker.
- Service information from the Drug and Alcohol Action team highlights that the majority of service users are unemployed and a substantial number are parents. This adds to the issue of hidden harm within Warrington.

**4.2c) Healthy Weight and Physical Activity:** The prevalence of obesity is increasing nationally, and projections suggest this is likely to continue, with an associated substantial impact on health. Key findings include:

- Current overweight and obesity levels in Warrington are estimated to be below the national average, but rates are increasing.
- Long-term projections suggest that by 2025 there may be almost 70,000 obese adults in Warrington.
- There are numerous adverse health effects of obesity, including heart disease, diabetes, asthma, heart failure and hypertension. Reported rates of all of these conditions except hypertension are higher in Warrington than nationally, (although the differences may not be statistically significant.) Although recorded prevalence of hypertension is currently lower than England, previous work suggests there may be substantial under-reporting.
- Warrington currently spend less than the Cheshire and Merseyside average on level 3 and 4 weight management services. Current spend is estimated to be almost £190,000 less than is needed.
- Although physical activity levels amongst children in Warrington are higher than the national average, levels appear to decline in adulthood.

### 4.3 BURDEN OF ILL-HEALTH

**4.3a) Life Expectancy:** is an over-arching measure of population health, and thus improvements in life expectancy and in the life expectancy gap are ultimate summary indicators of improvements to population health and health inequalities.

Key findings from the JSNA highlight that life expectancy within Warrington is increasing, and there is evidence to suggest that the internal inequalities gap for males is decreasing. However, some issues still need to be addressed in order to make further improvements:

- At 77.6 years, life expectancy for males in Warrington is lower than the England average of 78.3 years. Female life expectancy is also lower; 81.2 years, locally compared with 82.3 years for England.
- The biggest contributor to reduced life expectancy for males by far is coronary heart disease, which accounts for almost 51% of the gap in life expectancy between Warrington and England. Heart disease is also the major contributor for females, accounting for 24% of the gap.
- There are substantial differences in life expectancy within Warrington, with the pattern following the pattern of deprivation. For males there is a difference of 9.9 years between the most and least deprived 10% of areas within Warrington. For females the difference is 7.4 years.
- The gradient between the least and most deprived areas is a useful measure which can be used to compare local authorities. The gradient within Warrington for males is the **87<sup>th</sup>** highest (worst) of 324 local authorities. For females, Warrington has the **88<sup>th</sup>** highest gradient for life expectancy inequalities.

**Disability free life expectancy** in Warrington for young people in Warrington is slightly higher than the average for England. However inequalities between Warrington and England widen with increasing age. Intra-Warrington inequalities in disability-free life expectancy are substantial, with the internal inequalities gradient in Warrington higher than the average for England for females, and substantially higher for males.

**4.3b) Heart Disease** is one of the most important diseases due to its high premature mortality, overall mortality and disproportionate effect on more deprived groups. It is also highly preventable with increased risk attributed to poor diet, physical inactivity, alcohol and smoking.

- Within Warrington, death rates from all cardiovascular diseases (CVD) amongst the all age population are decreasing, but currently remain 17% above the average for England, and CVD is the biggest cause of reduced Life Expectancy within Warrington. CVD death rates amongst those aged under 75 years are 23% above the average for England.
- There is a strong association with socio-economic deprivation. Analysis has shown that the vast majority of 'excess' deaths in Warrington (relative to England) occur amongst people living in those local areas that are ranked amongst the 40% most deprived in England.
- In light of the health needs highlighted above and in the recent Health Profile<sup>1</sup>, there is an urgent need to consider the development of a comprehensive CVD

---

<sup>1</sup> [www.apho.org.uk](http://www.apho.org.uk)

strategy. This strategy and resulting commissioning development plan should consider evidence-based ways to address and reduce incidence and impact of CVD and Stroke in Warrington in order to both improve (1) health outcomes in relation to cardio-vascular disease and (2) resource impact of CVD.

**4.3d) Cancer** is the second most common cause of death nationally. It is also very costly to the NHS. Analysis has highlighted some encouraging findings for Warrington, with one of the main findings showing that overall cancer mortality rates are reducing in Warrington and are currently in-keeping with the average for England.

