Cheshire East
Joint Strategic Needs Assessment 2009/10

EXECUTIVE SUMMARY
Introduction – Executive Summary

The Joint Strategic Needs Assessment (JSNA) provides a summary of the current and future health and wellbeing needs of people in Cheshire East. Its development has been centred on transforming data into knowledge to provide a comprehensive picture of the needs of the population of Cheshire East.

The first Joint Strategic Needs Assessment report was produced in November 2008; “Cheshire East Joint Strategic Needs Assessment: A First Look”. It set out the initial findings of the Joint Strategic Needs Assessment and focused on five key areas:

- Children and young people aged 0 to 18 years;
- Older people aged 65 years and over;
- Long-term health conditions - these are conditions such as diabetes, high blood pressure, dementia and strokes which all affect people’s daily living;
- Inequalities - the causes of different health outcomes for people in Cheshire East including access to services; and
- Lifestyle choices that impact on the health and quality of life of an individual.

The Needs Assessment and the First Look Report was the subject of local consultation and helped to shape and inform the development of the PCT Commissioning Strategic Plan (2008 – 2013), the accompanying annual operating plan 2009/10, the Director of Public Health Annual Report 2009, the advice on health priorities given to the newly formed Cheshire East Local Authority, the interim Sustainable Community Strategy and the constituent Local Area Partnerships, the 2009/10 Practice Based Commissioning plans and current Local Area Agreement changes.

The primary footprint of the JSNA relates to the area covered by the Cheshire East Local Authority. However, the needs assessment is being used to support a range of commissioning decisions; hence in most cases Primary Care Trust (PCT) footprint data is also included. See Figure 1.
The PCT and the newly formed Cheshire East Local Authority have continued to build on the First Look Report and during 2009/10 and have made further developments, including:

- Segmentation of the data in order to examine internal health inequalities
- The use of modelling techniques and population projections to enable future needs to be examined
- Expansion of community voice and patient experience sections
- Prioritisation of key issues

1. How is the JSNA Produced?

The production of the JSNA is overseen by a Steering Group which is a sub-group of the Cheshire East Local Strategic Partnership. The Steering Group is jointly chaired by the Director – People East Cheshire Council and the Joint Director of Public Health for Central and Eastern Cheshire PCT and East Cheshire Council. Senior Commissioning and Service leads from both organisations, plus data and intelligence, 3rd sector, general practice and thematic representatives attend. The Steering Group is required to advise all LSP Thematic Groups on the needs of the local population and support them in defining their priorities, see Figure 2. The Steering Group is supported by an operational group which draws on key staff from the PCT and Council. This ensures the JSNA is embedded into key decisions and operational planning of both organisations.

Figure 2

Partnership Working in Cheshire East

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<thead>
<tr>
<th>Cheshire East Executive (LSP)</th>
<th>JSNA Steering Group</th>
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<tr>
<td>Thematic Groups</td>
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<td>Neighbourhood &amp; Community Partnerships</td>
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2. Focus of the Steering Group in 2009/10

The ambition for the Cheshire East JSNA is to increase access to data information and knowledge via local JSNA web-pages and provide the main assessment tool through which all commissioning decisions for Cheshire East are made.

The steering group has focused on four main areas in 2009/10. The drive behind this is to realise the ambition outlined above to make the JSNA more accessible and relevant to commissioners of services, providers of services and the local public.

2.1. Broaden Community Voice Section

Any needs assessment must consider explicitly the views of the local public and users of relevant services, hence the JSNA and chapters have been populated with more community voice /patient/user information drawing on existing consultations, surveys, service focus groups that have been convened by the Local Strategic Partnership, Central and Eastern Cheshire Primary Care Trust, Cheshire East Council through their existing community engagement processes. These processes use consistent and validated methodologies to gather qualitative and quantitative data.

2.2. Development of the JSNA Web-Pages

The JSNA has been a web-based tool since it commenced in 2008. During the transition period from Cheshire County Council to the new Cheshire East Council, Central and Eastern Cheshire Primary Care Trust hosted the JSNA web pages. The pages have now been migrated to the East Cheshire Council Website, with an improved format. This maximises the audience and provides consistency with the JSNA footprint (See figure 1 on page 2).

