Staffordshire Enhanced Joint Strategic Needs Assessment

The Staffordshire Joint Strategic Needs Assessment
July 2013
Staffordshire Enhanced Joint Strategic Needs Assessment

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1  Forward

Staffordshire has seen some key successes in health and wellbeing over recent years. Overall the health of the population is improving and reductions in early deaths in Staffordshire are amongst the best in England, particularly in CVD and COPD.

There still however remain some key health and wellbeing challenges across the life course of the county’s population, mainly due to risky lifestyle behaviours and the ageing process. Smoking in pregnancy rates have risen in Staffordshire in contrast to trends across England, and breastfeeding rates are lower than for England as a whole. Incidence of cancer, alcohol admissions, adult obesity and sexually transmitted infections are all increasing. The increasing older population is leading to increases in number of falls, number of long term conditions, and cases of dementia. Thus, the need to focus on dual actions that ensures prevention and behaviour changes as well as early intervention and provision of high quality care remains a key priority within the County.

In areas where Staffordshire compares well to other areas, analysis at a district level identifies additional challenges. These additional challenges disproportionally affect people living in Staffordshire’s most deprived areas and are associated with the wider determinants of health including income, housing, transport, education, crime and social isolation. Reducing the impact of these factors on people’s health should be at the core of the emerging health and wellbeing priorities of the County.

Our bottom up approach to the development of the eJSNA (from local districts councils to the county) is an indication of the Staffordshire HWB Board’s recognition and commitment to producing a comprehensive and relevant needs assessment for better health and social care across the County.

We wish to thank all partners and particularly the District and Borough councils and CCGs for coordinating and developing their locality focussed JSNAs. These have not only help in using the information and intelligence on the health and social needs of their residents, but also provided relevant local knowledge to build on the development of the comprehensive countywide JSNA.

We are commitment to ensuring that the information and intelligence contained in this eJSNA is used by the Health and Wellbeing Board to inform the development of its Joint Health and Wellbeing Strategy – Living Well in Staffordshire – Keeping you well, making life better.

Professor Aliko Ahmed
Director of Public Health

Councillor Robbie Marshall
Cabinet Member for Health and Wellbeing
Joint Chair Health & Wellbeing Board

Dr Johnny McMahon
Chair Stafford and Surrounds CCG
Joint Chair Health & Wellbeing Board
2 Summary

Staffordshire is a county characterised by a diversity of people and place. As a large county, covering a range of rural and urban settings, Staffordshire’s communities compare well with the rest of the West Midlands and England.

Residents tell us they feel proud of their heritage and are happy to live in an environment rich in natural beauty and full of economic potential. Health and wellbeing is important to them. When asked to describe their main measure of quality of life, top priorities include being fit and healthy, having access to strong social networks and having the ability to be a productive member of their local community.

Staffordshire’s population has changed considerably over the last decade. We now have an older population, with a 25% increase in the number of people aged 65 and over in the ten years between 2001 and 2011. This is greater than the national rate of change.

The county is also more ethnically diverse, with an increase in the black and minority ethnic population, which now includes around 86,500 people, roughly 10% of the total.

These demographic changes have contributed to a changing health and wellbeing profile for the county.

Although the overall health of the population has improved in recent years, with people living longer and fewer people dying from major illnesses, significant inequalities exist across the county. Life expectancy rates vary by up to 12 years between different areas and communities.

The nature of community needs has also changed, with increased demand for support with long-term conditions, vulnerability to becoming a victim of crime, mental illness, substance misuse and increased rates of obesity.

In particular, an ageing population has required a shift to support people to maintain an independent life, with greater scope for modern technology to help them remain in their own homes.

The economic structure in Staffordshire has also changed considerably in recent years, along with ways of working and patterns of employment. Manufacturing remains a key sector for the county, but the public sector now provides around a fifth of all jobs. There has also been growth in rural employment, with an increase in the range of industries represented, as well as the number of roles.

These changes have seen an increase in part-time working and also a rise in youth unemployment, which continues to be the focus of national and local economic development strategies.
Crime and anti-social behaviour continue to fall in Staffordshire, but there is still more to be done.

‘Troubled families’ cost taxpayers well over £100m a year in Staffordshire, and pressure on limited budgets is increasing, with more children living in poverty and more looked after children.

Inadequate housing causes, or contributes to, many preventable diseases and injuries, including respiratory, nervous system, and cardiovascular disorders, and cancer, as well as mental health and wellbeing. At a national level, it is estimated that poor housing costs the NHS at least £600m per year.

Although the rate of house building has fallen over the past six years, the provision of affordable housing in Staffordshire has increased annually since 2007 (other than between 2011 and 2012). House prices in Staffordshire fell by 1.2% between 2012 and 2013, suggesting that more accommodation is available for families and individuals. This is supported by an increasing number of sales. Nonetheless, national data suggests that homelessness rates are continuing to rise and affordability remains an issue, particularly in rural areas.

Based on figures from 2012, 22% of households in the West Midlands are in fuel poverty, higher than any other English region. This rate is higher in rural households (24%) and higher still in households where adults are unemployed.

A key driver of housing need within any given area is population change. A bigger population increases the need for housing and jobs to support it, alongside the full range of community and commercial services. District and borough council spatial strategies are being developed to take account of changes to our population.
3 Introduction: An Enhanced Joint Strategic Needs Assessment - the Staffordshire approach

The purpose of the Joint Strategic Needs Assessment is to analyse and examine the current and future health and wellbeing needs of the local population and to inform and guide the commissioning of health, wellbeing and social care services. It should inform the priorities of the Health and Wellbeing Board’s Health and Wellbeing Strategy and provide a shared evidence based on a consensus of the key local priorities across health and social care for Staffordshire. The JSNA is an essential part of the commissioning cycle, guiding decisions made at all stages from strategic planning and service provision through to monitoring and evaluation. (Figure 1)

**Figure 1: The role of the E-JSNA across the commissioning cycle**

![Diagram showing the commissioning cycle with steps for Strategic Planning, Monitoring and Evaluation, Procuring Services, Review opportunities for joint action, Decide priorities, Assess needs, Designing shape and structure of supply, Planning capacity and managing demand, Seeking public and patient views, Supporting patient choice, Managing performance.]


The Health and Social Care Bill 2011 created a central role for the JSNA as the primary focus for local leaders to identify local health and social care needs, and building a robust evidence base on which local commissioning plans can be developed. Upper tier local authorities and clinical commissioning groups have an equal and explicit obligation to produce a JSNA - a duty which should be discharged through the Health and Wellbeing Board. The board brings together partners from across the NHS, local government and other partners including the voluntary sector to analyse current and future health needs of populations and to produce a joint health and wellbeing strategy informed by the JSNA to guide the commissioning of health, wellbeing and social care services in a local authority area.
The JSNA is not new - it has been a statutory responsibility jointly held by the NHS and upper tier local authorities since 2007 and we have used intelligence from a range of sources to inform the JSNA process. This includes information about the population, housing, employment, the effects of lifestyle on health, prevalence of diseases, services used and their effectiveness, community perspectives and other local data from a variety of sources. However, our approach to date has been ‘needs’ or deficit led, concentrating on negative aspects of health and wellbeing. Our vision for the 2012/13 JSNA was to enhance this intelligence, based on current guidance on the production of JSNAs and joint Health and Wellbeing Strategies, to produce an ‘enhanced’ JSNA, or EJSNA for Staffordshire.

Staffordshire is a two tier local authority and the guidance has been interpreted locally by using information and intelligence at both a lower and upper tier authority level in order to identity needs at the appropriate population level. Following an agreement by all Staffordshire Chief Executives each of the eight districts and boroughs agreed to produce their own EJSNA. These eight EJSNAs pull together a wide range of information to give a rich ‘picture of place’, building on existing intelligence. Each district was asked to enhance their needs led JSNA intelligence by:

- Adopting an asset based approach in parallel to the more familiar needs led approach. An asset approach looks beyond needs to examine how local assets, including the local community itself, can be used to meet identified needs. This approach generates energy and makes best use of all available resources but also stimulates innovation for example through joining up services to find local solutions to address local needs.

- Providing a focus on the wider social determinants of health - including factors which influence health and wellbeing such as housing status, work status, or support from families and friends, plus wider social, environmental and economic factors that impact on health and wellbeing such as opportunities for physical activity, housing type, community safety and working conditions.

- Including more intelligence based on the community voice by involving people who access or potentially could access services in the area.

See Section 7 and Appendix 1 for a summary of each of the district and borough EJSNAs.

In addition, a Staffordshire wide perspective ensures that the Staffordshire EJSNA is as comprehensive an assessment of needs as possible by capturing needs that are not highlighted in the district EJSNAs, for example vulnerable groups, carers, people with disabilities.

1 JSNAs and Joint Health and Wellbeing Strategies - Guidance. Department of Health January 2012
This report provides a summary of the information and intelligence already available on the health and social care needs of Staffordshire residents from our Joint Strategic Needs Assessment (JSNA) evidence base. This information and intelligence informs the Health and Wellbeing Board about the current picture of needs and provides a robust evidence base on which to agree the priorities to be included in the Joint Health and Wellbeing Strategy.

The report is a summary - it does not contain detail about the health and social care needs highlighted. For further detail, refer to the documents referenced in Section 8.
Life expectancy in Staffordshire

Overall the health of the population is improving - particularly deaths in the under 75 age group which are considered to be preventable. Reductions in mortality rates in Staffordshire are amongst the best in England - premature mortality rates for cardiovascular disease and overall mortality from chronic obstructive pulmonary disease (COPD) are amongst the best 20% (quintile) of values in England whilst premature deaths from all causes and cancer are in the second best quintile\(^2\). Overall life expectancy in Staffordshire is 79.1 years for a man, and 82.9 years for a woman\(^3\) which are both similar to the England average. A focus on life expectancy in older age shows that, although in some cases these differences are not statistically significantly different from the England average, there is room for improvement in keeping older people healthy.

**Table 1: Life expectancy at age 75 in Staffordshire, 2009-2011 (provisional)**

<table>
<thead>
<tr>
<th></th>
<th>Life expectancy at age 75 (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>Cannock Chase</td>
<td>11.2</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>11.0</td>
</tr>
<tr>
<td>Lichfield</td>
<td>11.0</td>
</tr>
<tr>
<td>Newcastle-under-Lyme</td>
<td>11.1</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>10.8</td>
</tr>
<tr>
<td>Stafford</td>
<td>11.5</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>11.4</td>
</tr>
<tr>
<td>Tamworth</td>
<td>11.3</td>
</tr>
<tr>
<td><strong>Staffordshire</strong></td>
<td>11.2</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td>11.5</td>
</tr>
</tbody>
</table>

Figures in **bold** and *italics* are statistically significantly lower than the England average

*Source: Death extracts, Office for National Statistics, Population estimates for lower level super output areas, Office for National Statistics, Crown copyright*

\(^2\) This relates to changes in rates between 1995-1997 and 2008-2010  
\(^3\) Provisional estimates for life expectancy based on death rates between 2009-2011
4.1 Inequalities in life chances in Staffordshire

“Inequalities are a matter of life and death, of health and sickness, of wellbeing and misery. The fact that today people in different social circumstances experience avoidable differences in health, wellbeing and length of life is, quite simply, unfair. Inequalities in health arise because of inequalities in society - in the conditions in which people are born, grow, live, work and age.”

The most important determinants of whether an individual will live a long and healthy life are the circumstances, in which they are born, grow up and live. Table 2 illustrates the differences in life experience and health outcomes amongst those living in the least and most deprived parts of Staffordshire. The differences are stark. These inequalities in life chances can persist as inequalities into old age and poor life chances lead to unhealthy lifestyles which can bring on early onset of disease, severe disease and death.

---

4 Fair Society, Healthy Lives, Marmott Review
Table 2: Inequalities in Staffordshire: comparison of babies born in the least deprived and most deprived areas in Staffordshire

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Least deprived</th>
<th>Most deprived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Claim incapacity benefit</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Have a limiting long term illness</td>
<td>15%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Smoke</td>
<td>16%</td>
<td>34%</td>
</tr>
<tr>
<td>Education</td>
<td>Get a least five GCSEs A*-C</td>
<td>71%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>16-18s not in education, employment or training</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Claim free school meals</td>
<td>3%</td>
<td>26%</td>
</tr>
<tr>
<td>Work</td>
<td>Become a professional or manager</td>
<td>40%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Are employment deprived</td>
<td>5%</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>Live on benefits</td>
<td>6%</td>
<td>24%</td>
</tr>
<tr>
<td>Home and family</td>
<td>Live in poverty as a child</td>
<td>5%</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>Live in income deprived households as an adult</td>
<td>4%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Go home to a council house</td>
<td>3%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>Are part of a lone parent family</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Have no access to a car or van</td>
<td>8%</td>
<td>38%</td>
</tr>
<tr>
<td>Experience of crime</td>
<td>All crime</td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Anti-social behaviour</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Burglary</td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td></td>
<td>Deliberate fire</td>
<td>0.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>Live alone as a pensioners</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Live in poverty when they are aged 60 and over</td>
<td>8%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Live to the age of (for men)</td>
<td>81</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Live to the age of (for women)</td>
<td>85</td>
<td>79</td>
</tr>
</tbody>
</table>

Data analysed and compiled by Public Health Intelligence, Public Health Staffordshire

4.2 Life expectancy and healthy life expectancy
The consequence of the inequalities identified in Table 2 is illustrated in Figure 3 which shows that men and women living in the most deprived areas of Staffordshire live eight and seven years less than those living in less deprived areas.

Other significant inequalities in life expectancy are:

- Men have a life expectancy of 79.1 years while women have a life expectancy of 82.9 years.
- Men in East Staffordshire have a life expectancy that is 13 months less than the England average, whilst women in Newcastle-under-Lyme have eleven months less life expectancy.
- Overall there is a 5.6 year difference between the average life expectancy of a man in East Staffordshire, compared to a woman in Stafford.
Gains in life expectancy should also be accompanied by gains in healthy life expectancy. Currently in Staffordshire, healthy life expectancy is estimated to be 69 years for men and 72 years for women. However there are also inequalities in the time lived in poor health. In Cannock Chase, Newcastle-under-Lyme and Tamworth men and women spend more time living in poor health compared to the England average.
The health of Staffordshire residents

- Section 7 summarises some key statistics about each stage of the disease pathway, starting with the main causes of death for Staffordshire residents. The story of the health of Staffordshire residents can be summarised as follows:

- Each year, around 8,000 people die, mainly from cardiovascular disease, cancer and respiratory conditions. Many of these diseases are preventable. Deaths before the age of 75 are considered to be preventable and in 2011, 2,500 deaths were to residents under the age of 75 (see section 7.2).

- Each year 127,000 Staffordshire residents are admitted to hospital. Around a fifth of these admissions are to people aged 75 or over.

- During 2011/12, 56,700 Staffordshire residents were admitted to hospital as an emergency (unplanned) admission. Around a quarter of emergency admissions are for people aged 75 or over and on average around a fifth of people aged over 74 in Staffordshire had one or more emergency admissions to hospital during the year. On average each patient aged over 74 was admitted 1.5 times. Around 7% of the population were admitted at least once and 2% (13,600) were admitted more than once.

- The most common cause of an unplanned admission was for an unknown condition (signs, symptoms and ill-defined conditions), and a just under a fifth of emergency admissions are recorded to this cause. This is followed by injuries and poisonings (15%) many of which will be due to the effects of alcohol, and respiratory conditions (13%). Circulatory diseases make up 11% of unplanned admissions. Therefore, these four causes, many of which are preventable, make up nearly 60% of unplanned admissions to hospital each year. See Section 7.3.

Table 3: Top diagnoses in top four causes of unplanned admissions, 2011/12

<table>
<thead>
<tr>
<th>ICD10 code</th>
<th>ICD10 diagnosis</th>
<th>Admissions</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R074</td>
<td>Chest pain, unspecified</td>
<td>2,050</td>
<td>3%</td>
</tr>
<tr>
<td>R104</td>
<td>Other and unspecified abdominal pain</td>
<td>1,890</td>
<td>2%</td>
</tr>
<tr>
<td>R074</td>
<td>Signs, symptoms and ill-defined conditions</td>
<td>14,870</td>
<td>19%</td>
</tr>
<tr>
<td>S720</td>
<td>Fracture of neck of femur</td>
<td>700</td>
<td>1%</td>
</tr>
<tr>
<td>S099</td>
<td>Unspecified injury of head</td>
<td>540</td>
<td>1%</td>
</tr>
<tr>
<td>S720</td>
<td>Injury, poisoning, &amp; other external causes</td>
<td>11,850</td>
<td>15%</td>
</tr>
<tr>
<td>J22X</td>
<td>Unspecified acute lower respiratory infection</td>
<td>1,470</td>
<td>2%</td>
</tr>
<tr>
<td>J181</td>
<td>Lobar pneumonia, unspecified</td>
<td>1,240</td>
<td>2%</td>
</tr>
<tr>
<td>I48X</td>
<td>Atrial fibrillation and flutter</td>
<td>960</td>
<td>1%</td>
</tr>
<tr>
<td>I500</td>
<td>Congestive heart failure</td>
<td>730</td>
<td>1%</td>
</tr>
<tr>
<td>ICD10 code</td>
<td>ICD10 diagnosis</td>
<td>Admissions</td>
<td>% of total</td>
</tr>
<tr>
<td>R074</td>
<td>Signs, symptoms and ill-defined conditions</td>
<td>14,870</td>
<td>19%</td>
</tr>
<tr>
<td>S720</td>
<td>Injury, poisoning, &amp; other external causes</td>
<td>11,850</td>
<td>15%</td>
</tr>
<tr>
<td>J22X</td>
<td>Respiratory diseases</td>
<td>10,210</td>
<td>13%</td>
</tr>
<tr>
<td>J181</td>
<td>Circulatory diseases</td>
<td>8,550</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: Hospital In-patient Data Extract, Staffordshire Commissioning Support Unit
• GP practices keep registers of those patients with severe disease. Last year there were, for example, over 41,000 patients recorded on diabetes registers, 31,800 patients on coronary heart disease (CHD) registers, 16,800 stroke patients and 14,300 patients diagnosed with COPD.

• Improving unhealthy lifestyles is where we can make a big difference to the prevalence of the diseases that cause severe disease and death in Staffordshire, but there are many challenges. About 506,600 adults aged 18 and over in Staffordshire have at least one lifestyle risk factor: either being a smoker, consuming too much alcohol, having a diet low in fruit and vegetables or not taking enough physical activity.
6 Identifying needs in the Staffordshire EJSNA

The Staffordshire EJSNA draws on a range of profile data and other sources to identify Staffordshire’s needs. Table 4 provides a summary of the most pressing needs identified, across the life course, based on a set of criteria in order to identify those health and wellbeing issues that the Health and Wellbeing Board should strive to improve. In this way, the EJSNA can hold the board to account and provide a baseline to measure board performance. The criteria used to identify the most pressing issues are:

- **Health trends** - routine monitoring of the health of the population shows that trends in disease incidence or prevalence are not going in the right direction to improve population health.

- **Unacceptable inequalities or variations in health across Staffordshire** - analysis of health and disease across Staffordshire’s population shows that there are unacceptable inequalities in health and healthy lifestyle experiences across the county. This could be amongst different groups, or amongst people living in different areas of the county.

- **Unacceptable outcomes or unacceptably high prevalence of disease** - there are some areas where we know that disease rates in Staffordshire are higher than they should be or that our performance on certain health outcomes are not as good as it should be.

- **Gaps in services / services not meeting needs** - there are some areas where services are not meeting the needs of particular client groups, particularly the needs of vulnerable or minority groups.