- The analysis has shown that the rate of incidence of cancer in Warrington is significantly lower than the rate for England<sup>2</sup>, ONS Cluster and the North West; however mortality rates are not significantly different to these areas.
- The incidence of lung cancer is significantly higher in Warrington when compared to the ONS Cluster. Incidence of lung cancer was significantly higher in some of the more deprived wards. Females from Warrington had a significantly higher mortality rate from lung cancer when compared to the ONS cluster.
- There are links between deprivation and mortality rates from cancer. As deprivation increases, the rate of mortality from cancer also increases.
- Cancer screening rates in Warrington are very good for cervical and breast. However, those GP Practices covering the most deprived 20% of the population have lower uptake rates for cervical, breast and bowel screening.
- Cancer staging data is incomplete. Where staging data was present, the percentage of cases that were diagnosed at a late stage was highest amongst older populations.
- Lung cancer survival in Warrington has been decreasing whilst nationally and regionally the rate had been increasing.
- Survival from colorectal cancer has increased at a faster rate in Warrington when compared to England.

**4.3e) Mental Health** is critical for the well-being and effective functioning of individuals, families, communities and society. Mental wellbeing is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care.

The incidence of mental illness is higher in deprived neighbourhoods. Income deprivation, low educational attainment, low skilled poorly paid employment and high proportions of self-reported ill health are all associated with higher levels of poor mental health. Physical health and well-being are also affected.

In Warrington, it is estimated that in 2009/2010 there were just over 1,500 residents in Warrington with a diagnosis of a severe and enduring mental illness. This group are at increased risk of coronary heart disease, diabetes, infections and respiratory disease. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease. A person with a diagnosis of schizophrenia can expect to live for ten years fewer than someone without a mental health problem.

---

<sup>2</sup>The decreasing cancer incidence rates require further investigation to ensure there are not data quality issues.

Individuals with depressive disorders are also affected by higher levels of physical illness and are approximately twice as likely to develop coronary artery disease, twice as likely to have a stroke and four times as likely to have a myocardial infarction as people who are not depressed.

Some of the other analysis findings highlight:

- Statistical modelling suggests there may be some under-reporting or under-diagnosis of common mental illnesses at GP Practice level
- The number of Warrington residents with a serious mental illness is higher than modelled prevalence estimates suggest might be expected.
- There is some (limited) evidence available locally to highlight the co-morbidity with physical ill-health
- There has been a substantial increase in the number of people recorded as being in receipt of social services for a mental health related issue.
- Prevalence models suggest there may be current under-reporting or under-diagnosis of dementia. GP reported current prevalence is 996, modelled estimates suggest actual prevalence may be almost 2,100
- The impact of an aging population is substantial, with the number of Warrington residents with dementia forecast to rise to between 3,400 and 3,900 by 2026.

#### **Population Groups at greater risk of poor health outcomes**

Older people, children and young people are more vulnerable to experiencing poor health than the general population. These groups are more susceptible to ill-health due to poorer immune systems. The very young (and very old) can lack the ability to take care of themselves. Adolescents are at higher risk of poor mental health and sexual health. Older people can easily become socially isolated leading to greater risk of mental health and injury. The sections of the JSNA refresh look in-depth at issues affecting children and young people, and vulnerable adults and older people.

#### **4.4 CHILDREN AND YOUNG PEOPLE**

**Children & Early years:** Experiences in childhood are important due to the effect they have on behaviours, attitudes and choices into adulthood. This has been championed by Professor Sir Michael Marmot in his 2010 Report “Fair Society, Healthy Lives: strategic review of health inequalities in England post-2010”. This report recommends greater support to families from pregnancy to birth and early child development. Examples include reducing smoking in pregnancy, increasing breastfeeding rates and improving parenting support through children centres and key workers.

##### **Infant mortality**

- The number of infant deaths each year is very small, and Warrington currently has an infant mortality rate of 4.5 deaths per 1000 live births. This is lower than the rate for England. There is variation within Warrington however due to very small numbers, it is impossible to calculate robust local level rates. In light of this it is useful to use other indicators of infant health such as the prevalence of low birth weight births, breastfeeding initiation and smoking in pregnancy.
- Overall, the percentage of mothers smoking during pregnancy is low in Warrington. However, high rates of smoking during pregnancy have been observed in the more deprived areas of the borough.

- Low birth weight births in Warrington have remained relatively stable over previous years, and the rate in Warrington is consistently lower than England and the North West.
- Warrington has lower breastfeeding initiation and continuation rates when compared to national figures. Initiation rates are very low in the more deprived areas of Warrington.

