Joint Strategic Needs Assessment

2013 - 2014

Contents

1 Introduction

1.1 Introduction to the Joint Strategic Needs Assessment

The JSNA identifies current and future health and well being needs and is a tool which helps provide partners with the information they need to agree priorities and plan interventions and services effectively to improve the lives of local people and meet the needs of South Tyneside's communities. (If you would like to see the full report, the data sources and annex and the full analysis then you can find this at www.southtyneside.info)

The JSNA brings together a wide variety of information relating to health, well being and social care needs, and sets out the details of priorities which will

- promote health and well-being, by investing now in prevention and early interventions for improved health;
- promote inclusion and tackle health inequalities;
- make sure that services are personal, sensitive to individual need and maintain independence and dignity;
- bring all partners together to focus on commissioning services and interventions that will achieve better health and improve the quality of life of the people of South Tyneside.

The JSNA tells us that the health of the residents has improved over recent years but overall health remains poor compared with both the region and nationally and confirms that South Tyneside's health is almost certainly determined by local people's wealth, education and life-chances.

Our vision is for the JSNA to assist local people and partners not only to be able to understand and describe what the health and social care issues are in South Tyneside but also to use that information to help us achieve agreed outcomes and our vision to

> "work in partnership to improve the health, well being and quality of life of our children, adults and families and reduce health inequalities to help people live longer and healthier lives".

1.2 What does this report contain?

This report is not a complete update of all the information and related conclusions from the previous JSNA. Instead, we have focused on a few key areas of importance to the area. A set of core indicators and additional CCG commissioning priority indicators are described in the next subsections, followed by a summary update of the core priority indicator values. We then present five themed chapters, focusing on particular aspects of the health and well-being strategy:

- Give every child the best start in life – we consider one element of this: the safeguarding of children.

- Increase life expectancy – there are many health conditions that affect life expectancy, which is lower in South Tyneside than in many areas of England. We consider one such condition – cancer.

- Employment and worklessness – being unemployed is known to have adverse effects on physical and mental health. We consider a range of issues around worklessness.

- Social isolation – a major contributor to mental ill-health, particularly depression. We focus on one specific group of individuals at risk of isolation: military veterans, who make up a greater proportion of the population in South Tyneside than they do in many other areas of England.

- Better quality services – having services that are not good quality is inefficient, ineffective and a waste of resources. We consider the improvement of services by focusing on four specific aspects: integration of services; services for those with chronic pain; using an asset-based approach; and the evaluation of services.

1.3 Core indicators

A core set of 29 'priority indicators' has been identified, covering a range of topic areas:

- Health outcomes – reflecting the health status of the population. This helps us to answer such questions as:
    - How healthy are South Tyneside residents?
    - What are the main health problems?
    - How many people suffer from particular health conditions?
    - Are our mortality rates from particular conditions higher than average?
    - Is the life expectancy of our residents as high as elsewhere?
- Health-related behaviour – reflecting the key lifestyle factors that affect health status. This helps us to answer such questions as:
    - How many people are putting their health at risk by smoking, unsafe drinking or drug misuse?
- Determinants of health – other factors affecting health, such as unemployment levels, educational attainment, levels of homelessness and number of children in care. This helps us to answer such questions as:
    - Is our population at risk because of high levels of unemployment?
    - Do we have a high proportion of people at risk of ill-health through being homeless?
    - Do we have a high proportion of children at risk of later ill-health because of problems with being looked-after?
- Service uptake and diagnostic rate – including the numbers of people using particular health services and numbers or rates of people diagnosed with particular conditions or the timeliness of diagnosis. This helps us to answer such questions as:
    - Are the numbers using services as high as we would expect for levels of disease?

- Are sufficient numbers being vaccinated/immunised against preventable disease?
- Is service use increasing or decreasing?
- Are we diagnosing as many people as we would expect?
- Are people being diagnosed soon enough?

The 29 priority indicator data items are summarised in Table 1. (Further detail on information sources and timetables of data availability appears in Appendix 1.)

Table 1: the 29 priority indicators

Topic area	Data item	Relevance
Health outcomes	Births, projected births	IMR is seen as an indicator of a population's general health.
	Infant mortality rate (IMR)	
	Life expectancy at birth by LA population	Life expectancy varies across England and many contributory factors have been identified and are modifiable
	*Healthy life expectancy at birth by LA population (placeholder)**	
	All age, all cause mortality rate	Certain conditions are caused largely by modifiable factors (e.g. lung cancer and circulatory disease are exacerbated by smoking). Early detection of some conditions increases likelihood of cure.
	Premature mortality rate due to circulatory disease	
	Premature mortality rate due to all cancers	
	All age mortality rate due to lung cancer	
	All age lung cancer registration rate	
	All age mortality rate due to colorectal cancer	
	All age colorectal cancer registration rate	
Health-related behaviour	Teenage conception rate	Many behaviours that have adverse effects of health can be modified (e.g. smoking, unhealthy eating' lack of exercise). Encouragement can be given to improve rates of health-enhancing behaviours such as breastfeeding.
	Proportion of mothers smoking at time of delivery	
	Breastfeeding – continuation	
	Obesity among primary school age children in Reception Year	
	Obesity among primary school age children in Year 6	
	Smoking prevalence	
Determinants of health	Number and proportion of children in care	Children in care have disproportionate levels of ill-health
	Rates of homeless households	Homelessness is a risk factor for both physical and mental health problems
	Educational attainment	Higher educational attainment and being employed are both linked with higher levels of physical health and mental and emotional health and well-being.
	Proportion of the working age population claiming Jobseekers Allowance (JSA)	
	Proportion of young adults 18-24 years claiming JSA	
Service uptake and diagnosis	Uptake of MMR 1st dose at 24 months	High MMR uptake reduces population risk from these diseases
	Uptake of MMR 1st and 2nd dose at 5 years	
	Coverage of cervical screening	For many conditions, early diagnosis can mean earlier

rates	Coverage of breast screening	intervention and an improved prognosis. Where forecasts are available of prevalence (e.g. of hypertension), comparison with numbers actually diagnosed shows that there are likely to be cases as yet undiagnosed.
	Hypertension, diagnosed vs expected prevalence	
	Chlamydia diagnoses (crude rate per 100,000 aged 15-24 yrs)	
	HIV late diagnosis	

*'placeholder' means that the indicator is under development

1.4 Additional CCG local commissioning priorities

As well as those indicators, additional indicators have been identified as CCG local commissioning priorities (see Table 2).

Table 2: additional CCG local commissioning priorities

Topic	Indicator
Urgent care	Number of four hour waits
Personalised care plans in mental health	Proportion of secondary mental health service users in suitable accommodation
	Proportion of secondary mental health service users in employment
Personalised care and independent living for patients with long-term conditions	Rate of older people (65+) being admitted to permanent residential care
Cancer services	Number of urgent suspected cancer referrals waiting more than two weeks to first appointment
	Number of urgent suspected cancer referrals waiting more than 62 days to first treatment
Seamless planned care pathways within and across organisations	Number of delayed discharges
End of life care	Proportion of people dying at home

1.5 Related South Tyneside strategies

The information in the JSNA can prove useful to a wide range of strategies. Primarily concerned with health and well-being, it recognises the many links with the 'wider determinants' of health, including some already mentioned among the indicators in Table 1: unemployment, education, being looked after. Poverty and deprivation are also strongly linked, as is social isolation. As can be seen, the task of addressing these wider determinants will usually be a multi-agency responsibility, with leadership falling to a range of departments rather than to health and social services.

We look firstly here at one strategy that does fall within the remit of health and social services: the Health and Wellbeing Board's 'Health and Wellbeing strategy',

1.5.1 Our Better Health and Wellbeing Strategy 2013/14

This strategy is largely based on previous JSNAs, which have helped to identify key areas of concern. The strategy considers approaches to address the risks, which will require the commitment of partners, and looks at innovative ways of working and making use of evidence of best practice. Its vision and strategic outcomes are shown in Box 1.

Box 1: Our better health and wellbeing strategy 2013/14 – vision and strategic outcomes

The South Tyneside Vision

We have a vision to make South Tyneside **an outstanding place to live, invest and bring up families.**

To achieve our overall vision we have agreed **10 strategic outcomes** under the themes 'People' and 'Place'. These are the things we will achieve over the next 20 years:

People

- Better education and skills
- Fewer people in poverty
- Protect children & vulnerable adults
- Stable and independent families
- Healthier people

Place

- regenerated South Tyneside with increased business and jobs
- Better transport
- Better housing & neighbourhoods
- A clean and green environment

The key needs identified in the strategy are noted in Box 2.

Box 2: key needs from our health and wellbeing strategy 2013/14

- Proportion of mothers smoking throughout pregnancy remains significantly higher than the North East and England average.
- Breastfeeding rates are lower than the England average and not increasing sufficiently over time.
- Over half of children live in low income families.
- Number of Looked After Children is comparable to neighbouring authorities but higher than the England average.
- Smoking, alcohol use, sexual health and emotional wellbeing for young people are key issues to be addressed.
- Youth unemployment higher than regional and national average.
- Job seeker allowance claims are higher than the North East and England average
- Life expectancy is increasing but the gap is not closing.
- Nearly half of the population live in areas among the 20% most disadvantaged across England.
- Health inequalities gap in relation to early deaths due to all cancers, respiratory and circulatory diseases.
- The rate of alcohol related hospital admissions has increased and is higher than the national average.
- Rates of smoking highest among young adults 18-24, adults 35-54 years.
- Adult obesity rates estimated to be 17% of males and 18% of females.
- 21,000 adults in South Tyneside have been diagnosed with depression.
- The number of people diagnosed with dementia in South Tyneside has risen to 1,047.

- Increasing older population with high dependency on services.

As will be noted, many of those key needs are included in the list of 29 priorities (in Table 1). They helped to inform the choice of the topic areas that form the focus of the five themed chapters of this year's JSNA.

1.6 Evidence and the JSNA

1.6.1 Introduction

The recommendations of the JSNA have been developed in accordance with evidence and guidance from a range of sources including agencies such as the National Institute for Health and Clinical Excellence (NICE). NICE in particular provides clear standards and recommendations, backed up by evidence and costs assessments, as well as implementation tools that help to put the guidance into practice, to achieve high quality care and better health improvement. There are also a range of specific tools developed by NICE to support preventative action and delivery in Local Authority and other settings , this include direction and advice for people working in and with local communities.

The evidence base generally and the NICE guidance in particular, enables the JSNA recommendations for commissioned services to be in line with the best available evidence of clinical and cost-effectiveness, enabling local people to be assured that local programmes will be provided using a consistent evidence-based approach, to not only provide a basis to support local people to improve their own health and prevent disease but also to effectively target resources and efforts at the areas that offer the most significant health improvement.

1.6.2 Examples of the use of Evidence base

1.6.2.1 Best Start in Life

Ensuring that our young people have the best start in life is a key Health and Well Being Board priority. The early years directly influences their health and wellbeing later as an adult impacting on risks factors for of long term ill health. In addition, seeking good health and wellbeing for school age children and young people in the transition to adult life can have a hugely positive impact on their future. Five of the ten most common risk factors in adult disease are formed during adolescence, including mental health problems and obesity. A broad range of evidence is available to direct action to address these issues including:

- NICE guidance PH26 Commissioning interventions to reduce harmful parental behaviours including alcohol and substance misuse and smoking and ensure all services safeguard children's welfare http://www.nice.org.uk/_gs/searchtracker/GUIDANCE/13023

- NICE guidance PH21 Ensure all families have access to the Healthy Child Programme 0 - 5yrs including screening and immunisation programmes and implement interventions to increase uptake http://www.nice.org.uk/_gs/searchtracker/GUIDANCE/12247
- Implement UNICEF Baby Friendly standards across all settings and provide local, easily accessible breastfeeding support programmes
- Work with its local partners to ensure that health and wellbeing needs are being met in a holistic way, recognising the totality of the individual's needs rather than single issues http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/reports/bestStartUpdate2010-2011/system.aspx
- Ensure all its directly provided and commissioned services meet You're Welcome standards https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

1.6.2.2 Across the Lifecourse

There is also substantial evidence base supporting Public Health interventions which improve health and quality of life, as well as the evidence for the provision of tailored advice and tools to support effective commissioning of health and wellbeing interventions, including weight management, sexual health, smoking cessation and tobacco control and drug and alcohol treatment services and the NHS Health Checks.
This includes:

- NICE guidance 42, Obesity: working with local communities, November 2012 http://publications.nice.org.uk/obesity-working-with-local-communities-ph42
- Commissioning regional and local HIV sexual and reproductive health services (PHE) 2014 https://www.gov.uk/commissioning-regional-and-local-sexual-health-services
- NICE PH10 Smoking cessation services: guidance http://guidance.nice.org.uk/PH10
- NICE Alcohol dependence and harmful alcohol use quality standard http://publications.nice.org.uk/alcohol-dependence-and-harmful-alcohol-use-quality-standard-qs11
- NICE guidance PH3 Prevention of sexually transmitted infections and under 18 conceptions http://guidance.nice.org.uk/PH3

In addition there are a number of NICE guidance papers relating to interventions such as Exercise Referral Schemes; Community Engagement; School based interventions to prevent smoking; Social and emotional wellbeing in primary education and Encouraging walking and cycling which can support the achievement of Public Health goals in a number of settings where the Council has influence

1.6.2.3 Commissioning and integrated services

There is also a wealth of evidence to support the commissioning of effective and high quality health care. Examples include

- Provide high quality maternity services for antenatal and postnatal care and for women with complex needs: NICE CG110- Pregnancy and complex social factors**:** A model for service prevision for pregnant women with complex social factors
- Guidance on how to commission services that integrate prevention and lifestyle modification as part of all clinical care pathways, e.g. physical activity throughout the care pathway for cancer http://www.macmillan.org.uk/Aboutus/Healthandsocialcareprofessionals/Macmillansprogrammesandservices/Physicalactivity.aspx
- NICE Commissioning Guidance. Smoking cessation service for people having elective surgery. (April 2009) http://www.nice.org.uk/media/0A4/1D/SmokingCessationCommissioningGuide.pdf
- NICE Guidance PH50: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (PH50) http://publications.nice.org.uk/domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-ph50/recommendations#recommendation-5-create-an-environment-for-disclosing-domestic-violence-and-abuse

1.6.3 Recommendation

Provide a series of interactive training sessions, developed in consultation with the local NICE link, for key officers the Council and Health and Well Being Board partners to enable them to understand the importance and accessibility of the correct evidence, particularly in relation to the NICE guidance and implementation tools.

Using NICE guidance and an evidence based approach to delivery

In 2013 the Council embarked on a programme of planning the delivery of the programme Every Contact a Health Improvement Contact (ECaHIC). ECaHIC is central to the Council's vision to make South Tyneside 'an outstanding place to live, invest, and bring up families'. In line with NICE guidance, PH6 Behaviour Change: the principles for effective interventions (http://www.nice.org.uk/_gs/searchtracker/GUIDANCE/11868) and PH 49 Behaviour change individual approaches (http://www.nice.org.uk/_gs/searchtracker/GUIDANCE/14347) the training programme uses a brief intervention tool as a framework to promote healthy conversations to support behaviour change. Given that 70% of the Council workforce lives in South Tyneside, cascading health messages to families, friends and wider community will have a substantial impact on the health of the population

This LGC award winning programme has been delivered to 500 Council staff ranging from social workers, refuse collectors, children centre staff and Councillors. 75 representatives from 15 community and public sector organisations have also participated. An example of the success the programme has had in changing behaviour is demonstrated by, four of the Street Cleansing Team who on completion of the training collectively lost 15 stone in weight by putting into practice simple healthy eating messages, and 'attacking the fruit bowl'.

2 Progress on previous JSNA

In this chapter, we outline progress that has been made on JSNA recommendations.

2.1 Every child to have a good start in life

Recommendation	Progress
Early years education, childcare and development needs should be focused proportionately across the social gradient.	Children's centres are now focusing on delivery across the social gradients but concentrating on meeting the needs of those from our poorest communities. As a result, engagement of our poorest families has increased by 30% in the last 12 months, with the unexpected side-effect that engagement of families across the entire social gradient has increased by 25% in the same period.
Support needs to be provided before conception and strengthened leading up to delivery to respond to key maternal health issues such as obesity, smoking and alcohol consumption. This requires a whole system approach across all partner organisations to deliver the change needed.	Maternity services have been improved to support women both before conception and up to delivery with a public health midwife appointed to increase the focus on smoking during pregnancy, breastfeeding and maternal obesity.
There is a need to an integrated approach to early identification of risk.	The threshold guidance within South Tyneside has been updated and refreshed. This is in line with the embedding of early help assessment, ensuring there is an integrated approach to the early identification of cases. The LSCB has strengthened and reshaped it's governance and oversight of those young people engaged in risk taking behaviour, further supporting this
Embed a Risk and Resilience model approach across all young people services to address alcohol, drugs, sexual health, smoking and emotional health and wellbeing needs of children and young people.	Work is underway to develop the change 4Life integrated model which will include a focus on children and young people and includes risk and resilience model approach. A review of emotional health and wellbeing education is underway.
Prevent children and young people becoming victims from child sexual exploitation (CSE) and protect and safeguard them from risk of harm from CSE.	Education relating to healthy relationships and internet safety is included in the Healthy Schools programme. In addition this year we plan to commission 'Chelsea's Choice: A hard hitting drama production about CSE. The target

	audience will be young people and their parents / carers / front line professionals.
Children and young people need to have access to timely, appropriate and accessible support to meet their weight management needs, through balanced school meals and via the provision of good information about healthy eating.	The Healthy Schools programme has increased its focus on healthy weight. School meals continue to be delivered to high standards of nutritional content

Continued active support for the adoption of the plain packaging for tobacco products during the Department of Health consultation.	Very supportive response from Agencies across South Tyneside was made to the Government's consultation on standardised packaging including input from the South Tyneside Youth Parliament

This year's key information

- Between 2012/13 there were 427 women known to smoke at time of delivery, an increasing trend in South Tyneside and significant worse than the England average.
- Smoking prevalence in South Tyneside is now at 20.7% of the population at 2012, similar to the England average and an improving trend.
- Breast feeding initiation during 2012/13 for South Tyneside was at 58.5%, significantly worse than the England average of 73.9%, although trend is improving.
- Breast feeding prevalence at 6-8 weeks after birth during 2012/13 was at 26%, significantly worse than the England average of 47.2%, but had improved on previous year.
- Excess weight in 4-5 year olds in South Tyneside during 2012/13 was at 24%, similar to England average and an improvement on previous year.
- Excess weight in 10-11 year olds in South Tyneside during 2012/13 was at 37.7%, significantly worse than the England average, and a marginal improvement n previous year.

2.2 Increased life expectancy with reduced differences between communities

Recommendation	Progress
Commissioned services that impact most effectively on life expectancy need to be focused proportionately across the social gradient.	The development of the new Change 4 Life integrated wellbeing service and work towards local integration and support for self-care is focused at local delivery level and addressing those across the social gradient
Awareness of early signs and symptoms of cancer to increase early diagnosis opportunities; the need to focus on the reduction in inter practice variation in referral; increasing the opportunity to engage with communities and examine the use of social marketing tools to convey the cancer awareness message effectively.	The Locality Cancer Group has developed a series of priorities and actions following a multi agency workshop. Action will deliver changes across the entire Cancer pathway from awareness and early identification to end of life planning. This includes raising awareness with Social Care and other key partners and providing training to improve awareness of signs and symptoms of cancer, and uptake of cancer screening programmes within vulnerable and marginalised population groups.
There is a need to develop culturally appropriate services to increase people from South Tyneside's BME communities awareness message effectively.	As part of the asset based approach to working with local communities, there has been engagement with BME communities as part of the development of services
Continue to improve the uptake of NHS Health Check to identify those with cardio vascular disease.	Revision of the delivery programme for NHS Health Checks being undertaken to improve uptake among those who still require an NHS Health Check, the marketing to encourage people to take up the check and a focus on reaching those at higher risk
To continue to commission a range of evidence-based prevention and treatment services in relation to tobacco, alcohol and overweight / obesity, including the development of an Integrated Wellness Service (linked to other services), with a life course approach and a greater focus on children and families.	NICE guidance has been used in the development of the emerging Change 4 Life service which will address lifestyle risk factors (including Smoking, alcohol, and weight issues) across the lifecourse, within an integrated model of delivery
Utilise the NICE guidelines to define longer term obesity action including active travel interventions (such as cycling and walking promotion), Council approval of fast food outlets and the undertaking of a Health Equity Audit of Leisure Services to identify their key	Work has been undertaken focusing on the issue of Hot Food Take Away and prevalence of obesity with joint work between public health, planning, environmental health supported by Health and Wellbeing Board. The Health Equity Audit has been carried

target groups.	out and results are informing the development of physical activity take up The People Select Committee has examined the issues relating to Obesity , utilising the best evidence and is driving action to address the factors influencing the increases in Obesity levels
Increase the use of the Wellbeing tool, across all commissioning and local action on limiting access to alcohol and minimum unit pricing and focusing on preventing the wider impact of excessive alcohol consumption.	Partners have worked together to produce an Alcohol strategy which is shaping action on reducing the impact of alcohol in South Tyneside, this includes support for Regional developments on minimum unit pricing, action to target dependant drinkers and reshaping of hospital alcohol services
All commissioned services need to identify the extent to which there is access to services by key groups and review their delivery accordingly.	The outcomes of the review of a range of Public Health services has refocused the delivery of services to ensure widest possible take up but also with targeted uptake by those most disadvantaged or vulnerable
Determine how many private dwellings particularly in the private rented sector meet the decent homes standard via a Housing Conditions Survey.	Funding options are being sought to carry out a Housing Conditions Survey by 2015/16 Survey to be supplemented by Health Impact Assessment Rapid Appraisal of private rented sector/Houses in Multiple Occupation tenancies
Maintain investment in warm homes initiatives aimed at vulnerable people.	Multi-agency groups now in place to promote warm homes, tackle fuel poverty, reduce Excess Winter Mortality and support falls prevention. Fuel Poverty Group monitors PHE Cold Weather Plan and cascades Met Office alerts. Cold Weather Plan links to the Winter Plans within the CCGs Urgent Care Delivery Group.
There needs to be better integration in the commissioning of coherent integrated services to address the needs to victims of Domestic Violence.	Domestic violence review underway looking at current provision, commissioning arrangements with the emphasis on the development of a integrated service for victims

This year's key information

- NHS Health checks being offered in South Tyneside are lower (14.1%) than national levels (16.5%), a downward trend from previous year 2012/13.
- Uptake of those being offered however is significantly better than the England average, at 52.7% uptake of those being offered during 2012/13.

- The rate of domestic abuse in South Tyneside is 23.8 per 1000 population recorded by the police in 2012/13.