Table 4 summarises the needs identified in each of the life course stages based on the above criteria:
Table 4: Health needs in Staffordshire across the life course

<table>
<thead>
<tr>
<th>Birth - 5 years</th>
<th>Unacceptable inequalities / variations across Staffordshire</th>
<th>Health trends are going in the wrong direction</th>
<th>Unacceptable outcomes or unacceptably high prevalence of disease</th>
<th>Gaps in services / services not meeting needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of teenage pregnancies are increasing in Tamworth year on year which now has the 6th highest annual rate in England (94 pregnancies in 2012).</td>
<td>Smoking in pregnancy rates have risen in Staffordshire while England rates have reduced.</td>
<td>Breastfeeding rates are lower than the England average and drop significantly at 6 to 8 weeks.</td>
<td>Maternal obesity and alcohol consumption during pregnancy cause risks to mother and baby and are a high cost to the NHS.</td>
<td>Numbers are increasing but inadequate services are commissioned for this group and existing lifestyle services exclude this group.</td>
</tr>
<tr>
<td>Perinatal and infant mortality rates are higher than the national average in Newcastle under Lyme.</td>
<td>Staffordshire teenage pregnancy rates are not reducing as quickly as predicted. Between 2010 and 1998 rates have reduced by 14% compared to 24% nationally.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Still birth rates and very low birth weight babies are higher in East Staffordshire.</td>
<td>There were 570 teenage pregnancies in Staffordshire in 2010 per annum.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is poorer dental health in Newcastle-under-Lyme.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 Maternal Lifestyle: Maternal Obesity in Staffordshire. Dr Nowmi Zaman, Public Health Staffordshire and Wellbeing Intelligence, November 2012
7 Maternal lifestyle: reducing harm caused by alcohol in pregnancy. Dr Mallika Biradar, Public Health Staffordshire, November 2012
<table>
<thead>
<tr>
<th>Children and young people</th>
<th>Unintentional injuries for children and young people under 18 are higher than the England average in Stafford and Cannock Chase. ³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Levels of educational attainment vary from 64% achieving 5 or more A*-C GCSE grades in Staffordshire Moorlands to 49% in Tamworth. ³</td>
</tr>
<tr>
<td></td>
<td>The proportion of those Not in Education, Employment or Training varies from under 4% in Stafford to 9% in Cannock Chase. ³</td>
</tr>
<tr>
<td></td>
<td>There are nearly 31,000 children aged between two and 15 who are estimated to be obese in Staffordshire and a further 18,600 who are overweight. ³</td>
</tr>
<tr>
<td></td>
<td>Each year there are on average 120 hospital admissions related to alcohol in children and young people aged under 18. ³</td>
</tr>
<tr>
<td></td>
<td>Unintentional injuries for children and young people under 18 are higher than the England average. ³</td>
</tr>
<tr>
<td></td>
<td>Services for vulnerable children / children in care</td>
</tr>
<tr>
<td></td>
<td>Child and adolescent mental health services</td>
</tr>
<tr>
<td></td>
<td>Relevant services for those with safeguarding issues</td>
</tr>
<tr>
<td></td>
<td>Substance misuse services for young people</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Admissions to hospital due to self-harm are higher in East Staffordshire, Cannock Chase and Stafford than the national average. Overall there were 1,500 admissions due to self-harm in Staffordshire.</td>
<td></td>
</tr>
</tbody>
</table>

- Monitoring of trends in the incidence of cancer shows that the rate for all cancers in Staffordshire has increased by 5% since 1995-1997 and by 2% since 2000-2002.
- Alcohol admissions are increasing
- Adult obesity is increasing. By 2010 it is estimated that 39% of men and women will be obese.
- Sexually Transmitted Infections are increasing.

- One in five adults smoke - an estimated 129,500 adults in Staffordshire.
- Nearly one in four adults drink more than the recommended limits of alcohol.
- Rates of unintentional injury in Staffordshire are higher than the England average.
- Over 10,000 hospital admissions due to unintentional injuries.
- Amongst the BME community, the Irish population (especially females) and Black Caribbean females record higher proportions in poor health.

- Mental Ill health: 1 in 6 adults has a mental health problem at any one time. Mental ill health is a contributory factor to substance misuse, criminal activity etc. People with a mental health problem die significantly earlier than the general population.

- Mental wellbeing - supporting resilience and mental wellbeing is a protective factor against mental ill health and has a positive effect on physical health.

- Substance misuse services/ Safeguarding issues/ Physical and mental disabilities

- ~3,600 people are recorded on a learning disability (LD) register in Staffordshire. Prevalence in Cannock Chase is higher than England. Numbers recorded on GP registers are significantly lower than expected numbers, which may suggest unmet need.

- There are about 5,000 adults with autism in Staffordshire. No formal diagnostic service is in place for adults with autism. The Autism Strategy Implementation Plan identifies gaps in training, transition, independence and work.

---


9 Staffordshire and Stoke-on-Trent Adults Autism Strategy 2012-2015
<table>
<thead>
<tr>
<th>Older people</th>
</tr>
</thead>
</table>
| Admissions from fall-related injuries in older people are higher than the England average in East Staffordshire.  

The number falls is expected to increase with the ageing population - almost 110 people die following an accidental fall every year in Staffordshire. 

There is an expected increase in Long Term Conditions (LTCs) due to ageing population. 

An expected increase in dementia due to the ageing population. 

Over 50% of sight loss is due to preventable or treatable causes - rising to between 50% and 70% in older people. It is expected that cases of glaucoma, cataracts, age related macular degeneration, low vision and diabetic retinopathy will increase with the ageing population. 

Significant numbers of people have undiagnosed LTCs, especially undiagnosed dementia, chronic kidney disease, Coronary Obstructive Pulmonary Disease (COPD) and hypertension. 

A third of patients with a registered disease are obese and 14% are smokers. 

Staffordshire is in the bottom of the league table for the number of carers receiving an assessment for carers services. 

Safeguarding issues: Malnutrition amongst older people in nursing and residential care settings is estimated to be between 40% and 45% and 14% amongst those living at home or sheltered accommodation. |

---


11 Public Health Staffordshire Team, 2012 (Nicola Day)
<table>
<thead>
<tr>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy variations - men and women living in the most</td>
</tr>
<tr>
<td>deprived areas of Staffordshire live eight and seven years less than</td>
</tr>
<tr>
<td>those living in less deprived areas.</td>
</tr>
<tr>
<td>Whilst life expectancy amongst those aged 75 and over is not</td>
</tr>
<tr>
<td>statistically significantly different to the England average, there is</td>
</tr>
<tr>
<td>room for improvement in keeping older people healthy.</td>
</tr>
<tr>
<td>More people die from smoking related diseases in Newcastle-</td>
</tr>
<tr>
<td>under-Lyme than England. There are more smoking attributable</td>
</tr>
<tr>
<td>admissions in Cannock Chase and East Staffordshire than England.</td>
</tr>
<tr>
<td>Overall premature mortality rates in the under 75 age group are</td>
</tr>
<tr>
<td>improving. There have been reductions in premature death rates for</td>
</tr>
<tr>
<td>all causes, cardiovascular disease, cancer and chronic obstructive</td>
</tr>
<tr>
<td>pulmonary disease.</td>
</tr>
<tr>
<td>Suicide rates of men are triple those of women in Staffordshire.</td>
</tr>
<tr>
<td>Alcohol specific deaths are high for men in Newcastle-under-Lyme and</td>
</tr>
<tr>
<td>for women in Cannock Chase.</td>
</tr>
<tr>
<td>Mortality from alcoholic liver disease is increasing.</td>
</tr>
<tr>
<td>Overall there are around 385 deaths which are either caused wholly</td>
</tr>
<tr>
<td>or in part caused by alcohol.</td>
</tr>
<tr>
<td>There are on average 500 excess winter deaths annually in Staffordshire.</td>
</tr>
<tr>
<td>There are variations in the provision of end of life services</td>
</tr>
</tbody>
</table>
7 What is health like in Staffordshire?

7.1 The disease pathway from good health to death

This section is structured to tell the story of the health of Staffordshire residents along the disease pathway under the following headings, using the most up to date intelligence produced from the JSNA process and products to date.

- Causes of death in Staffordshire
- Causes of severe disease in Staffordshire (hospital admissions)
- Long term conditions
- Lifestyle risk factors (adults and children)
- Keeping people healthy (immunisation and screening)
- Looking after vulnerable people in Staffordshire
- Factors that impact on health - the wider determinants of health

In most cases, each death is preceded by a severe disease which may have been curable if detected and treated in its early stages (early onset of disease). Early stage disease in many cases could have been prevented in the first place by adopting healthy lifestyles, and right at the start of the pathway we know that poor life chances lead to the major causes of poor health in our communities and to health inequalities, as demonstrated in the life expectancy gap in Section 4. This disease pathway is illustrated in Figure 4.

**Figure 4: Pathway to illness and health inequalities**

<table>
<thead>
<tr>
<th>Underlying causes</th>
<th>Inequalities in health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor life chances</td>
<td>Unhealthy lifestyles</td>
</tr>
<tr>
<td>Smoking</td>
<td>Early onset of disease</td>
</tr>
<tr>
<td>Obesity</td>
<td>Severe disease</td>
</tr>
<tr>
<td>Diabetes</td>
<td>CHD</td>
</tr>
<tr>
<td>Hypertension</td>
<td>COPD</td>
</tr>
<tr>
<td>CHF</td>
<td></td>
</tr>
</tbody>
</table>

Figure 5 expands on the pathway from good health to severe disease and death with estimates of the numbers of Staffordshire residents in each stage in the pathway. Whilst the numbers towards the right of the diagram are a small proportion of the population, i.e. numbers of people with severe disease, Figure 5 also shows that the amount of the NHS and social care budget spent here is very high (about £1 billion in Staffordshire).
Figure 5: Distribution of health need and spend across the disease pathway in Staffordshire, 2011/12

Analysed and compiled by Public Health Intelligence, Public Health Staffordshire

7.2 Causes of death in Staffordshire

Common causes of death in Staffordshire

Around 8,000 people die every year in Staffordshire of which around a third are premature (aged under 75). A breakdown of common causes of death is shown in Figure 6. Almost three quarters of deaths are due to cardiovascular disease, cancer and respiratory diseases. Analysis by age group show that suicides and accidents make a larger proportion of deaths in young people aged 16-24 (Figure 7).
Figure 6: Common causes of deaths in Staffordshire, 2009-2011

- Circulatory diseases: 31%
- Cancers: 29%
- Respiratory diseases: 13%
- Accidents: 2%
- Suicides: 1%
- Other causes: 24%

Source: Death extracts, Office for National Statistics

Figure 7: Common causes of deaths in Staffordshire (ages one and over), average annual between 2009 and 2011

- Circulatory diseases
- Cancers
- Respiratory diseases
- Accidents
- Suicides
- Other causes

Source: Death extracts, Office for National Statistics
**Premature mortality (deaths before the age of 75)**

Overall the health of the population is improving - particularly death rates in the under 75 age group which are considered to be preventable - Figure 8 to Figure 11 show reductions in premature (preventable) death rates for all causes, cardiovascular diseases and cancer and overall mortality for chronic obstructive pulmonary disease (COPD). These conditions make up the biggest proportion of deaths (see section 7.2).

Reductions in mortality rates in Staffordshire are amongst the best in England - premature mortality rates for cardiovascular disease and overall mortality from COPD are amongst the best 20% (quintile) of values (ranked 11th and 20th of 152 upper tier authorities respectively) whilst premature deaths from all causes and cancer are in the second best quintile (ranked 52nd and 36th respectively)\(^\text{12}\).

**Figure 8: Trends in premature mortality from all causes**

\[\text{Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or www.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright}\]
Figure 9: Trends in premature mortality from cardiovascular diseases

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright

Figure 10: Trends in premature mortality from cancer

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright
However, whilst rates have decreased across all Staffordshire districts, there are some differences across Staffordshire:

- Premature mortality rates for cardiovascular disease in Lichfield, South Staffordshire and Stafford are lower than the national average;
- Early deaths from cancer, particularly lung cancer, are high for men in Cannock Chase. Premature cancer death rates are lower than England in Stafford;
- Rates are lower than the national average for chronic obstructive pulmonary disease in Staffordshire as a whole, and lower for Lichfield, South Staffordshire and Stafford. The mortality rate for men in Cannock Chase is higher than national average for chronic obstructive pulmonary disease.
Figure 12: Premature mortality rates, 2009-2011 (provisional)

![Bar chart showing premature mortality rates for various areas.]

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or www.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright

Stillbirths, perinatal and infant mortality

The latest data shows that stillbirth and perinatal rates are similar to England for all areas (Figure 13 and Figure 14). Infant mortality rates for Newcastle-under-Lyme remain higher than the national average (Figure 15). Trends show that after having had significantly high rates, infant deaths in East Staffordshire have been similar to the England average since 2007-2009 (Figure 16).
Figure 13: Stillbirth rates, 2009-2011

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright

Figure 14: Perinatal mortality rates, 2009-2011

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright
Figure 15: Infant mortality rates, 2009-2011

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright

Figure 16: Trends in infant mortality rates

Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright
**Child mortality**

Provisional data for 2009-2011 show that significantly more girls under 15 die in Newcastle-under-Lyme every year than the England average although the overall rate has reduced since its peak in 2007-2009 (Figure 17). The largest component in this indicator is infant deaths (see previous section).

![Figure 17: Trend in child mortality rates (under 15s)](image)

*Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. © Crown Copyright*

**Alcohol-related deaths**

In Staffordshire annually around 280 deaths are either caused wholly or caused in part by alcohol. Alcohol-specific deaths are high for men in Newcastle-under-Lyme and for women in South Staffordshire.

**Suicides**

Although suicide rates have fallen nationally in recent years they had shown an upward trend in the south of the county, where between 2007 and 2009 the number of suicides and undetermined injuries increased markedly from 39 to 73. There were fewer in the south in 2010 (35 suicides and injuries undetermined) before increasing, provisionally, to 63 in 2011. In the north of the county the numbers remained fairly flat between 2007 and 2009 (13 to 15) before increasing to 24 in 2010 and provisionally to 20 in 2011. Suicide rates for men are over treble those for women.

**Accidental deaths**

There are over 200 deaths from accidental causes in Staffordshire per year and provisional death rates from accidents are now similar in Staffordshire to England after having been significantly higher for several years. Rates are particularly high for women in Lichfield. Provisional data show that mortality from accidental causes is
higher in Staffordshire than England amongst the elderly (over 65s) - in particular, Lichfield, Newcastle-under-Lyme and Tamworth.

Hospital admission rates for accidents in Staffordshire are also higher than the national average (see section 7.3). They are higher in Cannock Chase, East Staffordshire and Stafford. However admission rates in other areas with high mortality from accidents either for all ages or over 65s, i.e. Tamworth and Lichfield, are similar to England. Further investigation is needed to understand the reasons for this.

**Excess winter deaths**

There are on average 440 excess winter deaths (EWD) annually in Staffordshire, mainly amongst older people. The EWD index is the number of excess winter deaths expressed as a ratio of the expected deaths based on the non-winter deaths. Excess winter deaths (EWD) are variable as Figure 18 illustrates. The Staffordshire EWD index trend mirrors the national trend; however the peaks and troughs seen in the EWD index do not mirror the mean winter temperatures experienced each year. Therefore, the EWD index depends on many factors and in order to reduce the number of EWDs it is important that services work together to look after the health of, in particular, older people. During 2006-2011 EWDs in Stafford were statistically higher than England and statistically lower in Tamworth (Figure 19).

**Figure 18: Excess winter trends with England mean winter temperature**

![Excess winter trends with England mean winter temperature](source: West Midlands Public Health Observatory)
7.3 Causes of severe disease in Staffordshire (hospital admissions)

Hospital admissions

During 2011/12, there were 79,300 emergency (unplanned) admissions for Staffordshire residents. Around 7% of the population were admitted at least once, and 2% were admitted more than once.

Common causes of unplanned admissions include signs and symptoms and ill-defined conditions, injuries and poisonings, respiratory, circulatory and digestive diseases (Figure 20 and Table 5) and these make up around 60% of unplanned admissions. Table 6 shows how the causes for admissions change by age band...
Figure 20: Causes of emergency admissions by ICD10 chapter in Staffordshire, 2011/12

- Signs, symptoms, and ill-defined conditions: 19%
- Injuries and poisoning: 15%
- Respiratory diseases: 13%
- Circulatory diseases: 11%
- Digestive diseases: 10%
- Genitourinary diseases: 7%
- Infectious diseases: 4%
- Musculoskeletal diseases: 3%
- Pregnancy and childbirth: 3%
- Other: 15%

Source: Hospital In-patient Data Extract, Staffordshire Commissioning Support Unit

Table 5: Common causes of emergency admissions in Staffordshire, 2011/12

<table>
<thead>
<tr>
<th>ICD 10</th>
<th>ICD 10 description</th>
<th>Number of admissions</th>
<th>Percentage (%) of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R10</td>
<td>Abdominal and pelvic pain</td>
<td>3,450</td>
<td>4.4%</td>
</tr>
<tr>
<td>R07</td>
<td>Pain in throat and chest</td>
<td>3,260</td>
<td>4.1%</td>
</tr>
<tr>
<td>N39</td>
<td>Other disorders of urinary system</td>
<td>2,520</td>
<td>3.2%</td>
</tr>
<tr>
<td>J18</td>
<td>Pneumonia, organism unspecified</td>
<td>2,470</td>
<td>3.1%</td>
</tr>
<tr>
<td>J22</td>
<td>Unspecified acute lower respiratory infection</td>
<td>1,470</td>
<td>1.9%</td>
</tr>
<tr>
<td>B34</td>
<td>Viral infection of unspecified site</td>
<td>1,450</td>
<td>1.8%</td>
</tr>
<tr>
<td>J44</td>
<td>Other chronic obstructive pulmonary disease</td>
<td>1,370</td>
<td>1.7%</td>
</tr>
<tr>
<td>S72</td>
<td>Fracture of femur</td>
<td>1,150</td>
<td>1.5%</td>
</tr>
<tr>
<td>J06</td>
<td>Acute upper respiratory infections multiple and unsp sites</td>
<td>1,050</td>
<td>1.3%</td>
</tr>
<tr>
<td>K52</td>
<td>Other noninfective gastroenteritis and colitis</td>
<td>1,040</td>
<td>1.3%</td>
</tr>
<tr>
<td>I50</td>
<td>Heart failure</td>
<td>1,030</td>
<td>1.3%</td>
</tr>
<tr>
<td>R55</td>
<td>Syncope and collapse</td>
<td>1,020</td>
<td>1.3%</td>
</tr>
<tr>
<td>I20</td>
<td>Angina pectoris</td>
<td>1,000</td>
<td>1.3%</td>
</tr>
<tr>
<td>I48</td>
<td>Atrial fibrillation and flutter</td>
<td>960</td>
<td>1.2%</td>
</tr>
<tr>
<td>L03</td>
<td>Cellulitis</td>
<td>920</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td><strong>Top 15 admissions</strong></td>
<td><strong>24,160</strong></td>
<td><strong>30.5%</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total admissions</strong></td>
<td><strong>79,250</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Hospital In-patient Data Extract, Staffordshire Commissioning Support Unit
Table 6: Causes of emergency admissions by age band in Staffordshire, 2011/12

<table>
<thead>
<tr>
<th>Age band</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>1,000</td>
</tr>
<tr>
<td>10-19</td>
<td>2,000</td>
</tr>
<tr>
<td>20-29</td>
<td>3,000</td>
</tr>
<tr>
<td>30-39</td>
<td>4,000</td>
</tr>
<tr>
<td>40-49</td>
<td>5,000</td>
</tr>
<tr>
<td>50-59</td>
<td>6,000</td>
</tr>
<tr>
<td>60-69</td>
<td>7,000</td>
</tr>
<tr>
<td>70-79</td>
<td>8,000</td>
</tr>
<tr>
<td>80+</td>
<td>9,000</td>
</tr>
</tbody>
</table>

Source: Hospital In-patient Data Extract, Staffordshire Commissioning Support Unit

**Alcohol-related admissions**

Similar to the national picture, alcohol-related admissions (which include alcohol-specific conditions such as alcoholic liver disease as well as alcohol-related conditions such as hypertension, where the proportion of those admissions attributable to alcohol are included in the metric) in Staffordshire are on the increase (Figure 21 and Figure 22). The rate of increase from 2002/03 to 2011/12 in Staffordshire is much higher (182% overall, up to 221% in Stafford) than national (113%) and regional rates (146%).

Each year there are on average 120 hospital admissions related to alcohol in children and young people under 18. Rates in Cannock Chase and Stafford are higher than the England average.
Figure 21: Trends in alcohol-related admission rates


Figure 22: Alcohol-related hospital admissions per 100,000 population, 2011/12

Admissions from accidents (unintentional injuries)
During 2010/11 there were over 10,300 admissions to hospital in Staffordshire due to unintentional injuries. Admission rates in Staffordshire are higher than the England average in particular Cannock Chase, East Staffordshire and Stafford. Overall admission rates from unintentional injuries in Staffordshire are higher in children and young people under 18 and in particular in Cannock Chase and Stafford. Further investigation is required to understand the reasons for this. See Figure 23. Admission rates via the updated Injury Profiles\(^{13}\) for 2011/12 should be available in July 2013.

![Figure 23: Admissions due to unintentional injuries, 2010/11](image)

Source: Injury Profiles 2012, South West Public Health Observatory

Almost 3,000 people aged 65 and over in Staffordshire were admitted to hospital for a fall related injury during 2010/11 with rates similar to the national average. Admissions from fall related injuries in people aged 65 are higher in East Staffordshire than the England average (Figure 24).

National research indicates that only one in three people who have a hip fracture return to their former level of independence and one in three have to leave their own home and move to long-term care (resulting in social care costs). The good news is that in Staffordshire hip fracture rates in people aged 65 and over appear to be decreasing (Figure 25). Rates across the districts are similar to the England average.