### **Childhood Immunisation**

- The MMR uptake in Warrington does not meet the nationally set target of 95% (2010/11). However, during 2009/10 Warrington had a significantly higher immunisation rate when compared to England.
- Locally, GP practices serving the most deprived 20% of the population had the lowest uptake of MMR.
- The uptake rate for the pre-school booster was low in Warrington during 2010/11. All deprivation quintiles failed to achieve the 95% target; however, Practices serving the most deprived 20% of the population had the lowest uptake rate.

### **Healthy Weight**

- Participation in the National Child Measurement Programme was very high in Warrington during 2009/10
- The percentage of children classed as obese in Reception (8.5%) and Year 6 (16.7%) was significantly lower than England and the North West – Warrington had the lowest percentage of Year 6 children classed as either overweight or obese in the North West during 2009/10
- In Warrington obesity was more prevalent in boys
- A link between deprivation and obesity prevalence has been identified, obesity prevalence is higher in the more deprived areas of Warrington
- 47% of girls and 25% of boys wanted to lose weight

### **Teenage conception rates and sexual health**

- Teenage parents and their children are at an increased risk of living in poverty, low educational attainment, poor housing and health and have lower rates of economic activity in later life.
- Teenage conception rates in Warrington increased in 2009. Despite this annual increase, the long-term trend shows a reduction. In fact, since the 1998-00 period, measured on a 3-year rolling average, the percentage decrease in Warrington is significantly better than national and regional averages.
- Teenage conception rates are linked to deprivation, with more deprived areas experiencing higher conception rates
- Young adults are generally disproportionately affected by STI's
- Warrington had the 2nd highest chlamydia diagnosis rate in Cheshire and Mersey

### **Unintentional injuries**

- The rate of admissions to hospital due to injury for those aged under 17 years has decreased over recent years; however, Warrington currently has a significantly higher admission rate than England.
- Admission rates are significantly higher in the more deprived areas, with the inner wards of Warrington experiencing significantly higher rates of admission compared to Warrington overall.

## Alcohol

- The trend in the rate of alcohol related admissions amongst under 18's has been reducing in Warrington. However, rates are currently significantly higher in Warrington than nationally; Warrington's rate is currently 38th highest in England.
- The Trading Standards North West Surveys suggest that the proportion of local young people attempting to purchase alcohol has decreased; from; 22% of those surveyed in 2007 to 18% in 2009.
- In addition to the direct impact of alcohol on an individual's health, there is the associated, but often hidden, problem of the harm to children of parents with alcohol or substance misuse related problems. There is currently a lack of robust data on the prevalence of hidden harm amongst children and young people locally. Applying the national estimates to the Warrington population suggests that there may be around 11,500 children in Warrington living with at least 1 binge drinker, and just over 2,200 with a dependant drinker.

## Oral Health

- Dental health of the population is improving both in the country as a whole and also in Warrington, but improvement in dental health amongst the youngest children has stalled. It is important that efforts are made to address this problem. There is variation in oral health amongst children in Warrington, with the pattern following the pattern of deprivation. This dental health inequality also needs addressing. Finally, older adults are retaining their natural teeth well into old age. These older cohorts will require extensive dental support if their dental health is to be maintained.
- The information provided in this report is presented as an overarching summary of the more detailed commentary which was produced for the JSNA refresh chapters this year. As such we would expect this document to work as a stand-alone report for those who wish to see a summary with the background commentaries and data available.

## 4.5 OLDER PEOPLE

Within Warrington the proportion of the population aged over 65 is currently slightly smaller than the regional and national averages, however it is expected to grow more rapidly, and by 2030 Warrington's it is anticipated that the local population aged over 80 years will have doubled.

### 4.5a) Illness in Old Age

Age is a risk factor for most diseases, with prevalence rates of most conditions rising with increasing age. Most chronic or long term conditions are more prevalent amongst older people, and mobility issues associated with arthritis put older people at a greater risk of falls. Some mental health problems, notably dementia, are most common among older people, and analysis suggests prevalence of this will increase significantly. Other important conditions affecting older people are depression, falls, sometimes leading to fractured femur, and arthritis.

### 4.5b) Deaths in Old Age

Mortality rates increase with increasing age and vary by gender. Age specific mortality rates for Warrington show that locally older people experience a greater excess burden of ill-health compared with the average for England, and the health of older people

across Warrington as a whole is worse than the national average (as measured by mortality rates).