2.3 Better employment prospects for young people

Recommendation	Progress
Expand policies that are focused on increasing levels of young unemployment.	The Employment and Skills Development Group has identified 7 areas of activity to develop pathways to employment in key employment growth areas. The measures focus on ensuring young people make academic and vocational choices that will ensure that they succeed in the North East economy. The Council will continue to work with local businesses to create training and apprenticeship opportunities for young people.
Increase advanced level training skills.	The Council is working in partnership with Sunderland Council to deliver the Sunderland and South Tyneside City Deal which will result in the creation of 5,200 new high skilled manufacturing jobs. Work is underway with local businesses to identify skills gaps within their existing workforce and to develop up skilling programmes.
Encourage growth in medium sized enterprises.	The Council has a comprehensive package of support to help attract, grow and retain businesses. The support available includes support to access new markets, support to find premises, recruitment and workforce development support and support to access finance.
The Health and Wellbeing Board member organisations need to be lead employer for 'employment pathways' interventions.	South Tyneside Foundation Trust is the lead employer for Health and Social Care on the Employment and Skills Development Group.
There needs to be work to better identify and refer NEETs on to appropriate programmes.	The Council is working collaboratively with other Councils across the region to coordinate and deliver additional support A re-design of Services for Young People in 2014 includes two posts specifically allocated to meeting the needs of NEET young people and to identifying and preventing others becoming NEET. The work being done by the Employment and Skills Development Group (see above) is also geared towards reducing NEET numbers in the medium to longer term.

This year's key information

- First time entrants to the youth justice system is now similar to England rates in 2012, an improvement on previous year, a rate of 478 per 100,000 population.

- 16-18 year olds no in education employment or training remains significantly above the national average

2.4 Better mental health and emotional well-being for older people

Recommendation	Progress
Tackle social isolation amongst the elderly is a priority and there needs to be a focus on reducing social isolation through providing social and educational opportunities.	Social isolation has been identified as a priority for the HWB and partners are working together to develop a range of actions and opportunities to promote social interaction
Identify older people at risk, particularly as a result of social isolation and commission interventions to reduce those risks including volunteering and community mentoring	Public Health have developed a range of actions in conjunction with Age UK including a brokerage scheme to support small scale social activity and the development of local lay health champions with AGE UK to increase the opportunities for local people to engage in local activity
Long term planning to meet future housing needs, should reflect the anticipated change in demands resulting from an older population.	There has been increased engagement between Public Health and Development Services to help understand and begin to plan for the demographic changes identified facing South Tyneside including input into the next iteration of the Development Plan and localised housing initiatives
Develop the actions identified in the dementia strategy including early diagnosis and secondary prevention.	Dementia awareness and the understanding of memory services available are now embedded within NHS Health Checks Programme. There has been support for a dementia friendly campaigns and the development of training across South Tyneside to help understand the support needed and the difficulties experienced by those with Dementia
Provide sufficient and appropriate opportunities for older people to begin and maintain physical activity.	The importance of physical activity has been highlighted in the emerging Falls Prevention Strategy. In addition the work of the new Change 4 Life service will be focused on encouraging the uptake of action which addresses lifestyle risk factors to all ages. South Tyneside's Pioneer programme to integrate services and focus on helping local people help themselves
Falls prevention promotion including greater identification of those at risk of a fall.	Multi- agency, Multi-disciplinary group formed to develop and implement a range of actions within a new Falls Prevention Strategy, based on the most recent Falls HNA. Prevention, Promotion and Early

	Intervention are key throughout all elements of the strategy.

This year's key information

- Social Isolation: 44.1% of adult social care users stated they have as much social contact as they would like in South Tyneside in 2012/13, similar to England average but a drop on previous year.
- Loneliness and Isolation in adult carers in South Tyneside at 36.2%, similar to the England average.
- Injuries due to falls in people aged 65 and over rate of 2,030 (per 100,000population) during 2012/13, similar to the England average for the past 3 years.

2.5 Better quality, integration and efficiency of services

Recommendation	Progress
Improved community pathways for high users of hospital services.	South Tyneside CCG Improving Care for Patients (STICS) programme focussed on promoting initiatives to identify and support isolated or seldom seen patients with potential to become high users of services. This ran alongside work to improve localised community provision in Primary Care
Provide local and accessible services, and more inter-agency working to ensure cohesive integrated delivery which includes risk identification, self care and reablement.	South Tyneside has been identified by the Department of Health as a leading area for the delivery of the integration of health and social care (one of 14 Pioneer sites across the Country) focussing on encouraging greater self care, better self management of disease and shared problem solving between clients and services
Analyse admissions and readmissions data to understand how urgent care services can be streamlined and to develop seamless planned care services across organisations.	Following the analysis of the data the CCG are working towards the delivery of services in the urgent care hub. The development of the Health and Wellbeing Board's Joint Strategic Commissioning group means that there is added joint planning and delivery in areas such as the uptake of Telehealth
Review the current delivery of diabetic screening, and diabetic testing and consider the commissioning on an integrated coordinated service.	STCCG are in process of examining the commissioning a diabetes one stop shop.
Review the current provision for carers	South Tyneside CCG Improving Care for

to consider short break care support, emergency service provision, particularly for dementia care, improved advocacy services for carers and flexible long term support as an alternative to residential care as well as information about access to services and assessment / eligibility.	Patients (STICS) programme focussed on promoting initiatives to identify and support isolated or seldom seen patients with potential to become high users of services. This ran alongside work to improve localised community provision in Primary Care

3 Core priority indicator data

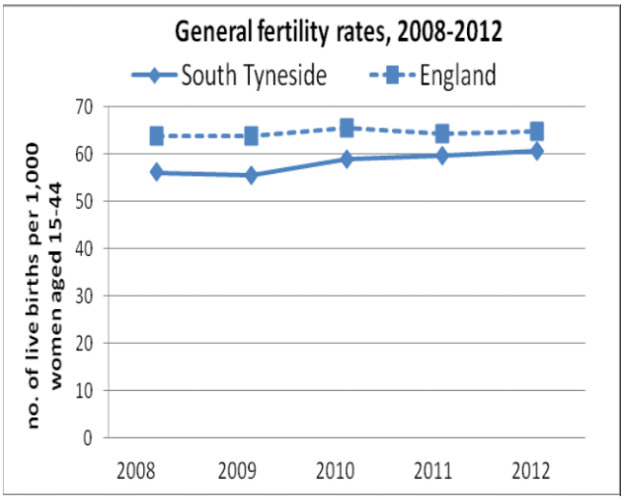
In this section, we provide information (in the form of values and charts, as appropriate) relating to the priority indicators described in the introduction. Where a priority indicator is of particular relevance to one of the five themed chapters, we indicate this and include it in that chapter rather than here.

3.1 Health outcomes

3.1.1 Births and general fertility rates

With around 1700 births per year in recent years, South Tyneside's general fertility rate (the number of live births per 1,000 women aged 15-44) has consistently been lower than England's (generally 56-61 per 1,000 compared to England's 64-66 per 1,000, see Figure 1).

Figure 1: numbers of births and general fertility rates



Year	South Tyneside births		*England rate*
	number	rate	
2008	1670	56.1	*63.8*
2009	1644	55.5	*63.7*
2010	1741	58.9	*65.5*
2011	1665	59.7	*64.2*
2012	1675	60.6	*64.8*

Data source: Office for National Statistics website May 2014. Rate is the General fertility rate (number of live births per 1,000 women aged 15-44)

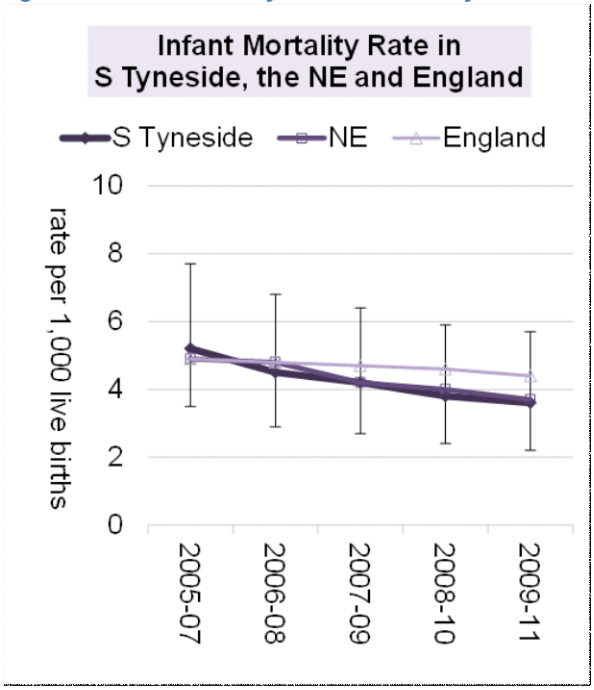
3.1.2 Projected numbers of births

Office for National Statistics Interim Population Projections up to 2021 (based on 2011 census) suggest that there will be around 1700 births each year in South Tyneside.

3.1.3 Infant mortality rate

South Tyneside's Infant Mortality Rate (deaths under the age of 1 year, per 1,000 live births) has been below England's (but not significantly lower) since 2006-08 (see Figure 2).

Figure 2: Infant mortality rate for South Tyneside Local Authority population



Year	South Tyneside deaths		*England rate*
	number	rate	
2005-2007	25	5.2	*4.9*
2006-2008	22	4.5	*4.8*
2007-2009	21	4.2	*4.7*
2008-2010	19	3.8	*4.6*
2009-2011	18	3.6	*4.4*

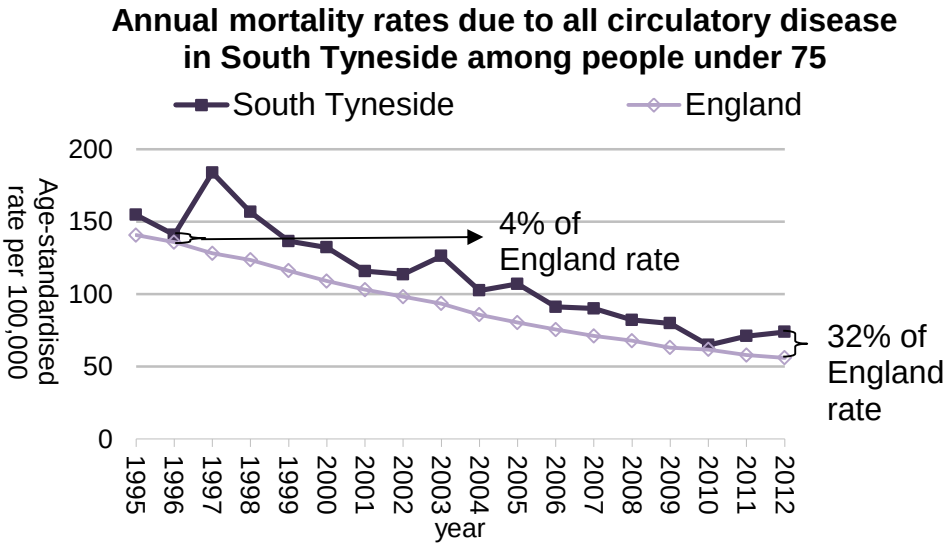
The rate is the three-year average of deaths under the age of one year per 1,000 live births. 95% confidence limits are shown on chart.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

3.1.4 Premature mortality rate due to circulatory disease

The early mortality rate due to heart disease, stroke and related conditions continues to fall among the population of South Tyneside. However the rate of fall has slowed down in the past five years and the gap between local and England rates has widened (see Figure 3).

Figure 3: annual mortality rate, circulatory disease



Source: Indicators Portal at https://indicators.ic.nhs.uk, Health and Social Care Information Centre

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

3.1.5 Core priority indicators presented elsewhere in this report.

Information on the following is contained within the relevant case study chapter (increasing life expectancy):

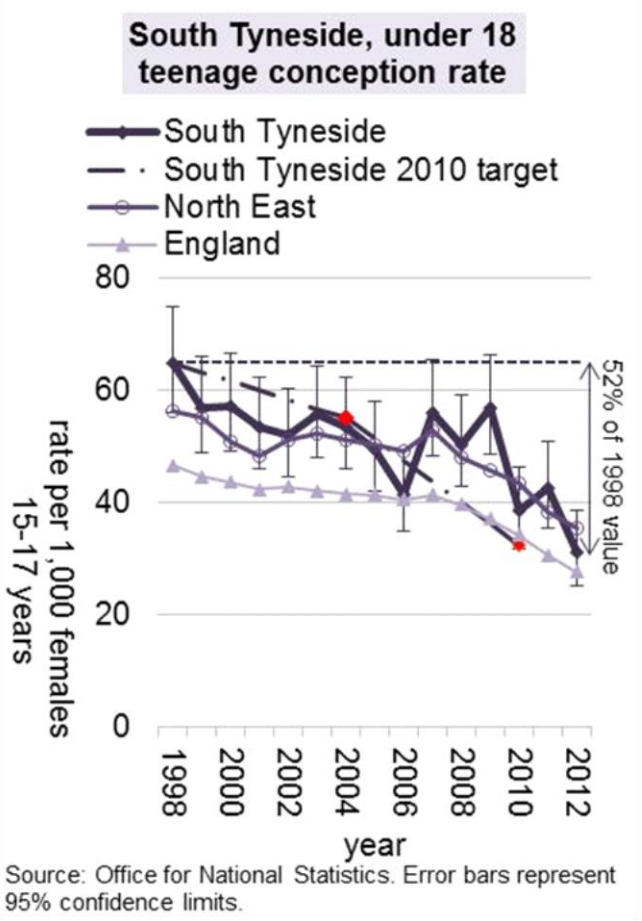
- all age, all cause mortality rate;
- Life expectancy at birth by LA population;
- *Healthy life expectancy at birth by LA population (placeholder)**;
- premature mortality rate due to all cancers;
- all age mortality rate due to lung cancer;
- all age lung cancer registration rate;
- all age mortality rate due to colorectal cancer;
- all age colorectal cancer registration rate.

3.2 Health-related behaviour

3.2.1 Teenage conception rates

Since 1998, the under 18 conception rate has fallen by 40% across England and the North East and by 50% in South Tyneside. However, South Tyneside's rate is still higher than England's (see

Figure 4: under 18 teenage conception rate



Year	South Tyneside under 18 teenage conceptions		*England rate*
	number	rate	
2010	108	38.5	34.2
2011	117	42.5	30.7
2012	84	31.1	27.7

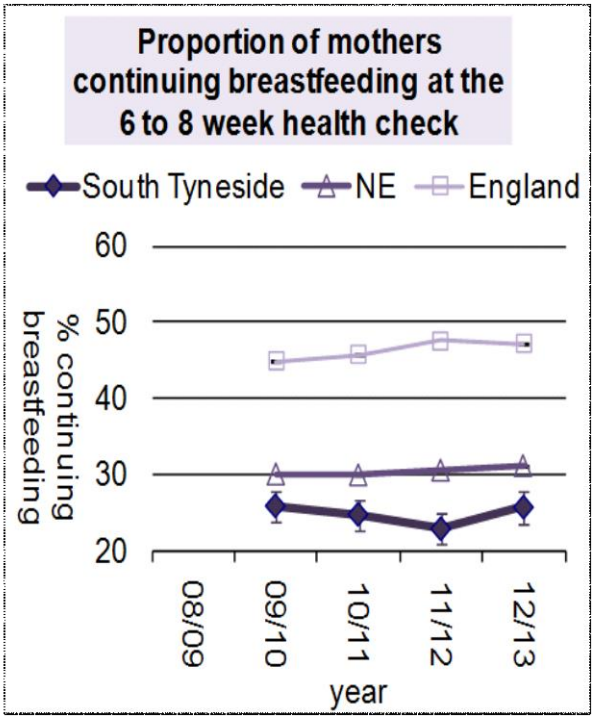
Data source: ONS. Rate is the number of conceptions under 18 years per 1,000 females aged 15-17 years

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, March 2014.

3.2.2 Breastfeeding – continuation

The North East region has the lowest number of mothers that continue to breastfeed up to 6 to 8 weeks among all 10 English regions and the proportion remains below the North East average in South Tyneside (see Figure 5).

Figure 5: proportion of mothers continuing to breastfeed at 6-8 weeks



Year	South Tyneside mothers continuing to breastfeed at 6-8 week health check		*England rate*
	Maternities	rate	
2009/10	1,775	**25.9**	*44.9*
2010/11	1,687	**24.8**	*45.7*
2011/12	1,657	**22.9**	*47.6*
2012/13	1,632	**25.7**	*47.2*

Figures in bold indicate that these are significantly higher or lower than England prevalence at 95% confidence. (95% confidence limits are shown on chart.) Data source: Dept of Health. Data for 2013/14 will be published in June 2014.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

The proportions vary by ward, as shown in Figure 6 and Figure 7, with several wards (Bede, Fellgate and Hedworth, Primrose and Biddick & All Saints) having rates consistently below the South Tyneside average.

Figure 6: Proportion of mothers breastfeeding to 6 to 8 weeks by South Tyneside ward, 2009/10 to 2012/13

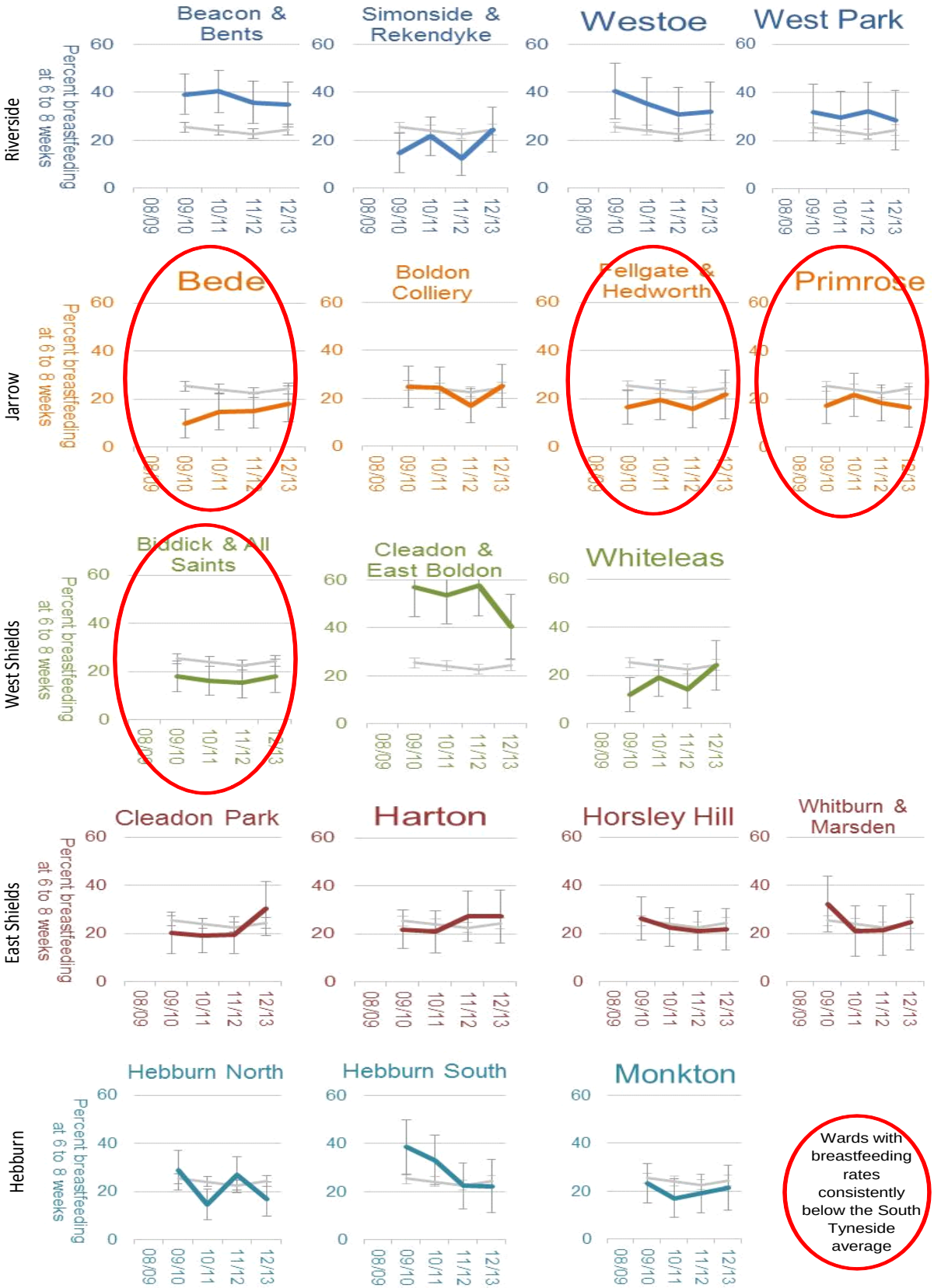
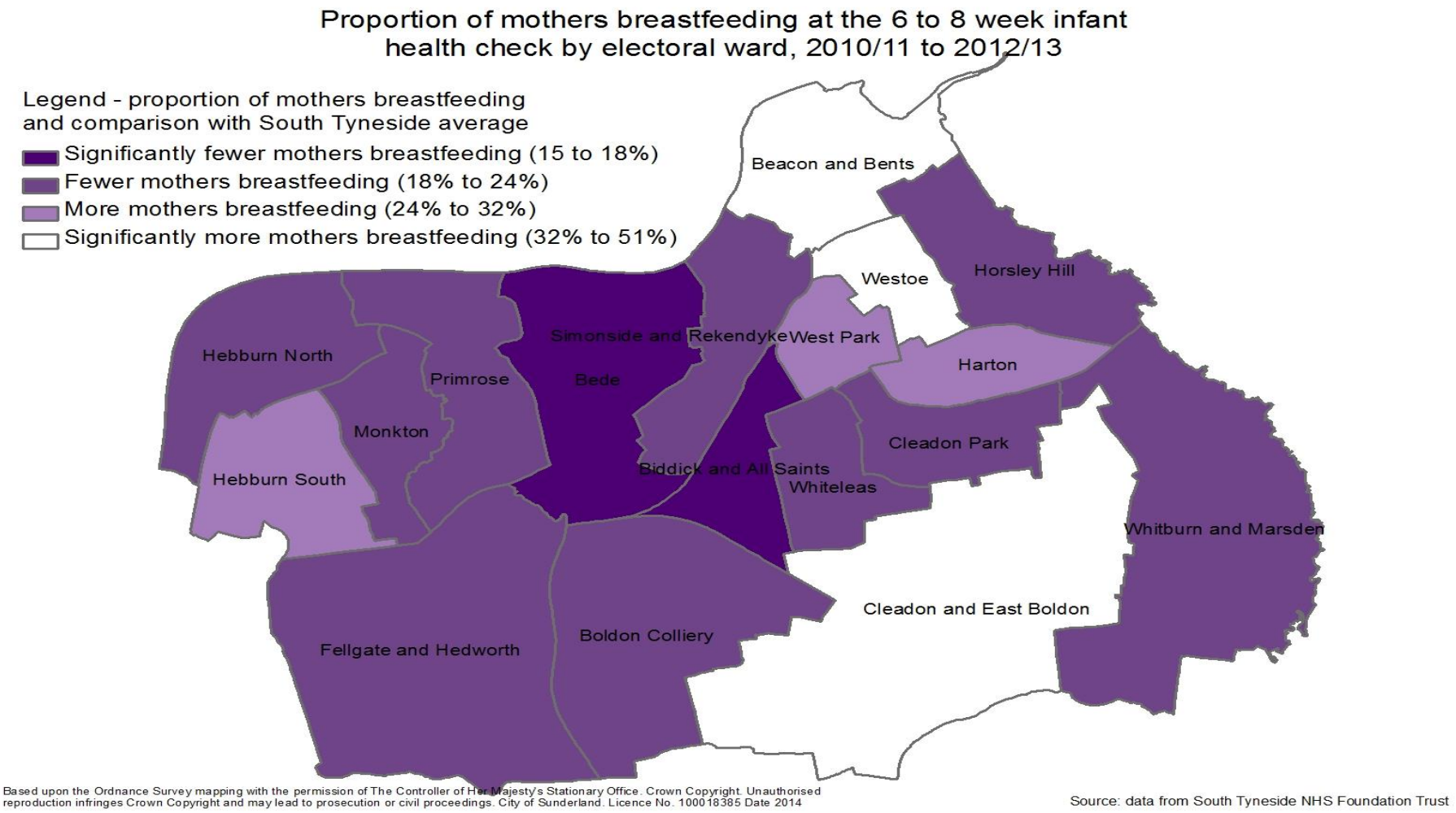


Figure 7: breastfeeding continuation at 6-8 weeks – ward map

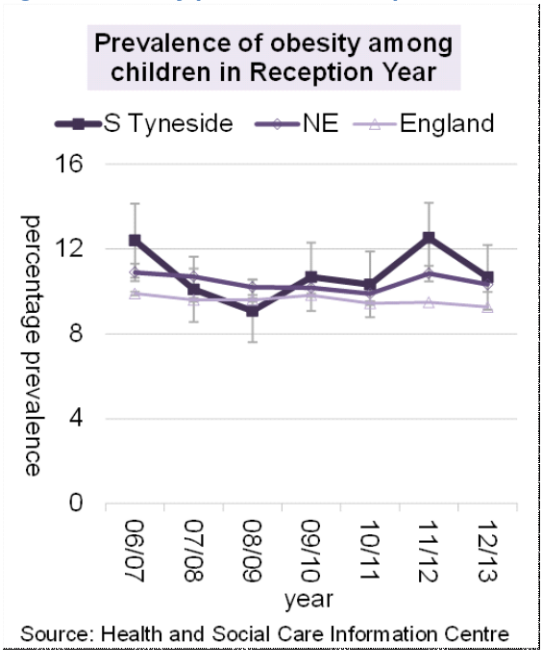


Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

3.2.3 Obesity among primary school age children in Reception Year

Following a peak in 2011/12, the prevalence of obesity among Reception Year children (11%) has fallen and is now close to the regional average (see Figure 8). There are areas within South Tyneside where the local prevalence of obesity is between 13% and 19%. There is one area, comprising the south of Bede ward, where the proportion of obese children in Reception Year is significantly higher than the England average at a 95% level of confidence.