---

\(^{13}\) Injury Profiles - produced by South West Public Health Observatory
Figure 24: Admissions due to falls in people aged 65 and over, 2010/11

Source: Injury Profiles 2012, South West Public Health Observatory

Figure 25: Trends in hip fracture admissions in people aged 65 and over

Source: Health Profiles 2011, Association of Public Health Observatories (APHO) and Department of Health, Crown Copyright and Injury Profiles 2012, South West Public Health Observatory

Self-harm admissions

Nationally self-harm is one of the top five causes of acute medical admission and those who self-harm have a one in six chance of repeat attendance at A&E within the
year. During 2010/11 there were over 1,500 admissions due to self-harm in Staffordshire with overall rates being similar to the national average (Figure 26). However self-harm admission rates in Cannock Chase, East Staffordshire and Stafford are higher than the England average.

Self-harm is often an expression of personal distress and there is a significant and persistent risk of future suicide following an episode of self-harm (see section 7.2).

**Figure 26: Self-harm admissions, 2010/11**

![Bar chart showing self-harm admissions by age-standardised rate per 100,000 population for various locations in Staffordshire and the West Midlands.](source)

Older people discharged from hospital

In Staffordshire, the provisional number of older people (aged 65 and over) discharged from hospital to intermediate care / rehabilitation / reablement was 1,525 of which 1,315 (86%) were still ‘at home’ after 91 days, which is higher than in 2010/11 (82%). Staffordshire was higher than the England average in 2011/12 and higher than its statistical neighbour Worcestershire (Error! Reference source not found.).
Figure 27: Achieving independence for older people: proportion of people aged 65 and over discharged from hospital to intermediate care, rehabilitation or re-ablement who are still living 'at home' three months after discharge, 2011/12

Source: National Indicator Set (provisional), Social Care and Mental Health Indicators

7.4 Long term conditions
This section highlights what we know about disability in Staffordshire and some key conditions that cause long term illness.

Cancer
Table 7 shows that overall between 2008 and 2010 (latest data available) there were 13,240 new cases of cancer (6,900 males and 6,350 females) amongst Staffordshire residents; an average of just over 4,400 per year. Breast, colorectal, prostate and lung cancers make up the biggest proportions of cases.
Table 7: Common cancers for Staffordshire residents (2008-2010)

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Staffordshire</th>
<th>% of all cancers</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>2,040</td>
<td>15.4%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>1,900</td>
<td>14.4%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Prostate</td>
<td>1,880</td>
<td>14.2%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Lung</td>
<td>1,480</td>
<td>11.2%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Malignant melanoma</td>
<td>470</td>
<td>3.5%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Bladder</td>
<td>420</td>
<td>3.2%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Oesophageal</td>
<td>380</td>
<td>2.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Stomach</td>
<td>350</td>
<td>2.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Cervical</td>
<td>130</td>
<td>1.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other cancers</td>
<td>6,240</td>
<td>47.1%</td>
<td>48.6%</td>
</tr>
<tr>
<td>All cancers</td>
<td>13,240</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: The NHS Information Centre for Health and Social Care. © Crown Copyright. Compendium of Population Health Indicators (indicator.ic.nhs.uk or nww.indicators.ic.nhs.uk). Source of data: National Statistics (Extracts may only be reproduced by permission.)

When adjusted for population size and structure, this represents a lower than England average number of cases. The only district in Staffordshire that has an average number of cases that is higher than England is males in Cannock Chase.

For specific cancer sites, incidence is similar to or lower than the England average rates, except for the following caners in specific areas of Staffordshire:-

- **Lung** cancer incidence is lower than England (45.8) for Staffordshire (38.6) but Cannock Chase is higher (54.3).

- **Prostate** cancer is similar than England (103.8) for Staffordshire (106.4) but higher for Cannock Chase (121.0), South Staffordshire (121.8) and Stafford (119.8).

- **All skin** cancer incidence is similar to England (126.4) for Staffordshire (128.1) but South Staffordshire (150.3) and Stafford (148.5) are higher.

**All cancer trends:**

Monitoring of trends in the incidence of cancer shows that the rate for of all cancers in Staffordshire has increased by 5% since 1995-1997 and by 2% since 2000-2002. However, since 1995-1997, South Staffordshire has seen an increase in cases of 12% and Cannock Chase and Stafford have both increased by 10%. There are also some differences between males and females:

- For males, the incidence rate in Staffordshire has increased by 2% during the same time period. Stafford increased by 15%, South Staffordshire by 13% and Cannock Chase by 7%.

- For females, cases have increased by 4% during the same time period. The incidence rate increased in every district apart from Tamworth, with the largest increases being in Cannock (9%) and East Staffordshire (8%).
Specific cancer trends:
Skin cancers are increasing both nationally and locally, especially in Lichfield, South Staffordshire and Stafford.

**Figure 28: Trend in directly standardised cancer incidence for skin cancers, Staffordshire residents, 1995-1997 to 2008-2010**

![Graph showing trend in skin cancer incidence](image)

The incidence of prostate cancer has risen in Staffordshire as it has nationally with particularly large increases in Cannock Chase, South Staffordshire and Stafford.

Cancer survival rates for Staffordshire residents for all cancers combined (excluding non-melanoma skin cancer) show that 72.2% of people survive for one year (higher than the West Midlands average); 59.5% are still living 3 years after diagnosis (higher than the West Midlands) and 52.8% are still living after 5 years (similar to West Midlands).

Health deprivation and disability index
An overall index combining poor health (both physical and mental), early mortality and disability shows that there are 13,300 people in Staffordshire whose health is in the worst 10% nationally.

Newcastle under Lyme has very poor health levels with areas in Cross Health, Knutton and Silverdale, Chesterton, Thistleberry and Town being in the worst 10%. There are also other areas: Littleworth ward (Stafford), Eton Park and Horninglow
wards (East Staffordshire), and Etching Hill and The Heath (Cannock Chase) that are in the most 10% health deprived areas of the country (Figure 29).

**Figure 29: Health deprivation and disability index in Staffordshire**

![Map showing health deprivation and disability index in Staffordshire](image)

Source: Indices of Deprivation 2010, Department for Communities and Local Government, Crown Copyright 2011
ONS, Super Output Area Boundaries. Crown copyright 2004. Crown copyright material is reproduced with the permission of the Controller of HMSO

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Long term conditions recorded on general practice registers

It is estimated that around one in five people in Staffordshire have a limiting long term condition which increases significantly with age.

Data from a sample of practices revealed that at least one in four people have a registered disease with one tenth of the population having more than one condition. Almost a third of all patients with a specified registered disease are also obese, around 14% are smokers and 19% are ex-smokers.

Expected prevalence shows that significant numbers of people with long term conditions may be undiagnosed or unrecorded on GP disease registers with the largest under-recording seen in chronic kidney disease, hypertension, COPD and dementia. With an ageing population, Staffordshire is also predicted to see an increase in numbers of long term conditions, placing an increasing burden on available health and social care resources (Table 8).

Table 8: Summary of current, expected and projected prevalence for selected long term conditions in Staffordshire for people aged 16 and over

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recorded prevalence (QOF 2011/12)</th>
<th>Expected prevalence (2011)</th>
<th>Estimated under recording - percentage</th>
<th>Projected prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2015</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>n/a</td>
<td>85,500 (12.2%)</td>
<td>n/a</td>
<td>92,500 (13.1%)</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>31,800 (4.6%)</td>
<td>39,300 (5.6%)</td>
<td>19.1%</td>
<td>43,600 (6.2%)</td>
</tr>
<tr>
<td>Stroke</td>
<td>16,800 (2.4%)</td>
<td>17,200 (2.5%)</td>
<td>2.3%</td>
<td>19,500 (2.8%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>126,000 (18.3%)</td>
<td>219,000 (31.3%)</td>
<td>42.5%</td>
<td>238,600 (33.7%)</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>14,300 (2.1%)</td>
<td>21,900 (3.1%)</td>
<td>34.7%</td>
<td>23,500 (3.3%)</td>
</tr>
<tr>
<td>Chronic kidney disease (18 and over)</td>
<td>27,700 (4.1%)</td>
<td>65,000 (9.6%)</td>
<td>57.4%</td>
<td>75,800 (11%)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>41,200 (6%)</td>
<td>50,500 (7.2%)</td>
<td>18.3%</td>
<td>55,400 (7.8%)</td>
</tr>
<tr>
<td>Dementia (65 and over)</td>
<td>4,400 (0.7%)</td>
<td>10,600 (1.6%)</td>
<td>58.8%</td>
<td>12,100 (1.9%)</td>
</tr>
</tbody>
</table>

Compiled by Public Health Staffordshire

**Sight problems**

Sight problems, especially amongst the elderly are a major cause of poor quality of life and loss of independence. Evidence suggests that over 50% of sight loss is due to preventable or treatable causes. This is most marked in the older population, where it is estimated that between 50-70% is preventable\(^\text{14}\). The main risk factors are age, ethnicity, diabetes and obesity, and other lifestyle risk factors such as smoking, and are therefore amenable to prevention. This section highlights the five main eye conditions i.e. glaucoma, cataracts, age-related macular degeneration, low vision and diabetic retinopathy.

**Glaucoma**

Glaucoma is a term that describes a group of eye conditions that affect vision. Glaucoma often affects both eyes, usually in varying degrees. One eye may develop glaucoma more quickly than the other. If left untreated, glaucoma can cause blindness, but if it is diagnosed and treated early enough, further damage to vision can be prevented.

In Staffordshire around 8,600 people are estimated to have glaucoma. The percentage of glaucoma cases in Staffordshire is the same as the national average (1.5%). In the main this is also reflected in the eight local authorities, with Tamworth (1.3%) and Cannock Chase (1.4%) having the lowest prevalence.

**Diabetic retinopathy**

Diabetic retinopathy is a common complication of diabetes. It occurs when high blood sugar levels damage the cells at the back of the eye, known as the retina. If it is not treated, it can lead to blindness, therefore it is important that it is identified and treated as early as possible. The National Screening Programme for Diabetic Retinopathy aims to reduce the risk of vision loss in people with diabetes. This is done by identifying retinopathy at an early stage and, if necessary, ensuring that appropriate treatment is given. Everyone with diabetes who is 12 years of age or over is invited for screening once a year and 91% of patients in Staffordshire have a record of retinal screening in the preceding 15 months.

**Cataracts**

Cataracts are the main cause of impaired vision worldwide, particularly in developing countries. They affect men and women equally.

Most cataracts are related to ageing, affecting a third of people over 65, although occasionally children may be born with the condition, or a cataract may develop after an injury, inflammation or disease. Vision can be restored by surgically removing the affected lens, and replacing it with an artificial one. These are one of the most common operations carried out by the NHS. Depending on the definition used, between 8,400 and 30,900 people in Staffordshire are estimated to have cataracts. The high level estimate prevalence varies little between districts (between 6-7%); similarly the low level estimate ranges from 1.3% to 2% across Staffordshire.

Age-related macular degeneration

Age-related macular degeneration (AMD) causes a gradual loss of central (but not peripheral) vision. Central vision is needed for detailed work and for things like reading and driving. The disease does not lead to complete blindness. Visual loss can occur within months, or over many years, depending on the type and severity of AMD. There are two main types of AMD, 'wet' and 'dry'. Around 90% of cases of macular degeneration are dry. 'Wet' AMD is most severe but more treatable. Visual loss caused by AMD cannot normally be reversed.

One of the most common early signs of dry AMD is drusen. Drusen, deposits in the retina, is a risk factor for late AMD, though not all people with drusen progress to late AMD.

Low vision

Low vision is when a person’s sight cannot necessarily be corrected with glasses or contact lenses. According to the RNIB, around two million people have significant sight loss in the UK. This includes an estimated 80,000 people of working age and 25,000 children. Very few people have complete ‘black’ blindness, so any residual vision (remaining eyesight) needs to be maximised. Low vision is treated by maximising the patient’s eyesight beyond what glasses or contact lenses can achieve, and managing a patient’s expectations. The estimated prevalence for low vision in Staffordshire is lower than the national average Table 9 summarises the estimated numbers with low vision conditions in Staffordshire.

Table 9: Estimated prevalence of main eye conditions in Staffordshire

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated number of cases</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma</td>
<td>8,600</td>
<td>1.5%</td>
</tr>
<tr>
<td>Cataracts (estimates of prevalence vary)</td>
<td>Between 8,400 – 30,900</td>
<td>1.8% - 6.8%</td>
</tr>
<tr>
<td>Age-related macular degeneration</td>
<td>7,700</td>
<td>2.4%</td>
</tr>
<tr>
<td>Impaired vision</td>
<td>12,800</td>
<td>3.9%</td>
</tr>
<tr>
<td>Low vision</td>
<td>11,000</td>
<td>3.3%</td>
</tr>
<tr>
<td>Severe sight impairment</td>
<td>1,900</td>
<td>0.6%</td>
</tr>
</tbody>
</table>


7.5 Lifestyle risk factors (adults and children)

About 506,600 adults aged 18 and over in Staffordshire have at least one lifestyle risk factor: either being a smoker, consuming too much alcohol, having a diet low in fruit and vegetables or not taking enough physical activity. Many people have more than one lifestyle risk factor (36%, 242,600 people). Over one in two adults in deprived areas have more than one risk factor compared with three in ten in the least deprived areas.

Poorer lifestyles, combined with an ageing population will mean that not only are there more older people in the population, but they will be suffering from more of the conditions related to poor lifestyles than in previous generations.
**Smoking**

The good news is that smoking rates in Staffordshire have decreased by 1% between 2010/11 and 2011/12. However, it is estimated that just under one in five adults (129,500) still smoke, varying between 15% (lowest, South Staffordshire) and 21% (highest, Stafford) (Figure 30). Smoking is much more common in manual groups (29%), contributing to increases in health inequalities.

More people die from smoking related diseases in Newcastle-under-Lyme than the England average whilst smoking attributable admission rates are high in Cannock Chase and East Staffordshire.

**Figure 30: Smoking prevalence in adults aged 18 and over, 2011/12**

![Smoking prevalence in adults aged 18 and over, 2011/12](image)

*Source: Integrated Household Survey, Office for National Statistics (experimental statistics)*

**Smoking in pregnancy**

Between 2007/08 and 2011/12 the England rate reduced whilst the rate in Staffordshire increased from 12.6% (1,080 women) to 14.8% (1,280 women). In 2007/08, Staffordshire had a lower smoking in pregnancy rate than England, but from 2008/09 onwards it has been higher than the national average. More recently, between April and September of 2012, the rate of pregnant women smoking was lower than the previous full year (13.7% and 14.8% respectively) and was statistically similar to England (12.7%) (Figure 31).
Figure 31: Trends for women who smoke throughout pregnancy


Smoking in children and young people
Based on national data, 2,200 children aged 11-15 in Staffordshire are estimated to be regular smokers (smoking at least once a week).

Obesity, physical activity and healthy eating
Nationally the obesity epidemic in adults is increasing. Unlike children, the trend in adults is still upwards and by 2015 it is expected that 29% of men and women will be obese. Estimates show that around 187,000 people in Staffordshire are obese and that Cannock Chase, South Staffordshire, Staffordshire Moorlands and Tamworth have a higher proportion of people who are obese than England (Figure 32).

Tamworth and Cannock Chase are also estimated to have lower proportions of adults consuming five portions of fruit and vegetables a day compared to England.

In Staffordshire, only 11% men and women achieved the recommended levels of physical activity which although similar to the national average is too low. 51% of men and women were inactive, higher than England. Inactivity levels are particularly low in Newcastle-under-Lyme and Tamworth.
Maternal obesity

The increasing proportion of women in the population who are overweight or obese has major implications for both pregnant mothers and their babies. Increased obesity levels impact negatively on both the woman and baby during the pre-conceptual, antenatal and postnatal period and can lead to the need for additional healthcare due to complications associated with the pregnancy as outlined in Table 10.

Table 10: Summary of risks related to obesity in pregnancy for the mother and baby

<table>
<thead>
<tr>
<th>For the mother increased risks include:</th>
<th>For the baby increased risks include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severe morbidity or maternal mortality</td>
<td>• Stillbirth and neonatal death</td>
</tr>
<tr>
<td>• Cardiac disease</td>
<td>• Cardiac diseases</td>
</tr>
<tr>
<td>• Spontaneous first trimester and recurrent miscarriage</td>
<td>• Congenital abnormalities</td>
</tr>
<tr>
<td>• Preeclampsia</td>
<td>• Spontaneous first trimester miscarriage and recurrent miscarriage</td>
</tr>
<tr>
<td>• Gestational diabetes</td>
<td>• Prematurity</td>
</tr>
<tr>
<td>• Thromboembolism</td>
<td></td>
</tr>
<tr>
<td>• Post-caesarean wound infection</td>
<td></td>
</tr>
<tr>
<td>• Other infections</td>
<td></td>
</tr>
<tr>
<td>• Postpartum haemorrhage</td>
<td></td>
</tr>
<tr>
<td>• Low breastfeeding rates</td>
<td></td>
</tr>
</tbody>
</table>
Resource implications relating to maternal obesity have been identified as:

- Increases in caesarean and operative deliveries
- Admission to hospital for complications
- Length of hospital stay
- Requirements of neonatal intensive care
- A need for appropriate equipment to manage safely the care of obese mothers

There are also technical issues including difficulties in performing ultrasound examinations, the size of blood pressure cuffs required, issues concerning foetal monitoring, women having reduced awareness of foetal movements, problems encountered with surgical deliveries and equipment and implications for regional and general anaesthesia.

Estimates of maternal obesity in Staffordshire are given in Table 11 which shows that about 20% of women giving birth in Staffordshire are overweight, with a higher prevalence in North Staffordshire.

<table>
<thead>
<tr>
<th>BMI</th>
<th>North Staffordshire</th>
<th>South Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of maternities</td>
<td>%</td>
</tr>
<tr>
<td>All maternities</td>
<td>5,688</td>
<td>100%</td>
</tr>
<tr>
<td>Maternities with a BMI:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30+</td>
<td>1,280</td>
<td>22.5</td>
</tr>
<tr>
<td>35+</td>
<td>512</td>
<td>9.0</td>
</tr>
<tr>
<td>40+</td>
<td>159</td>
<td>2.8</td>
</tr>
</tbody>
</table>


**Childhood obesity and physical activity**

Since a peak in 2004 and 2005 nationally, obesity trends in children have shown a slight downward trend. Based on national data, it is estimated that there are nearly 22,500 children aged between two and 15 who are obese in Staffordshire. In addition it is estimated that 19,000 children are overweight.

From the national child measurement programme (NCMP) data collection, 9% of reception (age four to five) children and 19% of Year 6 children (aged 10 to 11) are obese, similar to the national average (Figure 33 and Figure 34). Obesity rates for both Reception and Year 6 children in Cannock Chase are higher than England. Additionally in Staffordshire, 14% and 15% of children in Reception and Year 6 are overweight. The prevalence of children who are either overweight or obese is high in Cannock Chase for both Reception and Year 6 children.
Figure 33: Prevalence of obesity in Reception children, 2011/12

Source: National Child Measurement Programme: results from the school years 2011/12 – headline results, Copyright 2012, The Information Centre for Health and Social Care. All Rights Reserved

Figure 34: Prevalence of obesity in Year 6 children, 2011/12

Source: National Child Measurement Programme: results from the school years 2011/12 – headline results, Copyright 2012, The Information Centre for Health and Social Care. All Rights Reserved
It is recommended that children undertake at least 60 minutes of physical activity each day of the week, but by the age of 15 only 32% of boys and 15% of girls do. Children in the lower income groups exercise more than those with higher incomes.

There is little local data on the levels of physical activity in children, however generally physical activity levels need to be increased. Based on national estimates, 36,600 children in Staffordshire meet recommended levels whilst 34,300 children are thought to have very low levels of activity.

School sport data shows that Staffordshire is better than average. In four of the eight districts (East Staffordshire, South Staffordshire, Staffordshire Moorlands and Tamworth), activity is significantly higher than England. However, Cannock Chase, Lichfield, Newcastle-under-Lyme and Stafford are lower.

Alcohol
Estimates show that almost one in four adults in Staffordshire drink more than the recommended levels of alcohol consumption, similar to the national level.

Levels of alcohol-related crime and alcohol-related violent crimes are higher than the national average in Cannock Chase and Tamworth.

Nationally the proportion of children who are regular drinkers (drinking at least once a week) has declined with the 2010 survey finding that only 8% of children aged 11-15 drank once a week compared with 18% the previous year. Based on these estimates around 3,100 children aged 11-15 in Staffordshire would be considered regular drinkers.