The excess death rates in Warrington amongst the older population make a substantial contribution to the gap in life expectancy between Warrington and England. The most substantial contribution to the gap is amongst the 70+ age groups, and the excess burden in these groups far exceed the average for other areas experiencing similar levels of disadvantage to Warrington<sup>3</sup>.

In all people aged 65+, the most common broad underlying cause of death is circulatory diseases (37%), followed by cancer (25%) and respiratory diseases (16%).

#### **4.5c) Use of Health Services by older people**

Older people attending A&E are more likely to be admitted to hospital, than those in younger age groups. Within Warrington unplanned admissions in the population as a whole are currently 25% higher than the average from England. Amongst the population aged over 65 rates are approximately 27% higher and trend analysis shows that rates have been increasing over recent years. Since 2001, rates within Warrington have been significantly higher than England, with rates increasing further over the last 3 financial years (2008/09 to 2010/11).

Some of the reasons for admission which are significantly higher than England include: Injuries and Poisonings (1397 admissions; 50% higher than England), circulatory (1653 admissions; 18% higher) and respiratory (1311 admissions; 12% higher).

#### **4.5d) Disability free life expectancy**

By age 65, Warrington males can expect a further 9.4 years life expectancy free from disability. Warrington females can expect to have a further 9.9 years of disability-free life expectancy. Disability-free life expectancy within Warrington is lower than the average for England. This is in contrast to disability free life expectancy at age 16, which is higher in Warrington than the average for England, highlighting the widening inequalities gap associated with increasing age.

---

<sup>3</sup> Defined as the 'Spearhead Group'

## **5. EMERGING PRIORITY THEMES**

This section provides further detail on the suggested priorities for future strategy development and commissioning in Warrington based on the substantial review of healthcare, social care and health improvement needs of our population. These are not currently recommendations for realigned, additional or new investment. Those recommendations will follow further strategy and commissioning plan development. These priorities are indicating a number of areas which the new Joint Health and Wellbeing Strategy should concentrate on and which Warrington Borough Council, NHS Warrington and Warrington Commissioning Consortia should include in future commissioning plans. A case could be made for a much longer list of priorities but limited budgets suggest a concentration of effort on a small number of major priorities.

**Marmot Policy Review Areas:** We have emphasised the need to link these priorities to the Marmot Review of Inequalities which produced a number of guiding principles. These are:

- a. **Give every child the best start in life**
- b. **Enable all children young people and adults to maximise their capabilities and have control over their lives**
- c. **Create fair employment and good work for all**
- d. **Ensure healthy standard of living for all**
- e. **Create and develop healthy and sustainable places and communities**
- f. **Strengthen the role and impact of ill health prevention.**

The overarching draft priorities for Warrington are to:

### **Reduce inequalities in Life Expectancy**

Although life expectancy is improving, Warrington males and females currently experience lower life expectancy than the average for England. There is also considerable variation within Warrington, with the more deprived wards experiencing substantially lower life expectancy.

Looking at the diseases which impact on life expectancy we find a similar pattern and previous analysis undertaken as part of the Joint Strategic Needs Assessment (2009) found that 91% of the 'excess' CVD deaths were amongst people living in those local areas that are ranked amongst the 40% most deprived in England. Similarly, there are links between deprivation and mortality rates from cancer. As deprivation increases, the rate of mortality from cancer also increases.

### **Links to Marmot principles; d, e and f.**

#### **Promote Healthy lifestyles**

It is clear from many of the data sets reviewed that some Warrington people need considerable support in changing to a healthy life style. The evidence in the JSNA indicates that although smoking prevalence appears to be declining, smoking is the most significant behaviour contributing to poor health and wellbeing in Warrington. Most smokers wish to stop and there are interventions which are proven to be effective. Evidence also suggests that greater investment in interventions to 'de-normalise' smoking and to deter young people from starting smoking would have substantial impact

on future prevalence rates. The JSNA evidence also indicates that obesity, and its two major components – diet and physical activity, are also major issues. Alcohol is another key issue and the high mortality rate for chronic liver disorders in women is of particular concern.

The JSNA intelligence clearly shows that there are some places, communities and groups of people where needs are greater and behaviours more entrenched. The strategy needs to acknowledge that interventions to improve health and wellbeing and reduce inequalities in these areas, need to be appropriately targeted and scaled. It also needs to be recognised that more intensive resource and alternative approaches are likely to be required.