Further developments have been made to the web-page lay out. Background information about the JSNA, a section for users to more easily identify key findings of the JSNA and priority measures, updated and additional JSNA chapters on topics outlined in the core data set have been included. A community voice information section has been added which incorporates existing consultations/surveys and user views linked to JSNA topic chapters. A needs assessment section has also been introduced which displays all in-depth needs assessments undertaken. A data set section is also available which will enable all interested parties to access and use data for further needs analysis as required.

The chapter lay out of the JSNA is organised under the following sections:

- Demography
- Social and Environmental Factors
- Lifestyle of ill health and disease
- Children and Young People
- Older People
- Services

These sections are derived from the lay out of the core data set and each section has a series of chapters linked to an indicator on the core data set. As the chapters interlink a section may include a chapter featured in another section on the JSNA web-pages for ease of navigation, for example a chapter on births appears in the Demography section and the Children and Young People section.
Indicators from the core data set are supplemented with additional, locally relevant information to add depth and insight into the needs of our populations.

2.3. JSNA Audit
There is a focus on establishing mechanisms for the Steering Group to more effectively monitor the use of the JSNA and its impact on the ways in which services are planned and commissioned. During the latter part of 2009/10 an audit of the Cheshire East JSNA is taking place using the PCT internal auditors to confirm a set of key performance indicators to monitor the effectiveness of the JSNA for 2010/11.

2.4. Key Areas and Priority Measures
There have been extensive updates to the JSNA. The emphasis on continually up-dating and refining the web-pages as new information and intelligence is developed is to enable an increasingly more sophisticated understanding of need at different levels for different audiences. This approach means that a policy maker in the Local Council will understand the local priorities for tackling health inequalities; a commissioning manager developing tier 1 and tier 2 alcohol services to access the detailed needs assessment for alcohol to inform commissioning plans, and a community group developing a parish plan can access information specific to their locality.

This approach to the JSNA has been progressed by developing the JSNA triangle of information:

**Figure 3**

The triangle demonstrates the three levels of data and information, at the base ‘raw’ data from the core data set indicators, user surveys and other data information is available. The next level is the JSNA chapters turning data into ‘knowledge’ across a range of health and social care topics, linking to the evidence base, giving guidance to commissionaires and identifying key areas for local planning and decision making. The top of the triangle are the JSNA priority measure which is used to drive strategic decisions.

The Priority Measures have been identified from the Key Areas, in order to inform the refresh of the Local Area Agreement, the refresh of the Sustainable Community Plan and the refresh of the Primary Care Trust Commissioning Strategic Plan. The key areas and priority measures identified in the 2009/10 JSNA are outlined in the next section.
3. JSNA Key Areas and Priority Measures

The Key Areas are outlined in the JSNA and the chapters derived from a comprehensive assessment of the core data. These Key Areas point out to a commissioner that further in-depth needs assessment is required for that Key Area to inform their commissioning plans. In 2009/10 these have included:

- HMP Styal Health Needs Assessment
- Young Peoples Sexual Health Needs Assessment
- Needs Assessment of Falls in Older People
- Cancer Screening Needs Assessment

This section of the Executive Summary outlines population demographics, population trends, headlines of positive health and social care findings and headlines of challenging health and social care findings.

3.1. Population Demographics

Data gathered from the 2006-based sub national population projections forecasts a population growth and age structure over the next 8 years. In 2008 the estimated resident population of Cheshire East was 362,800. Over the next 8 years the population is expected to increase by 4.3% (15,500 more people) to 378,300, the largest increase will be in the 65 plus age group. This will result in a high ‘old age’ dependency ratio i.e. low numbers of working age supporting a high non-working dependant older population.

Expected population growth 000

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<td>2.3</td>
<td>0.61%</td>
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3.2. Population Trends

Over the next 10 years the following changes to the age profile of the community of Cheshire East will be experienced:

- An increase in the number of children under 14 years
- A decrease in the number of 15-44 year olds
- An increase in the 45-64 year olds
- A significant increase in the population of 65-74 year olds and 75 plus

![Bar chart showing population trends](image)

3.3. Headlines of Positive health and social care findings:

- Cheshire East life expectancy is higher than the North West Average for Males and Females
- Unemployment in Cheshire East is low
- Lifestyle estimates indicate that fruit and vegetable consumption amongst adults is reasonable across Cheshire East
- The Cheshire East Place Survey indicates that residents are quite satisfied with health and well-being services.
- Under 18 conception rate for Cheshire has been consistently lower than England and North West