Sexual health
Sexually transmitted infections (STIs) are increasing, especially chlamydia, herpes and genital warts. Locally (as nationally), the chlamydia screening programme is failing to meet the Department of Health’s target of 50% of all young people aged 16-24 being screened. The Staffordshire figure of 32% screened is higher than the national figure of 28% for 2011/12. Around 6.5% of those screened test positive for chlamydia.

Teenage pregnancy
Staffordshire teenage pregnancy rates are not reducing as quickly as was predicted with under-18 conception rates in Staffordshire reducing by 30% compared to 34% nationally, between 1998 and 2011. However, the under-18 rate in 2011 (30.4) was significantly lower than the previous year (37.3). There were around 470 girls in Staffordshire who became pregnant in 2011 with over half (56%) resulting in an abortion.

In 2011 Cannock Chase had higher teenage pregnancy rates than England (40.0 compared with 30.7 for England). Both Cannock Chase and Tamworth had higher rates than England over the three year period, 2009-2011 (Figure 35).

Teenage conceptions reduced for all Staffordshire districts between 2011 and 2010 though only Staffordshire as a whole saw a fall that was statistically lower between
the two years. In 2010 Tamworth recorded the sixth highest 15-17 conception rate nationally but in 2011 the rate (40.1) is now similar to the England average.

Table 12 gives the number of conceptions, by year, over the last three years. The latest information for Staffordshire shows that there has been a reduction in the rate of teenage pregnancies for the four quarters to March 2012 (31.4%) compared with England which was 30.7 for the same period.

**Figure 35: Teenage pregnancy: under 18 conception rates, 2009-2011**

![Bar chart showing teenage pregnancy rates per 1,000 girls aged 15-17 for various locations from 2009 to 2011. The chart includes England, West Midlands, Staffordshire, Cannock Chase, Tamworth, Newcastle-under-Lyme, East Staffordshire, Lichfield, Stafford, Staffordshire Moorlands, and South Staffordshire.](chart)

*Source: Office for National Statistics and Department for Education*

**Table 12: Teenage pregnancy: trends in numbers of under-18 conceptions**

<table>
<thead>
<tr>
<th>Location</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannock Chase</td>
<td>110</td>
<td>87</td>
<td>73</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>87</td>
<td>78</td>
<td>74</td>
</tr>
<tr>
<td>Lichfield</td>
<td>69</td>
<td>58</td>
<td>53</td>
</tr>
<tr>
<td>Newcastle-under-Lyme</td>
<td>96</td>
<td>68</td>
<td>59</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>66</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>Stafford</td>
<td>66</td>
<td>81</td>
<td>59</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>54</td>
<td>53</td>
<td>42</td>
</tr>
<tr>
<td>Tamworth</td>
<td>83</td>
<td>94</td>
<td>59</td>
</tr>
<tr>
<td><strong>Staffordshire</strong></td>
<td><strong>631</strong></td>
<td><strong>571</strong></td>
<td><strong>469</strong></td>
</tr>
</tbody>
</table>

*Source: Office for National Statistics and Department for Education*
**Falls**

It is estimated that annually around 41,700 people aged 65 and over will fall at least once. Around 9,300 of these will result in an accident and emergency (A&E) attendance and 3,100 will result in a hospital admission. Based on population projections, there will be an increase in falls and consequently an increase in numbers of fall related A&E attendances and admissions (Figure 36). Over 210 people die following an accident (including falls) every year in Staffordshire (see section 7.2).

**Figure 36: Staffordshire current and projected trends in falls in people aged 65 and over**

![Graph showing trends in falls, A&E attendances, and hospital admissions](image)

Source: Projecting Older People Population Information (POPPI)

### 7.6 Keeping people healthy in Staffordshire

There are a number of factors that can help prevent ill health or diagnose problems early to enable better treatment, especially immunisation and screening. This section reports on some interventions designed to keep Staffordshire’s population healthy by preventing ill health or detecting disease early to improve outcomes of treatment.

**Breastfeeding**

Initiation rates in Staffordshire were lower than the England average in 2011/12 - 66% compared with 74%. This has risen from 61% in 2007/08 but still means that around 3,000 women do not breastfeed their babies soon after the birth. The latest data show that rates have increased to 68% between April and September 2013 although this is still lower than the national position which is still 74%.
Furthermore there is a significant drop in breastfeeding rates at six to eight weeks - 36% in Staffordshire compared with 47% nationally of babies being totally or partially breastfed at this stage with only 26% of Staffordshire women feeding their babies exclusively with breast milk.

Reducing low birth-weight babies
The proportion of babies with a low birth weight (LBW) (under 2,500 grams) is 7%, similar to the national average. East Staffordshire has a higher rate than England of babies who weigh under 1,500 grams.

Screening
Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. The uptake of screening programmes varies across Staffordshire. Factors which affect screening uptake include deprivation, ethnicity and age.

Whilst screening has the potential to save lives or improve quality of life through early diagnosis of serious conditions, it is not a fool-proof process. Screening can reduce the risk of developing a condition or its complications but it cannot offer a guarantee of protection. In any screening programme, there is a minimum of false positive results (wrongly reported as having the condition) and false negative results (wrongly reported as not having the condition). 15.

A number of screening programmes have been implemented in England for both antenatal and new-born (Down’s Syndrome, Foetal Anomaly Ultrasound Scan, Antenatal Sickle Cell and Thalassaemia, New-born and Infant Physical Examination, New-born Blood Spot and New-born Hearing Screening) and young people/adults (Abdominal Aortic Aneurysm, Diabetic Retinopathy, Breast Cancer, Cervical Cancer and Bowel Cancer).

Breast screening
- Coverage for Staffordshire, excluding Stoke-on-Trent, (80%) is higher than the England average (77.0%)16, and well above the 70% national target.
- The percentage of women who failed to attend for their screening varied from less than 10% in the least deprived quintile nationally to over 25% in the most deprived quintile.
- Coverage was over 80% for all Staffordshire Clinical Commissioning Groups with the exception of North Staffordshire and Cannock Chase. North Staffordshire was marginally lower than 80% whilst Cannock Chase coverage was 78%17.

15 UK National Screening Committee
16 NHS Information Centre 31st March 2012
17 Staffordshire KC63 return March 2012
Cervical screening

- Coverage for Staffordshire, excluding Stoke-on-Trent, (80.6%) is higher than the England average (78.6%)\(^{18}\), and similar to or higher than the 80% target.

- Coverage was over 80% for Staffordshire Clinical Commissioning Groups with the exception of East Staffordshire and Stafford & Surrounds which were both marginally lower than 80\(^{19}\).

Immunisation

After clean water, vaccination (and the immunisation response it elicits) is the most effective public health intervention in the world for saving lives and promoting good health (Health Protection Agency 2012). Immunisation programmes are essential to the wellbeing of communities; protecting individuals and populations against diseases that cause long term ill health or even death. There are a number of national immunisation programmes in place in England, including the routine childhood programme, immunisation programmes targeted at individuals in specified at risk groups and adult vaccinations.

A more detailed JSNA for Health Protection\(^{20}\) has highlighted the following areas where action is needed in Staffordshire.

Childhood immunisations

- Population vaccination coverage for children in Staffordshire is generally better than the England average. However coverage for some vaccinations (e.g. measles, mumps and rubella (MMR)) is still below the 95% optimum protective target set by the World Health Organisation.

- An MMR equity audit has been undertaken and showed variation in the uptake according to GP practice and school. Further actions need to be taken to address this issue - consideration should be given to commissioning further capacity within the school nursing service.

- Vaccination of children aged 12-13 with human papillomavirus (HPV) vaccine with all three doses in Staffordshire is also consistently higher than the England average.

- There is a low uptake of the school leavers booster vaccination (notably in South Staffordshire) due to issues with the self-consent policy and the administrative support needed for this. Therefore consideration should be given to commissioning additional administrative capacity for this task in the School Nursing service review.

- Continued and increased effort needs to be given to the maintenance and further improvement of all childhood vaccination programmes, to achieve the WHO recommended 95% vaccination uptake rates for all vaccine preventable childhood diseases.

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\(^{18}\) NHS Information Centre 31\(^{st}\) March 2012

\(^{19}\) Staffordshire KC53 return March 2012

\(^{20}\) JSNA (Health Protection) 2012/13
**Adult immunisations:**

Similar to childhood immunisation programmes, vaccination coverage is the best indicator of the level of protection the population has against preventable infectious diseases. There are two routine programmes in place for adults:

- Annual flu vaccine which protects against flu (including swine flu) for all people aged 65 years and over, those with a long-term health condition, carers and pregnant women at any stage of pregnancy
- Pneumococcal vaccine (PPV) which protects against pneumococcal disease for all people aged 65 years and over and those with a long-term health condition
- Pneumococcal vaccine (PPV) coverage in Staffordshire is lower than the England average.
- The proportions of people who were vaccinated against flu during the 2011/12 flu season aged 65 and over, and those under 65 who are at risk, were also lower than the England average.
- Uptake of flu vaccination in pregnant women during 2011/12 was higher than England. Work with maternity services has highlighted a need to commission additional capacity to vaccinate at antenatal clinics (hospital and community settings).
- Performance management of flu vaccination coverage has highlighted persistent poor performance in some GP practices. Therefore commissioning of alternative models of delivery needs to be considered in such cases.

**Capacity to implement new vaccination programmes:**

- Implementing new vaccination programmes is often challenging as it tests the resilience of the system to accommodate the additional demand on immunisation clinic time, training of staff to administer the vaccine safely including preparation of Patient Group Directions (PGD) etc. Newly announced programmes include:
  - Monday 1st October 2012 saw the introduction of a temporary programme to vaccinate pregnant women against Pertussis (whooping cough) to protect their infants.
  - Rotavirus vaccination is to be added to the childhood immunisation schedule starting in September 2013. This will see babies under four months of age, given drops of vaccine by mouth to help protect them against rotavirus infection (a common cause of sickness and diarrhoea in young children).
  - The annual influenza vaccination programme is to be extended to include school-aged children (spanning ages five to less than 17 years) expected to be rolled out in 2014.
  - A universal herpes zoster (shingles) vaccination programme for adults aged 70 up to and including 79 years is recommended provided that a licensed vaccine is available at a cost effective price.
Capacity to respond to vaccine preventable disease incidents and outbreaks

- The incidence of tuberculosis (TB) in Staffordshire is significantly lower than the England average. However from time to time a potentially infectious TB case is confirmed in an employment or educational setting. In one such incident involving a school and college in Burton upon Trent, the Health Protection Unit worked closely with the local hospital, school / college, the Primary Care Trust (PCT), Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) School nursing service and County Council to organise screening and then subsequent Bacillus Calmette–Guérin (BCG) vaccination of eligible students and staff.

- Immunisation uptake and GP registration in travelling communities tends to be lower than in the settled community. Locally there have been several measles outbreaks within the travelling community; this has been dealt with a joint effort of the local NHS (PCT immunisation leads and general practices with travellers residing in their practice area), Local Authority teams and health visitors working with local Traveller communities. Therefore commissioning additional capacity in the Health Visitor service is required to address the issue of low vaccination uptake (especially MMR) within travelling communities.

- An outbreak of Hepatitis A affecting primary school children within the Staffordshire / Stoke on Trent cluster in 2011 concluded that the infection was brought into the school via a family with recent travel history to a developing country. Outbreak control measures included administration of Hepatitis A vaccination to 207 children and 40 adults identified as having been exposed and at risk of acquiring the disease. Consideration should be given to commissioning additional support to raise awareness of the need for travel vaccines in families from high prevalence countries when visiting relatives and returning to the UK.

Bowel screening:

- Coverage for Staffordshire is higher than the England average
- Coverage varies from 58% in East Staffordshire CCG to 62% in both South East Staffordshire & Seisdon Peninsular CCG and Stafford & Surrounds CCG

7.7 Looking after vulnerable people in Staffordshire
This section highlights needs of some of the most vulnerable people in Staffordshire.

Substance misuse - adults needing treatment
Drug addiction leads to significant crime, health and social costs. Evidence based drug treatment reduces these and delivers real savings particularly in crime costs, but also in savings to the NHS through health improvements, reduced drug related deaths and lower levels for blood-borne diseases. Although drug treatment services treat dependence for all drugs, heroin users remain the group with most complex problems. The National Treatment Agency for Substance Misuse has produced

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21 General Practice Profiles for Cancer – December 2012 – National Cancer Intelligence Network
JSNA Support Packs for both Adult Drug Treatment and Young People in Staffordshire and this section draws on this information. The estimated number of opiate and / or crack users (OCU) and injectors aged 15 - 64 in Staffordshire, compared with national rates is given in Table 13 below. Collectively, they have a big impact on crime, unemployment, safeguarding children and welfare dependency.

Table 13: Estimated numbers of opiate and / or crack users and injectors aged 15 - 64 in Staffordshire

<table>
<thead>
<tr>
<th></th>
<th>Staffordshire</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated</td>
<td>Rate per 1,000 population</td>
</tr>
<tr>
<td>OCU</td>
<td>3,897</td>
<td>7.2</td>
</tr>
<tr>
<td>Opiate</td>
<td>3,238</td>
<td>6.0</td>
</tr>
<tr>
<td>Crack</td>
<td>1,825</td>
<td>3.4</td>
</tr>
<tr>
<td>Injecting</td>
<td>1,533</td>
<td>2.8</td>
</tr>
</tbody>
</table>


The Adult Drug Treatment (NTA), the support pack identifies that investment in drug treatment in Staffordshire in 2011/12 was £10,996,000 and in 2011/12 it was £10,474,000. This includes allocations from a range of sources.

The NTA has developed a Value for Money Tool and a Cost Effectiveness Tool to help areas make sure that they are getting the best value for money from their investments and to assess the benefits and consequences of increased investment and disinvestment.

Key intelligence from the Adult Support Pack includes:

- Waiting times: 97% of Staffordshire drug users waited under three weeks to start treatment. Keeping waiting times low will play a vital role in supporting recovery in local communities.
- Treatment engagement: The proportion of adults in 2011/12 who have been in treatment for three months or more - a measure for effective treatment engagement - was 92% (87% for opiates, 13% for non opiates).
- Successful completions: 14% of drug users in treatment successfully completed their treatment (compared to 15% nationally).

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22 Adult JSNA support pack
23 Children’s JSNA support pack
88% of drug users who successfully completed treatment did not return within 6 months (compared to 86% nationally). This figure was 10% less than in 2010/11 compared to a 7% increase nationally.

43% of drug users had been in treatment for more than two years compared to 44% nationally.

Parents and families: Table 14 below shows that there are 770 drug users in treatment in Staffordshire who live with children; 352 users who are parents but do not live with children; and 98 users for whom there is incomplete data. This last item may show hidden populations of drug dependent parents or those with childcare responsibilities in contact with local treatment services. An estimated one in three of the treatment population has a child living with them at least some of the time.

### Table 14: Drug users living with children in Staffordshire

<table>
<thead>
<tr>
<th></th>
<th>Staffordshire</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Proportion of treatment population</td>
</tr>
<tr>
<td>Adults who live with children</td>
<td>770</td>
<td>38%</td>
</tr>
<tr>
<td>Adults who are parents but do not live with any children</td>
<td>352</td>
<td>17%</td>
</tr>
<tr>
<td>Adults with incomplete data</td>
<td>98</td>
<td>5%</td>
</tr>
</tbody>
</table>


**Substance misuse - young people needing treatment**

The Government’s drug strategy says that specialist interventions should prevent young people’s drug and alcohol use from escalating, reduce harm young people cause to themselves and others and prevent them from becoming drug or alcohol-dependent adults. Specialist interventions should be delivered according to a young person’s age, degree of vulnerability and the severity of the problem. The interventions should help young people to become drug and alcohol-free.

Specialist interventions should be integrated with wider children’s services to effectively address the root causes of their problems and build the resilience they need to resist substance misuse in the future. Good practice is to meet their substance misuse needs as part of a broader package of care that involves support with housing, education and family relationships. For those with the most complex needs the best outcomes occur when services such as child and adolescent mental health services, youth offending teams and Children’s Social Care work with substance misuse practitioners.

In 2010/11 there were 303 young people aged under 18 receiving treatment in specialist substance misuse services in Staffordshire and 276 in 2011/12. Most are referred to specialist services from the youth justice system (32%), education services (27%) or referred by self, family or friends, children and family services or mental health services (10% each).
Investment: The Young People Drug Treatment, the Support Pack identifies that investment in drug treatment in Staffordshire in 2012/13 was £508,856. This includes allocations from the Pooled Treatment Budget and secure estate funding. A Department for Education cost benefit analysis found that every £1 invested in specialist interventions delivered up to £8 in long-term savings and almost £2 within two years. The evidence indicates that investing in specialist interventions for young people is a cost-effective way of securing long term outcomes, reducing future demand on health, social care, and mental health services, and supporting the Troubled Families agenda.

Many young people receiving specialist interventions have a range of vulnerabilities. They are more likely to not be in education, employment or training (NEET), have contracted a sexually transmitted disease (STD), have a child, be in contact with the youth justice system, be receiving benefits by the time they are 18, and half as likely to be in full time employment. Universal and targeted services have a role to play in providing substance misuse support at the earliest opportunity and specialist service should be provided for those whose use has escalated and is causing them harm. There should be effective pathways between specialist services and children’s social care for those young people who are vulnerable and age-appropriate care should be available for all young people in specialist care. Table 15 below gives the profile of young people in Staffordshire with each risk / vulnerability.

Table 15: Profile of young people in specialist substance misuse services

<table>
<thead>
<tr>
<th></th>
<th>Staffordshire</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Proportion of treatment population</td>
</tr>
<tr>
<td>Opiate and/or crack user</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Alcohol user</td>
<td>22</td>
<td>10%</td>
</tr>
<tr>
<td>Using 2 or more substances</td>
<td>157</td>
<td>73%</td>
</tr>
<tr>
<td>Began using main problem substance under 15</td>
<td>173</td>
<td>80%</td>
</tr>
<tr>
<td>NFA/unsettled housing</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>NEET</td>
<td>37</td>
<td>17%</td>
</tr>
<tr>
<td>Involved in self-harm</td>
<td>11</td>
<td>5%</td>
</tr>
<tr>
<td>Involved in offending</td>
<td>62</td>
<td>29%</td>
</tr>
<tr>
<td>Pregnant and/or parent</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Looked after child</td>
<td>26</td>
<td>12%</td>
</tr>
</tbody>
</table>


Autism

Autistic spectrum disorders (ASDs)

ASDs are the result of a neurological disorder that has an effect on normal brain function, affecting the development of a person’s communication and social interaction skills. ASDs are experienced on a spectrum comprising of the following conditions:

- Asperger’s syndrome - this is a milder form of autism. Key characteristics include social isolation and eccentricity, difficulty with verbal communication and a narrow range of interests.
- High Functioning Autism - people with high functioning autism have autism but have normal learning and cognitive learning skills. Language development is difficult initially but they become proficient eventually.
- Pervasive Development Disorder - these children / adults have autism but not to the extent whereby they meet the definition of high functioning autism.
- Retts Syndrome - affects females only and is extremely rare, affecting only one in 100,000 children. Characteristics include handwringing movements and the criteria for autism.

26 Ref: Estimated current and future prevalence of mental health and learning disabilities in Staffordshire Update August 2011. Staffordshire Health Intelligence an Clinical Evidence Team.

- Childhood Disintegrative Disorder - this term defines children whose development appears normal for the first few years but then regresses, with the loss of speech and other skills, until the characteristics of autism are conspicuous.

In 2010, 8,000 people in Staffordshire were estimated to have autistic spectrum disorders. Of this figure, 1,400 were estimated to be under 18 and 6,600 were estimated to be over 18. This figure is predicted to remain similar in future years for those under 18 whilst those over 18 may see an increase of around 9% (See Table 16).

<table>
<thead>
<tr>
<th>Table 16: Estimated numbers in Staffordshire predicted to have autistic spectrum disorders in Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children and younger people under 18</strong></td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Adults over 18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>


**Autistic spectrum disorders amongst children and adults with learning disabilities**

In 2010 it was estimated that between 960 and 3,800 children and younger people under 18 were living with learning disabilities and ASD. It is estimated that these figures will fall slightly in 2015 (between 840 and 3,400) and then remain similar in future years.

For adults over 18 it is estimated that in 2010 between 3,100 and 5,100 are living with learning disabilities and ASD. By 2030, the numbers are estimated to have risen to between 3,400 and 5,600.