Figure 8: obesity prevalence, Reception Year



Year	South Tyneside		*England prevalence (%)*
	% of children measured	prevalence (%)	
2008/09	97.3	9.1	*9.6*
2009/10	88.0	10.7	*9.8*
2010/11	97.3	10.3	*9.4*
2011/12	96.8	**12.5**	*9.5*
2012/13	91	10.7	*9.3*

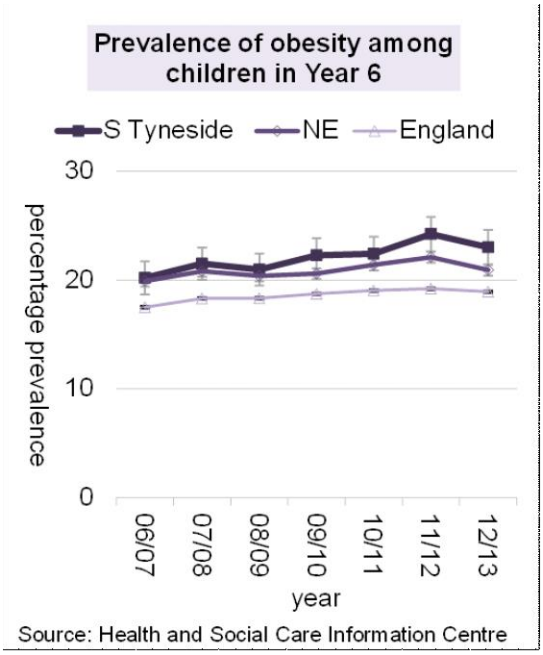
Figures in bold indicate that these are significantly higher or lower than England prevalence at 95% confidence. (95% confidence limits are shown on chart.) Data source: HSIC National Child Measurement Programme. Data for 2013/14 will be published in December 2014.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, Aug 2013

3.2.4 Obesity among primary school age children in Year 6

The proportion obese among Year 6 children (23%) has fallen compared to the previous year but remains higher than the regional average (see Figure 9). There are areas within South Tyneside where the local prevalence of obesity is between 26% and 32%.

Figure 9: obesity prevalence, Year 6



Year	South Tyneside		*England prevalence (%)*
	% of children measured	prevalence (%)	
2008/09	95.6	**21.0**	*18.3*
2009/10	85.4	**22.3**	*18.7*
2010/11	98.0	**22.4**	*19.0*
2011/12	96.8	**24.2**	*19.2*
2012/13	91	**23.0**	*18.9*

Figures in bold indicate that these are significantly higher or lower than England prevalence at 95% confidence. (95% confidence limits are shown on chart.) Data source: HSIC National Child Measurement Programme. Data for 2013/14 will be published in December 2014.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, Aug 2013

3.2.5 Core priority indicators presented elsewhere in this report.

Information on the following key indicators is contained within the relevant themed chapter (increasing life expectancy):

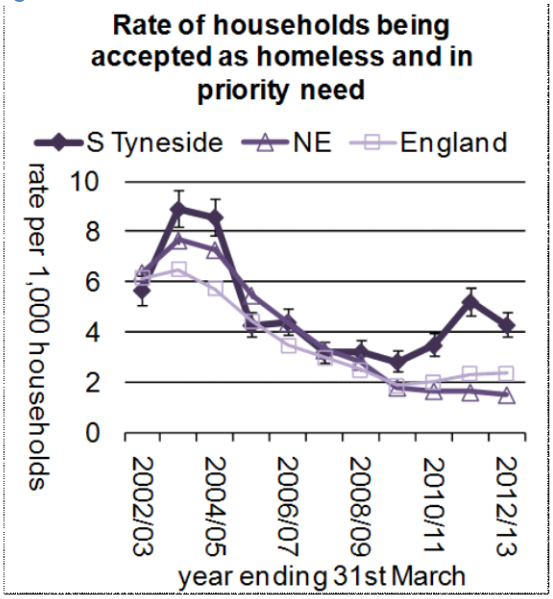
- Proportion of mothers smoking at time of delivery;
- Smoking prevalence.

3.3 Determinants of health

3.3.1 Rates of homeless households

The average rate of households being accepted as homeless and in priority need across the North East is below the national average. The rate has begun to fall in South Tyneside after rising sharply in the previous two years, but is still significantly higher than the national average (see Figure 10).

Figure 10: rate of homelessness



Year	South Tyneside accepted homeless		*England rate*
	number	rate	
2006/07	294	**4.4**	*3.5*
2007/08	213	3.2	*3.0*
2008/09	217	**3.2**	*2.5*
2009/10	189	**2.8**	*1.9*
2010/11	236	**3.5**	*2.0*
2011/12	353	**5.2**	*2.3*
2012/13	295	**4.3**	*2.4*

Figures in bold indicate that these are significantly higher or lower than England prevalence at 95% confidence. (95% confidence limits are shown on chart.) Data source DCLG.

3.3.2 Core priority indicators presented elsewhere in this report

Information on the following is contained within the relevant themed chapter:

- Number and proportion of children in care (chapter 4 – the best start in life);
- Proportion of the working age population claiming Jobseekers Allowance (chapter 6 – employment);
- Proportion of young adults 18-24 years claiming Jobseekers Allowance (chapter 6 – employment);
- Educational attainment

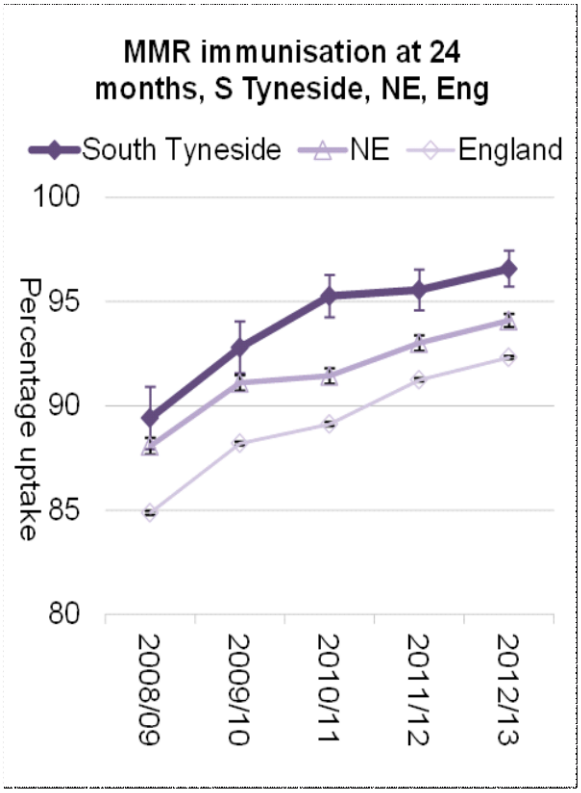
3.4 Service uptake and diagnosis rates

3.4.1 MMR vaccination

Local uptake of MMR vaccination has risen in 2013/14 and is above regional and national averages.

Notably, local uptake of the measles, mumps and rubella (MMR) vaccination 1st dose at 24 months is now close to 95% (see Figure 11). For MMR 1st and 2nd dose at 5 years, where promoting uptake has been more challenging, uptake has also risen to between 90% and 93% (see Figure 12).

Figure 11: uptake of MMR 1st dose at 24 months

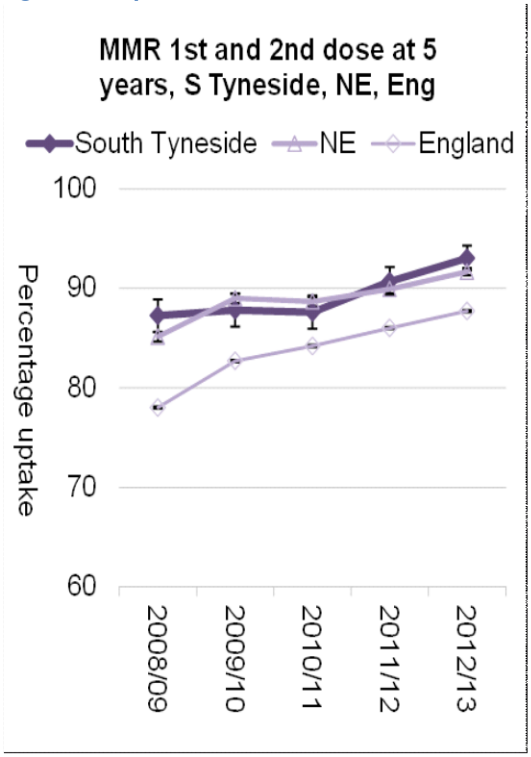


Year	South Tyneside children		*England uptake (%)*
	number	uptake (%)	
2008/09	1,625	**89.4**	84.9
2009/10	1,659	**92.8**	88.2
2010/11	1,667	**95.3**	89.1
2011/12	1,689	**95.6**	91.2
2012/13	1,725	**96.6**	92.3

Figures in bold indicate that these are significantly higher or lower than England rate at 95% level of confidence. (95% confidence limits are shown on chart.) Data source: Health and Social Care Information Centre. Data for 2013/14 will be published in Nov 2014.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

Figure 12: uptake of MMR 1st and 2nd dose at 5 years



Year	South Tyneside children		*England uptake (%)*
	number	uptake (%)	
2008/09	1,601	87.3	78.0
2009/10	1,500	87.8	82.7
2010/11	1,517	87.6	84.2
2011/12	1,591	90.7	86.0
2012/13	1,623	93.0	87.7

Figures in bold indicate that these are significantly higher or lower than England rate at 95% level of confidence. (95% confidence limits are shown on chart.) Data source: Health and Social Care Information Centre. Data for 2013/14 will be published in Nov 2014.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

3.4.2 Hypertension, diagnosed vs expected prevalence

In 2011, the Eastern Region Public Health Observatory (now part of Public Health England) produced a series of estimates of the true prevalence of certain conditions, including hypertension (high blood pressure). An estimated 30.6% of people over 16 in England had hypertension and in South Tyneside the estimated proportion was 32.4%. Conclusions from the work were that there remain large numbers of people in whom hypertension exists but has not yet been recognised by doctors.

NHS Health Checks continue to be delivered in South Tyneside, which include a blood pressure check. However, the total number of people diagnosed with hypertension has remained the same over the past year, as shown in Table 3. Although higher than England's diagnosed proportion, it remains considerably short of the estimated true prevalence of 32.4%.

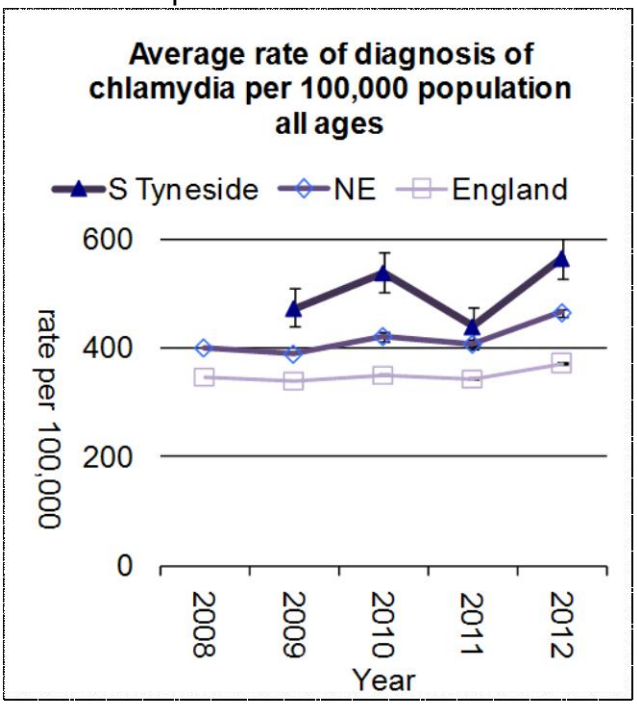
Table 3: prevalence of hypertension

	South Tyneside		England
	Number of patients	Proportion of patients	Proportion of patients
2011/12	24,837	16.1	13.6
2012/13	24,894	16.1	13.7

Data source: Health and Social Care Information Centre QOF 2012/13. Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, November 2013

3.4.3 Chlamydia diagnoses (crude rate per 100,000 aged 15-24 years)

Rates of new diagnoses of Chlamydia are above the national and regional averages in South Tyneside, as shown in Figure 13, but this may be due in part to a high rate of screening. 38% of young adults 15-24 years of age were screened for Chlamydia in 2012 compared to 35% across the North East and 26% across England



Year	South Tyneside diagnoses		*England rate*
	number	rate	
2009	720	**472**	*338*
2010	826	**538**	*350*
2011	650	**439**	*343*
2012	836	**564**	*372*

Data source: Public Health England. Figures in bold indicate that these are significantly higher or lower than England at 95% confidence. (95% confidence limits are shown on chart.) Rates are number of diagnoses per 100,000 population all ages. Data for 2013 will be published in June 2014.

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Figure 13: rate of diagnosis of chlamydia

4 Health and well-being strategy: (i) the best start in life: *"Safeguarding Children"*

The focus of this chapter is on one particular aspect of giving people the best start in life – Childrens Safeguarding and Looked After Children analysis

4.1 Introduction

Safeguarding children is a shared responsibility and as such all agencies and professionals are required to work together to safeguard and promote the welfare of children. This requires taking a child centred approach, ensuring that any intervention is informed by a thorough understanding of what life is like for each child in their own home environment. Their focus is very much on individual need.

There are two constants that must shape how we seek to identify and resolve the safeguarding needs of children. The first is that safeguarding is everyone's business: it is essentially a multi-disciplinary responsibility. The second is that it is families, and parents and carers in particular, who have the greatest impact upon children. Alongside these two factors is the overwhelming evidence from research conducted over the last decade that shows that the needs of children and young people can be best addressed by developing services that facilitate early identification of problems and early intervention.

This approach is reflected in South Tyneside's Children & Young People's strategy for 2014-17 which prioritises the need to achieve **stable and stronger families in healthier communities**. This encompasses a number of outcomes including:

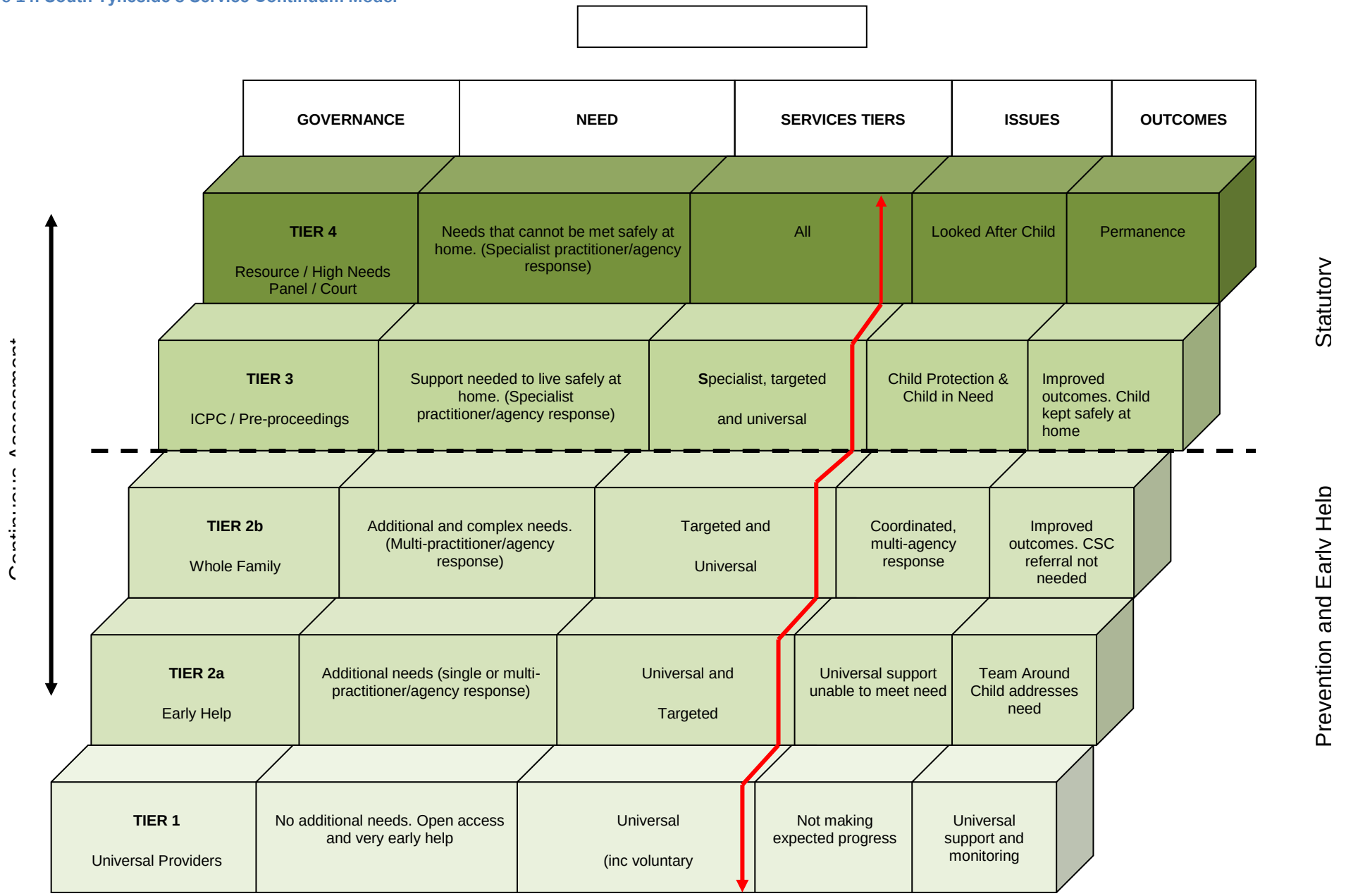
- More children and young people live safely and positively within their family homes and local communities.
- Far fewer children & young people experience neglect in the home.

Having a clear understanding and analysis of the safeguarding picture within South Tyneside is critical to making a difference to the lives of children and families within South Tyneside and as such influences the actions that we need to take to drive forward positive outcomes.

4.2 South Tyneside's service model

South Tyneside's services are structured around a four tier model divided into five steps from universal services to specialist. The model is shown in Figure 14. Our aspiration is to support children, young people and families at the earliest opportunity. It places particular responsibility on our universal and targeted services in delivering early help and consequently reducing demand for higher level interventions

Figure 14: South Tyneside's Service Continuum Model



The model is predicated on the notion that if need cannot be met within one tier, professionals will work together and share information, in partnership with children and families, in order to identify new services and approaches to address need. This, in effect, takes the child and family on a seamless journey as they **step up and down** the tiers of services in response to their changing needs. Data on the levels of need across each tier are provided in Table 4 below and it is important that agencies use this in planning commissioning activity

Table 4: South Tyneside – identified need by tier

Tier 1

Outline of children and young people at this tier of need

Children and young people who are achieving expected outcomes and have their needs met through universal service provision. This includes children that require targeted early help services delivered within a universal service setting. Universal services remain in place regardless of which level of need a child is experiencing**.**

Characteristics of these children and young people

- There are approximately 33000 children aged 0-19, who make up over 22% of the population. Of the 0-15 age group 93% are 'White British', 4% are Asian / Asian British and 1.7% are of mixed/multiple ethnicities.
- After considering the children in tiers two to four it leaves 93.3% of the population supported by tier 1 universal services alone. These are primarily delivered by health and education agencies.

  Tier 1 also includes:
- Other disabled children and other children with special educational needs (SEN)
  - The Education services support a large number of children with a range of disabilities and other SEN.
- Early Years Services:
  - 3875 (49%) of under five used a children's centre in the year to the end of September 13. Of these:
    - 107 were disabled (2.7 of total under fives, and 88% of disabled under fives)
    - 922 had single parents (64% of those with lone parents)
    - 342 were from BME groups (59% of those from BME groups)
    - 71 where the parents were teenagers (61% of all teenage parents)

Tier 2

Outline of children and young people at this tier of need

2a - Early Help – children and young people who are not achieving expected outcomes and will require additional support from a maximum of two agencies for a time limited period. An Early Help Assessment may be helpful in coordinating support to families with this level of need.