#### **Links to Marmot principles a, b, e and f.**

##### **Improve health and wellbeing for older people & vulnerable groups**

The data illustrates that the proportion of older people living in Warrington will increase substantially over the next decades. This, coupled with the fact that the working age population is projected to grow at a considerably smaller rate will have considerable impact on service provision. Older people within Warrington experience poorer health and suffer a greater burden of excess deaths. Priorities for action need to take account of the likely impact of the aging population on health and social care provision, benefits and pensions, housing and transport, and also on prevention of ill-health, and the promotion of independence, wellbeing and quality of life.

#### **Links to Marmot principles b, c, d, e and f.**

##### **Deliver high quality systematic care for major causes of ill health**

The review of all major illnesses illustrates the benefits of prevention, early diagnosis and good management of risk factors and the condition itself. There is clear evidence that systematic care with defined care pathways and protocols which utilise effective interventions will produce better outcomes. The JSNA provides evidence that systematic prevention and care is not universally available in Warrington. For instance, within Warrington, death rates from CVD amongst the all age population are currently 17% above the average for England and premature CVD mortality rates are 23% above the average for England and yet we have not invested sufficient funds in our health checks programme.

We must ensure we have in place systematic programmes of risk identification and management for long-term conditions and other major diseases such as heart disease, stroke, and cancer. The Warrington Strategy is a mechanism to achieve this.

#### **Links to Marmot principles d and f.**

##### **Improve health and reduce health inequalities for children**

Whilst the educational achievements, participation in exercise and the health of children in Warrington are generally good, the commentaries point to significant inequalities which we have to address to give all children the best start in life. The evidence contained in the JSNA points to deprivation and poverty being major drivers of health inequalities in children. Alcohol harm amongst young people is a significant issue which needs addressing. In looking to the future, the projected trend in childhood obesity

needs consideration now to ensure that Warrington's rates do not follow national trends. In addition, preventative work to 'de-normalise' smoking and discourage children and young people from starting smoking needs a greater focus, and this will help achieve long term reductions in prevalence. There is a lack of analysis in regard to mental health and the emotional well-being of children that needs to be addressed.

#### **Links to Marmot principles a, b, c, d, e and f.**

##### **Growing Sustainable Healthy Communities**

A major misconception is that health and ill-health is primarily the business of the health sector. Certainly, the health sector has a vital role to play in tackling the misdistribution of services and access to them (the so-called 'inverse care law') as this is one of the social determinants of health. But the key drivers that account for people's poor health in large part lie in the 'conditions in which people are born, grow, live, work, and age'. We know that healthy places grow healthy people, and that factors such as fair employment and decent working conditions contribute to health and well-being.

As discussed, worklessness is a highly significant determinant of people's health. And findings from the JSNA indicate that in certain parts of Warrington this is a major issue for health and wellbeing. Other issues identified include: housing affordability, fuel poverty, and the wider factors that promote healthy lifestyles. This thematic area links strongly to reducing health inequalities between geographic communities and communities of interest, for example older people.

#### **Links to Marmot principles c, d and e.**

**The table on page 17 shows the links between these suggested priorities for Warrington and the Marmot principles. A comprehensive set of specific priorities to support these thematic priorities can be found in Appendix 1.**

During the engagement events a number of other suggestions for priorities will be made. These will be captured and fed back in the final report.

**Table 1: Suggested priorities linked to Marmot policy objectives**

	<b>Give every child the best start in life</b>	<b>Enable all children young people and adults to maximise their capabilities and have control over their lives</b>	<b>Create fair employment and good work for all</b>	<b>Ensure healthy standard of living for all</b>	<b>Create &amp; develop healthy &amp; sustainable places &amp; communities</b>	<b>Strengthen the role and impact of ill health prevention</b>
Priority 1: Reduce life expectancy differences	😊			😊	😊	😊
Priority 2: Promote Healthy life styles	😊	😊			😊	😊
Priority 3: Improve health & well-being for older people		😊		😊	😊	😊
Priority 4: Deliver high quality systematic care for major causes of ill-health				😊		😊
Priority 5: Improve health and well-being and reduce health inequalities for children and young people	😊	😊	😊	😊	😊	😊
Priority 6: Grow Healthy Communities			😊	😊	😊	

We have attempted to ensure that the suggested priorities for future strategy development are evidence based and can clearly be linked to the content of this report as well as to the wider commentaries and data which informed this report.