Table 17 shows the prevalence of ASD in Staffordshire as recorded through Special Education Needs statements, for children and young people within the compulsory school age. Compulsory school age is from Reception (age 4 at start of year) to Year 11 (age 16 by end of academic year).
Table 17: Children and young people by compulsory school age only estimated to have autistic spectrum disorders by local authority, based on their primary and secondary need

<table>
<thead>
<tr>
<th>District</th>
<th>Compulsory School Age Population</th>
<th>Percentage ASD</th>
<th>ASD Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannock Chase</td>
<td>12,863</td>
<td>1.5%</td>
<td>189</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>14,957</td>
<td>0.7%</td>
<td>108</td>
</tr>
<tr>
<td>Lichfield</td>
<td>12,063</td>
<td>1.0%</td>
<td>124</td>
</tr>
<tr>
<td>Newcastle-under-Lyme</td>
<td>13,741</td>
<td>0.6%</td>
<td>76</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>11,545</td>
<td>1.6%</td>
<td>182</td>
</tr>
<tr>
<td>Stafford</td>
<td>14,207</td>
<td>1.7%</td>
<td>241</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>11,143</td>
<td>0.5%</td>
<td>58</td>
</tr>
<tr>
<td>Tamworth</td>
<td>10,359</td>
<td>1.2%</td>
<td>128</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>108,101</td>
<td>1.1%</td>
<td>1,171</td>
</tr>
</tbody>
</table>

Source: January School census 2011 including Academies Landau Forte, De Ferrers and John Taylor, Staffordshire County Council.

Learning disabilities

Learning disability is one of the most common forms of disability and is a lifelong condition. It is acquired before, during or soon after birth and affects an individual’s ability to learn. Similar to people suffering from mental ill health, people with learning disabilities also face challenges and prejudice every day, for example:

- Half of all families with children with a learning disability live in poverty.
- Less than one in five people with a learning disability work, although at least 65% of people with a learning disability want to work. Of those people with a learning disability that do work, most only work part time and are low paid.
- Just one in three people with a learning disability take part in some form of education or training.
- At least half of all adults with a learning disability live in the family home - meaning that many do not get the same chances as other people to gain independence, learn key skills and make choices about their own lives.
- People with a learning disability are 58 times more likely to die aged under 50 than other people.
- Less than a third of people with a learning disability have some choice of who they live with, and less than half have some choice over where they live.

A range of factors will influence the prevalence of future mental health and learning disabilities both locally and nationally including the ageing population and advances in science and medicine. Understanding the current and future profile for

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Staffordshire is important to allow for appropriate service planning and commissioning of health and social care services for populations with learning disabilities.

The expected prevalence of learning disability suggests that there may be significant numbers of people undiagnosed or unrecorded on GP disease registers in Staffordshire (Table 18). It is estimated that there are nearly 14,000 people aged 18 and over who have a learning disability, but the actual number of people on GP disease registers is much lower (nearly 3,000). Table 18 also presents projections of people with learning disabilities. The numbers of adults with learning disabilities is projected to remain similar over the next 15 years.

**Table 18: Summary of current, expected and projected prevalence for learning disabilities in Staffordshire for people aged 18 and over**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannock Chase</td>
<td>400 (0.5%)</td>
<td>1,600 (2.2%)</td>
<td>76%</td>
<td>1,600</td>
<td>1,600</td>
<td>1,700</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>500 (0.4%)</td>
<td>2,100 (2.1%)</td>
<td>78%</td>
<td>1,900</td>
<td>2,000</td>
<td>2,100</td>
</tr>
<tr>
<td>Lichfield</td>
<td>300 (0.5%)</td>
<td>1,600 (2.1%)</td>
<td>82%</td>
<td>1,700</td>
<td>1,800</td>
<td>1,800</td>
</tr>
<tr>
<td>Newcastle-under-Lyme</td>
<td>500 (0.5%)</td>
<td>2,200 (2.1%)</td>
<td>79%</td>
<td>2,200</td>
<td>2,200</td>
<td>2,300</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>200 (0.5%)</td>
<td>1,600 (2.1%)</td>
<td>86%</td>
<td>1,800</td>
<td>1,800</td>
<td>1,800</td>
</tr>
<tr>
<td>Stafford</td>
<td>300 (0.3%)</td>
<td>2,100 (2.1%)</td>
<td>85%</td>
<td>2,200</td>
<td>2,300</td>
<td>2,300</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>400 (0.4%)</td>
<td>1,500 (2.2%)</td>
<td>76%</td>
<td>1,600 (2.1%)</td>
<td>1,700 (2.1%)</td>
<td>1,700 (2.0%)</td>
</tr>
<tr>
<td>Tamworth</td>
<td>300 (0.3%)</td>
<td>1,400 (2.1%)</td>
<td>79%</td>
<td>1,300 (2.1%)</td>
<td>1,300 (2.1%)</td>
<td>1,400 (2.1%)</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>2,800 (0.5%)</td>
<td>14,200 (2.1%)</td>
<td>80%</td>
<td>14,400 (2.1%)</td>
<td>14,700 (2.1%)</td>
<td>15,000 (2.1%)</td>
</tr>
</tbody>
</table>

Note: Numbers may not add up due to rounding


**Vulnerable children and young people**

The Children in Need Census is an annual survey of all children referred to children’s social care services, even if no action is taken. In Staffordshire there are 6,087 children identified as being in need on 31st March 2011, an increase of nearly 30% compared to 31st March 2010 (4,751 children). Neglect remains the highest category of harm for children who are made the subject of a Child Protection Plan, although the number decreased between 2009/10 and 2010/11. It is also the main reason for children being looked after (abuse and neglect accounts for 59% of all cases).
Nearly a third of the children identified as being in need are in the 0 to 5 age group was highlighted as a key risk group in analysis of Serious Case Reviews and this group is also over-represented amongst vulnerable children in Staffordshire. Children who have been identified as being at risk for various reasons are made the subject of a Child Protection Plan (CPP). On 31st March 2011, there were 365 children who were a subject of a CPP. Over half of these children were aged 5 and under (including unborn) reflecting the findings of the Serious Case Reviews. Table 19 shows that the biggest reasons for a child becoming the subject of a CPP are for neglect or emotional abuse.

Table 19: Reason for a child becoming the subject of a Child Protection Plan in Staffordshire, 2010-11

<table>
<thead>
<tr>
<th>Reason</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>192</td>
<td>43%</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>154</td>
<td>35%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>78</td>
<td>17%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>Multiple</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>446</td>
<td>-</td>
</tr>
</tbody>
</table>


The term Looked After Children (LAC) refers to children and young people who are in the care of, or are provided with accommodation for more than 24 hours, by the local authority. As at March 31st 2011, there were 793 looked after children in Staffordshire. Over a quarter (27%) are aged between 0 and 5 years old. The main category of need was abuse or neglect (59% of all cases) followed by family in acute stress (16%) and family dysfunction (13%).

The concentration of vulnerable children in the 0 - 5 age group reiterates the importance of effective universal provision for young children and the safeguarding role of midwives, health visitors, GPs and other practitioners in contact with this age group.

Teenagers are another key risk group, identified through the Serious Case Reviews, although the nature of the risk is significantly different to other groups. They are more likely to come to harm in community settings and take part in or suffer from the consequences of risk taking behaviour, such as substance misuse, anti-social behaviour and becoming a parent at a young age.

Children in care are clearly a vulnerable group and are also more likely to offend, become a teenage parent and have lower educational attainment, thus impacting on their ability to progress in the future, gain further skills and qualifications and access good quality employment. Therefore it is important that they have the appropriate level of support to protect them from harm and enable them to have the same opportunities as other children and young people.
**Vulnerable adults**

Abuse is any behaviour that can lead to harm or distress; for example hitting, pushing, bullying, stealing, neglect or sexual activity without consent (or with consent if the alleged perpetrator is in a position of trust or the vulnerable person lacks capacity). A vulnerable adult can be anyone over the age of 18, and has a physical or sensory disability, drug or alcohol problems, a mental health problem and/or a learning disability, and may not be able to protect themselves from harm or abuse. Many frail or confused older people are especially vulnerable.

During 2011/12 there were 2,467 adult protection referrals made in Staffordshire County. The highest number of allegations still relates to physical abuse in Staffordshire (accounting for around 30% of all referrals) but there has been an increase in allegations of neglect between 2010/11 and 2011/12. This may be due to an increase in the number of Large Scale Investigations and in staff being named as alleged abusers.

Neglect is a concern among adults, particularly as research findings suggest that it is generally under-reported. It is often difficult to detect and may be hidden.

The older population are a particularly vulnerable group, with over half of all adult protection referrals for people aged 75 and over. Females in this age group are most vulnerable and account for over a third of all adult protection referrals recorded in Staffordshire in 2011/12. The proportion of Staffordshire’s residents within this age group is expected to more than double by 2033. Figure 37 shows the age and gender of referrals to adult protection in Staffordshire during 2011/12.
For further information on individuals, families and communities at risk of harm see 'Vulnerability and Risk. A Needs Assessment for Staffordshire, 2012, Staffordshire Observatory'. This report highlights some common characteristics shared by the most vulnerable and at risk residents across Staffordshire. These include problems with mental health, substance misuse (including young people living with substance misusing parents), families living in poverty and those experiencing the greatest levels of deprivation. These problems are cross-cutting in nature, often within a family environment. Being able to identify these families will help to break down the inter-generational cycle of need, and therefore reduce pressures across all partners in Staffordshire.

Malnutrition

Data collected and extrapolated by the British Association for Parenteral and Enteral Nutrition (BAPEN) in various settings, using criteria based on the Malnutrition Universal Screening Tool (MUST) has indicated that malnutrition is an issue of significant public health concern across the UK and in Staffordshire. Malnutrition is

estimated to be between 40 and 45% in residential care homes and nursing homes; 25% in hospital patients and 10% amongst the population living in their own homes.

Of the three million people currently in the UK estimated to be either malnourished or at risk of being malnourished, 93% are living in community settings. With an ageing population, the number of older people at higher risk (especially in the over 85 age group) is set to increase sharply (see Figure 38).

**Figure 38: Estimated numbers of people with malnutrition in Staffordshire, 2009 and 2030**

Based on 2007 estimates, malnutrition is calculated to be costing the NHS and social care £13 million per year. If, as national statistics suggest, 14% of community dwelling older people living at home or in sheltered accommodation are malnourished, the annual cost of malnutrition in this population group alone is currently considered to be between £60 and £80 million in Staffordshire and increasing with the ageing population (see Figure 39).
**Mental health and dementia**

Most mental ill health is mild and self-limiting and does not reach the level of diagnosis of a disorder. However, a significant proportion is chronic and causes moderate disability while a small number of people suffer life-long severely disabling illness. Anxiety and depression affect the largest number of people and often occurs in conjunction with relationship and social problems, substance misuse or physical illness. At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.

Mental illness often carries a stigma, and people with a mental illness are more likely to be living in poverty, unemployed and suffer from other ill health, for example:

- One in ten children aged between five and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression.
- About one in 100 people has a severe mental health problem.
- Some 60% of adults living in hostels have a personality disorder.
- Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.
- Unemployed people are twice as likely to have depression as people in work.
- Children in the poorest households are three times more likely to have mental health problems than children in well off households.
- People who have been abused or been victims of domestic violence have higher rates of mental health problems.
- Between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent.
- People with drug and alcohol problems have higher rates of other mental health problems.
- People with physical illnesses have higher rates of mental health problems.

Anxiety and depression affect the largest number of people and often occurs in conjunction with relationship and social problems, substance misuse or physical illness. Table 20 provides estimates for mental health problems in Staffordshire, now and projected into the future.

---

30 No health without mental health - A cross-government mental health outcomes strategy for people of all ages. Department of Health 2011
Table 20: Current and projected numbers of selected mental health problems for people aged 18 and over in Staffordshire

<table>
<thead>
<tr>
<th>Problem</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common mental disorder (adults aged 18-64)</td>
<td>82,038</td>
<td>80,823</td>
<td>80,363</td>
<td>79,869</td>
<td>78,869</td>
</tr>
<tr>
<td>Borderline personality disorder (adults aged 18-64)</td>
<td>2,292</td>
<td>2,258</td>
<td>2,244</td>
<td>2,230</td>
<td>2,201</td>
</tr>
<tr>
<td>Antisocial personality disorder (adults aged 18-64)</td>
<td>1,790</td>
<td>1,767</td>
<td>1,760</td>
<td>1,753</td>
<td>1,739</td>
</tr>
<tr>
<td>Psychotic disorder (adults aged 18-64)</td>
<td>2,038</td>
<td>2,008</td>
<td>1,996</td>
<td>1,984</td>
<td>1,959</td>
</tr>
<tr>
<td>Depression (adults aged 65 and over)</td>
<td>13,297</td>
<td>15,559</td>
<td>17,118</td>
<td>18,812</td>
<td>20,788</td>
</tr>
<tr>
<td>Severe depression (adults aged 65 and over)</td>
<td>4,186</td>
<td>4,901</td>
<td>5,450</td>
<td>6,207</td>
<td>6,879</td>
</tr>
<tr>
<td>Early onset dementia (adults aged 45-64)</td>
<td>237</td>
<td>233</td>
<td>245</td>
<td>250</td>
<td>237</td>
</tr>
<tr>
<td>Dementia (adults aged 65 and over)</td>
<td>10,196</td>
<td>12,099</td>
<td>14,413</td>
<td>17,365</td>
<td>20,625</td>
</tr>
<tr>
<td>Likely to commit suicide adults aged 18-64</td>
<td>38</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Dependent on illicit drugs (adults aged 18-64)</td>
<td>17,362</td>
<td>17,126</td>
<td>17,042</td>
<td>16,960</td>
<td>16,791</td>
</tr>
<tr>
<td>People aged 18 or over with a drug problem in effective treatment</td>
<td>1,976</td>
<td>2,033</td>
<td>2,080</td>
<td>2,129</td>
<td>2,180</td>
</tr>
<tr>
<td>Total population aged 18-64 predicted to have alcohol dependence</td>
<td>30,654</td>
<td>30,246</td>
<td>30,103</td>
<td>29,967</td>
<td>29,687</td>
</tr>
<tr>
<td>Survivors of childhood sexual abuse (adults aged 18-64)</td>
<td>58,560</td>
<td>57,671</td>
<td>57,329</td>
<td>56,953</td>
<td>56,194</td>
</tr>
</tbody>
</table>

Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI)

Disease registers

Levels of people with severe mental illness (people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses) and dementia are recorded on GP disease registers for Staffordshire practices.

In 2011/12 there were over 5,000 people registered with a severe mental illness on GP registers across Staffordshire and 4,350 people with dementia (Table 21 and Table 22). Levels of people with severe mental illness are lower than the England average. Levels of dementia overall in Staffordshire are similar to England. However levels in Newcastle-under-Lyme are significantly higher than England which may be due to a combination of differences in case finding and recording on GP disease registers as well as real differences in prevalence due to demographic and risk factors between areas, for example more older people.

As highlighted in the section on long term conditions, comparison with expected numbers of people with dementia show that numbers on GP disease registers significantly under record the prevalence of dementia in the County. The numbers of people with dementia are expected to increase rapidly in the coming decade and beyond due to the ageing population (see Table 23).
### Table 21: Number and proportion with mental health illness, 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Number on register</th>
<th>Percentage</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower limit</td>
</tr>
<tr>
<td>Cannock Chase</td>
<td>540</td>
<td>0.56%</td>
<td>0.51%</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>710</td>
<td>0.55%</td>
<td>0.51%</td>
</tr>
<tr>
<td>Lichfield</td>
<td>550</td>
<td>0.62%</td>
<td>0.57%</td>
</tr>
<tr>
<td>Newcastle under Lyme</td>
<td>870</td>
<td>0.69%</td>
<td>0.64%</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>420</td>
<td>0.44%</td>
<td>0.40%</td>
</tr>
<tr>
<td>Stafford</td>
<td>770</td>
<td>0.62%</td>
<td>0.57%</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>660</td>
<td>0.76%</td>
<td>0.70%</td>
</tr>
<tr>
<td>Tamworth</td>
<td>510</td>
<td>0.61%</td>
<td>0.56%</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>5,030</td>
<td>0.60%</td>
<td>0.59%</td>
</tr>
<tr>
<td>England</td>
<td>452,610</td>
<td>0.82%</td>
<td>0.81%</td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework (QOF) for April 2011 to March 2012, Quality Management and Analysis System (QMAS) database - 2011/12 data as at end of July 2012, Copyright 2012. The Information Centre for health and social care, Prescribing Support Unit. All rights reserved

### Table 22: Number and proportion of people with dementia, 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Number on register</th>
<th>Percentage</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower limit</td>
</tr>
<tr>
<td>Cannock Chase</td>
<td>470</td>
<td>0.56%</td>
<td>0.44%</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>700</td>
<td>0.55%</td>
<td>0.51%</td>
</tr>
<tr>
<td>Lichfield</td>
<td>440</td>
<td>0.62%</td>
<td>0.45%</td>
</tr>
<tr>
<td>Newcastle under Lyme</td>
<td>760</td>
<td>0.69%</td>
<td>0.56%</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>500</td>
<td>0.44%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Stafford</td>
<td>650</td>
<td>0.62%</td>
<td>0.49%</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>460</td>
<td>0.76%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Tamworth</td>
<td>360</td>
<td>0.61%</td>
<td>0.38%</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>4,350</td>
<td>0.52%</td>
<td>0.51%</td>
</tr>
<tr>
<td>England</td>
<td>293,740</td>
<td>0.53%</td>
<td>0.53%</td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework (QOF) for April 2011 to March 2012, Quality Management and Analysis System (QMAS) database - 2011/12 data as at end of July 2012, Copyright 2012. The Information Centre for health and social care, Prescribing Support Unit. All rights reserved
Table 23: Increase in numbers with dementia in Staffordshire

<table>
<thead>
<tr>
<th>Location</th>
<th>Current prevalence (2011/12)</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannock Chase</td>
<td>470</td>
<td>1,120</td>
<td>1,350</td>
<td>1,620</td>
<td>1,890</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>700</td>
<td>1,550</td>
<td>1,810</td>
<td>2,180</td>
<td>2,620</td>
</tr>
<tr>
<td>Lichfield</td>
<td>440</td>
<td>1,530</td>
<td>1,870</td>
<td>2,260</td>
<td>2,720</td>
</tr>
<tr>
<td>Newcastle-under-Lyme</td>
<td>760</td>
<td>1,770</td>
<td>2,050</td>
<td>2,350</td>
<td>2,720</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>500</td>
<td>1,800</td>
<td>2,150</td>
<td>2,580</td>
<td>3,050</td>
</tr>
<tr>
<td>Stafford</td>
<td>650</td>
<td>1,980</td>
<td>2,360</td>
<td>2,820</td>
<td>3,330</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>460</td>
<td>1,560</td>
<td>1,830</td>
<td>2,170</td>
<td>2,550</td>
</tr>
<tr>
<td>Tamworth</td>
<td>360</td>
<td>830</td>
<td>1,030</td>
<td>1,300</td>
<td>1,590</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>4,350</td>
<td>12,140</td>
<td>14,440</td>
<td>17,270</td>
<td>20,470</td>
</tr>
<tr>
<td>England</td>
<td>293,740</td>
<td>692,150</td>
<td>788,510</td>
<td>915,920</td>
<td>1,069,560</td>
</tr>
</tbody>
</table>


7.8 Carers’ services

In Staffordshire, the total number of carers receiving a carer’s specific service or advice and information is 3,525. As a proportion of the total number of people receiving community services, Staffordshire is at the very bottom end of the distribution of local authorities for this indicator at 13%. Staffordshire is consistently below the England average and consistently below its statistical neighbour Worcestershire (Figure 40) which has trebled the proportions of carers receiving specific carers’ services in the last three years (18% to 55%).

To achieve the England average of 28% receiving an assessment for carer’s specific services in 2010/11, Staffordshire would need to provide services to 7,444 carers; an increase of over 3,900 new carers receiving services.
Figure 40: Carers receiving needs assessment or review and a specific carer’s service, or advice and information, 2010/11 (NI 135)

In Staffordshire, 10% or less of carers caring for specific client groups receive specific carer’s services i.e. carers of a service user aged 18-64 with a physical disability was 10.1% (360 clients) compared to 9.5% (165 clients) for carers of a service user aged 18-64 with a mental health problem and 8.3% (135 clients) for carers of a service user aged 18-64 with a learning disability. Table 24 shows the number of carers that would be expected to receive services if Staffordshire achieved the England averages for these client groups.