3.4. Headlines of challenging health and social care findings:

Older People
- Cheshire East has a high number of older people. By 2016, the population over aged 65+ will increase by 29.0% and the population aged 85+ by 41.5%.
- Due to the higher than average older population there is a high requirement for dementia care. Modelling indicates that services are not finding and effectively managing all people with dementia.
dementia. The top three recommendations from a consultation with people with dementia and their families was to increase public and professional awareness and understanding of dementia, earlier diagnosis and intervention and provision of more information to families about dementia and the services available.

- In the UK falls are the major cause of disability and the leading cause of mortality due to injury in older people aged over 75 years of age. In Eastern Cheshire between January 2007 and December 2007 there were 313 people aged over 70 who had a falls risk assessment completed. Out of these 178 were classified as high risk.

**Children**

- Breastfeeding rates are much lower in Cheshire East than they are nationally. In 2006/07 only 62.8% of women in Congleton borough, 63.0% in Crewe and Nantwich and 62.8% in Macclesfield breastfed their babies, compared to a national rate of 69.2%.

- The rates of teenage pregnancy are slowly reducing in East Cheshire through not fast enough to reach the 2010 reduction figures.

- In Macclesfield and Congleton, over 60% of teenage conceptions result in a termination; this is higher than national average and shows an increasing trend.

- Patient and public engagement about sexual health found that 41% of young people stating that they need access to better information

**Social and Environmental Factors**

- Cheshire East has HMP Styal prison within its geography which is one on the largest women’s prisons in the UK and has a young offenders wing and a mother and baby unit. Prisoners entering Styal have complex healthcare needs as well as a range of learning disabilities that are not often recognised.

- At least 6.1% of the population in Cheshire East are in a state of fuel poverty (based on a survey in 2003) this is higher than the national average.

- In 2007, 48% of disabled people and up to 41% of people with health problems in Cheshire East were classed as economically inactive.

- The overall percentage of the working age population educated to NVQ Level 3 and above is 50%, although in the former borough of Crewe and Nantwich it is only 38.4%, one of the lowest figures in the North West.

- 23% of the population (83,300) of Cheshire East experience barriers to housing and services. This includes measures of housing affordability, overcrowding, homelessness, tenure and access to local amenities and services.

- On average 1,318 people from Cheshire East were treated for an assault injury in each of the years 2007/08 and 2008/9 with higher rates in Crewe, Macclesfield, Nantwich and Middlewich.

- An average of 1,888 people from Cheshire East attended an A&E department for treatment of a road traffic injury in each of the years 2007/8 and 2008/9. Injury rates were highest in residents of Middlewich, Crewe, Nantwich and surrounding rural areas.

- 25.1% of the population used the A&E department in 2008/9, 50% of these attendances could have been managed by a primary care service.

**Lifestyles and Health and Diseases**

- Circulatory Disease (heart disease, heart attacks, heart failure and stroke) remains the main cause of premature death in Cheshire East, accounting for 41% of deaths under 75 years. Stroke accounts for 11 % of all deaths in England and is the single largest cause of disability in adults.
Stroke comprises about a quarter of all CVD deaths in Cheshire East. Over 2006/08 there was 166 premature deaths from stroke (under 75s).

- Cancer death constitutes 26% of all deaths locally, making it the second biggest cause of premature mortality and morbidity following CVD.

- Binge drinking and hazardous and harmful drinking is a serious Public Health issue in Cheshire East Out of 324 local authorities in England, Cheshire East currently ranks 156th for binge drinking, 309th for hazardous drinking and 216th for harmful drinking (where a rank of 1 is the best local authority in England and a rank of 326 is the worst).

- Across Central and Eastern Cheshire PCT area there are 112,000 ‘increasing and high risk’ drinkers (previously hazardous and harmful drinkers) or approximately 30% of the adult population. There is significant variation in the geo-demographic groups across the PCT and LA footprint that are drinking hazardously or harmfully, ranging from ‘traditional male pub drinkers to the elderly and rural isolated drinkers.