2b - Children and Young People who are not achieving expected outcomes and will require additional multi agency coordinated support. There is an expectation that an Early Help Assessment will be instigated. A Team around the Child and Family (TACF) will be established, coordinated by a lead professional, and outcomes for the child and family will be regularly reviewed.

NB: If the family meets the criteria for the High Impact Family Programme (HIF) then the practitioner must work with the family at Level 2b.

Characteristics of these children and young people
Early Intervention:

- There are approximately 50 contacts each month requiring a lower level of preventive support.
- Currently there are about 650 (2.1% of the total population) current cases at this level of early intervention. Some have been worked with for short periods, but about 20% have had support for more than 18 months.
- Over half of these cases relate to unborn children or those aged under five. 23% are children aged 11 or older.
- The early intervention work with these children is co-ordinated by a wide range of professionals. These include teachers, other education staff, health staff and others.
- When closed, 56% need no further support, with the remainder needing a higher level of support at tier 3 or above.

TIER 3
Outline of children and young people at this tier of need Children and young people who are not achieving the expected outcomes and require more intensive support, often on a statutory basis. This will include support provided by Children's Social Care, such as a social work assessment, support from the Family Support Service or through the provision of Direct Payments for a disabled child. The needs are likely to be more complex and resolution will require input on a multi-agency basis coordinated by a social worker and possibly through a Child Protection Plan. Where there is statutory Youth Justice involvement, planning will be coordinated by a Youth Justice Officer or jointly with a Social Worker as relevant

Child Protection / Safeguarding:

- As of March 2013 172 (0.57% of the total population) children were being supported and receiving interventions generally at home, while subject to a Child Protection Plan. CPPs are intended to be relatively short term, lasting less than two years.
- The need for a child to be subject to a CPP more than once may indicate that the work done during the previous CPP was not effective in either ensuring the child's longer term safety with their family, or in identifying that long term safety in their family was not realistically achievable. In 2013/14 7.9% of child protection plans were repeat plans.
- Generally our numbers on CPP have been lower than in similar authorities but currently our numbers are rising. The reasons for these changes are not evident within local data and so warrant further investigation. In 2013/14, the South Tyneside rate of CPPs rose from being the lowest in the region, to being mid-range.
- Of CPPs that finished in 2013/14, 31 % had been subject to a CPP for less than 6 months, while 32.7% had been for more than 12 months but less than 2 years. Few children in South Tyneside have had a CPP lasting for than two years, and few are subject to repeat plans. In 2013 -2014 there were 4 plans that lasted over 2 years.
- In 2013/14, about 15 children have become subject to a CPP each month, with about 11 ceasing. The trend analysis for CPP numbers over recent years shows variability with numbers changing in response to factors such as presenting need, thresholds and practice. These changes warrant further investigation.
- When ceasing to be subject to a CPP, 33.3% became LAC, while the remainder remained at home and were subject to on-going monitoring as open cases for a further period. This compares well to previous years where up to 40% have become LAC and may indicate that the CPP has proved effective. This proportion remains higher than in most authorities in the region.
- Of the children subject to a CPP (excluding those who were unborn), 78% are White British. The ethnicity of 12% is unidentified, with the remaining 10% from BME groups. The proportion of BME children with CPPs is broadly in line with the proportion of children from BME backgrounds in the local population, but the proportion where the ethnicity is not identified raises questions about this. The profile of ethnicity among children differs from the overall population, with more children from BME groups. Since the end of the year the rate of children where the ethnicity is not identified has been reduced to under 3%
- Children subject to a CPP are younger than LAC. 45% are unborn or under 5. 23% are 10 or older.

In 2013 one child with a disability was subject to a CPP. Accepting the estimate that 1.2% of children will have a disability (see children with disability section p7), the number of disabled children with a CPP might be expected to be 1-2 at any time. The expected number is small, and the absence of any disabled child from CPP numbers does not necessarily mean that disabled children are being left in unsafe situations. Were this situation to continue over a sustained period, the area would need to be carefully reviewed.

Children in Need (CIN):

- CIN are children for whom there is a concern about their welfare that warrants social care intervention, but the concern is not of a safeguarding nature. This includes children with a wide range of needs often stemming from neglect and some children with disabilities.
- At any time there are about 1000 (3.4% of the total population) cases of CIN. Of these, about 75 are Care Leavers and about 220 are children with a disability, not including those who are Looked After. These numbers change each week, with the work with many children being time limited, taking under six months.
- Accepting the national estimate that 1.2% of children will require additional support as a consequence of disability, the number of cases open to children's social care might be expected to be about 380. This is an area for further exploration that requires improvements to our data and understanding.
- There is a considerable turnover of CIN cases. Of those open at the end ofMarch 2014, 49% had been open for less than 6 months, a further 16% between 6 months and a year, while 10% had been open for more than five years. Most of these will be Care leavers and nearly half of the cases of disabled children have been open for more than five years. Considerable move towards shorter time open – want to comment on this?

On average each month there are 580 contacts to Children & Families Social Care leading to around 140 cases becoming active.

TIER 4

Outline of children and young people at this tier of need

Children and young people who require intensive help and support from a range of specialist services. These children will often need to be accommodated outside of their immediate family or may require admission into hospital. In most cases the multi-agency involvement would be led by Children's Social Care however for those who are subject to custodial sentences, the work will be led by the Youth Justice Service working closely with a range of other partners. .

Characteristics of these children and young people
All data at June 2014, or for April –June 2014, unless stated

Looked After Children (LAC)

- There are 317 LAC – marginally over 1% of the total population.
- Historically South Tyneside has had a higher number of LAC than in similar authorities, although the trend is that local numbers are reducing, with the numbers in similar authorities increasing by over 1% in 2013/14.moving towards those in similar authorities.
- Of these 88.6% were from the White British group, 9.7% from BME groups, with 1.7% where their ethnicity had been refused by the young person. For all children and young people in South Tyneside, 93% are white and 7% from BME groups, LAC numbers from BME groups appear to be similar to the overall population.
- LAC are from all age groups but over 51.7% are aged over 10. Just over half (52%) are boys.
- 23 LAC have disabilities, which might not be the major reason for their being looked after. Accepting the estimate that 1.2% of the population of children will be disabled and needing additional support (see children with disability section), this number is higher than might be expected (4-5). This might indicate some shortfall in support to families with a disabled child, although having a disabled child places the family under more stress, potentially leading to a greater need for the child to become looked after. This uncertainty indicates a lack of clarity in our data that needs to be resolved.
- 28% of LAC have been looked after for less than a year, but 22% have been looked after for more than five years. This is similar to most authorities.
- 78% of LAC are placed in substitute foster families. Of the others 6.7% are placed for adoption, and 5% placed with their families. The remainder are in residential care or other placements.
- Of children who have been LAC for more than 2½ years, provisional data for 13/14 shows 62% have been in the same placement for over 2 years. This is lower than in general in the region.
- Most became cases with social care because of neglect (95%), with the remainder mainly due to family dysfunction or acute family distress.
- Analysis of children leaving care in 2013/14 indicates:
    - 31% have returned to their parents
    - 26% have been adopted
    - 13% have become subject to Residence Order and 17% to a Special Guardianship Order mostly to their former foster parents. The proportion adopted in South Tyneside is higher than in nearly all authorities.

4.3 Understanding need in South Tyneside

Table 4 above provides a summary of key data regarding need across all four tiers. The following provides further analysis of the data so that we can better understand:

- the specific issues facing children and families in each tier
- Whether some children and young people are at greater risk from particular needs, in terms of age, gender, socio-economic background, ethnicity or disability
- Whether there are some needs that we are better or worse at addressing than others and why this might be the case.

4.3.1 Tier 1 - Universal

Universal services such as education and health are all that the vast majority of children need to fulfil their potential. However, agencies need to be mindful of 'risk factors' that may indicate that a child or family are more likely to require additional support. These factors may reflect a wide range of issues, including disability and non engagement with universal services which are considered below.

4.3.1.1 Disability

All children with a disability are legally entitled to an assessment by social care services as potential children in need. The aiming high programme indicates that around 1.2% of the child population might require additional support due to disability. For South Tyneside this would equate to approximately 354 disabled children (not including children with special educational needs). Of these approximately 26 (7.3%) would be from a non-white British background.

However, the number of disabled children is likely to be significantly higher as most will not require additional support beyond universal and targeted services. In South Tyneside, 234 disabled children had an open social care involvement as at 31st March 2014.

The Children and Families Act was passed in March 2014 and is a wide-ranging piece of legislation which has particular implications for children and young people with SEN and/or disabilities. It is accompanied by a new SEN and disability code of practice, which covers the age-range 0 to 25. Approximately 800 children and young people in South Tyneside have a Statement of SEN or a Learning Difficulty Assessment (LDA), for whom the implications of the new legislation are particularly significant.

Key aspects of the new legislation include:

- A system which is person-centred and outcome focused, with children young people and their parents at its heart.
- An integrated Health, Education and Care (EHC) Plan to replace Statements and LDAs.
- A more streamlined and transparent assessment process that takes a maximum of 20 weeks and that co-ordinates education, health and care services.

- A requirement for education, health and care services to commission services jointly to meet the needs of children and young people with SEN and/or disabilities.
- Publication of a 'Local Offer' which gives clear and transparent information about all of the services on offer for children and young people with SEN and how they can be accessed, including eligibility criteria and referral processes, so parents and young people understand what is available and can make informed decisions/choices.
- New statutory protections for young people aged 16 -25 in further education and a stronger focus on preparing for adulthood.
- The offer of a personal budget for families and young people with an EHC Plan.

The aspects of the new legislation relating to SEN and disability, as summarised above, are to be implemented in September 2014. Here in South Tyneside, we are on track to deliver the processes and procedures necessary to implement the reforms, and to ensure this, the following key actions have been taken:

- There has been a pilot of the new assessment process, about which feedback from parents has been highly positive.
- The web-based Local Offer has been developed and will go 'live' in September 2014.
- A joint commissioning body has been established in relation to SEN.
- There has been comprehensive training for staff in education, health and care who will be involved in delivery of the new processes and procedures. Within this training, which is ongoing, there has been a strong focus on person-centred planning.
- A detailed timetable has been prepared which sets out when Statements will be converted to EHC Plans for various groups of children and young people.

Overall, it is envisaged that the new system will enable us to target resources, streamline the system for families and improve outcomes for children and young people with SEN and/or disabilities.

4.3.1.2 Engagement with universal services

As of 1st October 2013 25 children in South Tyneside were being home educated (10 were male and 15 female and 17 were in years 8 or above). The parents' decisions to educate their children at home will reduce the level of professional educational input, although the adequacy of the education provided is monitored. The arrangement might also reduce access to health and social care supports which are often initiated as a result of school based interventions. This does not necessarily mean that the children's needs are not being addressed but it is important that agencies work together with the parents to ensure such children have access to relevant support and monitoring if opportunities for early intervention are not to be lost.

As well as home educated children there are others including those who have poor school attendance or who are not registered with key health services such as GPs. A greater understanding of this might be beneficial, given the importance of

engagement with universal services in securing early intervention and preventing the escalation of need. It might be helpful to understand how South Tyneside compares with other similar authorities in this regard.

4.3.1.3 Information from Child Death Review

All child deaths are reviewed to promote local learning. Because child deaths are rare, South Tyneside works with Gateshead and Sunderland to study them from a larger population.

Between 2008 and 2012 (the 2013 figures will not be available until 2014) 176 child deaths have occurred across the South of Tyne & Wear. 63% were male and 61% occurred within the first year of life, with the most common cause of child deaths relating to neonatal/perinatal events followed by known life limiting conditions. This means that the vast majority of deaths were unavoidable. Locally there have been no deaths resulting from deliberately inflicted harm and fewer than 10 cases due to trauma or other external factors generally the result of accidents.

Modifiable factors identified through the review process have focused on public education about the sleeping arrangements for infants, primarily around co-sleeping and the increased risk when co-sleeping is combined with alcohol and tobacco use. Other risk factors identified include leaving infants to sleep in car seats and on sofas and the danger of allowing infants access to nappy sacks. The data reveals correlation between child deaths and deprivation within SOTW that is consistent with national data.

There do not appear to be patterns or associations evident in the child death data that might warrant a commissioning response.

4.3.2 Tier 2 - targeted early help

4.3.2.1 Early Help Processes (formerly referred to as Common Assessment)

In 2014 the Common Assessment Framework (CAF) processes were revised and replaced with a less bureaucratic Early Help Assessment process. This is designed to identify and respond to need that cannot be met through universal provision. It aims to support agencies involved with children and families to identify and address need through the provision of multi-agency, coordinated early help.

Accountability for the effectiveness of Early Help has been strengthened in the new processes and an Early Help Operational Management Group has been established to monitor early help activity, outcomes and impact.

During the transition period at the end of March 2014 there were 566 open CAF or Early Help episodes. This number has remained relatively static over recent years. Monitoring the quality, rather than the quantity, of early help activity will be a focus for 2014/15.

4.3.2.2 High Impact Families

Analysis of the risk factors associated with ‘high impact families’ (worklessness, involvement in crime/ anti social behaviour and non school attendance) shows how they can, in combination, cause long term and cyclical difficulties for families and

challenges for the agencies seeking to support them. South Tyneside is estimated to have approximately 450 families that met the criteria for the programme (that is families with two of the three risk factors mentioned above). To date HIF has 375 families recorded as engaged and of these 180 have made progress against the DCLG outcomes.

The High Impact Families programme is an example of how a clearer understanding of need allows for more effective targeting of resources. The national Troubled Families Programme is now in the process of launching 'phase 2', which will be fully implemented by April 2015. Phase 2 will target families with lower levels of need against a much broader criteria. South Tyneside will be required to target 1350 families over a 5 year period (270) a year. This will promote the application of the 'think family' approach more widely across South Tyneside given that the increased flexibility with the criteria means that most families receiving support and interventions will be included.

4.3.2.3 Children's Centres

In line with the 2011 revised core purpose, the majority of the activity in the Children's Centres is focused on Early Intervention and Prevention and on supporting children and families with a particular need.

Quantitative data for 2012/13 shows that Outreach Family Support staff have supported 326 individual children with targeted provision in the home; the 2-year old pilot Funded Offer has supported 168 individual children in day-care settings;176 children have received Family Support which can include day-care provision and 78 children have been supported with Sponsored Childminding placements. In addition to this, the centres have supported 38 Looked After Children, 59 children on Child Protection Plans and 62 children on Child in Need Plans. Of these, four were part of the High Impact Families Programme.

Overall this represents 11.36% of the 0-4 population and is a significant increase on 2011/12's figures (7.2%) and an illustration of the re-focusing of the service on those in most need.

The September 2013 report on the work of children's centres shows the improving reach of the service against key target groups, those for whom there are increased risk factors regarding the propensity for their children to require additional support .

Table 5: level of engagement in Children's Centres, by client group

Client Group	Level of Engagement	
	April 2013	Sept 2013
Teenage mothers / mothers to be	45%	61%
Lone Parents	38%	64%
Disabled children	72%	88%
Workless	54% (May)	58%

Whilst there has been significant progress in most areas the data highlight the challenge of reaching some key target groups. Failure to reach these families reduces our ability to intervene early and prevent needs from escalating. It is the aim of the children's centres to improve their reach to these target groups and it is an

approach that should be replicated by services across tier two in order to maximise opportunities for early intervention and to better manage demand for higher tariff service.

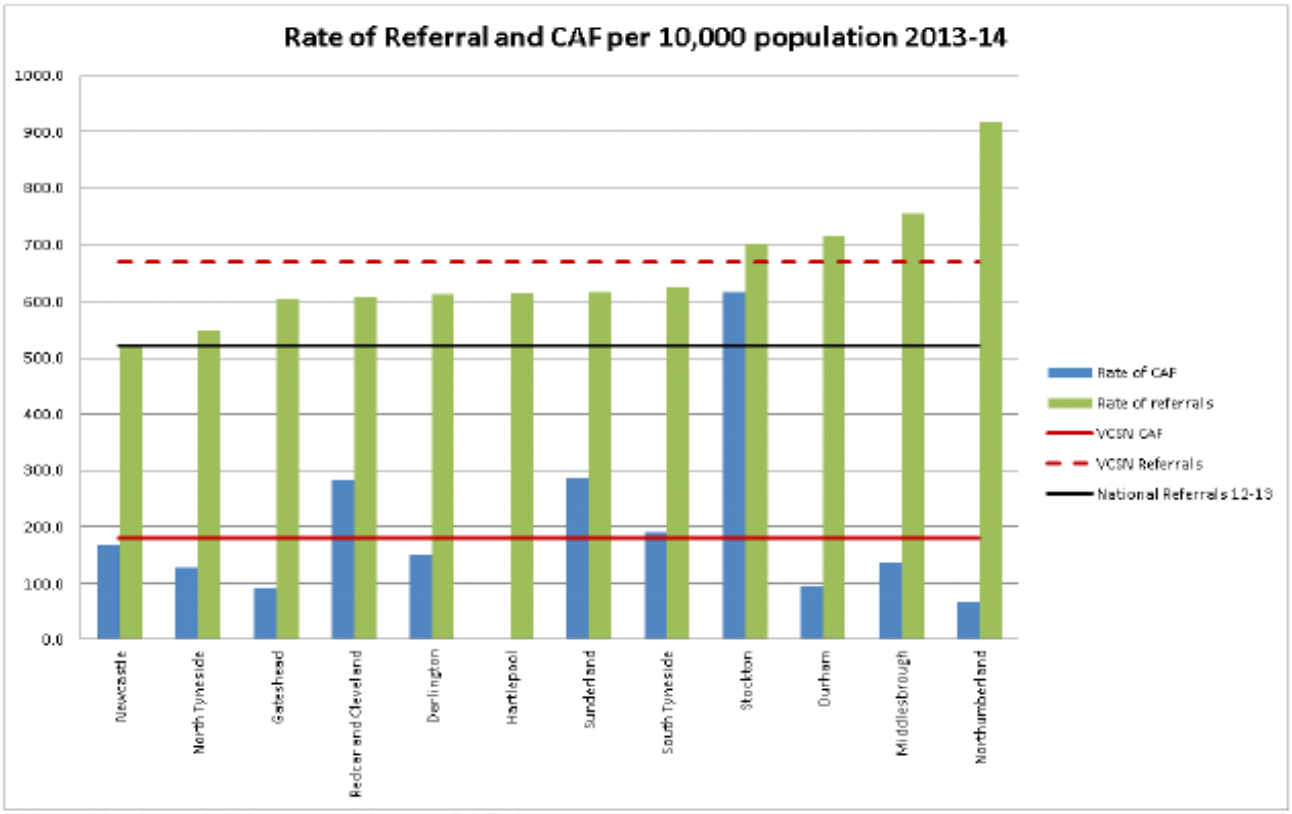
4.3.3 Young Carers

There are approximately 350 young carers in South Tyneside. These young people take on caring responsibilities for parents, siblings and / or other family members. They receive support through after school clubs, access to school holiday activities, residential support and 'drop-in' services based in schools. Young carers are often 'hidden' and as such it is important that services for them are widely publicised and promoted. It is also important that those working with parents or children consider the needs of children who may take on caring responsibilities within a family and ensure their needs are identified and addressed.

4.3.4 Tiers 3 & 4 Children in need, child protection and looked after children

Contacts and referrals to social care are a useful indicator of the level of need within an area, although the numbers can be affected by changes in working relationships and arrangements between agencies. They reflect our ability to identify and resolve needs at tiers 1 and 2 and provide information about the types of need which are perhaps most pervasive and most challenging.
It is therefore useful to understand this within the context of CAF / Early Help activity

Figure 15: Local Authority rate of referral



Note: Hartlepool did not provide any CAF data

As can be seen the rate of referral to Children and Families' Social Care within South Tyneside remains above that of the national average but below that of our regional neighbours, with Early Help activity being slightly higher than the regional average.

The numbers of contacts made to South Tyneside 2013 -14 was 9024 and the numbers of referrals made was 1858 .However the number of referrals has varied over recent years which reflect changes in need, thresholds or practice and in order to understand how this informs about level of need within South Tyneside it is important to develop a shared understanding of contacts (pieces of information being shared) as opposed to referrals (where there is a need for action to be taken).

Table 6 detailed analysis of referral South Tyneside 2012/13

	2010/11	2011/12	2012/13
Number Referrals	1207	1881	1699
Number children	1037	1691	1685
Referrals / child	1.16	1.11	1.01
of which unborn/not born	11%	7%	9%
aged 0 - 4	32%	32%	33%
aged 5 - 9	23%	24%	23%
aged 10+	34%	36%	35%
unknown	0%	0%	0%
Child Care Concerns	67%	55%	43%
Child: Neglect	4%	11%	21%
Child Domestic Violence	5%	15%	16%
Susp/Act Phy/Sex Abuse	2%	4%	6%
Child Assessment of Need	5%	2%	2%
Family Supp (Not Financial)	2%	5%	2%
Other	3%	2%	2%

In 2012-13 a detailed analysis of referrals to Children & Families Social Care identified that 42% of all referrals related to children under 5 of which 9% were unborn.

The largest single presenting factors were identified as being are 'neglect' (21%) and domestic violence (16%). The number of children and young people living in households were neglect or domestic violence is feature continues to be significant and is reflected in our safeguarding activity.

Our data shows a falling rate of repeat referrals to Children and Families Social Care, from 2010 onward and the 2013 re- referral rate is 12%, the lowest regionally. This can be taken as an indication of an improved ability to correctly identify and address need by providing the right service first time. – evidence that our Early intervention strategies are beginning to demonstrate impact . However in light of the continued demand on tier 3 and 4 services it is essential to understand the story behind these figures . All agencies need to be able to categorise need in a way that allows for greater understanding of the presenting issues and causal factors, including detailed qualitative analysis of data.

4.4 Children with disabilities in receipt of specialist services

- 14% (52,300) of children in need in England at 31 March 2013 had a recorded disability.

  Sources: Department for Education (2013) Table B2 in Main tables: characteristics of children in need in England, 2012-13 (Excel). London: Department for Education.

  - 3% (2,260) of looked after children in England were looked after due to their disability at 31 March 2013.

  Sources: Glenndenning, J. (2013) Children Looked After by Local Authorities in England (including adoption and care leavers) - year ending 31 March 2013 (PDF). London: Department for Education (DfE).

Research indicates that disabled children are 3 times more likely to experience abuse and neglect.

In September 2013 there were 174 cases open to the Children and Adults Disability Service. Of these 154 were categorised as children in need (including short breaks provided under s.17), 20 were looked after, none had a child protection plan, 7 were receiving short breaks under s.20, but not looked after.

On the basis of these estimates we would expect the numbers of disabled children in the LAC and CP populations to be higher. Further investigations into local need might be warranted.

As of March 2014, 18 young people attended educational day placement outside of Borough as a consequence of complex needs, with autism being a prevalent feature. All but one of the children are 'White British'.
A key aspect in these children receiving services from external providers is the ability to offer integrated speech, language and physio therapy support within the school curriculum.
The associated annual cost of these placements is £807,587 which equates to an average cost of £ 44,866.
In order to effectively support children with complex needs in their community it is essential that we offer holistic, integrated support in the most accessible way for children and families based on individual child and family's assessed need and circumstances.