Table 24: Gap analysis for carers’ services in Staffordshire

<table>
<thead>
<tr>
<th></th>
<th>Number of carers receiving services</th>
<th>Number of carers required to achieve England average</th>
<th>Increase needed from current Staffordshire levels of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with a physical disability</td>
<td>360</td>
<td>1,142</td>
<td>782</td>
</tr>
<tr>
<td>Adults with a mental health problem</td>
<td>165</td>
<td>318</td>
<td>153</td>
</tr>
<tr>
<td>Adults with a learning disability</td>
<td>135</td>
<td>536</td>
<td>401</td>
</tr>
</tbody>
</table>

Source: National Indicator Set (provisional), Social Care and Mental Health Indicators

7.9 Factors that impact on health - the wider determinants of health

This section highlights some of the factors that impact on health and an individual’s life chances. Some of these are the responsibility of upper tier authorities, some are the responsibility of the lower tier authority and some are the responsibility of, or are impacted on by, partner agencies. Therefore, all stakeholders have a role to play in
influencing these wider determinants. A summary of these wider determinants and their impact on health and wellbeing is given below. Section 8 below outlines the main findings of the district and borough EJSNAs which have a focus on the wider determinants of health and their impacts on preventing ill health and reducing inequalities.

Deprivation
One of the purposes of measuring deprivation is to highlight small localities which are deprived but may be hidden, especially within a generally less deprived area such as Staffordshire. Only nine of the 525 lower super output areas in Staffordshire are in the top 10% most deprived areas in England. These areas fall in Glascote ward in Tamworth, Cross Heath, Knutton and Silverdale, and Chesterton wards in Newcastle-under-Lyme, Winshill, Stapenhill, Eton Park and Shobnall wards in East Staffordshire and Cannock North ward in Cannock Chase. Over 12,500 people live in these areas making up 2% of the population.

Income deprivation affecting children
Just over 22,000 children under 16 in Staffordshire live in income deprived households. Areas falling in the top 10% nationally include: Winshill ward in East Staffordshire, Knutton and Silverdale and Chesterton wards in Newcastle under Lyme, Cannock North ward in Cannock Chase, Highfields and Western Downs ward in Stafford, Glascote and Amington wards in Tamworth.

Income deprivation affecting older people
Almost 31,600 people aged over 60 live in low income households. Areas falling in the top 10% nationally include: Glascote and Stonydelph wards in Tamworth, Etching Hill and The Heath and Hednesford North wards in Cannock Chase, Shobnall ward in East Staffordshire, Perton Lakeside in South Staffordshire and Butt Lane in Newcastle-under-Lyme.

Local economy
The health of the local economy is vital as it impacts on different aspects of people’s lives. A thriving economy will provide a basis for the improvement in the general health and quality of life of Staffordshire residents. However there are a number of threats facing Staffordshire that may stifle growth and the restructuring of the economy has seen a decrease in traditional manufacturing employment, with large reductions in the number of jobs over previous years. Nevertheless, manufacturing is likely to continue to be of importance in the future, with increasing high-technology manufacturing being a significant opportunity in developing the local economy. Staffordshire is also likely to experience a significant fall in public sector employment as Government cutbacks continue to be implemented. There were around 58,000 public sector employee jobs in Staffordshire in 2009 and it is uncertain how the Government’s drive to reduce the national deficit will impact on the sustainability of public sector employment in the future.

Unemployment
The number of people unemployed (measured by the working age population claiming Job Seekers Allowance) in Staffordshire was 3.6% lower in December 2012 (13,300 claimants) than five years before in December 2008 (13,800 claimants). Rates over this period have remained lower than the England average for
Staffordshire as a whole - rates for Cannock Chase and Tamworth were higher than England for December 2008 but lower than England in December 2012. The largest job seekers allowance caseloads are in Cannock Chase where there were 2,100 (3.4%), Newcastle-under-Lyme also had 2,100 claimants (2.6%) and there were 1,800 (2.1%) claimants in Stafford at December 2012.

**Education**
Areas of low educational attainment and skills are often associated with high levels of worklessness, deprivation and poor health. In 2011, nearly 56% of Staffordshire pupils achieved five or more A*-C GCSE grades (including English and Maths). However this varies from 64% in Staffordshire Moorlands to 49% in Tamworth. A further indicator of later unemployment, low income, teenage motherhood, depression and poor physical health is the proportion of 16 to 18 years olds not in education, employment or training (NEET). This is 5% overall in Staffordshire and again varies from under 4% in Stafford to 9% in Cannock Chase.

**Crime and antisocial behaviour**
The rate of crime recorded in Staffordshire is lower than the national rate and shows a clear downward trend over the last three years, although there is some variation by crime type, for example there have been increases in reported domestic violence across Staffordshire. This may be due to proactive work over recent years to increase reporting. Serious acquisition crime and anti-social behaviour have shown a downward trend. Anti-social behaviour however remains a key issue for Staffordshire due to the high volumes reported particularly in relation to ‘rowdy and inconsiderate behaviour’ where over 16,000 incidents were recorded in 2010/11, and ‘neighbourhood disputes’ due to the increasing trend. A local survey revealed that the main crime and anti-social behaviour issues are felt to be drugs (37% of respondents), teenagers hanging around (34%), rubbish or litter lying around (31%) and people being drunk and rowdy in public places (29%).

**Housing**
The links between poor health and housing are well established. Multiple housing deprivation poses a health risk of the same magnitude as smoking and, on average, greater than that posed by excessive alcohol consumption. The health effects of poor housing also fall disproportionately on vulnerable groups including older people, disabled people and children. The greatest health impact is likely to be achieved when the following conditions are targeted:
- Cold and damp housing
- Overcrowded and under-occupied housing
- The incidence of accidents in the home
- Poor security and high crime
- Inadequate public and open space

**Planning / environment**
Local planning can help to improve prosperity and positively influence health by creating sustainable communities, identifying sites and allocating land for facilities and job opportunities. Planning can also improve the environment and positively influence health by making physical activity an attractive option and making sure that green spaces are well maintained, accessible and safe. Planning can also ensure that physical activity and health equity can be maximised and considered through the
planning processes and by using powers to govern the location of certain businesses and activities.

**Transport**

Lack of physical access to transport can lead to social isolation, particularly for vulnerable groups, for example people with mental health problems, older people, those living in rural areas and without access to a car. Those without good access to transport can encounter barriers in accessing services and accessing information. There may also be concerns about safety, all which can affect an individual’s quality of life. Improved accessibility helps to support economic regeneration and attract investors; facilitate the transition from welfare to work; improve participation and attendance in education and improve people’s general physical health. A good transport system can positively influence health by connecting people to jobs, services, affordable, nutritious and sustainable food; encouraging engagement in the community; reducing social isolation; encouraging physical activity by accessing green spaces; and providing people with improved walking and cycle routes.
Summary of district and borough enhanced joint strategic needs assessment (EJSNA)

Main findings and conclusions

The district enhanced joint strategic needs assessments (EJSNAs) have provided an enhanced picture of issues and priorities at a lower tier local authority level, and most have gone on to identify needs and inequalities at a community level which are often hidden at a district level. In particular, a wealth of information is provided on the wider social determinants of health which are known to have the biggest impact on an individual’s life chances and health experience. Further work is needed to fully understand the implications for the local health economy of investing upstream in these wider social determinants.

As well as informing the Staffordshire EJSNA, the purpose of a local EJSNA is to provide the evidence base to inform commissioning of services within a defined area, therefore, each district has produced a document that suits the commissioning needs of the respective partnerships.

2012 is the first year that districts and boroughs throughout Staffordshire have produced their own EJSNA. A common theme was that all partnerships saw this as the first step in a process of intelligence gathering and that the information and intelligence resource would grow and that the EJSNAs would be 'live' documents that informed commissioning locally. For example in South Staffordshire District their locality profiles are used as part of an annual commissioning process.

“This EJSNA is a ‘living document’ and will be updated periodically as new evidence is found”

Some EJSNAs identified priorities for the district, others identified a series of key themes or key issues for commissioners, but had not prioritised them - for example Staffordshire Moorlands EJSNA concentrates on 3 priorities, while East Staffordshire EJSNA highlights a wide range of issues for commissioners to consider. In general, three common themes emerged:

- The district EJSNAs confirmed the focus on healthy lifestyles, the prevention agenda and reductions in premature mortality as identified in the existing JSNA evidence base.

- A focus on the wider determinants of health and more specific issues and actions that can be taken forward to promote health through housing, transport, leisure, the environment etc. In particular common themes were on housing and its impact on health, employment / worklessness / economic

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32 Stafford and Surrounds Enhanced Joint Strategic Needs Assessment 2012
prosperity and its impact and also education, skills and aspirations especially amongst young people. The theme of worklessness was the most commonly mentioned theme around the wider determinants. Some other common themes raised were rurality, the impact of an ageing population, transport, crime and antisocial behaviour.

- An important thread running through many of the EJSNAs was the need to focus on smaller localities in order to get a true picture and to identify inequalities. Districts analysed their data based on their locality structures, making the point that statistics at an overall district level can mask hidden need and inequality. Some EJSNAs broke down their intelligence into locality areas e.g. Newcastle (11 localities) and South Staffordshire (5 localities) while others identified particular hotspot wards e.g. Stafford and Surrounds.

- Some EJSNAs have been produced in association with, or have been informed by, their local Clinical Commissioning Groups (CCGs), for example Stafford and Surrounds; however, in some areas this is more complex than others, for example, in Lichfield, residents look to three CCGs for their health needs. Partnership working and local commissioning will be strengthened, if going forward; all CCGs are engaged with locality EJSNAs in the future.

- In addition, further consideration by upper and lower tier authorities, CCGs and other partners will be needed to maximise opportunities to improve outcomes related to meeting the needs identified in both the local and Staffordshire wide EJSNAs, by recognising the part each can play along the disease pathway.
9 Community voice
This section considers the views of our residents, businesses and communities relating to their health, wellbeing and quality of life. It covers a wide array of issues from health and social care to the wider determinants of health and wellbeing, such as access to high quality education, employment, community safety and quality of life.

9.1 What are the overall priorities for our communities?
Listening and responding to the views of people and communities in Staffordshire ensures that the services we commission and provide meet their wants and needs, increase their satisfaction and enhance their quality of life.

Recent consultation from the Feeling the Difference survey shows that the top three priorities for Staffordshire residents are:
- Reducing crime levels
- Improving health services
- Access to good schools

The three areas which our residents think need improving are:
- Crime levels
- Cleanliness of streets
- Facilities and activities for young people

The matrix below maps these issues highlighting priorities, improvements and strengths.

Figure 41: Priorities and improvements for Staffordshire residents
9.2 What are the top issues that contribute to quality of life?

The environment where people live, such as their home, street and community has a major impact upon quality of life and it is important to create conditions that enable a healthy way of life for all ages and communities.

The top priorities for residents are demonstrated in Figure 42. There are some variations by age, with younger residents most likely to mention employment and having enough money, whereas older residents were most likely to prioritise health and family.

Figure 42: Top priorities of Staffordshire’s residents

9.3 Community voice – wider determinants of health

Health issues do not sit in isolation, with wider determinants, such as the economy and community safety, impacting on individuals’ wellbeing and quality of life.

Economic wellbeing

The strength of the local economy is vital as it impacts on many aspects of people’s lives. A thriving economy will provide a basis for the improvement in the quality of life of the people of Staffordshire.

Staffordshire’s communities are still feeling the effects of the recession but are feeling more positive about their financial futures. The findings from the Staffordshire’s Peoples Panel in July 2012 indicated that although half of the respondents felt their finances had got worse over the last 12 months, this figure was lower than in previous years and more felt their finances had improved or stayed the same. Respondents were also more positive about finances for the year ahead than in previous years, expecting them to stay the same, with far fewer expecting them to get worse. Although increases in the cost of living continue to cause concern, a significant proportion of respondents commented on signs of improvement including...
that their finances were getting “better”, becoming “more stable”, with a few also having received recent “promotions” at work.

Long-term finance is less of a concern for our communities. The Ipsos MORI Issues Index shows that concern about pensions, for instance, is consistently cited by around one in ten of the public as one of the most important issues facing Britain today, far below more immediate issues like the economy, immigration, the NHS and unemployment, suggesting that work needs to be done to convince people of the need to plan for the future.

In terms of the business voice on these issues, various consultation events held across Staffordshire have raised issues to be addressed including access to superfast broadband, the take up of apprenticeships and other training for the young unemployed, and schools producing young people with the right skills for employment. A national UK Commission Employer Skills survey indicated that where recruits were considered not ready for work, the main reasons were lack of experience (of the world of work, life experience and maturity in general) or personality (poor attitude or lack of motivation).

Feeling safe
Feeling safe relates to your sense of personal security and wellbeing in the places where you live, work or spend your leisure time. One of the consistent messages from the communities of Staffordshire is that being safe and feeling safe is a top priority. Despite the levels of actual crime falling, fear of crime remains at a relatively constant level and is disproportionately higher than the likelihood of being a victim.

In the most recent wave of the Feeling the Difference survey, crime was the most important factor for people in making somewhere a good place to live. Overall the majority of respondents felt safe when outside during the day (98%), although this feeling of safety dropped to 78% when asked how safe they felt during the hours of darkness. Approximately 11% of residents in Staffordshire felt fearful of the possibility of becoming a victim of crime at some point within the past 12 months. This compares favourably with the British Crime Survey (BCS). Based on the BCS interviews during the 12 months to June 2011, the proportion of adults with a high level of worry of becoming a victim of crime was between 10% and 13% (dependant on type of crime). Local analysis highlights that females aged between 35 and 45 years were most likely to feel fearful of crime in Staffordshire.
9.4 **Community voice – lifestyle risk factors**

At a national level there has been very little change since December 2010 in terms of what the public think are the biggest health problems facing people today, these are listed below:\(^{33}\)

- Cancer (36%).
- Obesity or overeating (34%)
- Alcohol abuse and drink-related illnesses (20%).

**Alcohol misuse**

There is limited consultation within Staffordshire relating to communities perceptions of alcohol misuse. However, through the Feeling the Difference Survey, alcohol is identified as the biggest problem in the local area for all respondents, predominantly in relation to anti-social behaviour and domestic violence.

The 2007 Health Survey for England explored attitudes towards drinking alcohol. Among adults who had drunk alcohol in the last year, 16% of men and 14% of women said they would like to drink less. Adults who had drunk more than twice the recommended daily maximum intake were more likely than other drinkers to want to drink less (24% of men and 25% of women who drank at this level).
A recent consultation with pupils aged 11-15 from schools across Staffordshire relating to alcohol drinking habits showed that 90% of respondents had already had their first alcoholic drink. The results of the survey showed clear relationships between the age at which they had their first drink of alcohol, how much alcohol they were currently drinking, how frequently they drank and their opinions of drunkenness \(^\text{34}\).

In terms of preventing young people from drinking, results from the survey highlighted that parents’ opinions and / or objection would cause them to reduce or stop drinking alcohol. This mirrors national perceptions that young people are less likely to drink if their parents disapprove, and more likely to drink if this is tolerated by their parents.

**Healthy lifestyle**

A whole range of health problems are linked to poor diet and low levels of physical activity and these can have serious impacts on home and work life. On the whole, participation in exercise in Staffordshire has remained unchanged over the past seven years. Recent results from the Active People Survey, identifies that 33.5% of Staffordshire’s population participate in at least 30 minutes of sport at moderate intensity at least once a week, lower than the national rate of 36.0% \(^\text{35}\).

Research conducted across the UK by the National Obesity Observatory \(^\text{36}\) in May 2011, explored perceptions of physical activity amongst adults and children and young people. The majority of adults (71%) considered themselves to be active, however only 28% knew what the recommended levels of physical activity were.

In terms of drivers for undertaking physical activity, the most popular reasons cited were:

- To maintain good health (61%)
- To get or feel fit (52%)
- To be outdoors (48%)
- To lose or maintain weight (47%)

Conversely, the research also highlights practical and emotional / psychological barriers that prevent adults from undertaking more physical activity.

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\(^{34}\) Staffordshire School Alcohol Survey, 2012

\(^{35}\) Active People Survey 2011/12

\(^{36}\) National Obesity Observatory, Knowledge and attitudes towards healthy eating and physical activity: what the data tell us. May 2011
Table 25: Barriers to undertaking more physical activity

<table>
<thead>
<tr>
<th>Practical</th>
<th>Emotional / psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work commitments</td>
<td>Lack of motivation</td>
</tr>
<tr>
<td>Lack of leisure time</td>
<td>Not being sporty</td>
</tr>
<tr>
<td>Caring for children or older people</td>
<td>Having other things to do</td>
</tr>
<tr>
<td>Not having enough money</td>
<td></td>
</tr>
</tbody>
</table>

*Source: National Obesity Observatory*

The Sodexho School Meals and Lifestyles Survey 2005 asked a sample of children and young people aged 5 to 16 years how healthy they believe their diets to be. The majority thought that their diet was healthy. Respondents were also asked what incentives that would help them to make healthier food choices at school. The most popular choices were the opportunity to win prizes, less queuing time for healthy dishes and better choices of healthy dishes.

**Smoking**

Nationally the proportion of pupils who have smoked continues to decline. In 2010, 27% of pupils had smoked at least once, compared with more than half of pupils (53%) in 1982. In 2010, 5% of pupils smoked regularly (at least once a week).37

**9.5 Community voice – ageing population**

Staffordshire’s population is ageing. This will have significant implications for a range of services and commissioning across the county, yet also represents an opportunity in terms of the skills and experience that older people are able to offer and share.

**Quality of life priorities for older residents**

The issues which have the biggest resonance for Staffordshire County’s older population (65+) are:

- Being fit and healthy (45%)
- Having enough money (21%)
- A network of family and friends (20%)

37 Smoking, drinking and drug use among young people in England, 2010
Figure 44: Top quality of life issues for residents in Staffordshire aged 65 and above

![Word cloud showing top quality of life issues](image)

Source: Staffordshire County Council Reputation Tracker, 2012

Results of a focus group with residents over the age of 50, highlighted particular concerns relating to social isolation. Respondents widely agreed that elderly people were ‘lonely’ and that there were not always the opportunities for them to spend time with others and this could sometimes lead to them behaving in an ‘anti-social way’ which did not encourage the integration and socialisation that they needed.

9.6 Community voice – health & social care services

How can health and care services be improved?

The quality of social care services in Staffordshire was generally commented on positively through the consultation on the Quality Green Paper for a Revolution in Social Care. Responses received from over a thousand people recognised that there was scope for improvement and the priorities that were highlighted in the consultation were:

- Being treated fairly and with dignity
- Behaviour and attitude of staff
- Knowledge and skills of staff

A recent Staffordshire survey indicated support for GP surgeries to review their appointment systems. Suggested improvements included being able to book appointments “online”, “quickly” and sometimes “more than a day in advance”.

Nationally, children and young people report difficulties in having their voices and views heard in relation to health and social care services. YoungMinds surveyed council Health Scrutiny Committee Chairs and found that 79% had not outlined to them how local young people would be involved in shaping local services. Research by the University College London Institute of Child Health has found that

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38 Ipsos MORI Reputation Tracker Qualitative Research Report, 2012

39 Staffordshire People’s Panel Summer 2012 Survey

the views of under-16s were only sought in 1 of 38 national surveys of patient experience in the NHS between 2001 and 2011.

**Perceptions of social care services**

The Green Paper for a Revolution in Care Quality 2012 survey shows that 43% of respondents felt that a quality care service was currently being provided in Staffordshire. A further 39% felt that this was partially happening, suggesting room for improvement. An additional 18% did not feel that quality care standards were currently being met. Those who had actual experience of care and support services were more likely to feel that a quality care service was being provided than those who did not have direct experience of using care and support services.

**Figure 5: Themed Comments on Social Care and Support Services**

![Themed Comments on Social Care and Support Services](source)

Source: Green Paper for a Revolution in Care Quality 2012

**Perceptions of health care services**

National research highlights that the majority of the public are satisfied with the running of the National Health Service. In 2012 a study on behalf of the Department of Health reported 70% satisfaction levels with the NHS, however the percentage has dropped since its peak in March 2009, when it was 74%\(^{41}\).

National public opinion surveys have also consistently recorded very high levels of satisfaction with GPs (at least 83% of people have said they were satisfied with their last visit to their local doctor or GP since 2002) and more than four in five agree that GPs are best placed to understand which services their patients need (83%). This proportion is very similar to that recorded in 2010\(^{42}\).

The Staffordshire People’s Panel Summer 2012 Survey indicated that GPs were by far the most commonly used health and social care service during the last year, with visiting an NHS hospital as an outpatient or visiting a pharmacy / chemist as the second and third most commonly used services. Good overall experiences were recorded for the two most commonly used health and social care services (GPs and hospitals) and respondents generally provided positive feedback when their

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\(^{41}\) Public Perceptions of the NHS and Social Care; 8 June 2012

\(^{42}\) Public Perceptions of the NHS and Social Care; 8 June 2012
expectations were met. Timeliness and efficiency were key as was being listened to and receiving clear and accurate information on a regular basis.
## 10 Summary of public health issues for districts

Note: A yellow box may still indicate an important public health problem, for example rates of teenage conceptions are already high across England so even if an area does not have a significantly high rate this does not mean that it is not a public health issue.