## **6. FUTURE PLANS FOR THE JSNA**

It is clear that the need to produce a JSNA will continue to be a requirement placed upon the council and its partners. It will become an increasingly important tool used to support closer working across health, social care, community and voluntary services.

Increasing the level and quality of engagement with the community will support the development and improvement of the JSNA. Crucially, by allowing a range of partners to both support and challenge the way the JSNA is produced, what it tells us about our community, and how it influences commissioning of services in the future, will only serve to enhance the quality of the JSNA over the coming years.

With that in mind the JSNA will continue to be a process of continuous development and improvement. In the engagement carried out to date there are already a number of areas where improvements have been suggested and whilst these have not been agreed or prioritised yet they include the following suggestions:

- Inclusion of more qualitative information such as data from well conducted and robust research.
- Further development of community asset mapping as part of JSNA approach (asset mapping finds out the value of what works well in an area and seeks to promote that activity further)
- Implementation of a Strategic Development Group to oversee on-going improvement and report progress to Health and Wellbeing Board;
- Alignment of JSNA with other needs assessments, e.g. Economic Assessment, Consortia Profiles, Child Poverty Needs Assessment etc.;
- Improvement to data quality including a more formally agreed process, and quality control criteria
- Development of the presentation of the JSNA, including further development of local profiles such as GP area profiles and area profiles.

A key test of the JSNA will be not about assessing content or how well written the document is, but an assessment of how the JSNA is used to impact on the commissioning of services. In order to assess the usefulness of the JSNA in future, Warrington Health and Wellbeing Board may choose to monitor the degree to which the JSNA impacts on commissioning, for example:

- What services have been commissioned or decommissioned as a result of JSNA or subsequent analysis?
- What has been the impact on use of resources, i.e., has money followed need?
- What are been the impact on health inequalities?
- What has been the impact on prevention/treatment ratio?

## APPENDIX 1: THEMATIC PRIORITIES WITH PLANNING PRIORITIES

Cross cutting priorities	Thematic Priorities			
	Priority 1: Promote healthy lifestyle	Priority 2: Promote health and well-being for older people and vulnerable groups	Priority 3: Improve health & well-being of children and young people	Priority 4: Grow healthy, sustainable communities
<b>CC1: Improving Healthy Life Expectancy</b>	Reduce levels of modifiable risk factors associated with CVD	Reduce levels of modifiable risk factors associated with CVD  Reduce impact on alcohol on older people	Reduce levels of young people who start to smoke  Increase rates of breastfeeding	Focus on the wider determinants of health especially deprivation and social exclusion
<b>CC2: Reduce health inequalities</b>	Reduce levels of smoking especially in deprived areas Reduce impact of alcohol in women, deprived groups	Reduce reliance on unscheduled care  Improve housing quality and support appropriate adaptations to maintain people in their own homes  Reduce fuel poverty  Recognise the value and support carers	Reduce levels of young people who start to smoke especially targeting more deprived areas and young parents Reduce levels of smoking in pregnancy  Increase rates of breastfeeding in deprived areas  Reduce the number and rate of teenage conceptions in deprived areas  Safeguard vulnerable children in families affected by alcohol or drugs  Promote sexual health	Provide an environment that promotes healthy lifestyles and healthy behaviours.  Reduce worklessness by providing opportunities for employment and skill development  Protect victims of domestic abuse  Work in partnership to prevent crime
<b>CC 3: Deliver efficient and effective high quality evidence-based systematic care</b>	Ensure all interventions used to promote healthy lifestyle are evidence based and outcome focused.	Support those affected by dementia/promote early detection and provide effective services  Prevent falls by ensuring an integrated falls strategy is in place  Develop integrated care for Long Term Conditions	Promote mental health and emotional well-being in children and Young People  Develop evidence-based integrated sexual health services	
<b>CC 4: Prepare for the future</b>	Develop an integrated CVD strategy to improve prevention,	Support provision of personal budgets to empower people to make decisions about their own care.  Plan for an aging population especially those with		Develop strategies to promote affordable housing (rental and other).

	<p>treatment and care of individual at risk or with established disease</p> <p>Engage with communities and individuals to explore the reasons for unhealthy behaviours and address using social marketing and other evidence-based approaches</p>	<p>complex needs, multiple LTCs or elderly carers</p> <p>Model needs of adults with learning, physical and sensory disabilities to help respond effectively to future need.</p>		
--	---	---	--	--