National studies indicate a rising trend in the incidence of autism. It is important for agencies to understand how this will be reflected in demand for services in South Tyneside and embedded in our early help approaches.

Table 7: Numbers of children by School group receiving support via a Statement of Educational Need or through Action Plus as a consequence of autism

	SEN	Action Plus	Combined
Primary Schools	44	23	67
Secondary Schools	46	25	71
Special Schools	37	2	39
TOTAL	**127**	**50**	**177**

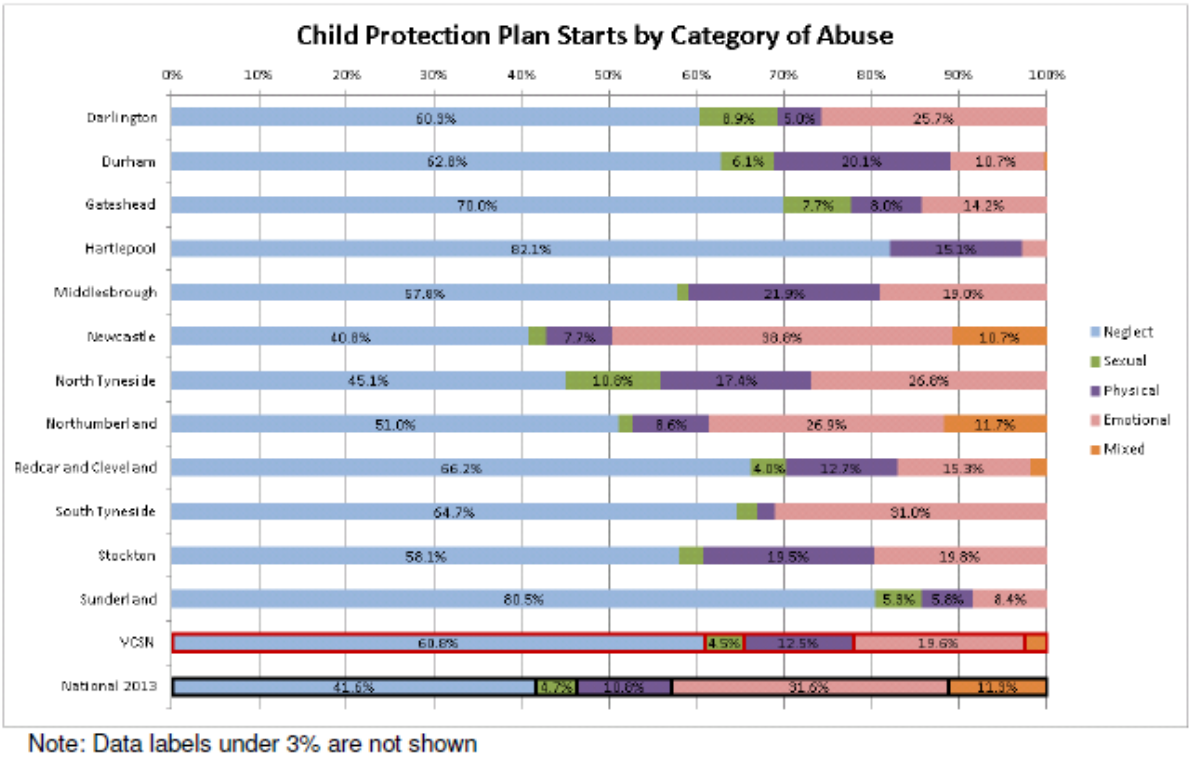
4.5 Child protection & safeguarding

The numbers of children in need of a formal safeguarding intervention in South Tyneside has risen significantly in 2013 , with the rate of child protection plans per 10,000 of population being 57.9 . This is a percentage change of 53.25 compared to the previous year and higher than the previous national rate of 37.9.
This changing trend may be a reflection of increased early identification of risk and evidence that the partnership approach to safeguarding is being effective.
Similarly this may be a reflection of changing picture in relation to looked after activity as the rate of children being looked after within South Tyneside is beginning to stabilise and reduce.

4.5.1 Child protection plans by category

In South Tyneside, a high proportion of plans are made in relation to Neglect and/or Emotional Abuse. Of the number of CCP starts in 2013 , 64.7% were in respect of neglect and a further 31.6% were in respect of emotional abuse. This high prevalence of neglect as a category of abuse is mirrored across the region and is higher than the national prevalence

Figure 14 Child Protection plans by Authority



Note: Data labels under 3% are not shown

National and local research has shown that it is cases of chronic neglect that agencies struggle with most; it is those families that present the greatest challenge and that populate our largest category of need. Neglect is, by its very nature, chronic, ill defined and more difficult to identify and address than the more acute forms of abuse:

> 'Child neglect has been the most frequently reported form of maltreatment in the developed world over the last 10 years. It is the main reason for child protection registrations in the UK, most often as the sole reason but sometimes coupled with another form of abuse....In England 17,200 of the 39,100 children (43.5%) registered in the year up to the end of March 2010 were on the register because of neglect, as either the partial or main reason.' (Action for Children – Neglecting the issue).

It is likely that these categories of abuse are reflective of parental difficulties associated with parental mental ill health, substance misuse or domestic violence, (the toxic trio).

An analysis of all children subject to a child protection plan at year end as of March 2013 found that, of the 118 children with a plan:

- 71 plans involved domestic abuse;
- 17 plans involved parental mental ill health;
- 37 plans involved drug and / or alcohol misuse**;**
- 64% of plans involved one of these factors ,4% involved 2 and 4 % involved all 3.

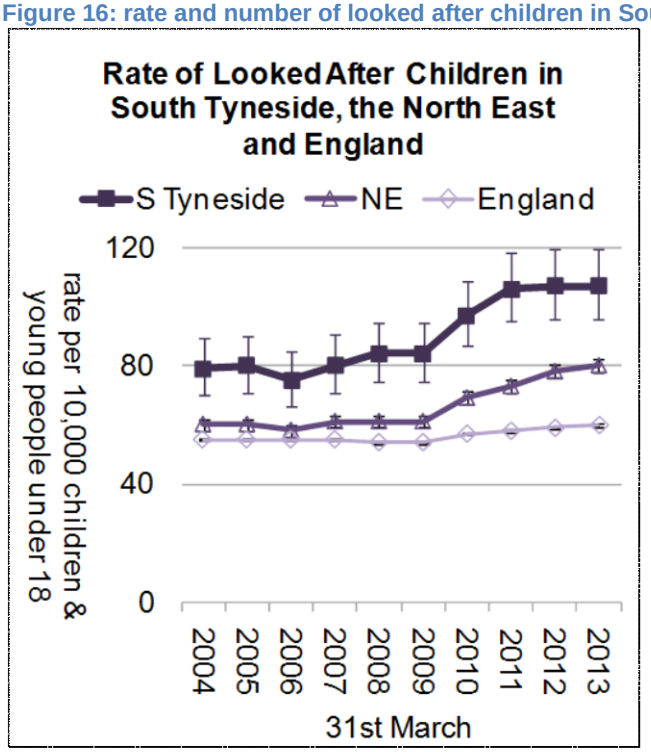
Children affected by domestic abuse are typically identified as being at risk of emotional abuse. Clearly these children are also at significant risk of physical abuse and national research indicates also increased risk of sexual abuse.
The presenting issues, whatever the associated cause or risk factor, could in almost all cases be described as neglect.
Therefore it is important to ensure that the categories of registration are interpreted carefully, with further work often required to pinpoint presenting needs both a individual level and community level.

4.5.2 Child Protection Plans ceasing - step up or down

Movement of children up and down the tiers of need reflects on our ability to identify and address need at the earliest opportunity and of the effectiveness of the interventions offered Lots of cases stepping up might suggest that we are failing to address need at an early stage resulting in the need escalating. Cases stepping down suggests that interventions have proved effective and need is reducing.
Within South Tyneside in 2013 a total of 171 child protection plans ceased : 33% of which ended due to the child becoming looked after and 66% were ended due to the case being "stepped down " to children in need status.
The number of child protection plans ending due to a child becoming looked after is the highest in the region .It is therefore important to learn from cases in which desired outcomes are achieved, those that 'step down' and those that 'step up'.

Error! Not a valid bookmark self-reference. shows the rate LAC numbers within South Tyneside. Comparing South Tyneside to similar areas, the number of LAC is higher than might be expected.

Figure 16: rate and number of looked after children in South Tyneside



Year	South Tyneside children		*England rate*
	number	rate	
2009	260	**84**	*54*
2010	295	**97**	*57*
2011	320	**106**	*58*
2012	315	**107**	*59*
2013	315	**107**	*60*

Data source: Dept for Education. Rates are per 10,000 children and young people. Figures in bold indicate rates are significantly higher or lower than England's at a 95% level of confidence.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, Oct 2013.

As can been seen there has been a significant increase in the LAC rate since 2010 with a 10% change compared to a regional increase of 17% and a national increase of 5.3% during the same time period.
However as the figures show we have seen a stabilising of the rate and this pattern has continued during 2013 – 14 with the year end figure remaining at 315.

The number of children who are looked after is perhaps the ultimate indication of the effectiveness of demand management and Early Help approaches. Our looked after children are children who are unable to remain safely in the care of their family regardless of support and interventions offered. This may be as a consequence of not identifying support sufficiently early but equally it may be a reflection of the complex and hidden needs that exist within families and need escalating over time

Again, neglect is the primary reason children enter the looked after system. Given that it is our aim to reduce the need for looked after services by supporting and strengthening families and communities, addressing neglect will be key to our success.

In promoting good outcomes for our looked after children it is essential to consider placement sufficiency; an inability to identify the right placement / care arrangement for a child– either through lack of placement choice or inaccurate assessment – will significantly reduce the likelihood of a successful outcomes and might result in

placement disruption. The resources for looked after children are addressed in more detail in the LAC sufficiency strategy and it is vital that this is used by those commissioning services for children.

The number of out of borough residential placements has reduced over recent years, from 22 (7.5%) in 2011/12 to 16 (6.0%) March 2014. These young people typically present considerable challenge to carers and can engage in high degrees of risk taking behaviour. Many of these children have experienced a number of in borough placement breakdowns because of challenging behaviour that is rarely acute in nature but reflective of early childhood experiences.

Of the young people placed outside of the borough boundary in residential provision: 5 have complex needs, with a prevalent feature being autism and a further 3 young people have mental health issues.

4.5.3 Sexual exploitation.

Child sexual exploitation is very much a 'hidden' problem and has become nationally a significant area of concern for children and young people. It can lead to significant harm to physical, mental health and emotional wellbeing which includes stress, anxiety, feeling of not being believed, post traumatic stress disorder and self harm. In addition, the consequences of CSE can affect education attainment, relationships and future opportunities in life.

While a great deal of evidence is of men sexually exploiting children and young people, women and 'boyfriends' can also be abusers. Children and young people may be drawn into CSE through well organised and sophisticated methods while others may be drawn in by peers who may be sexually exploited themselves. Alcohol and drugs often play a part in this with young people being groomed into a 'party' lifestyle. The Barnardos '*Puppet on a String'* report defines sexual exploitation in three broad categories:

1. Inappropriate relationships
2. 'Boyfriend' model of exploitation and peer exploitation
3. Organised / networked sexual exploitation or trafficking.

It is acknowledged that young people with particular characteristics are more vulnerable to sexual exploitation; an example of this is that situations which lead young people to living in care. Indeed the actual experience of living in care may also make some young people more vulnerable as they are at an increased risk of 'running away'.

Keeping our children and young people safe in South Tyneside is of high priority for our Local Safeguarding Children's Board (LSCB) and we have made steady progress in identifying those young people at greater risk of CSE.

There is no national data on CSE and therefore comparison to other areas is not possible. However we do have local data which recognises the connectivity between CSE and children / young people missing from home, which is shared at our LSCB and subsequent sub groups for analysis. Our local data is telling us that:

4.5.4 Missing Children Data

The number of potential CSE concerns received in 2013/14 was 16. The data was derived from the Child Sexual Exploitation Proformas and the associated risk assessment tool that professionals who have a CSE concern complete and submit to the Children's Standards Unit. This information was discussed at the South Tyneside Exploited and Missing (STEM) subgroup and appropriate multi-agency action taken to ensure the safety and welfare of the young people. This data collection supported the development of the local and regional CSE profile and local CSE intelligence.

CSE Proformas 2013 /14

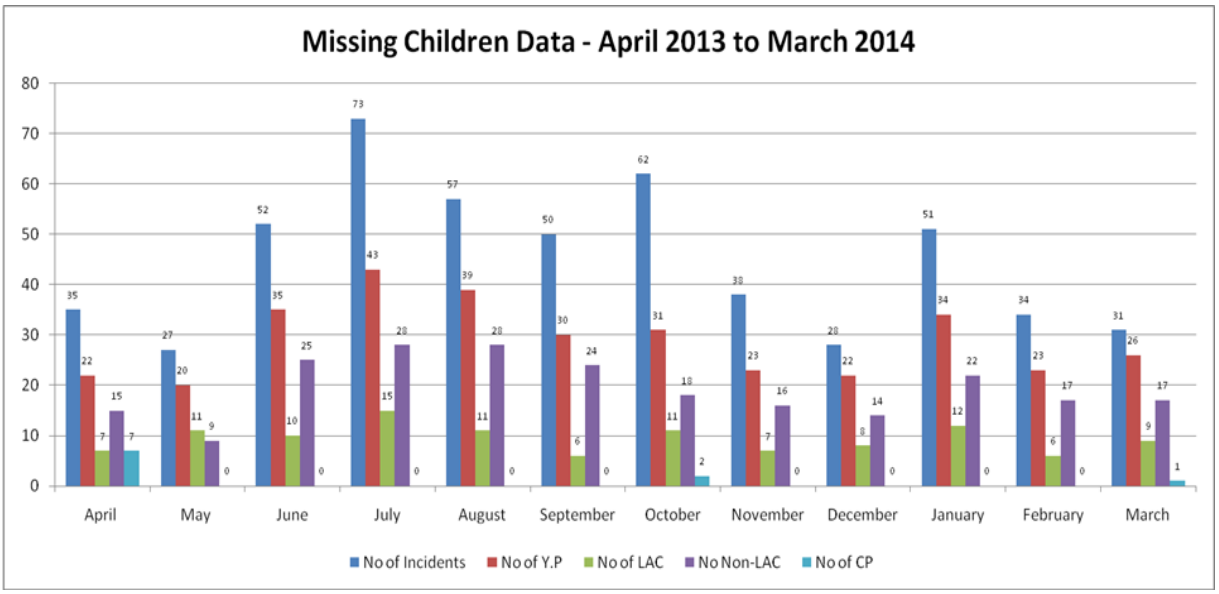
Proformas Received	16
Female	15
Male	1
CAF	4
CIN	3
LAC	3
Universal	2
Not Recorded	4

The Association of Chief Police Officers undertook a Child Sexual Exploitation and Abuse problem profile for the North East between September 2012 and February 2013.The aim of the problem profile was to provide an analysis on the scale and nature of child sexual exploitation, particularly but not limited to, group child sexual exploitation.

Key areas of learning from these profiles have been incorporated into the CSE Training and included within the CSE local and sub-regional strategy. In January 2014 Operation Sanctuary was launched by Northumbria Police. This is an on-going investigation regarding allegations of a series of sexual offences involving a number of men and vulnerable female victims including teenagers and young adults.

The table and graph below provides data in respect of our children and young people who go missing from care and home .

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of Incidents	**35**	**27**	**52**	**73**	**57**	**50**	**62**	**38**	**28**	**51**	**34**	**31**
No of Y.P	**22**	**20**	**35**	**43**	**39**	**30**	**31**	**23**	**22**	**34**	**23**	**26**
No of LAC	**7**	**11**	**10**	**15**	**11**	**6**	**11**	**7**	**8**	**12**	**6**	**9**
No Non-LAC	**15**	**9**	**25**	**28**	**28**	**24**	**18**	**16**	**14**	**22**	**17**	**17**
No of CP	**7**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**1**



Our local figures show a high degree of fluctuation from 27 incidents involving 20 young people (some go missing more than once) in May 2013 to 73 incidents involving 43 children in July 2013. It should be noted seasonal fluctuations are common and may be associated with factors such as lighter nights.

Looked after children are significantly over- represented in the figures, especially children living in residential care. This reflects the particular vulnerability of these young people and their increased propensity to engage in risk taking behaviour.

Whilst greater understanding of local need arising from children running away or going missing is required, it is already recognised as an area of local and national concern. A review of the efficacy of local responses to children going missing would prove beneficial in ensuring all that can be done is being done.

Work within the Borough continues to be progressed to both understand the underlying factors in relation to children who go missing at an operational and strategic level. The LSCB has re- shaped its missing and exploited group arrangements with operational and strategic groups being established to ensure that action is taken at all levels in respect of this growing national issue.

South Tyneside works with the Children's Society's SCARPA Project to offers specialist support to young people who go missing or are at risk of sexual exploitation. A dedicated SCARPA worker is based with the MATRIX service in South Tyneside and undertakes independent return interviews with young people who go missing from home as well as providing dedicated advice and support.

This ensures a consistent response to young people at risk of sexual exploitation

What have we done?

- We have developed a Local and Sub Regional Child Sexual Exploitation Strategy.
- Child Sexual Exploitation is a standard item on the LSCB agenda
- The LSCB Sexually Exploited and Missing Group (STEM) meet regularly to discuss individual cases of young people potentially at risk of CSE
- The LSCB offers multi-agency CSE Training via both direct delivery and an 'E – learning' module. This multi-agency training is available free of charge to those organisations working directly with children and families within South Tyneside
- We are currently revising the 'health' training programme for Residential care staff and foster carers through the MALAP Health sub group. Current programme includes CSE and internet safety

4.5.5 Healthy Schools

In South Tyneside 100% of our schools had achieved Healthy Schools status in 2011, this is valid for three years. Since 2013 schools can apply for 'Reaccreditation', this document has a number of elements which relate to healthy relationships and sexual exploitation. Schools are consulted about their staff professional development, PHSE curriculum, pupil satisfaction of their PHSE curriculum, provision of 1-2-1 support for young people, school policy and partnership with parents and the local community.

Healthy Schools also offers activities for teachers, parents and pupils for Anti-Bullying Week, Being Kind Day and the White Ribbons Campaign which all have a healthy relationships basis.

4.6 Looked After Children

4.6.1 LAC Health

'Looked after children and young people are a population group that are particularly vulnerable to poor health. The majority enter care because of

abuse and neglect and it is estimated that 45% have a diagnosable mental health condition.' (Meltzer 2003).

Our ability to understand our looked after children's health needs is impacted upon by limitations in respect of the systematic collation of qualitative data across the partnership.

We know that for 2013/ 14, 84.6% of looked after children had their annual/biannual health checks completed, with 100% of under 5 year olds having their Health Development Check completed. ,Over 95% have had all necessary immunisations and 71% have had standard dental checks completed.

Specialist support for looked after children in relation to substance misuse is provided by the Matrix Service, with a dedicated worker for looked after children. In 2013-14 just over 5% (11 children) of looked after children had an identifiable substance misuse issue. Of this cohort, 82% (9 children) had received an intervention with the remaining 2 young people offered services but had refused.

In 2013-14, 11 looked after children and care leavers became pregnant. Support in relation to sexual health is addressed through their care plans and pathway plans with support offered through specialist sexual health services. Those young people who become pregnant and who have left statutory education are supported to attend the "Mums To Be" study programme through Adult and Community Learning which educates young people regarding their health needs and the needs of the unborn during pregnancy.

Looked after children receive therapeutic support from the Children and Young People's Service. This support is provided through one to one therapeutic intervention as well as support and training offered to foster carers. From April 2013 to January 2014 72 looked after children were referred to the service for assessment and support.

However, we have little information about the incidence of issues that might raise safeguarding concerns – such as sexual health or self harm – or about access to therapeutic support.

Care leavers, nationally are a group of young people who have poor outcomes in terms of their physical and emotional health. South Tyneside's offer to care leavers, through the Integrated Looked After Children's team continues to support the young people in all aspects of their lives, recognising the links between good emotional and physical health and being in suitable accommodation and engaged in education, employment and training. In 2013-14 62% of care leavers aged 19-21 years were in education, training and employment and over 96% were in suitable accommodation.

Undertaking a full needs analysis of looked after children and care leavers to reduce health inequalities in relation to looked after children and care leavers is a priority.

4.6.2 Access to CAMHs Tier 3

The total number of children / young people in South Tyneside accessing CAMHS services in 2013 was 1423. This equated to approximately 83 referrals made each month, of which around 80 are accepted by the service.
However local data shows that of the total number of appointments offered in the year 24.6% were not attended or cancelled.
Waiting times for the service continues to be challenging and the table below shows the waiting times for 2013.

Table 8: Access to Child and Adolescent Mental Health Services

CQUIN Performance Monitoring	% of Patients Waiting > 18 Weeks			% of Patients Waiting > 13 Weeks
	Q1	Q2	Q3 (To Date)	Q4
NHS Gateshead CCG	36%	18%	40%	19%
NHS South Tyneside CCG	33%	19%	27%	22%
NHS Sunderland CCG	28%	19%	25%	21%

Work remains ongoing with the provider to drive down waiting times through the specifically commissioned waiting time initiatives and to embed a menu of services across the tiers of need in respect of emotional well being and mental health.

In progressing this work there is need to understand the data and presenting need in relation to some of our most vulnerable children and young people including those who are looked after and care leavers.

4.6.3 Children involved in the Youth Justice system

Involvement in crime and/or anti social behaviour is both a significant risk factor for the increased likelihood of harm and an indicator that a child may be living in less than optimal circumstances. Local data for 2013/14 show

- The rate of proven re offending is 1.06
- The custodial rate is 4.6% still under the 5% target of all youth justice disposals
- No BME groups were disproportionally overrepresented in the youth justice system in South Tyneside.
- 94.2% were in ETE
- 7.4% of LAC form the relevant cohort offended. This equates to 10 LAC offenders of whom 3 were placed outside of the Borough boundary.
- 100% in suitable accommodation

All young people engaged in the youth justice service have a physical health check and this is inclusive of access to health and well being support through a CPN

4.7 The causes of safeguarding concerns

National and local research confirms the fact that children's needs are almost always the product of adult need and behaviours. This relates both to socio-economic factors – such as poverty, disadvantage and worklessness – and to the toxic trio of mental ill health, drug and alcohol use and domestic violence. It is these causes of abuse and neglect that we need to focus on if we are to achieve our aspirations of a child centred system.

4.7.1 Child poverty

Child poverty reduces the quality of childhoods and damages children's ability to fulfil their potential. South Tyneside's **child poverty rate of 31%** is well above the national average of 20%. It has been estimated that South Tyneside has around 5000 children living in 'severe' poverty, a rate of 18% (New Policy Institute Report for Save the Children – Feb 11).

Children living in households affected by poverty are more likely to experience poor outcomes, such as:

- Lower than average birth weight;
- Reduced life expectancy;
- Poor educational outcomes;
- Unemployment;
- Inadequate housing;
- Greater likelihood of criminal activity.