<table>
<thead>
<tr>
<th>Life expectancy</th>
<th>Cannock Chase</th>
<th>East Staffordshire</th>
<th>Lichfield</th>
<th>Newcastle-under-Lyme</th>
<th>South Staffordshire</th>
<th>Stafford</th>
<th>Staffordshire Moorlands</th>
<th>Tamworth</th>
<th>Staffordshire</th>
<th>England</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy for males (years)</td>
<td>78.4</td>
<td>77.9</td>
<td>79.4</td>
<td>78.7</td>
<td>79.7</td>
<td>80.0</td>
<td>79.0</td>
<td>79.2</td>
<td>79.1</td>
<td>79.0</td>
<td>2009-2011 (Provisional)</td>
</tr>
<tr>
<td>Inequality in male life expectancy (Slope Index of Inequality)</td>
<td>6.7</td>
<td>9.9</td>
<td>7.1</td>
<td>9.9</td>
<td>5.1</td>
<td>7.7</td>
<td>4.3</td>
<td>9.8</td>
<td>8.0</td>
<td>8.9</td>
<td>2006-2010</td>
</tr>
<tr>
<td>Life expectancy for females (years)</td>
<td>82.7</td>
<td>83.0</td>
<td>82.5</td>
<td>82.1</td>
<td>83.3</td>
<td>83.5</td>
<td>83.1</td>
<td>83.0</td>
<td>82.9</td>
<td>82.9</td>
<td>2009-2011 (Provisional)</td>
</tr>
<tr>
<td>Inequality in female life expectancy (Slope Index of Inequality)</td>
<td>2.5</td>
<td>7.1</td>
<td>7.2</td>
<td>10.0</td>
<td>5.0</td>
<td>7.0</td>
<td>4.3</td>
<td>5.6</td>
<td>6.2</td>
<td>5.9</td>
<td>2006-2010</td>
</tr>
</tbody>
</table>

### Life chances

| School readiness: foundation stage profile attainment for starting Key Stage 1 (age five) | 61% | 61% | 73% | 58% | 72% | 66% | 68% | 63% | 65% | 59% | 2011 |
| GCSE achievement five A*-C including English and Maths | 51% | 54% | 58% | 59% | 58% | 58% | 64% | 49% | 56% | 59% | 2011 |
| Young people aged 16-18 not in employment, education or training (NEETS) | 8.9% | 4.9% | 5.1% | 5.0% | 3.9% | 3.7% | 4.1% | 4.7% | 4.9% | 6.0% | 2010/11 |
| Percentage of people of working age with no qualifications | 6.4% | 6.5% | 5.5% | 11.6% | 6.0% | 6.5% | 7.3% | 17.1% | 8.1% | 6.0% | Jan 2012 – Dec 2012 |
| Claimant count rate (as a proxy for unemployment) | 3.5% | 3.0% | 2.2% | 2.9% | 2.5% | 2.2% | 2.0% | 3.0% | 2.7% | 3.8% | March 2013 |

### Infant health

| Infant mortality rates per 1,000 live births | 4.1 | 5.3 | 6.0 | 7.9 | 3.0 | 3.9 | 5.7 | 5.9 | 5.2 | 4.4 | 2009-2011 |
| Perinatal mortality rates per 1,000 total births | 6.1 | 8.4 | 9.4 | 8.4 | 4.4 | 6.2 | 8.3 | 9.6 | 7.6 | 7.5 | 2009-2011 |
| Smoking in pregnancy (APHO estimates from PCT returns) | 15.4% | 15.9% | 15.9% | 17.4% | 15.9% | 15.9% | 17.7% | 15.4% | 15.7% | 13.7% | 2011/12 |
| Low birth weight (proportion under 2,500 grams) | 7.9% | 8.1% | 7.9% | 8.2% | 6.3% | 5.8% | 6.6% | 7.9% | 7.4% | 7.4% | 2009-2011 |
| Teenage pregnancy rates per 1,000 girls aged 15-17 | 49.6 | 36.5 | 32.4 | 35.3 | 27.2 | 30.7 | 28.3 | 51.8 | 35.9 | 34.8 | 2009-2011 |

### Mortality and preventable death

<p>| Premature mortality from all causes per 100,000 population | 283 | 278 | 245 | 278 | 234 | 234 | 258 | 256 | 257 | 271 | 2009-2011 (Provisional) |
| Premature mortality rates from circulatory diseases per 100,000 population | 60 | 65 | 53 | 63 | 48 | 49 | 57 | 61 | 56 | 63 | 2009-2011 (Provisional) |
| Premature mortality rates from cancers per 100,000 population | 117 | 111 | 102 | 105 | 104 | 98 | 104 | 107 | 105 | 108 | 2009-2011 (Provisional) |
| Premature mortality rates from chronic obstructive pulmonary disease per 100,000 population | 10 | 9 | 8 | 10 | 7 | 7 | 10 | 10 | 9 | 11 | 2009-2011 (Provisional) |
| Excess winter mortality index | 6.6% | 18.0% | 27.3% | 21.2% | 17.3% | 28.4% | 21.4% | -0.4% | 18.9% | 17.9% | August 2008 – July 2011 |</p>
<table>
<thead>
<tr>
<th></th>
<th>Cannock Chase</th>
<th>East Staffordshire</th>
<th>Lichfield</th>
<th>Newcastle-under-Lyme</th>
<th>South Staffordshire</th>
<th>Stafford</th>
<th>Staffordshire Moorlands</th>
<th>Tamworth</th>
<th>Staffordshire</th>
<th>England</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence (adults aged 18 and over)</td>
<td>20%</td>
<td>20%</td>
<td>17%</td>
<td>20%</td>
<td><strong>15%</strong></td>
<td>21%</td>
<td>19%</td>
<td>20%</td>
<td>19%</td>
<td>20%</td>
<td>2010/11</td>
</tr>
<tr>
<td>Smoking prevalence in routine and manual groups (adults aged 18 and over)</td>
<td>23%</td>
<td>30%</td>
<td>30%</td>
<td>28%</td>
<td>24%</td>
<td>33%</td>
<td>41%</td>
<td>25%</td>
<td>29%</td>
<td>30%</td>
<td>2011/12</td>
</tr>
<tr>
<td>Childhood obesity (Reception)</td>
<td>12%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>9%</td>
<td>9%</td>
<td>2011/12</td>
</tr>
<tr>
<td>Childhood obesity (Year 6)</td>
<td>23%</td>
<td>19% <strong>16%</strong></td>
<td>20%</td>
<td>21%</td>
<td>19%</td>
<td>20%</td>
<td>17%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>2011/12</td>
</tr>
<tr>
<td>Obesity (adults) (synthetic estimates)</td>
<td><strong>28%</strong></td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>27%</td>
<td>24%</td>
<td>28%</td>
<td>31%</td>
<td>27%</td>
<td>24%</td>
<td>2006-2008 revised</td>
</tr>
<tr>
<td>Physical activity - at least three days a week of 30 minutes moderate participation</td>
<td>24%</td>
<td>23%</td>
<td>24%</td>
<td>21%</td>
<td>21%</td>
<td>23%</td>
<td>20%</td>
<td>19%</td>
<td>22%</td>
<td>23%</td>
<td>2010-12</td>
</tr>
<tr>
<td>Physical activity - at least five days a week of 30 minutes moderate participation</td>
<td>11%</td>
<td>13%</td>
<td>13%</td>
<td>10%</td>
<td>13%</td>
<td>12%</td>
<td>8%</td>
<td>9%</td>
<td>11%</td>
<td>11%</td>
<td>2009-2011</td>
</tr>
<tr>
<td>Healthy eating – eating at least five portions of fruit and vegetables daily (adults) (synthetic estimates)</td>
<td>23%</td>
<td>27%</td>
<td>28%</td>
<td>26%</td>
<td>27%</td>
<td>29%</td>
<td>26%</td>
<td>22%</td>
<td>26%</td>
<td>29%</td>
<td>2006-2008 revised</td>
</tr>
<tr>
<td>Increasing and higher risk drinking (adults) (synthetic estimates)</td>
<td>23%</td>
<td>22%</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>24%</td>
<td>24%</td>
<td>23%</td>
<td>24%</td>
<td>23%</td>
<td>2008/9</td>
</tr>
<tr>
<td>Alcohol-related hospital admissions per 100,000 population</td>
<td>2,100</td>
<td>1,789</td>
<td>1,601</td>
<td>1,875</td>
<td>1,628</td>
<td>1,801</td>
<td>1,546</td>
<td>1,714</td>
<td>1,754</td>
<td>1,974</td>
<td>2011/12</td>
</tr>
</tbody>
</table>

**Lifestyle risk factors**

**Accidents and unintentional injuries**

<table>
<thead>
<tr>
<th></th>
<th>Cannock Chase</th>
<th>East Staffordshire</th>
<th>Lichfield</th>
<th>Newcastle-under-Lyme</th>
<th>South Staffordshire</th>
<th>Stafford</th>
<th>Staffordshire Moorlands</th>
<th>Tamworth</th>
<th>Staffordshire</th>
<th>England</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality from accidents per 100,000 population</td>
<td>16</td>
<td>15</td>
<td>20</td>
<td>14</td>
<td>12</td>
<td>16</td>
<td>13</td>
<td>20</td>
<td>16</td>
<td>15</td>
<td>2009-2011 (Provisional)</td>
</tr>
<tr>
<td>Mortality from accidental falls per 100,000 population</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>7</td>
<td>4</td>
<td>2009-2011 (Provisional)</td>
</tr>
<tr>
<td>Admissions from fall related injuries in people aged 65 and over per 100,000 population</td>
<td>1,737</td>
<td>1,914</td>
<td>1,692</td>
<td>1,544</td>
<td>1,149</td>
<td>1,546</td>
<td>1,310</td>
<td>1,625</td>
<td>1,544</td>
<td>1,642</td>
<td>2010/11</td>
</tr>
<tr>
<td>Hip fracture admissions in people aged 65 and over per 100,000 population</td>
<td>529</td>
<td>484</td>
<td>490</td>
<td>471</td>
<td>423</td>
<td>373</td>
<td>389</td>
<td>507</td>
<td>449</td>
<td>452</td>
<td>2010/11</td>
</tr>
</tbody>
</table>

**Mental health**

<table>
<thead>
<tr>
<th></th>
<th>Cannock Chase</th>
<th>East Staffordshire</th>
<th>Lichfield</th>
<th>Newcastle-under-Lyme</th>
<th>South Staffordshire</th>
<th>Stafford</th>
<th>Staffordshire Moorlands</th>
<th>Tamworth</th>
<th>Staffordshire</th>
<th>England</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self harm admissions per 100,000 population</td>
<td>236</td>
<td>243</td>
<td>152</td>
<td>182</td>
<td>93</td>
<td>196</td>
<td>125</td>
<td>172</td>
<td>178</td>
<td>212**</td>
<td>2011/12 (Provisional)</td>
</tr>
<tr>
<td>Suicides and injuries undetermined per 100,000 population</td>
<td>12</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>2009-2011 (Provisional)</td>
</tr>
<tr>
<td>Mental health - people identified on dementia registers</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>2011/12</td>
</tr>
<tr>
<td>Violent crime rate per 1,000 population</td>
<td>19.7</td>
<td>14.6</td>
<td>9.5</td>
<td>15.1</td>
<td>9.4</td>
<td>15.1</td>
<td>11.4</td>
<td>19.4</td>
<td>14.1</td>
<td>14.8</td>
<td>2010/11</td>
</tr>
</tbody>
</table>

**Key:** denotes statistically better than England; denotes statistically worse than England

**Note:** 1. **England comparator is 2010/12 data 2. Synthetic estimates are used for adult obesity, healthy eating and increasing and higher risk drinking in the absence of local survey data across Staffordshire. These indicate the expected prevalence for an area based on national surveys and the area’s characteristics (e.g. age, gender and deprivation levels) and should be treated with caution and cannot be used to measure performance or change over time. Compiled by Public Health Intelligence, Public Health Staffordshire
Appendix 1: Summary of District / Borough EJSNAs

Staffordshire Moorlands District Council

Staffordshire Moorlands EJSNA builds on work undertaken in 2011 by Moorlands Together Partnership to identify a set of shared priorities for the district. Three priorities emerged - these were Biddulph East, Older People and Worklessness. Further consideration by Moorlands Together Partnership has confirmed these three priorities should remain the focus for 2013/14. As well as the priorities, the EJSNA focuses on actions already being taken to address the priorities and identified 14 key focus areas as follows:

Priority: Biddulph East

- **KEY FOCUS 1: understanding children and young people’s aspirations**
  Understanding the needs and aspirations of children and young people currently growing up in Biddulph East.

- **KEY FOCUS 2: multi-agency action plan**
  The Locality Action Partnership will develop a shared action plan which will set out how partners will work together to address priorities identified in the Enhanced JSNA.

- **KEY FOCUS 3: adults skills group**
  Addressing the issue of no / low adult skills, by pooling resources and maximise outcomes for the community.

- **KEY FOCUS 4: support for troubled families**
  Moorlands Together Partnership will support the delivery of Troubled Families in Biddulph East.

- **KEY FOCUS 5: redevelopment of community-run amenities**
  Moorlands Together Partnership is planning to help Biddulph East Community Association (BECA) redevelop the facilities available at Biddulph Resource and Information Centre (BRIC) and the Community Café.

- **KEY FOCUS 6: building a sustainable community organisation**
  Moorlands Together Partnership will help BECA develop and implement a sustainable and deliverable Business Plan to secure the future of BRIC beyond December 2015 (when BIG Lottery funding runs out).

- **KEY FOCUS 7: locality action partnership**
  Moorlands Together Partnership will establish a ‘Locality Action Partnership’ style forum to guide services in the area, promote a partnership approach and prioritise key issues.
Priority: Older people

- **KEY FOCUS 8: extra care housing**
  With regard to physical assets, the Partnership’s priority is the provision of extra care housing to meet the needs of the older population.

- **KEY FOCUS 9: social enterprise**
  To address gaps in both community activities and other provision, the extension or creation of a social enterprise that will draw together a range of opportunities for people across Staffordshire Moorlands.

- **KEY FOCUS 10: innovation fund**
  Staffordshire Moorlands District Council has recently launched an Innovation Fund which will be managed by the Beth Johnson Foundation to support and develop innovative and sustainable community-led activity targeting identified gaps in provision.

Priority: Worklessness

- **KEY FOCUS 11: work experience and employment opportunities**
  To create and develop work experience and employment opportunities for young people and adults with learning disabilities who are capable of undertaking supported employment.

- **KEY FOCUS 12: service provider matrix**
  The Worklessness Forum is currently mapping service provision throughout the Moorlands. This will be used by practitioners as a sign-posting and referral tool. It will also indicate which services are over or under stretched.

- **KEY FOCUS 13: wordlessness model**
  The Worklessness Forum is currently reviewing 20 examples of best practice from around the country and comparing them to provision and needs within the Moorlands to identify gaps and make proposals for new projects that would meet identified need.

- **KEY FOCUS 14: Churnet Valley living landscape partnership**
  To conserve, enhance and celebrate the Churnet Valley landscape.

The EJSNA includes a detailed asset mapping of assets contributing to each of the above priorities.
Lichfield District Council

Led by Lichfield District Strategic Partnership, Lichfield EJSNA particularly focuses on the underling determinants of health and wherever possible includes statements of need, assets, and community voice as evidence. The report should be seen as a start of an on-going process, not an end in itself. A summary of the overarching themes and assets is included for the district as a whole. The overarching themes are:

- General affluence means that localised problems can be overlooked
- Some areas suffer from health and related inequalities
- Rural deprivation and associated problems such as access to services
- Working through the wider determinants to provide better life chances, as evidenced by the 'Building Family and Community Resilience' programme
- Ageing population and net migration out of younger people who cannot afford to stay within the district
- Complex cross boundary issues for commissioners with three clinical commissioning groups (CCGs) covering the resident population of the district

Key messages for commissioners are:

Population profile

- The ageing of the population within Lichfield District and its movement into retirement and older age groups could be a greater issue than for many other areas in the region

Access to services

- Services need to be accessible for local residents in the district, to meet their needs and take account of their circumstances.
- Commissioners need to take account of the rural areas in Lichfield as well as the more urban areas; this includes the provision of primary care services.
- The needs of particular groups should be taken into account specifically when planning and commissioning services e.g. carers, Lesbian, Gay, Bisexual and Transgender (LGB&T).
- There should be better integration when commissioning services to include the voluntary as well as the statutory sector. This will help to meet the needs of local residents.
- The internet is not always the answer for information on services.
Education and training

- Need to improve Early Years life experiences by providing joined up child and adult health provision, universal family support, parenting support and family learning.
- There is a shortage of primary school places in the south of the City which needs addressing.
- Educational attainment levels at GCSE varies across the district. Educational aspiration also varies (measured by access to higher education).
- Not in Education Employment or Training levels vary by ward with higher levels in wards with higher levels of multiple deprivation.

Transport

- Physical access to key services is difficult, particularly for those who are elderly and living in rural settlements.
- There is no disabled access for passengers at Lichfield Trent Valley station, which could impact on residents’ ability to access key services and employment.

Environment

- People’s health and wellbeing is significantly influenced by the environment in which they live.
- Maintaining and improving a local healthy environment can have a significant impact on physical and mental health and health inequalities.
- The ‘look of a place’ influences how people feel about where they live.
- The less visible systems and frameworks which regulate the environment help to ensure that residents can avoid hazards, which would adversely affect their health.
- Environmental health practitioners represent the only local government professional considered to be a full time public health practitioner.

Income and debt

- There is a need for more debt and money management advice and assistance at an earlier stage.
- Consideration should be given to enabling advice to be provided in appropriate locations within the National Health Service which should improve access to advice services.
- Recognition that whilst Lichfield District is a relatively affluent there are pockets of deprivation and low incomes within the district which will impact on health and wellbeing.
- Raise the awareness of the welfare benefit changes
Housing and fuel poverty

- Good quality and warm housing is an important factor influencing a person’s health and wellbeing.
- The ageing population will place significant impact on demand for services to help people remain in their own homes, in particular repairs and maintenance help. This may be complicated by a lack of affordable homes.
- The economic recession and changes in welfare benefits will impact people’s ability to pay rent, mortgages or maintenance costs. This is likely to increase homelessness. Commissioners need to be aware of these issues when designing services and pathways around keeping people healthy and independent in their own homes.
- There are limited housing options for young people, those on low incomes and those threatened with homelessness, mainly due to a lack of affordable housing.
- The housing related floating support services are well used and important to assist vulnerable households in maintaining their independence and keeping them in their own homes.
- With rising fuel prices and the economic climate, initiatives to tackle fuel poverty are increasingly important, particularly for vulnerable, elderly people.

Local communities and social isolation

- Local communities and social isolation is one of the greatest threats to health. As the elderly population increases, there will be a growing number of residents who will need help and support to maintain basic social contact.
- Other groups particularly at risk of isolation include carers, people with disabilities and chronic health problems, families with complex needs including where there are children with disabilities, lone parents’ especially teenage mothers and victims of domestic abuse. Individuals and families in these groups are particularly at risk of feeling alone and isolated, increasing their vulnerability to mental health issues.
- The voluntary sector could play a greater role in preventing and responding to individuals and families who feel isolated. Community initiatives can help alleviate isolation (e.g. good neighbour schemes and community activities).
- Partners need to work together to identify those who are at greatest risk of social isolation and to enable people to remain living safely and happily at home; the 'Let’s Work Together' initiative (including 'Make Every Contact Count') needs to be further embedded across the district.
- Commissioners should participate in the development of Neighbourhood (or Parish) Plans to ensure health issues are addressed locally.
Community safety

- Alcohol is a key component to many community safety issues both for victims of crime and the perpetrators.
- Increasing local provision is needed for young people to help them to take part in physical activity. This will have the additional impact of crime diversion.
- Local GPs and hospitals can assist in signposting and raising awareness around domestic abuse issues.
- Many vulnerable individuals become victims of anti-social behaviour, alcohol abuse and domestic abuse.
- There is a need to identify opportunities to tackle this by working in partnership.

Physical activity and green spaces

- Support the need for improved indoor leisure facilities to serve Lichfield City and ensure this includes enhanced provision and access for disabled and elderly people.
- Support initiatives which address identified shortfalls in quantity, quality and accessibility of play, open space, sport and recreation, allotments, walking and cycling provision in the district.
- Identify and maximise all opportunities to encourage an increase in physical activity levels.
- Take into account local provision and gaps when designing programmes that should increase physical activity levels.
- For health professionals to encourage sport and physical activity by residents.