- Ten primary care practices in the East Cheshire Council area have statistically higher admission rates for alcohol attributable conditions than Central and Eastern Cheshire PCT average.

- Smoking remains one of the large causes of preventable morbidity and premature death; it is the primary reason for the gap in healthy life expectancy between rich and poor. Prevalence varies greatly across Cheshire East with rates as high as 26.2% in Crewe compared with 12.7% in Macclesfield rural.

- Adult participation in physical activity (as measured through sport and active recreation) in Cheshire East is generally similar to the national average. Activity rates are lowest in Crewe & Nantwich and highest in Macclesfield.

- There has been an increase in both HIV incidence and prevalence rates in the Macclesfield area.

4. JSNA Priority Measures

The JSNA Key Areas have been taken through a prioritisation process. This process has identified those which, by focusing on them, will have the greatest impact on health and social care, health improvement and the reduction of health inequalities. The prioritisation process confirmed findings from the 2007/08 PCT Strategic Needs Assessment and the JSNA First Look Report.

Since the first look report there is considerably more data and information added to the JSNA which has enabled us to more fully answer critical questions about understanding of health needs both met and unmet and reduction of inequalities in East Cheshire and the services commissioned for the local population. The JSNA top five priority measures are listed below:

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<th>Priority Measures</th>
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<tr>
<td>Reduce Cardiovascular Disease rates</td>
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<tr>
<td>Reduce Cancer Rates</td>
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<tr>
<td>Alcohol Harm Reduction</td>
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<tr>
<td>Improve the health of older people</td>
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<tr>
<td>Improving the health of children</td>
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Summarised below is the rational for these priority measures addressing each priority measure will impact on reducing health inequalities.
Reduce Cardiovascular Disease (CVD) rates

Cheshire East has a CVD mortality rate is similar to that of England overall however it is higher than the average of its peers with similar population make up, prosperity etc (Smaller Prospering Towns ONS cluster.) Although premature mortality (under 75s) from CVD has been reducing, there remains a large inequality gap between the best and worst experiences within the Cheshire East population when analysed by deprivation index or geographical areas (local areas and MSOAs). The inequality gap between the best and worst experiences has decreased more rapidly in the population as a whole than in the under 75s. This means that we must continue efforts to reduce premature mortality from CVD.

This large inequality gap in CVD experience contributes to the wide gap in life expectancy in the Cheshire East area and is a serious concern for commissioners and planners to take into consideration when making decisions on reducing health inequalities and improving the health of the population. A particular reference should be taken to the data modelling which indicates that in some practices about half of all people with hypertension remain undiagnosed. The JSNA also points to rates of access to cardiac revascularisation procedures (coronary artery bypass grafting and angioplasty) that are lower than our peers in the Cardiac Network.

Stroke comprises about a quarter of all CVD deaths in Cheshire East. In 2006-08 there were 166 premature deaths from stroke (under 75s). In common with the overall CVD picture, there is a marked difference in stroke mortality rates associated with deprivation. Many of the effective primary and secondary CVD prevention strategies are common to both CHD and stroke. Stroke care is part of the comprehensive provision of health care locally and there is a defined PCT work stream to ensure quality provision in this pathway which includes a focus on prompt (treatments for people with mini strokes or TIA’s) physiotherapy assessment for people with stroke.

Population reductions in smoking, cholesterol and blood pressure through dietary changes, lowering population obesity rates and increasing physical activity are all important contributors to lowering population premature mortality from CVD.
Reduce Cancer Rates

Alongside CVD cancer is the second biggest cause of premature mortality and high morbidity rates. Breast, Colorectal and Lung Cancers are the most significant causes of death. There have been some small reductions in early death rates from cancer but inequalities appear to be widening. 50% of cancers are preventable. Prevention through reducing the prevalence of smoking, improvements in diet and physical activity rates will make a significant difference along side earlier detection and better treatment and care of cancer. Cancer predominantly affects older people and is a particular priority for our ageing population. Action to tackle cancer will improve life expectancy and reduce the inequalities gap.