Local studies (High Impact Families) have identified a strong correlation between the child poverty hotspots and those areas of the borough which produce the most contacts for targeted and specialist services.

4.8 Toxic trio

'Parental problems such as mental illness, alcohol and drug use and domestic violence are all known to increase the likelihood of children experiencing emotional abuse and neglect, particularly when they appear in combination" (Safeguarding Children Across Services.' Davies & Ward 2012)

4.8.1 Substance misuse

'An estimated 250,000 to 350,000 children in the UK have parents who are problematic drug users. About four times as many (1.3 million) live with parents that misuse alcohol. This can have an enormously detrimental effect on children from before birth onward. Furthermore, we know that drug and alcohol problems rarely occur without other issues such as mental illness and domestic violence.' (Safeguarding Children Across Services - Davies & Ward 2012)

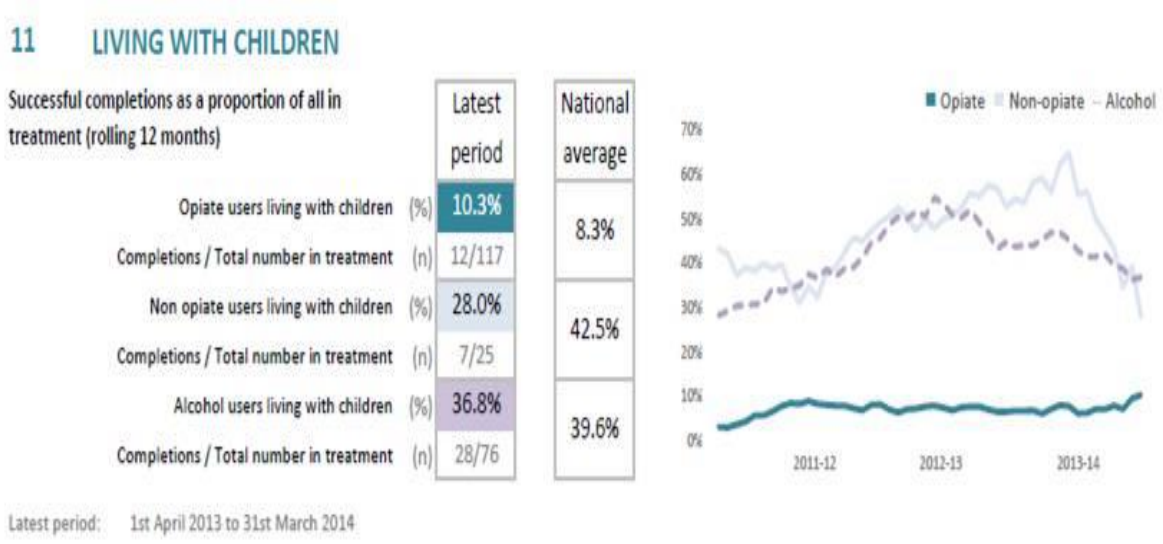
In South Tyneside, the estimated number of Opiate and Crack Users (OCU) is 829 in those aged 15-64 years. During 2012/13, we had a total of 529 clients accessing treatment, which means for every eight estimated OCUs, services engaged with five. We currently have 446 (adults) active OCUs accessing treatment services.

The total numbers living with Children are as follows:

- Opiate 117
- Non Opiate 25
- Alcohol 76

All substance misuse clients living with Children (including alcohol) was 218 (142 excluding alcohol).

Figure 17: Substance misuse clients with children 2013/14



There were 33 clients newly entering treatment services identified as carers/parents of children

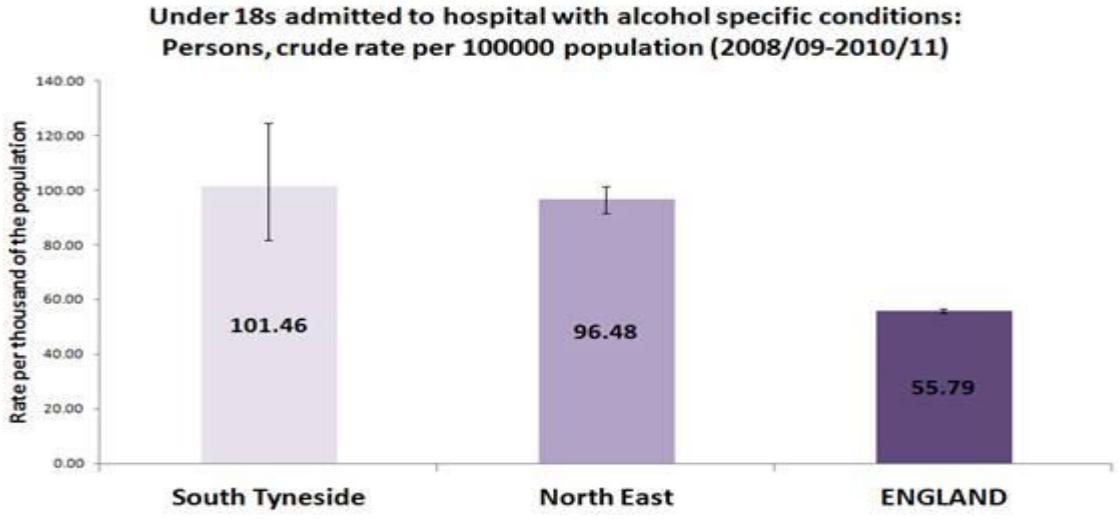
Additionally we have around 66 young people accessing our young people service provision.

4.8.1.1 Alcohol Prevalence

It is important the incidence of adult alcohol and substance misuse is understood within the context of parenting given the high numbers of child protection plans were parental substance misuse is a factor

South Tyneside has the 6th highest Alcohol Treatment prevalence per 1000, population. There has been an increasing trend of alcohol specific hospital admissions since 2008/9 and this is reflected in the high number of young people adversely affected by alcohol misuse.

Figure 17: Under 18's admitted with Alcohol specific conditions



4.8.2 Mental health factors

> 'Two thirds of adults diagnosed with psychiatric disorders are parents of children under 18. We know that abuse is not inevitable but we need to recognise that mental health problems can lead to a deterioration of parenting capacity" (Safeguarding Children Across Services" Davies & Ward 2012).

The Mental Health Profile for South Tyneside (summarised in Table) shows that the borough's population has a higher prevalence of many risk factors associated with mental ill health. In all of these areas, local figures show higher levels of need than regionally or nationally: this again indicates a need for improved local data regarding the impact of mental ill health on children adults and families.

Table 10: risk factors for mental health, South Tyneside, regional and national rates

Risk factor for mental health	South Tyneside	Regional	National
Percentage of the relevant population living in the 20% most deprived areas in England, 2010	39.9	32	19.8
Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12	38.4	32.7	23.0
Statutory homeless households, rate per 1,000 households, all ages, 2010/11	3.47	1.67	2.03
Percentage of adults (18+) with depression, 2011/12	17.77	15.6	11.68

4.8.3 Domestic abuse

> 'Children are twice as likely to have neglect confirmed within their first five years of life if there is domestic violence in the household.... "Safeguarding Children Across Services.' (Davies & Ward 2012)

The table below provides a comparative break down of the prevalence of domestic abuse incidents within South Tyneside compared to Northumbria force wide figures

Table 11: Domestic violence prevalence change 2012 -13 to 2013 -14

	South Tyneside			Force		
	2012-13	**2013-14**	**Change**	**2012-13**	**2013-14**	**Change**
Domestic Abuse Incidents	3,673	3,830	4.3%	27,275	28,928	6.1%
% Partner/Ex-partner	81%	77%	-4%	81%	78%	-2%
Incidents with Children Involved	1536	1632	6.3%	12787	13413	4.9%
Number of victims	2,283	2,359	3.3%	16,861	18,019	6.9%
Female Victims	1760	1788	1.6%	13111	13944	6.4%
Male Victims	521	571	9.6%	3741	4071	8.8%
BME Victims	73	91	24.7%	749	868	15.9%
Victim age 16 or 17	1	60	N/A	27	417	N/A
Victim age over 55	182	203	11.5%	1209	1370	13.3%
Number of repeat victims	885	937	5.9%	6423	6749	5.1%
% of repeat victims	38.8%	39.7%	1.0%	38.1%	37.5%	-0.6%
No. of crimes involving alcohol	260	391	50.4%	2,366	2,946	24.5%

As can be seen from the above data the number of domestic violence incidents within the Borough has increased but the rate of increase is lower than that for the Force area. The number of crimes involving alcohol and domestic abuse has significantly increase with the Borough seeing a 50% increase in this figure compared to a force wide increase of 24.5%.

Whilst this increase does not specifically relate to incidents involving parents the significance of this from a safeguarding perspective cannot be under estimated.

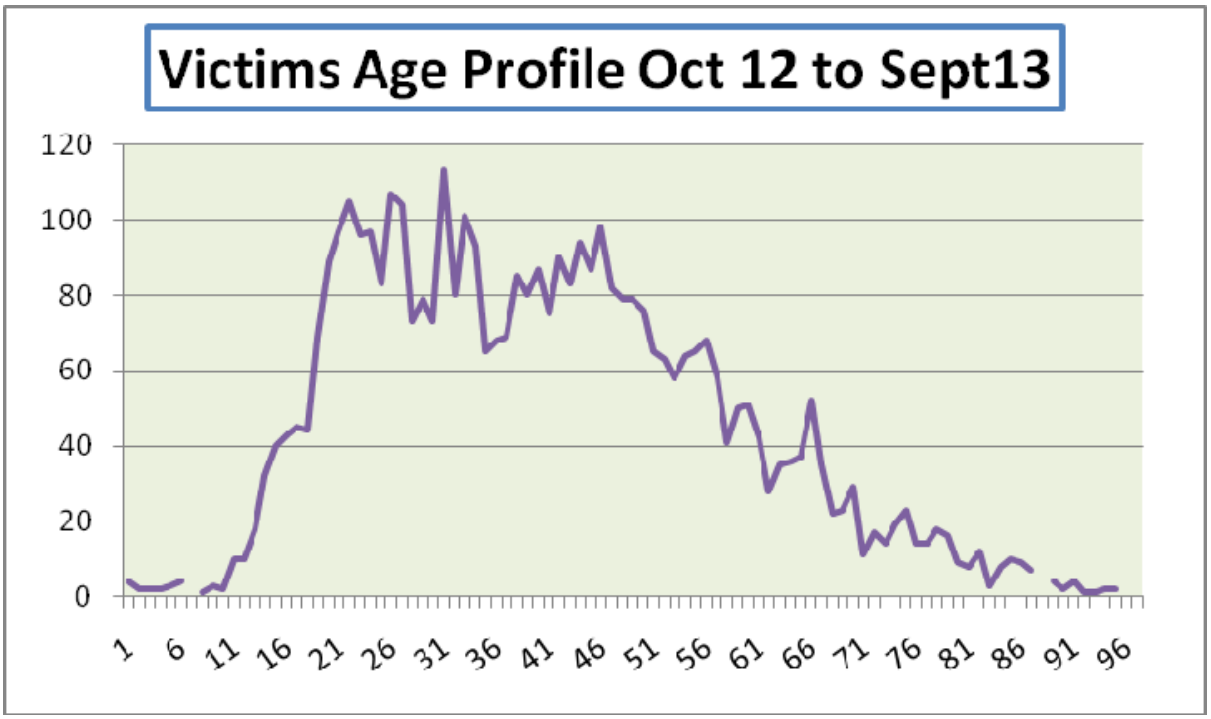
An analysis of all contacts to Children and Families Social Care in 2013 identified that 43% of all contacts and referrals to Children and Families' Social Care were from the Police attending Domestic Violence incidents at households with children. However that the majority of these incidents were notifications of attending an incident (as determined by Police risk assessment) as opposed the need for an intervention in line with agreed multi agency thresholds .
Work has been ongoing with the Police to ensure consistent application of thresholds and effective identification of incidents that require an assessment of need.

4.8.4 Young Victims of crime

National and local statistics show that young people and young adults (15- 21yrs) are amongst those most likely to become victims of crime.
In 2012/13 Theft, Criminal Damage and Violence Against the Person, accounted for 76% of total crime. Where allegations of bullying and harassment are dealt with via the police, they are recorded under the category of Violence against the person.

The following diagram identifies the age profile of the victims during the period. The peak age for victimisation rises considerably at age 15, peaking between ages 20 and 30 and then starting to decline from the mid forties onward.

Figure 18: Victims of crime profile October 2012 – September 2013



For young people who have suffered in this way, their emotional and mental health can be greatly affected, particularly if they are a repeat victim of bullying and harassment and/or violence.

4.8.5 Young People as direct victims and/or perpetrators of domestic abuse.

''Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

The change to government guidelines lowering the age from 18yrs to 16yrs at which a young person can be identified as a direct victim of domestic abuse has implications for the way we work to support young people. In the first quarter of 2014, 10 young people (all female) were accessing intensive support after self identifying as direct victims within their own relationships. Of these 10, 2 had involvement with the justice system as perpetrators of other offences; all 10 of their partners had involvement as perpetrators of a range of crimes. All 20 young people had been exposed to domestic violence in the family home as a child.
Although these numbers are low, it is clear that they support much of the wider findings relating to experiences of adult victims and perpetrators.

4.9 Identifying our priorities

The local data and national research demonstrate that poverty, domestic abuse, drug and alcohol misuse and parental mental ill health are the factors that pose the greatest risk to the welfare and life chances of children and young people of South Tyneside. These issues are particularly devastating when they occur in combination. The impact of these risk factors upon children is more often than not harm that is best described as neglect. Neglect is the largest category of need across all tiers both nationally and locally.

There is a growing evidence base as to the importance of recognising and tackling neglect early in a child's life and when problems manifest themselves. There is robust evidence that it has serious long-term consequences across all areas of children's health and development. The effects appear to be cumulative and pervasive, making early recognition and intervention necessary if the likelihood of longer term harm is to be minimised.
The impact of neglect can be particularly severe when they occur during early childhood, because the first three years of life are critical to children's later development. Studies conducted in many countries – including Great Britain and North America – suggest that the numbers of children and young people experiencing neglect might be up to ten times as many as those who come to the attention of professionals.

> 'Children who are experiencing neglectful or abusive home environments may not stand out at school as being any different from their peers, or may present with otherwise non-specific emotional or behavioural indicators. Staffs in universal services need to be alert to this, and aware of the limitations of seeing children only in the safe environment of the school. When young children display worrying behaviour such as truanting, running away or stealing food, attempts should be made to understand the child's context and to listen to them, not merely to return them home.' (Marian Brandon et al. New learning from serious case reviews: a two year report for 2009-2011 (2012)

Demand for child protection and looked after services in South Tyneside is high, especially for children aged 0-5. Neglect and domestic abuse are the key drivers behind this demand. The rate of children subject to a child protection plan is rising. We need to continue to build upon the progress that has been made to date and

further strengthen supporting new parents/parents to be and to address needs arising out of neglect and domestic abuse in particular if we are to break the cycle of need and disadvantage.

The Action for Children Report - State of Neglect in the UK (Jan 2013) highlights the structural factors influencing our ability and readiness to address neglect at an early stage.
It requires high level commitment to driving forward improvements in the way we deal with poverty, domestic abuse, drug and alcohol misuse and the impact of parental mental ill health.

Our data clearly shows that having a clear strategic focus on the causes of neglect, the toxic trio and poverty and not just the symptoms is a priority.
There is a need to better understand when parents access adult services in relation to drug and alcohol misuse and mental ill health in order to further develop our think family approach and manage potential risk within the context of families and communities.

It is important to recognise that for many when parenting is compromised accessing support may be difficult and services need to be proactive in taking the help to parents and carers, including parents of children with complex needs (disabled children).

We need to continue to strengthen the way we identify and manage need and risk for older young people. Local and national data – such as those regarding alcohol use by under 18s and young people going missing and at risk of sexual exploitation. These issues may similarly be “hidden issues” with young people not identifying themselves as being at risk of harm.

Tackling the emotional health and well being of our young is key priority and it is recognised that there is more to do to ensure that approach in this regard is promoted at all tiers of need and intervention.
Similarly enhancing our understanding the health needs of our looked after population and care leavers continue to be a priority for the partnership.

4.10 Recommendations

1. To continue to work with partner agencies to embed early approaches to reduce demand upon specialist and acute services

2. To work collaboratively with partners and the LSCB to reduce the prevalence of children and young people experiencing neglectful parenting through early identification and intervention.
3. To undertake a comprehensive analysis of the health and well being of looked after children and care leavers and implement to drive forward improved health outcomes for our most vulnerable.

4. To embed the Emotional Health and Well Being Strategy and priority actions across all tiers of need to ensure timely and appropriate interventions are offered to children and young people in accordance with identified need.

5. To work with Tier 3 CAMHS providers to improve timeliness of services offered and service take up.

6. To work collaboratively across the health and well being, safeguarding and community safety partnerships to reduce the impact of parental substance misuse and domestic violence upon children.

7. To develop and implement joint commissioning intentions and priorities in respect of children with complex needs and autism to reduce demand for out of Borough placements, including educational placements.

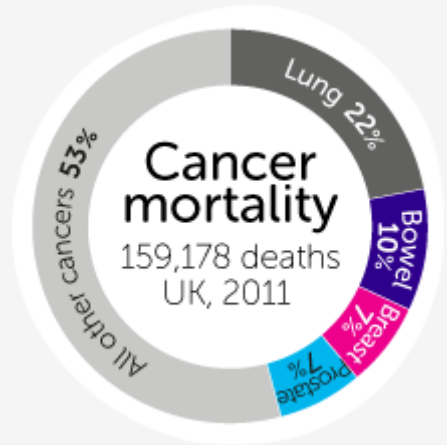
5 Health and well-being strategy: (ii) increased healthy life expectancy with reduced differences between communities – *"A focus on cancer"*

5.1 Introduction to cancer

Cancer (malignant neoplasm) is a disease in which a group of cells displays uncontrolled growth, invasion of adjacent tissues and sometimes metastasis to distant parts of the body via the blood or lymph vessels.

It is responsible for about 29% of deaths. In 2011, there were 157,000 cancer deaths in the U.K., and the commonest tumours resulting in death were lung, bowel, breast, and colon accounting for slightly under half of all cancer deaths (see Figure).

Figure 19: cancer mortalities by type of cancer

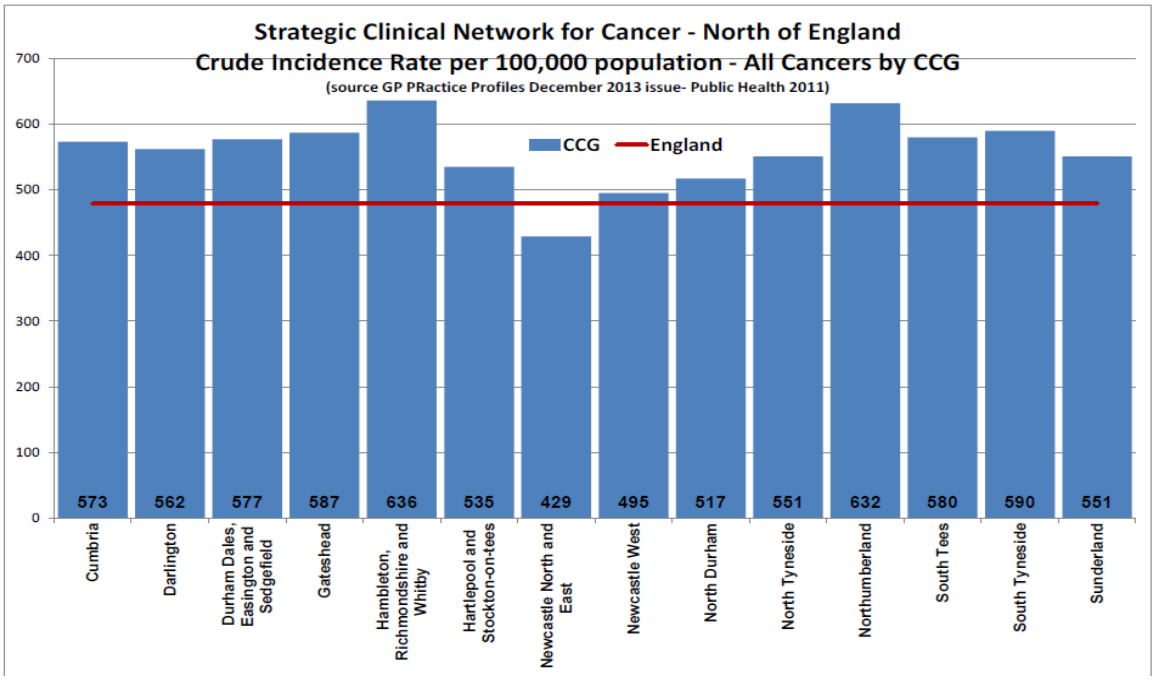


Source: Cancer Research U.K.

5.2 Cancer and early mortality in South Tyneside

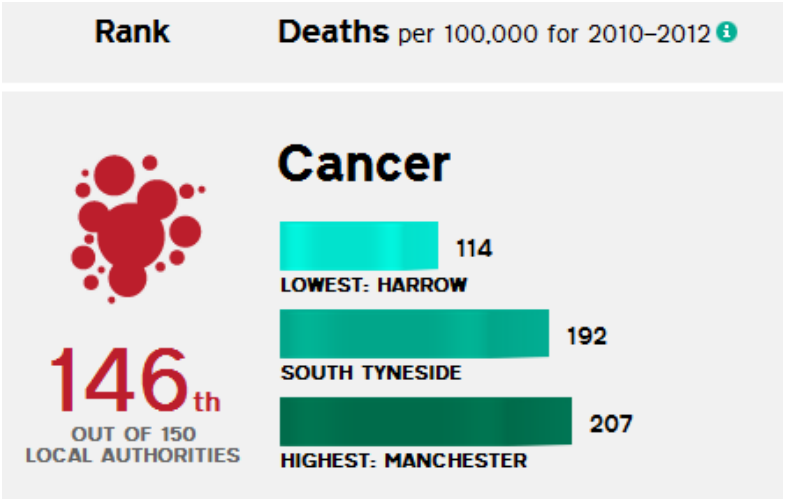
In South Tyneside more people are dying from cancer than in England and in the North of England, as shown in Figure 17. This alone is enough to make cancer a big priority for South Tyneside.

Figure 17: mortality rates from cancer, North of England



As with all deaths, South Tyneside compares badly with other local authorities with regard to deaths from cancer, ranking 146th out of 150 local authorities, with 192 deaths per 100,000 for 2010-12 (see Figure).

Figure 21: cancer deaths in South Tyneside compared to all other local authorities



Source: Longer Lives website

South Tyneside's high levels of socio-economic deprivation, will also impact on cancer incidence and mortality. However, even when compared with local authority areas with similar deprivation levels, South Tyneside has very poor outcomes in relation to cancer deaths, ranked bottom among similar authorities (see Figure 18).