Culture, heritage and the arts

- Recognise the vital role that culture, heritage, arts and tourism play in promoting good health and wellbeing through jobs, volunteering opportunities, family activities, business support and much more.
- Ensure commissioning supports the protection and enhancement of cultural assets and other facilities.
- Ensure that the cultural offer is inclusive for all of the population.

Employment and prosperity

- Ensure more jobs are available locally which pay better wages and are better matched with the skills and qualifications of residents. This will help to retain more people of working age within the district and encourage younger people to stay. It will also have a positive impact on balancing the population demographically and reducing commuting.
- Reduce amount of commuting and ensure employment is located in sustainable locations, easily accessed by a variety of means - public transport, walking and cycling, so opportunities are not just available for car drivers.
- Ensure routes to work are safe with good lighting, surfaces, signage, junctions, speed regulation, separate cycle paths and footways.
• Provide the right conditions to support local supply chains, so businesses work more effectively together.
• Improve broadband coverage.
• Support initiatives which contribute to ensuring workplaces are healthy and accessible, by public transport, walking, cycling, and to those with disabilities. Ensure workplaces are supportive of employees' needs e.g. childcare.
• Recognise and support role of voluntary sector.
• Recognise and support the need for links between skills, training and employers.
East Staffordshire Borough Council

East Staffordshire EJSNA, produced by the Local Strategic Partnership provides a local picture of health and wellbeing with particular focus on the wider determinants of health. The report includes a Place summary and population profile. Each section is informed by profile information, information on local assets and community voice information to produce key messages in each of the following areas:

**Employment and economic prosperity**

- In general business confidence is increasing.
- Higher proportion of workers employed in low skilled low paid work; there may be an opportunity to develop more effective workplace health schemes.
- The Borough has an aspiration to develop a more diverse higher skilled economy and workforce.
- Companies need more support to be able to take on workers who suffer from mental health conditions.
- There is an opportunity to prioritise resources towards young people particularly those who are out of work and are at risk of suffering from mental health issues.
- There is a general correlation between people being in employment and being in good overall health.
- The employability and aspirations of young people need to be improved through co-ordinated effort amongst agencies / employers / schools.
- There will be a need to mitigate the impact of large scale employment growth within the Borough on other public services e.g. Transport, Air quality, Health, Education services.

**Housing**

- Housing is a key health determinant and the opportunities to achieve better outcomes by different ways of working between housing and health should be explored.
- There are a range of specialist housing issues that impact on various partners, and partners should participate in developing new strategic approaches.
- There needs to be a debate about how we meet future specialist needs i.e. elderly population in the context of 6,712 houses to plan for in East Staffordshire by 2031.
- The potential for large scale housing development in Burton and Uttoxeter will create additional demand for health services and facilities and village centres.
Regeneration
- Key regeneration projects in East Staffordshire will contribute to the prosperity of the Borough and create new employment opportunities which will be targeted at local people; a partnership approach will ensure that these opportunities filter down to unemployed residents and consequently lead to improved health outcomes for the Borough.

Transport
- Maintain a strong focus on encouraging people to use sustainable transport (i.e. bus / cycle / train) to improve health and wellbeing and alleviate congestion on our road network.

Education and skills
- There is a need to adopt an embedded partnership approach to tackling health and wellbeing amongst school age children; working with schools and parents to tackle the rising problem of obesity.
- Promoting young people’s emotional wellbeing and resilience is key to ensuring abilities to achieve educationally.

Health and wellbeing
- Maintain a strong focus, across the partnership, on health and wellbeing, with a priority on the most deprived wards to reduce health inequalities and improve life expectancy.
- Focus preventative services on areas of greatest need.

Community safety
- There is a correlation between those individuals who commit crimes or are involved in anti-social behaviour and poor health & lifestyle.
- There should be a partnership led approach to tackling alcohol / misuse within the Borough, involving schools and linking in with Troubled Families programme.

Environment
- There are opportunities to develop projects that exploit environmental assets within the Borough, these projects will contribute to improvements in public health through increased participation in leisure and recreational activities.
- A tranquil, high quality landscape accessible from principal areas of population which offers opportunities to develop projects that exploit environmental assets within the Borough.
- Environmentally safe and attractive public places and ‘fit’ homes promote individuals health and sense of wellbeing.
Green spaces
• Opportunity exists for increasing physical activity through gardening and contributing to Open Space.
• Access to good quality open space is beneficial to residents' health and wellbeing.

Leisure and culture
• Decrease the proportion of sedentary people in East Staffordshire and increase physical activity and sports participation.
• Make use of leisure and culture provision to support improved health outcomes e.g. mental health, reduce obesity etc.

Our community pride
• Ability to influence and control one's situation and to feel proud promotes wellbeing and health for individuals.
• Opportunities to meaningfully come together as communities to achieve collective goals, builds community wellbeing.
• To develop this all future commissioning processes must include community voice and participation and the Community Impact Assessment process.

Overall key messages are identified as follows:

Children & young people
• Scope the need for better linkages between local strategic partnerships (LSP) and young people in need (Young people not in education, employment, or training (NEET), out of work, emotional resilience).
• Work with schools to build and develop health and wellbeing plans.

A focus on prevention
• Ensure commissioning of preventative services is focused on areas of greatest need, and ensure schemes meet population level outcomes (e.g. activity).
• Develop an East Staffordshire alcohol plan.
• Develop a joined up mental health plan for East Staffordshire, with a focus on young people.
• Continue to invest in leisure, culture and sport activities across all age groups to improve physical and emotional wellbeing.

Infrastructure & development
• Develop a Housing and Health plan.
• Health and planning - Health Impact Assessment.
• Transport - ensure future integrated transport strategy for the Borough secures additional sustainable transport provision and proposed new development does not add to existing congestion and adversely affect air quality.
• Build Health and Wellbeing into environmental planning.

Economy and workforce
• Develop the employability of our young people to ensure that they can secure employment to stay healthy, fit and happy.
• Develop effective employer engagement mechanisms to ensure that we work in partnership with local businesses to improve workplace health.
The report includes an introduction to Newcastle-under-Lyme and provides a profile summary for Newcastle-under-Lyme in relation to the Marmot Review key themes of birth, grow, live, work and age. The main part of the report profiles the 11 Locality Action Partnerships (across 10 areas of the Borough) and identifies specific issues for each area based on the profile data, i.e.

<table>
<thead>
<tr>
<th>Local Action Partnerships (LAP)</th>
<th>Areas covered</th>
<th>Specific issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Butt Lane LAP</strong>&lt;br&gt;Butt Lane and Talke</td>
<td>Butt Lane</td>
<td>• High proportion of mothers who smoke during pregnancy&lt;br&gt;• Highest proportion of babies with low birth weight in the Borough&lt;br&gt;• Highest rates of premature death attributable to cardiovascular disease in the Borough&lt;br&gt;• Higher than average levels of adult obesity&lt;br&gt;• Third highest rate of teenage pregnancy in the Borough</td>
</tr>
<tr>
<td>Talke</td>
<td></td>
<td>• Seventh highest proportion of babies with low birth weight in the Borough&lt;br&gt;• Higher than average levels of adult obesity</td>
</tr>
<tr>
<td><strong>Kidsgrove LAP</strong>&lt;br&gt;Kidsgrove, Newchapel, Ravenscliffe</td>
<td>Kidsgrove</td>
<td>• Higher than average proportion of adults who are obese&lt;br&gt;• Low rates of breast feeding initiation&lt;br&gt;• Higher rates of obesity amongst children in reception</td>
</tr>
<tr>
<td>Newchapel</td>
<td></td>
<td>• High rates of premature death attributable to cancer&lt;br&gt;• Higher than average proportion of adults who are obese</td>
</tr>
<tr>
<td>Ravenscliffe</td>
<td></td>
<td>• Higher than average proportion of adults who are obese&lt;br&gt;• Higher than average all-cause mortality rate&lt;br&gt;• High rates of premature death attributable to cardiovascular disease and cancer&lt;br&gt;• Lower life expectancy for males</td>
</tr>
<tr>
<td><strong>Audley LAP</strong></td>
<td>Audley &amp; Bignall End</td>
<td>• Higher than average levels of smoking, adult obesity and binge drinking&lt;br&gt;• High proportion of babies with low birth weight – third highest in the Borough</td>
</tr>
<tr>
<td>Halmerend</td>
<td></td>
<td>• Higher than average levels of smoking, adult obesity and binge drinking</td>
</tr>
<tr>
<td><strong>Madeley &amp;</strong></td>
<td>Madeley</td>
<td>• Slightly higher than average proportion of...</td>
</tr>
<tr>
<td>Local Action Partnerships (LAP)</td>
<td>Areas covered</td>
<td>Specific issues</td>
</tr>
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</tr>
<tr>
<td><strong>District LAP</strong>&lt;br&gt;Balterley, Betley, Wrinehill and Madeley</td>
<td>Halmerend&lt;br&gt;NB Only the Betley/Balterley area of Halmerend ward falls into the Madeley LAP</td>
<td>adults prone to binge drinking&lt;br&gt;• Slightly higher than average proportion of adults prone to binge drinking</td>
</tr>
<tr>
<td><strong>Newcastle Rural LAP</strong>&lt;br&gt;Chapel and Hill&lt;br&gt;Chorlton, Loggerheads, Maer and Whitmore</td>
<td>Loggerheads and Whitmore</td>
<td>• Problems with access to services</td>
</tr>
<tr>
<td><strong>Silverdale, Parksite and Keele LAP</strong>&lt;br&gt;Keele, Silverdale and Parksite</td>
<td>Silverdale and Parksite</td>
<td>• Lowest rate of access to maternity services&lt;br&gt;• Lowest rates of breast feeding initiation in the Borough&lt;br&gt;• Fourth highest rate of teenage conceptions in the Borough&lt;br&gt;• Higher rates of pregnant women who are smoking when first accessing maternity services&lt;br&gt;• Higher than average proportion of adults who smoke and are prone to binge drinking&lt;br&gt;• High rates of premature death attributable to cardiovascular disease and cancer</td>
</tr>
<tr>
<td><strong>Greater Chesterton LAP</strong>&lt;br&gt;Chesterton and Holditch&lt;br&gt;NB SOME AREAS IN THE MIDDLE OF THE MAP</td>
<td>Chesterton&lt;br&gt;Holditch</td>
<td>• Problems with access to services&lt;br&gt;• Higher rates of obesity amongst children in reception&lt;br&gt;• Higher than average rates of babies with a low birth weight&lt;br&gt;• High rates of teenage pregnancy&lt;br&gt;• High mortality rate and higher than average rate of premature death particularly attributable to cardiovascular disease and cancer&lt;br&gt;• Lower than average life expectancy for women</td>
</tr>
<tr>
<td><strong>East Newcastle LAP</strong>&lt;br&gt;Wolstanton, May Bank, Bradwell and Porthill</td>
<td>Bradwell</td>
<td>• Less likely to eat recommended portions of fruit and vegetables and to be physically inactive&lt;br&gt;• Highest mortality rate in the Borough and higher than average rate of premature death particularly attributable to</td>
</tr>
<tr>
<td>Local Action Partnerships (LAP)</td>
<td>Areas covered</td>
<td>Specific issues</td>
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<tr>
<td></td>
<td></td>
<td>cardiovascular disease</td>
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<td></td>
<td></td>
<td>• Lower than average life expectancy for men and women</td>
</tr>
<tr>
<td>Porthill</td>
<td></td>
<td>• Estimated higher than average levels of binge drinking</td>
</tr>
<tr>
<td>May Bank</td>
<td></td>
<td>• Estimated higher than average levels of binge drinking</td>
</tr>
<tr>
<td>Wolstanton</td>
<td></td>
<td>• Estimated higher than average levels of binge drinking</td>
</tr>
<tr>
<td>Knutton &amp; Cross Health LAP</td>
<td>Cross Heath</td>
<td>• Low breast feeding initiation rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Highest rates of premature death in the Borough</td>
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<tr>
<td></td>
<td>Knutton and Silverdale</td>
<td>• Lower than average life expectancy for women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Highest rates of premature death attributable to cancer in the Borough</td>
</tr>
<tr>
<td>Town Thistleberry Poolfields LAP</td>
<td>Thistleberry</td>
<td>• Less likely to eat recommended portions of fruit and vegetables and take part in physical activity</td>
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<tr>
<td></td>
<td></td>
<td>• More adults likely to smoke</td>
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<tr>
<td></td>
<td>Town</td>
<td>• Lower than average life expectancy for men and women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More adults likely to smoke</td>
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<tr>
<td></td>
<td></td>
<td>• More likely to be prone to binge drinking</td>
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<tr>
<td></td>
<td></td>
<td>• High mortality rate and higher than average rates of premature death</td>
</tr>
<tr>
<td>Clayton LAP</td>
<td>Clayton</td>
<td>• Among some of the more disadvantaged areas in the country in terms of access to services</td>
</tr>
<tr>
<td></td>
<td>Westlands</td>
<td>• Among some of the more disadvantaged areas in the country in terms of access to services</td>
</tr>
</tbody>
</table>
Tamworth Borough

The Tamworth EJSNA has been prepared by the Tamworth Strategic Partnership. The Partnership brings together key local agencies from the public, private, voluntary and community sectors. Its purpose is to:

- Provide strategic co-ordination linking other plans and bodies at local, sub regional and regional levels.
- Prepare and implement a long term framework for action to benefit all the people of Tamworth.
- Work with key partners to develop and deliver our priorities.

The priorities of the Partnership are.

1. “One Tamworth Perfectly Placed” (the people) (the place).
2. To aspire and prosper in Tamworth.
3. To be healthier and safer in Tamworth.

The EJSNA contains sections on Place, Community Voice and the Voluntary and Community sector and sections on health and wellbeing and the wider determinants of health, i.e.

- Employment and economic wellbeing.
- Housing and homelessness.
- Infrastructure.
- Environment and leisure.
- Health and inequalities.
- Health and wellbeing.
- Educational attainment.
- Community safety.

These sections include profile, community voice and asset information to determine the resulting key messages:
Employment and economic wellbeing

Key messages

- Reduce amounts of commuting.
- Influence how people get to work, cycling, walking.
- Ensure employment is in sustainable areas.
- Raise awareness of health related factors at work, e.g. non-smoking, mental health and stress.

Housing and homelessness

Key messages

- Households who are in poor health struggle to access suitable and affordable housing. This can be addressed by ensuring a greater choice of homes through regeneration, new development and improvements to existing stock.
- Poor quality stock in the private sector must be addressed by initiatives and projects to keep housing safe, warm and well maintained.
- Some of Tamworth's households need ongoing support to maintain a healthy home and lifestyle through the use of homeless prevention tools, intervention and support.
- Quality of life of some residents is affected by poor external environments which must be addressed through well managed neighbourhoods and area renewal.

Infrastructure

Key messages

- Ensure good local rail services including a dedicated train service to Birmingham and Worcester.
- Retention of fast services to London.
- Access to key housing (Anker Valley Link Road) and employment sites to unlock development.
- Increase sustainable travel.
- Ensure sewer and waste water infrastructure can cope with demand.
- Urban park to east of Borough.
- Improved quality of open spaces.
Environment and leisure

Key messages

• Preservation of sustainable links leading to healthier lifestyles.
• Enhance open spaces leading to better wellbeing.
• Flood defences.
• Increasing activity levels with direct enabling of deliver to the Borough’s community.
• Preservation of cultural assets.

Health & wellbeing

Key message:

• Maintain a strong focus across the partnership on improving health and wellbeing outcomes, and prioritise the most deprived wards (e.g. Belgrave) to reduce health inequalities and improve life expectancy.

Aspirations & educational attainment - young people

Key messages:

• Promote educational excellence for all children and young people including the provision of excellent academic and vocational pathways for learning.
• Improve educational attainment, narrow the gaps for the most disadvantaged and promote wider wellbeing of children and young people including at key transition point.

Aspirations & educational attainment - adults

Key message:

• Achieve a positive dialogue between education and the business community with the aim of raising awareness of local, regional and national job opportunities and ensuring that education and training matches the demand for skills and “work readiness” in the economy.
Community safety

Key messages

- Continue to tackle the fear of crime, recognising that whether residents feel their views are sought and understood may be more important than the absolute level of crime and disorder itself.

- Continue to work to increase reporting though raising awareness of the services available to victims and families and work to protect these people who are most vulnerable, and particularly to reduce repeat victimisation.

- Continue to prioritise violent crime and the misuse of alcohol in young people and adults.

Themes

- Maintain a strong focus across the partnership on improving health and wellbeing outcomes and prioritise the most deprived wards (e.g. Belgrave) to reduce health inequalities and improve life expectancy – Healthy Town. (Tamworth Strategic Partnership/Public Health)

- More people are able to maintain an independent and healthy lifestyle. (Clinical Commissioning Group/Public Health)

- Continue to develop Healthier Housing Strategy (suitable homes for everyone, healthy warm and safe homes. (Tamworth Borough Council)

- Improve educational attainment and work closely with schools. (Staffordshire County Council)

- Neighbourhood environments that enable safer and healthier communities. (Police)

- Promote sustainable links and active travel especially cycling & walking. (Staffordshire County Council)

- Enhance open spaces leading to better wellbeing e.g. Urban park to east of Borough. (Tamworth Borough Council)

- Preserve cultural assets. (Tamworth Borough Council)

- Develop health at work schemes. (smoking, mental health, stress) (Public Health)

- Infrastructure improvements Ventura / Town Centre, Gas supply to Belgrave, flood defences, sewer and water infrastructure, rail etc. (Tamworth Borough Council /Staffordshire County Council)
Stafford and Surrounds

The Stafford and Surrounds EJSNA has been produced by the Stafford and Surrounds Health and Wellbeing Group to identify the current and future health and wellbeing needs of the residents of Stafford and Surrounds. The six stages of life identified by the Marmot Review ‘Fair Society, Healthy Lives’ have been used as the basis of the EJSNA. The report brings detailed information on local health and wellbeing together in one place with particular reference to the evidence associated with the wider determinants of health.

The report is written under six life course themes, Start Well, Develop Well, Live Well, Work Well, Age Well, Die Well. Each of these stages incorporates information on a Picture of People, Picture of Place, Community Voice information and information on the wider determinates of health.

Specific health issue are characterised as either

- Data identifies issue as an area of concern
- Data shows hotspots of concern
- There is little district level data available on the issue

The top 5 Wards which showed the most areas of concern in this document are:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Start Well</th>
<th>Develop Well</th>
<th>Live Well</th>
<th>Work Well</th>
<th>Age Well</th>
<th>Die Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority</td>
<td>Sexually transmitted infections</td>
<td>Childhood obesity &amp; physical activity</td>
<td>Adult obesity &amp; physical activity</td>
<td>Skills base</td>
<td>Ageing population</td>
<td>Life expectancy</td>
</tr>
<tr>
<td>Priority</td>
<td>Breast feeding</td>
<td>Child substance &amp; alcohol misuse</td>
<td>Hospital admissions for self-harm</td>
<td>Type of employment</td>
<td>Accidents including falls</td>
<td>Common causes of death</td>
</tr>
<tr>
<td>Priority</td>
<td>Teenage pregnancy</td>
<td>Child mental health</td>
<td>Housing &amp; homelessness</td>
<td>Unemployment and worklessness</td>
<td>Excess winter deaths</td>
<td>Premature mortality</td>
</tr>
</tbody>
</table>

( ) denotes how many health issues identified in each area

The EJSNA identifies three priorities in each stage of the life course
South Staffordshire District Council

South Staffordshire Partnership has been producing Locality Profiles since 2007. These profiles are published annually in September and are at the heart of a consultation process that involves elected members, residents, voluntary and community groups and parish councils. This allows a ‘confirm and challenge’ to the information contained in the profiles and allows priorities to be set that reflect local community needs. The South Staffordshire EJSNA utilises these profiles and has added information on local assets to produce an overall picture of People and Place within the district, and of inequalities in health and wellbeing. For each of the five Localities identified within South Staffordshire District, key messages are derived using a combination of customer insight, consultation and assets. The South Staffordshire District EJSNA is produced as a web resource and can be found here: http://www.sstaffs.gov.uk/default.aspx?page=21014

The priorities identified for South Staffordshire District are:

**Wider determinants of health**
- Older people
- Housing
- Economic prosperity

**Additional health and wellbeing priorities are**
- Breastfeeding
- Life expectancy - women
- Childhood obesity
Cannock Chase District

At the time of writing, (January 2013) the Cannock Chase EJSNA is currently still being produced. The following summary details needs identified from the Health and Wellbeing profile for Cannock Chase District Council produced by the Public Health Staffordshire and Wellbeing Intelligence Team in May 2012.

This profile highlighted a range of health and wellbeing issues including

- Deprivation.
- Maternal and child health.
- Mortality and morbidity.
- Healthy lifestyles, especially concerning smoking, alcohol, obesity physical activity and healthy eating and sexual health.
- Long term conditions.