Trends in Cancer Mortality in CECPCT (standardised rates ages 0-74)

Trends in Cancer Incidence in CECPCT (standardised rates ages 0-74)

Rise in prostate cancer and melanoma
Falls in lung and bladder cancer
Rise in breast cancer, lung cancer, and melanoma
Alcohol Harm Reduction

Out of 324 local authorities in England, Cheshire East currently ranks 156th for binge drinking, 309th for hazardous drinking and 216th for harmful drinking (where a rank of 1 is the best local authority in England and a rank of 326 is the worst) - (source October 2009 Local Alcohol Profiles for England www.nwph.net/alcohol/lape). Out of the 152 Primary Care Trusts in England, Central and Eastern Cheshire Primary Care Trust currently ranks 108th for binge drinking, 146th for hazardous drinking and 73rd for harmful drinking (where rank 1 is the best PCT and rank 152 the worst) - (source October 2009 Local Alcohol Profiles for England www.nwph.net/alcohol/lape). This means that the population is likely to see more of the adverse effects of alcohol in the future.

Women in the PCT area have relatively high death rates from alcoholic liver disease and high months of life lost from alcohol as compared to others; national deaths from liver disease for men and women are increasing. Drinking costs the PCT £31.5m per annum, projected to increase by between 0.5-1.0 million per year, unless we reverse the increasing consumption of alcohol.

Every adult ‘pays’ £80 per annum to treat alcohol related problems in the East Cheshire area which is set to rise to £100 in 2012/13. This is out of a total health budget allocation per person of just over £1400 per annum. Alcohol is a risk factor for CVD and cancer (two major killers) in addition to individual health effects on the person individual person, harm caused from alcohol includes crime and antisocial behaviour ask well of loss of productivity for businesses.

Partners in East Cheshire must address the needs of the very large numbers of hazardous drinkers who without support may progress to become harmed by alcohol and whose care requirements will continue to grow by over £1m per annum. Commissioners should adopt the seven high impact changes identified by the Department of Health in order to reduce the potential for future harms.

For the wider partnership, it is recommended that an implementation plan for the Alcohol Harm Reduction Strategy be agreed and acted on through the existing LSP partnership structure with a view to moving NI 39 to a designated LAA target from 2011.

Hospital Admissions for Alcohol related Harm NI39
Central & Eastern Cheshire PCT

[Graph showing hospital admissions for alcohol-related harm from 2002-2014]
Improve the health of older people

17.8% (30,500) of the population in East Cheshire is over 65 compared with 15.9% nationally. This results in a high ‘old age’ dependency ratio i.e. low numbers of working-age supporting a high non-working dependant older population. The percentage of ‘older’ or ‘frail’ old is also considerably higher, 2.3% (8,200) persons 85 and over compared to 2.1% nationally.

Cheshire East has the fastest growing older population in the North West. By 2016, the population aged 65+ will increase by 29.0% and the population aged 85+ by 41.5%. Cheshire East’s high life expectancy and ageing community is something to celebrate and planning services to keep this population relatively fit and active is important for our residents to enjoy a healthy older age and lower the risk of long term illness into old age.

However the projected increases in the residents over 65 and particularly the ‘frail’ old (85 and over) will need to be considered in service development proposals. This is a potentially vulnerable group who will require more input from both social and health services. It is of particular importance to plan services and review care pathways for falls prevention, stroke and dementia services.

Improving the health of children

Breastfeeding is lower than expected in the area and is a priority area to increase rates because of its health legacy for both baby and mother. Breastfeeding positively impacts in the long term on blood pressure and total cholesterol for the child and is linked to increasing protection in the mother from certain forms of cancer (breast and ovarian).

Although the level to teenage pregnancy is lower than the average in Cheshire East there are areas of high teenage conception located wards in Crewe and Macclesfield which are the same wards with higher deprivation, higher rates of benefit claimants and lower educational attainment.

Uptake of childhood immunisations is good across the East Cheshire area, however Measles Mumps and Rubella (MMR) has remained at or below 88% for several years. As this is much lower than herd immunity requirements, sporadic cases and outbreaks continue occur and the area experience a significant measles outbreak in 2008/09.

5. Conclusion

The Joint Strategic Needs Assessment provides a picture of the needs of our population now and into the future. The continued process of assessment and update, working with all our local partners and stakeholders will be continued to be used to inform commissioning and to identify priority measures for action for the future for the Cheshire East Local Area Agreement, Central and Eastern Cheshire Commissioning Strategic Plan, the Sustainable Community Plan and other Local Strategic Partnership Plans.