Figure 18: cancer deaths in South Tyneside compared to similar local authorities

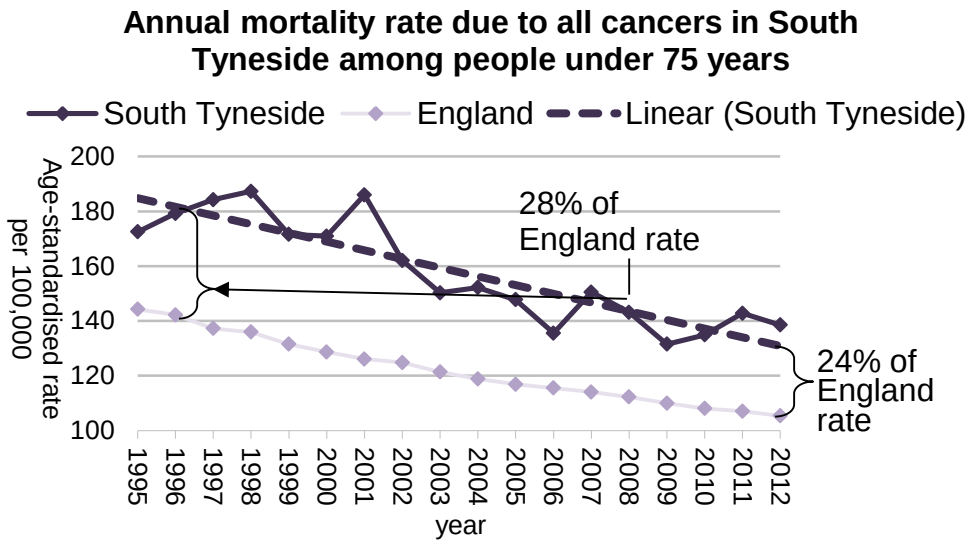
Source: Longer Lives website

This suggests that there is significantly more to our poor cancer outcomes than our high deprivation profile.

5.2.1 Premature mortality rate due to all cancers (one of the 29 core priority indicators)

There is a downward trend in the early mortality rate due to all cancers among the population of South Tyneside (see Figure 19). There is considerable variation in the rate from year to year within local authority populations due to relatively small numbers of deaths when compared to mortality at regional and national level.

Figure 193: annual mortality rate, all cancers, people under 75 years



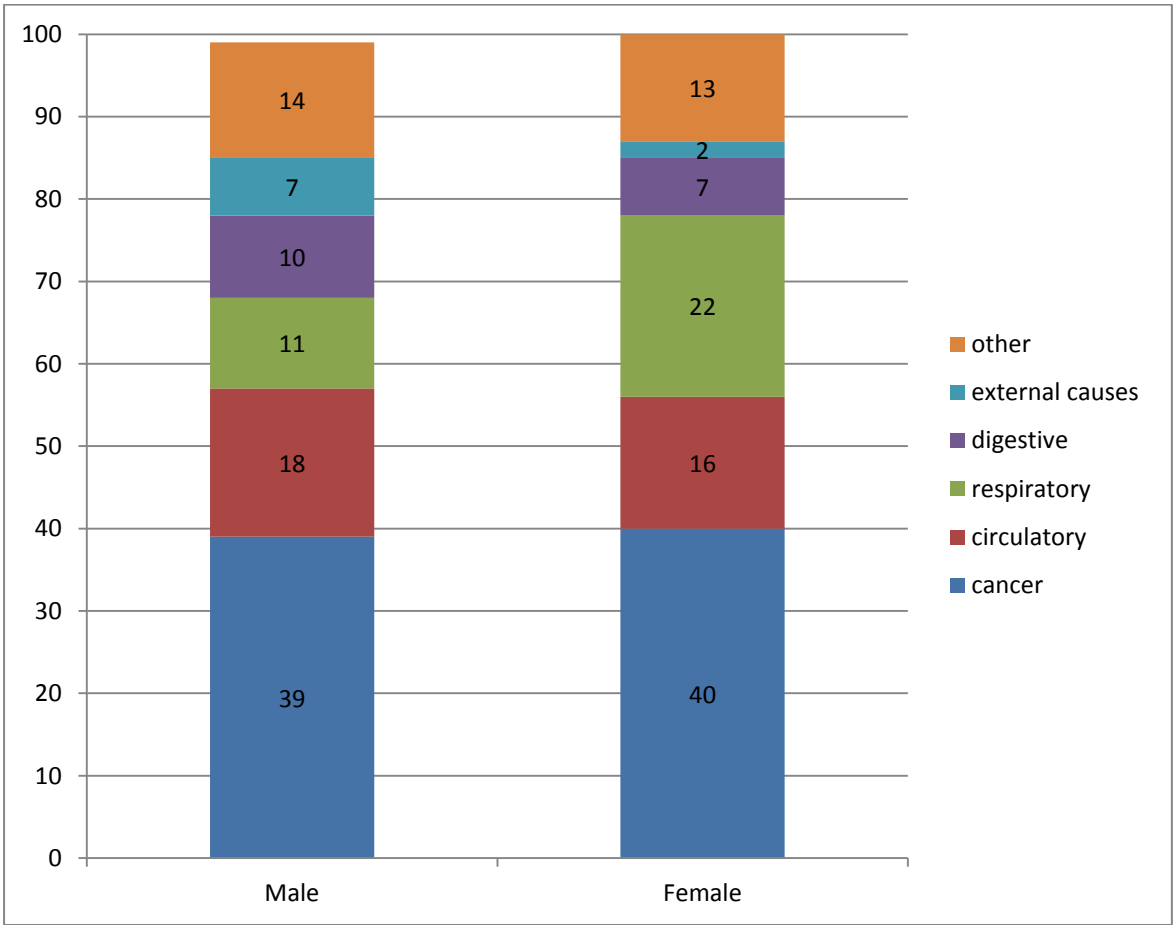
Data source: Indicator Portal, Health and Social Care Information Centre at https://indicators.nhs.ic.uk

5.3 Life expectancy gap between South Tyneside and England – estimated causes

Figure 20 shows how much different health conditions contribute to the gap in life expectancy between South Tyneside and England:

- 40% of the total life expectancy gap between South Tyneside and England among males is due to excess mortality due to all cancers – 15% is due specifically to lung cancer
- Among females, one quarter of the gap is due to all cancers and 15% is due to lung cancer
- All cancer mortality rates are significantly above the England average among males and females. All cancer registration rates are significantly higher than England among males.

Figure 204: Impact of conditions on the gap in life expectancy between South Tyneside and England, 2009-11 (%, rounded figures)



Data source: Public Health England, Segment Tool.

5.4 Lung cancer

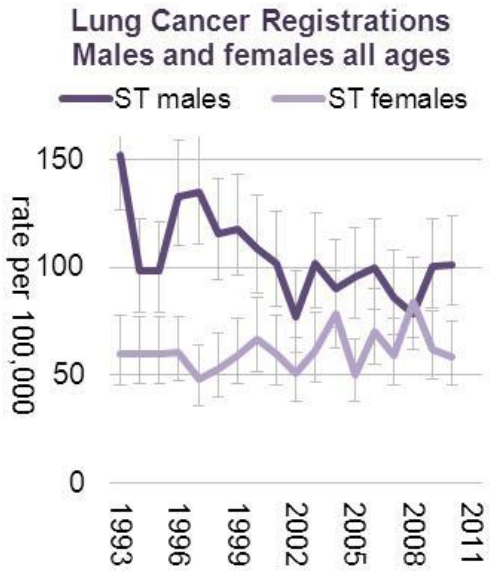
5.4.1 Incidence and mortality

South Tyneside is among the 10% of former PCT populations with the highest lung cancer mortality and incidence rates among both males and females.

Incidence (registration) and mortality rates due to lung cancer among males have been falling, while they have remained level among females over the past 20 years. This pattern is evident both locally and nationally.

Smoking is a major contributor to lung cancer. Smoking rates have been falling among the South Tyneside population (see later in this chapter) , but current patterns of incidence and mortality due to lung cancer will be influenced by smoking behaviour 10-20 years ago.

Figure 25: all age lung cancer registration rate (one of the 29 core priority indicators)

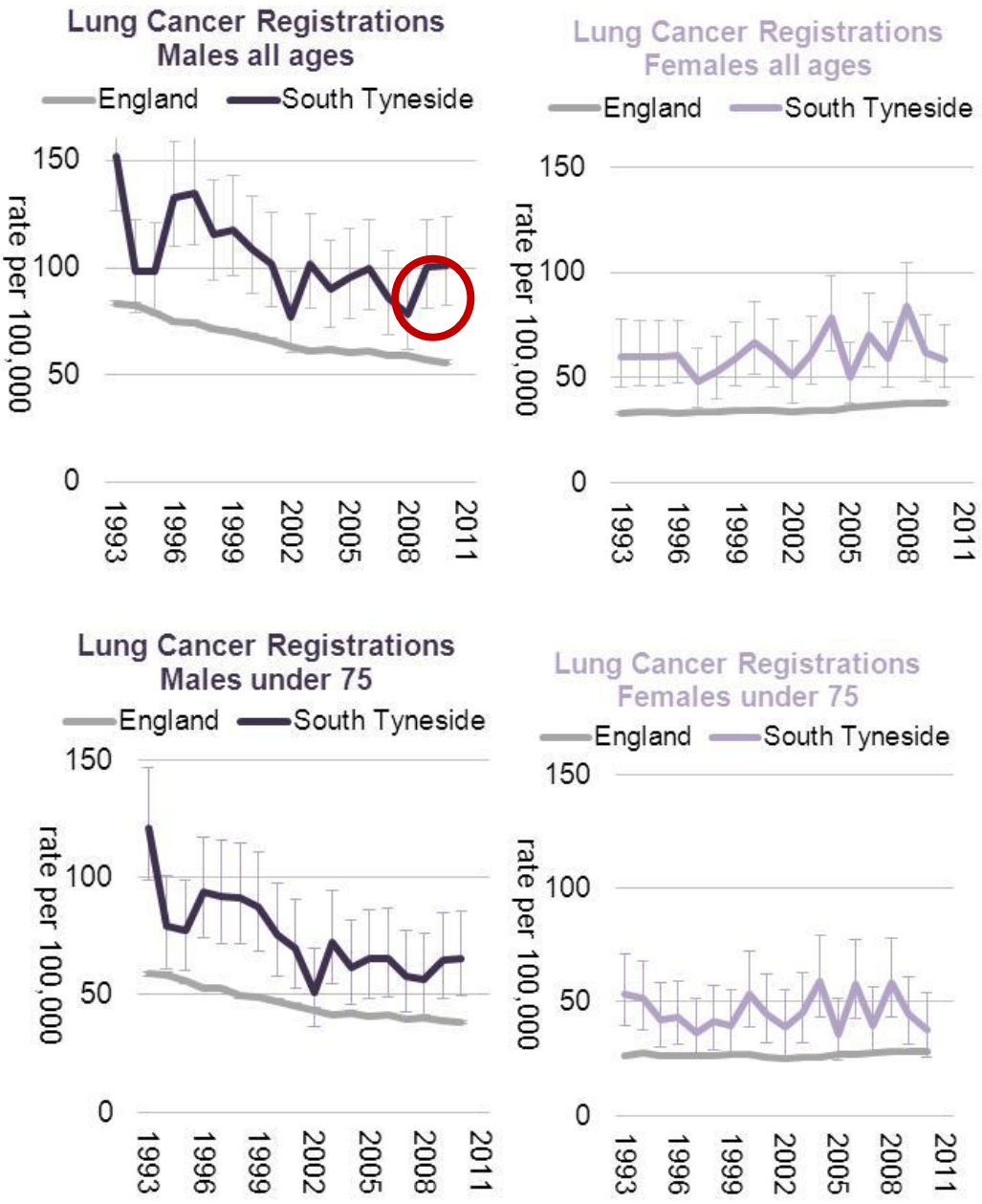


Notes:

The male registration rate was falling from 1995 – 2000 but the trend has flattened since then.

The gap in the registration rate between England and South Tyneside is of equal magnitude for all lung cancer mortality and early mortality (under 75 years).

High all age registration rates among South Tyneside males in 2010 and 2011 will cause high mortality rates in 2011 and 2012.

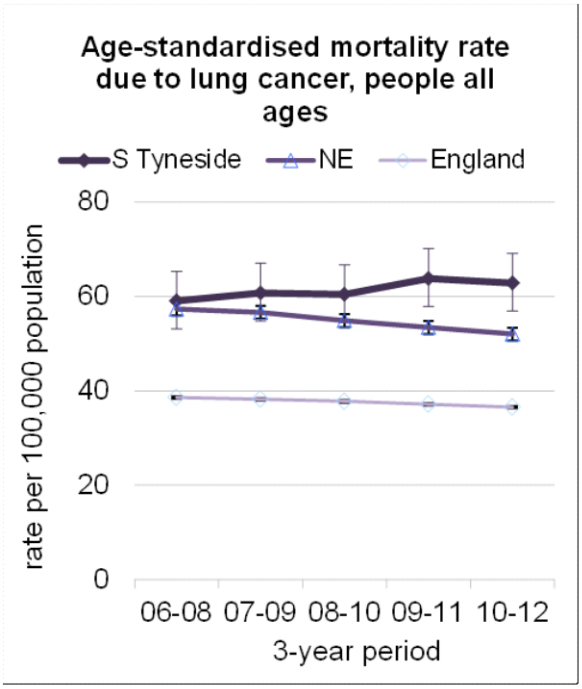


Source: UK Cancer Information System, National Cancer Intelligence Network at www.ncin.org.uk

5.4.2 Mortality trends

Death rates from lung cancer have historically been higher than those of England and the situation appears to be worsening. See Figure 21, which shows the age-standardised mortality rate due to lung cancer per 100,000 population all ages, 3-year average, and Figure 22, which shows mortality rates by sex.

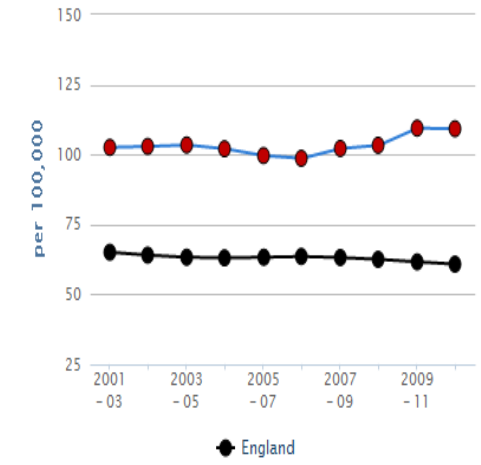
Figure 216: All age mortality rate due to lung cancer (one of the 29 core priority indicators)



Year	South Tyneside deaths		*England rate*
	number	rate	
2006-2008	419	59.0	*38.6*
2007-2009	440	60.8	*38.2*
2008-2010	446	60.4	*37.8*
2009-2011	474	63.8	*37.2*
2010-2012	475	62.8	*36.6*

95% confidence limits are shown on chart. Data source: Health and Social Care Information Centre. Data for 2011-13 will be published in December 2014.

Deaths from lung cancer South Tyneside — Directly standardised rate - per 100,000

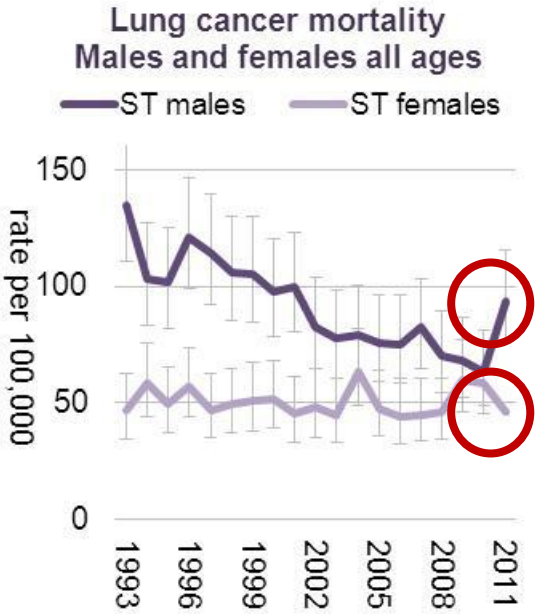


Period	Sig	Value	Lower CI	Upper CI	Industrial Hinterlands	England
2001 - 03		102.6	93.1	112.9	92.0	65.1
2002 - 04		103.0	93.4	113.2	89.5	64.1
2003 - 05		103.5	94.0	113.8	88.2	63.4
2004 - 06		102.1	92.6	112.4	88.3	63.1
2005 - 07		99.7	90.3	109.8	89.8	63.4
2006 - 08		98.7	89.4	108.7	92.0	63.6
2007 - 09		102.2	92.8	112.3	91.6	63.3
2008 - 10		103.4	93.9	113.5	89.8	62.6
2009 - 11		109.5	99.8	119.9	88.0	61.7
2010 - 12		109.3	99.6	119.7	86.3	60.9

Source: Public Health England (based on ONS source data)

Source: PHE 2013 tobacco Profiles

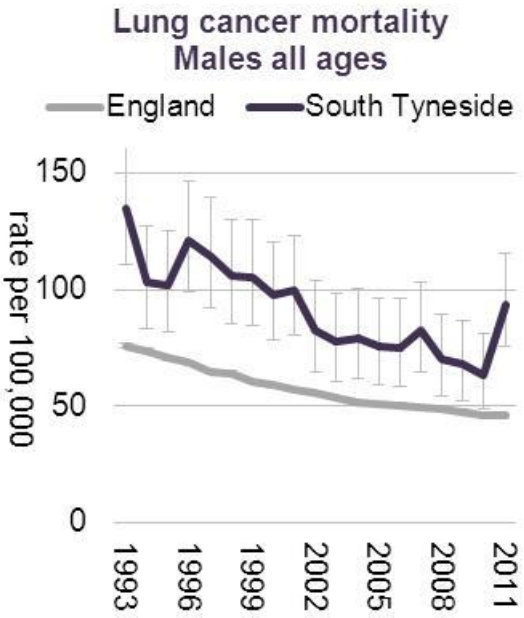
Figure 22: lung cancer mortality by sex

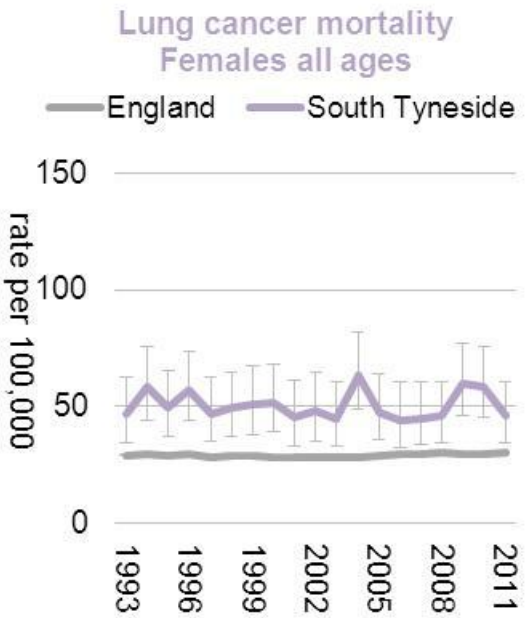


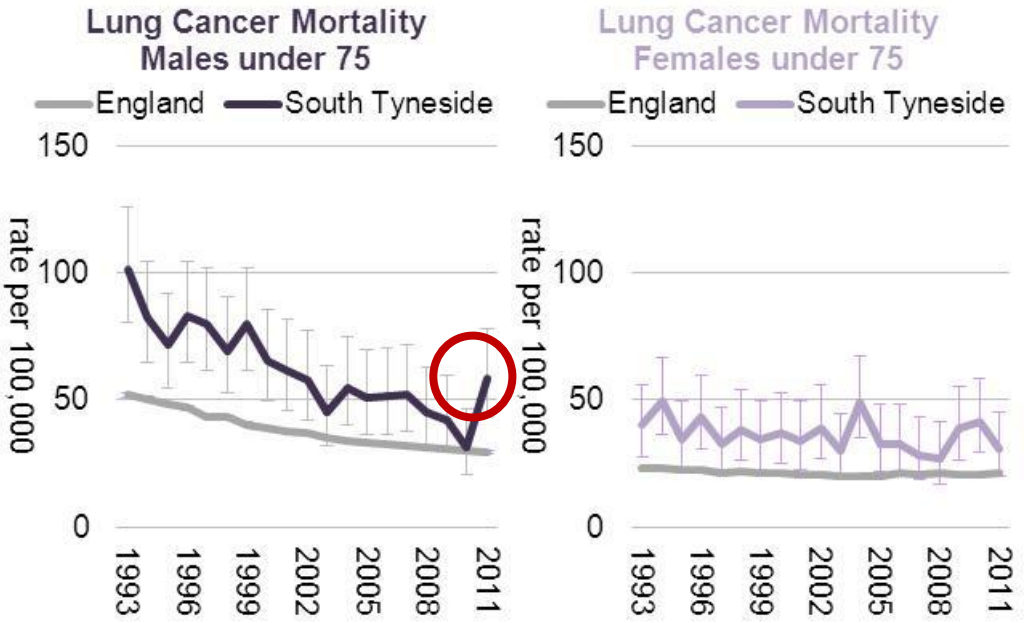
Notes:

High all age registration rates in 2010 and 2011 among South Tyneside males will lead to high mortality rates in 2011 and 2012.

Mortality among males in South Tyneside has fallen while the mortality rate among females has remained level.



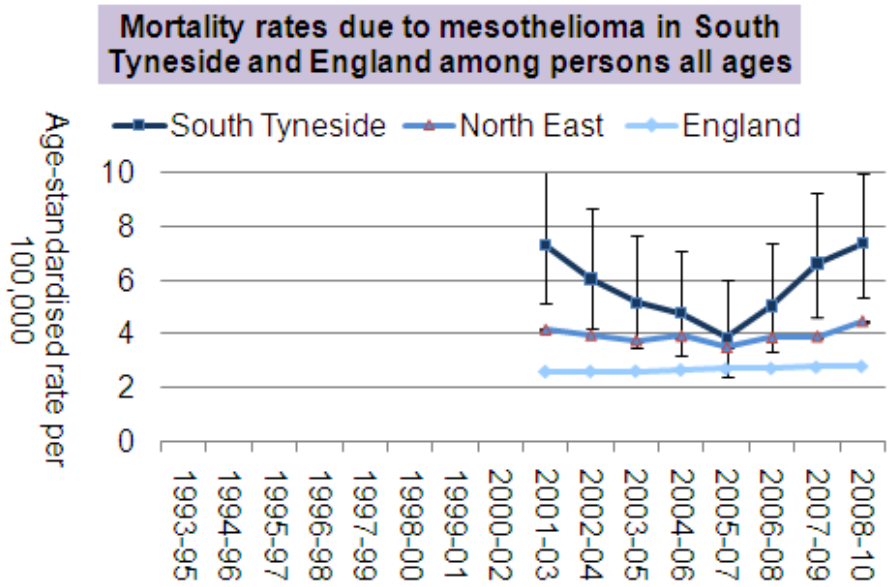




5.4.3 Mesothelioma

Mesothelioma is a disease of the linings of bodily organs. It is almost always caused by exposure to asbestos dust. . Most exposures are occupational and the ratio of male to female cases is 5:1. Although the numbers are small, mortality rates from mesothelioma are, for most recent years, statistically significantly higher in South Tyneside than for England overall and for the North East. This can be attributed to South Tyneside's former industrial past, where in industries such as Ship building and construction used asbestos as part of daily production.

Figure 28: Mortality rates due to mesothelioma 2001-3 to 2008-10



The majority of deaths due to mesothelioma occur among males. Mortality rates for persons are shown here due to the small number of deaths among women at

primary care organisation level. This would mean that separate statistics for males and females would have to be suppressed to avoid disclosure.

The numbers of registrations of mesothelioma among the populations of Gateshead, South Tyneside and Sunderland are too small to allow the calculation of a robust indicator of survival. Regional and national survival rates to one year and three years are shown below (Figure 23 and Figure 24 respectively).

Figure 239: survival to 3 years following diagnosis of mesothelioma

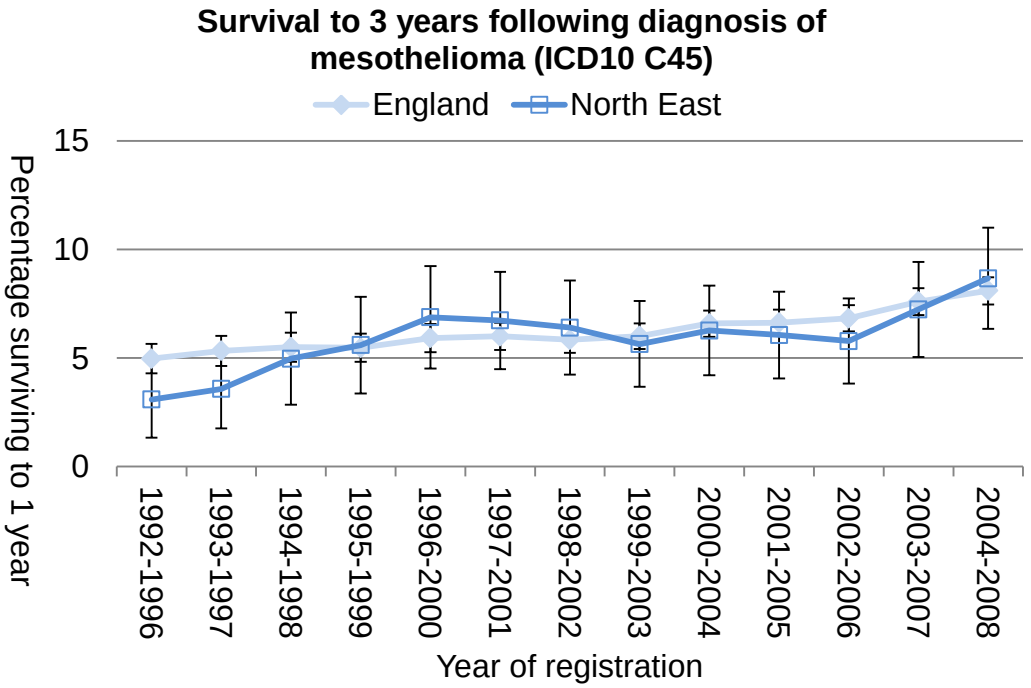
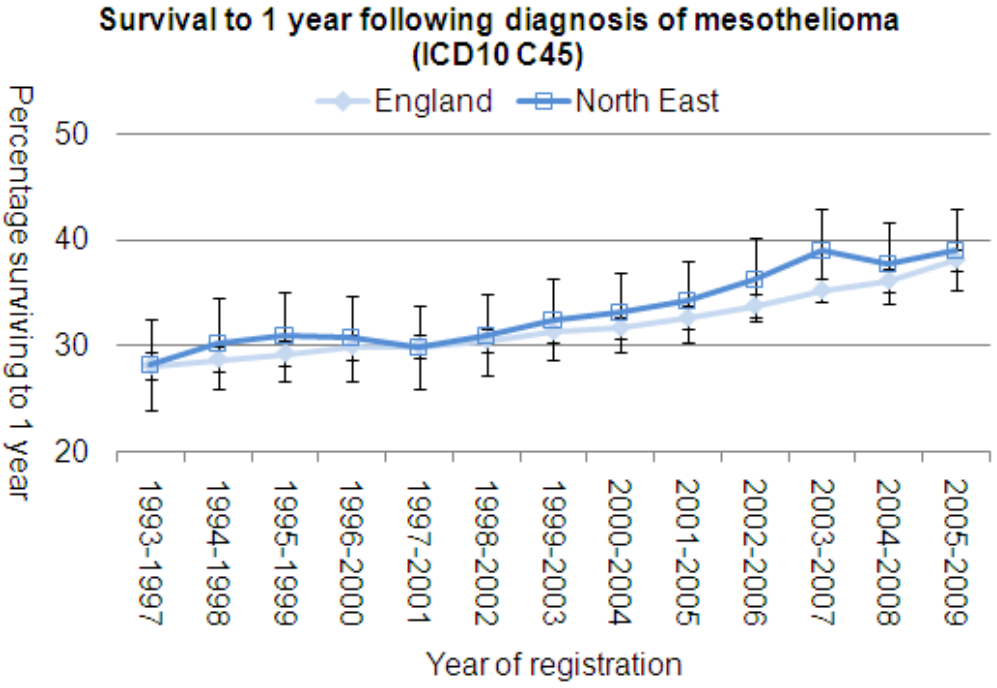


Figure 24: survival to 1 year following diagnosis of mesothelioma



5.4.4 Taking action on Lung cancers

Since lung cancer is not currently amenable to screening, the key interventions in relation to awareness and identification are about tobacco control strategies, systematic risk factor assessment, and the promotion of awareness to encourage early presentation with potential signs and symptoms.

5.4.5 Smoking rates (one of the 29 core priority indicators)

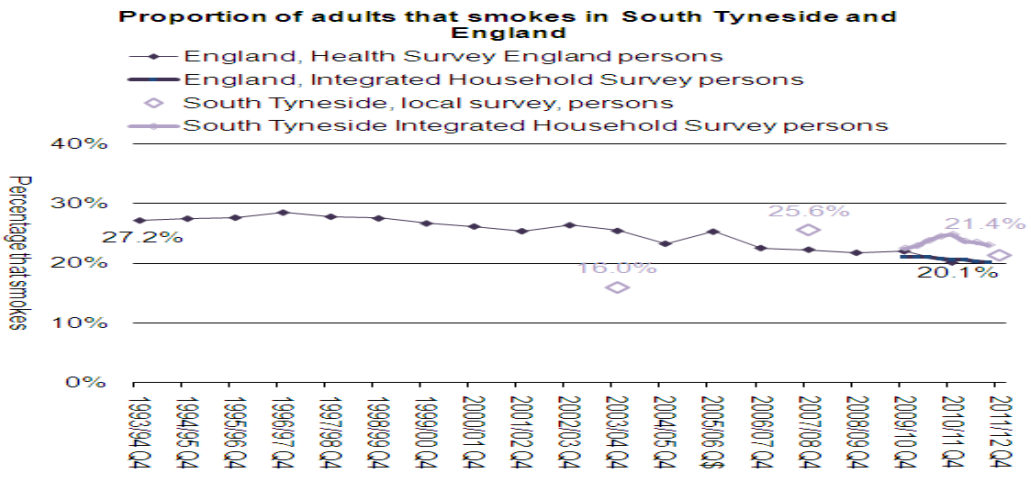
Public Health England publishes annual profiles for each local authority with a range of indicators relating to tobacco and related health issues. South Tyneside compares very poorly with England as a whole in the most recent (2013) profile (see Figure 25). In particular, it has the highest rate of smoking-related hospitalisations in England, and close to the highest rate of lung cancer deaths.

Figure 25: smoking-related profile

Indicator	Period	S Tyneside		ONS cluster group	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Smoking attributable mortality	2008 - 10	1,093	286.6	-	210.6	371.8		125.2
Smoking attributable deaths from heart disease	2008 - 10	129	38.3	-	30.3	58.4		14.6
Smoking attributable deaths from stroke	2008 - 10	39	10.7	-	9.8	19.2		4.8
Deaths from lung cancer	2010 - 12	475	109.3	86.3	60.9	112.7		29.8
Deaths from chronic obstructive pulmonary disease	2010 - 12	365	83.4	71.3	50.1	97.1		19.7
Lung cancer registrations	2009 - 11	576	132.9	-	75.5	144.2		42.1
Oral cancer registrations	2009 - 11	66	15.0	-	12.8	21.1		5.9
Smoking attributable hospital admissions	2010/11	2,662	2,536	-	1,420	2,536		726
Cost per capita of smoking attributable hospital admissions	2010/11	4,839,294	54.9	47.6	36.9	61.7		14.5
Smoking prevalence - routine & manual	2012	-	27.0%	-	29.7%	54.7%		6.0%
Smoking Prevalence (IHS)	2012	-	20.7%	-	19.5%	30.1%		8.4%

Figure 26 shows the trends in proportions of adults that smokes in England and South Tyneside. At the times of the two most recent relevant household surveys, South Tyneside's rates were higher than England.

Figure 262: proportion of adults that smokes in South Tyneside and England



5.4.5.1 Smoking in pregnancy rates (one of the 29 core priority indicators)

There remains a large and persistent gap between England and South Tyneside in the proportion of females that continues to smoke throughout pregnancy. In 2012/13 there was a fall in the number of pregnant women setting a quit date following a steady increase over the past four years.

Smoking in pregnancy rates are significantly higher in South Tyneside (26%) than in England as a whole (13%), as shown in Figure 27.

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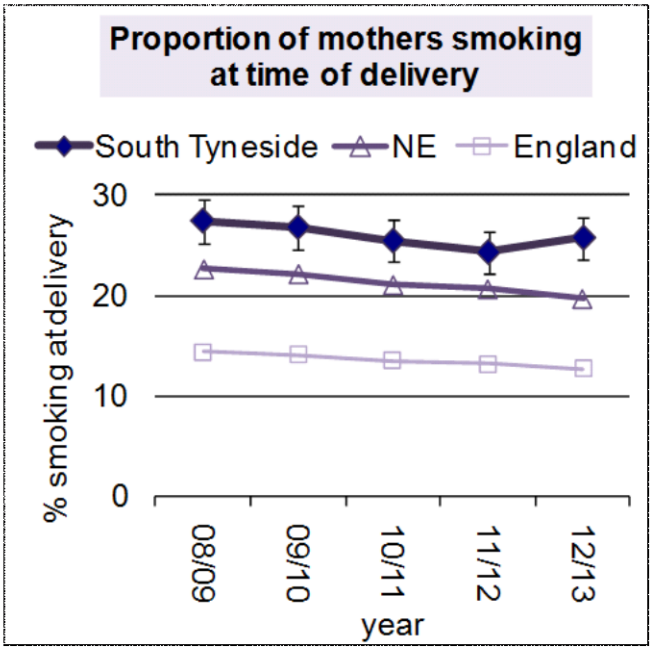
Figure 27: proportion of mothers smoking at time of delivery (one of the 29 core priority indicators)



Year	South Tyneside mothers smoking at time of delivery		*England rate*
	Maternities	rate	
2008/09	1,644.0	**27.4**	*14.4*
2009/10	1,686.0	**26.8**	*14.0*
2010/11	1,691.0	**25.5**	*13.5*
2011/12	1,657.0	**24.4**	*13.2*
2012/13	1,633.0	**25.8**	*12.7*

Figures in bold indicate that these are significantly higher or lower than England prevalence at 95% confidence. (95% confidence limits are shown on chart.) Data source: Dept of Health. Data for 2013/14 will be published in June 2014.

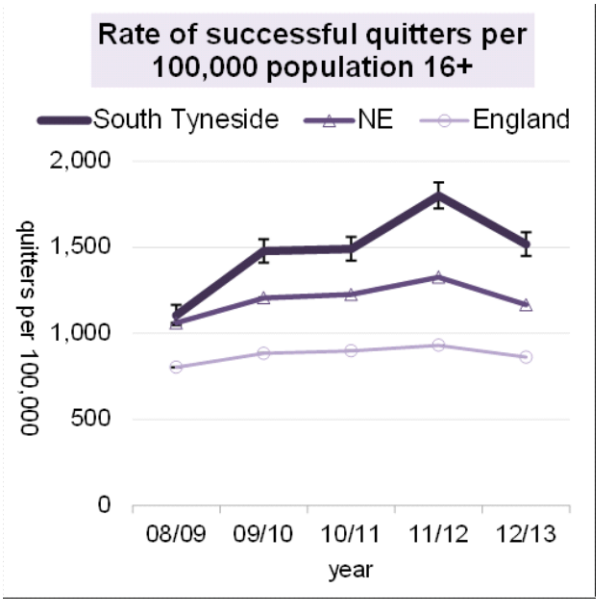
Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, July 2013

There is a regional initiative to drive up quit rates in expectant mothers, based on some positive outcomes from a new model of care in Rotherham. We are currently working with other stakeholders to consider how aspects of that model can be implemented in our locality.

5.4.6 Use of NHS Stop Smoking Services

Smoking prevalence has been falling in recent years among local populations. However, the number of people using NHS Stop Smoking Services, who successfully quit, fell both locally and nationally in 2012/13 compared to the previous year, as shown in Figure 28. The transition to a new model of service delivery, a new organisation managing the programme and increased sales of e-cigarettes all could have contributed to the downturn.

Figure 28: rates of quitting smoking



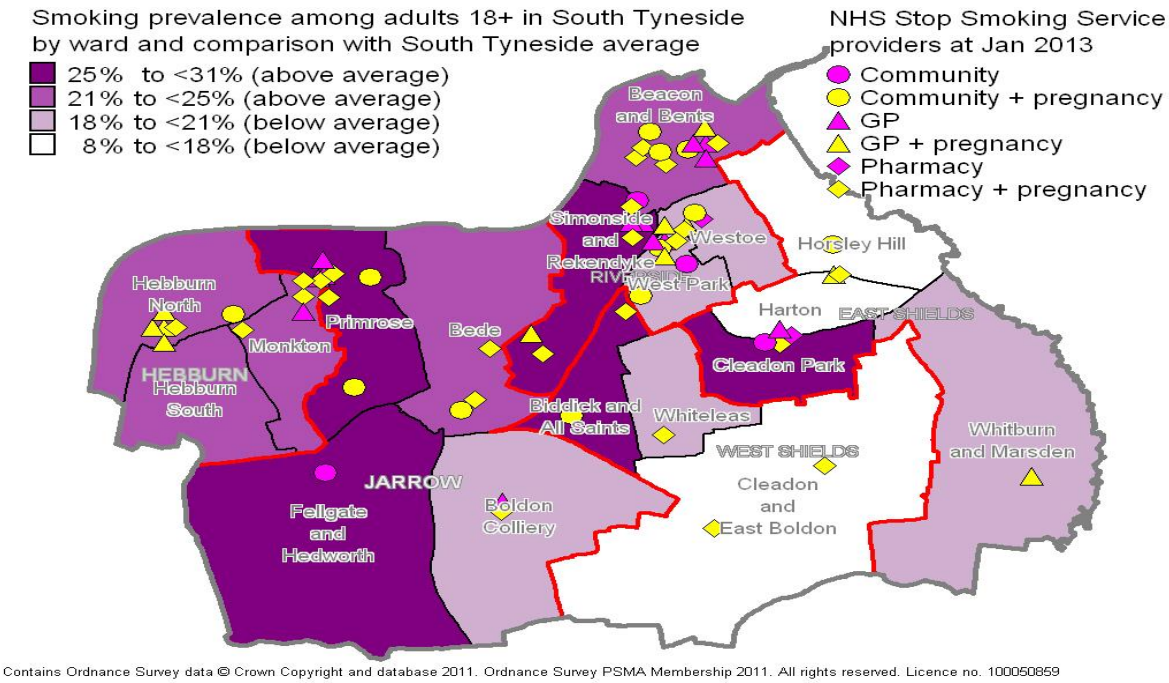
Year	South Tyneside quitters		*England rate*
	number	rate	
2008/09	1,346	1,105	*803*
2009/10	1,805	1,478	*884*
2010/11	1,823	1,491	*899*
2011/12	2,201	1,799	*931*
2012/13	1,862	1,518	*862*

Data source: Health and Social Care Information Centre (2013) "Statistics on NHS Stop Smoking Services, England, April 2012 to

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, July 2013

Since the beginning of 2013, all local Stop Smoking Services have been provided within GP Practices, pharmacies and a range of other community settings. This new model of delivery is more cost effective and, in time, this will help to reduce the cost per quitter, which has been above the regional average in South Tyneside. Figure 29 shows smoking prevalence by ward and also shows the locations of the stop smoking services. Further information on the service (and its evaluation) is provided in section **Error! Reference source not found.**.

Figure 295: smoking prevalence and stop smoking services, ward map

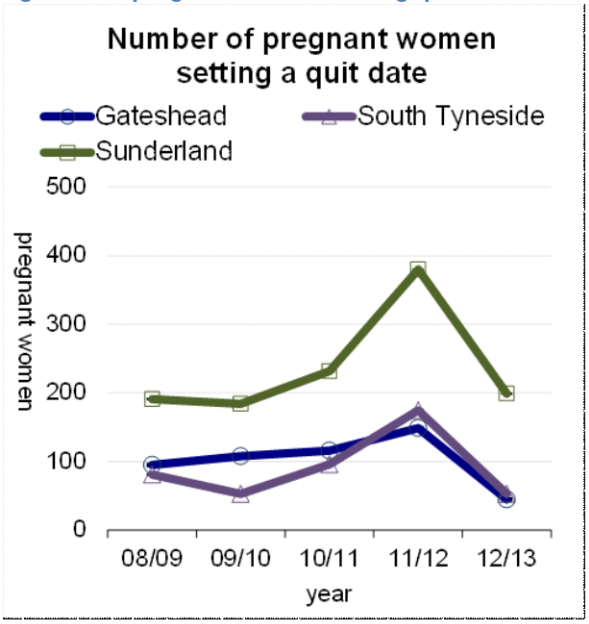


Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, Dec 2013

The recent fall in the number of pregnant women accessing Stop Smoking Services is of particular concern (see Figure 30). Smoking rates among pregnant women in local populations remain stubbornly high. It is hoped that an increase in the number of local

providers specially trained to deliver support to pregnant smokers since January 2013 will help to buck the trend.

Figure 306: pregnant women setting quit dates



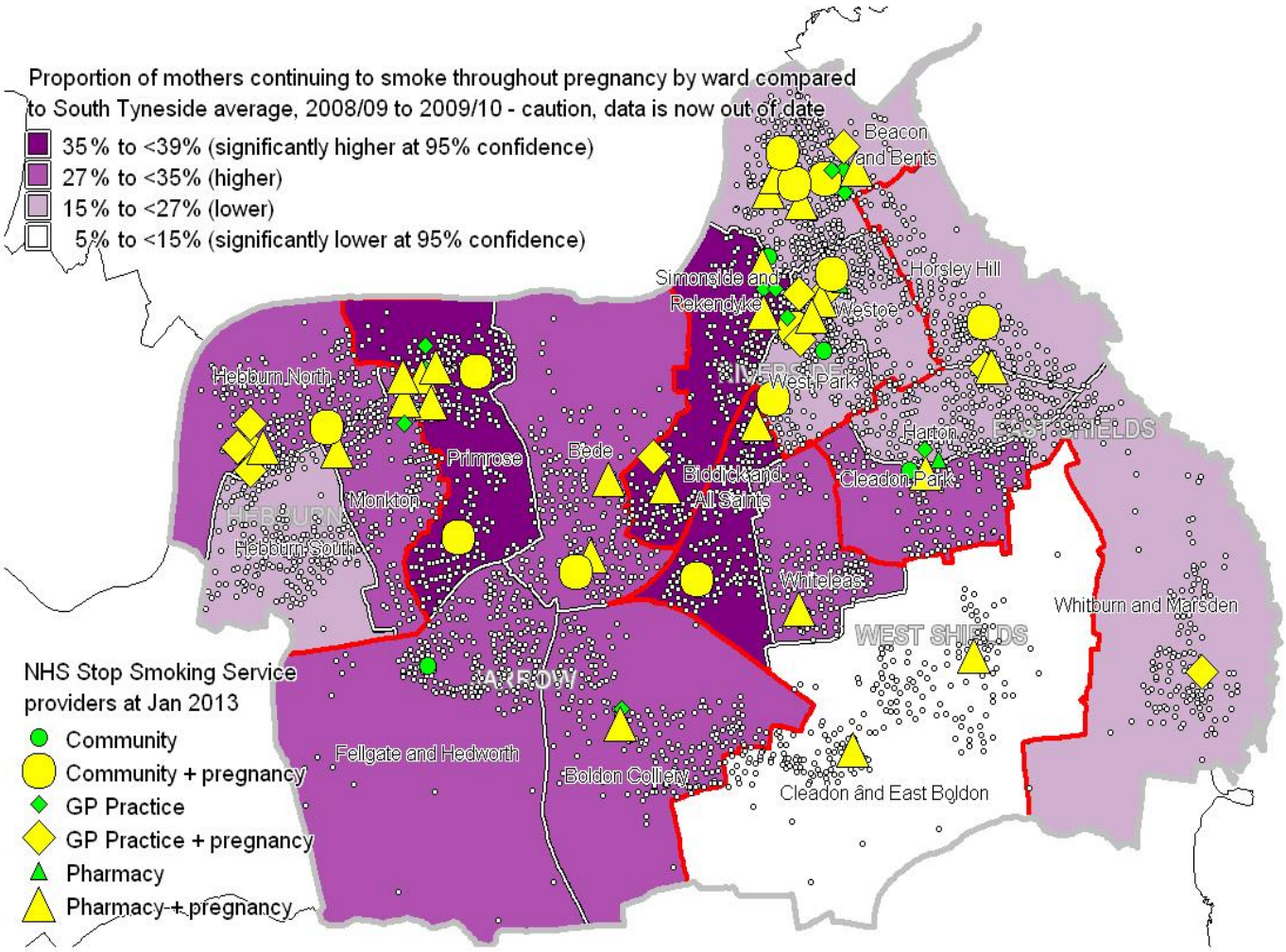
Year	number of South Tyneside pregnant women setting a quit date
2008/09	81
2009/10	53
2010/11	96
2011/12	175
2012/13	53
2013/14 Q1	27

Data source: Health and Social Care Information Centre (2013) "Statistics on NHS Stop Smoking Services, England, April 2012 to

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, Dec 2013

Figure 317 shows smoking prevalence in pregnant women by ward and also shows the locations of the stop smoking services. (Note that these data are now out of date but could still provide some useful information.)

Figure 317: smoking in pregnancy and stop smoking services, by ward



Source: NHS South of Tyne and Wear, Business Information based on data provided by South Tyneside NHS Foundation Trust. Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, July 2013.

5.4.6.1 Tobacco strategy

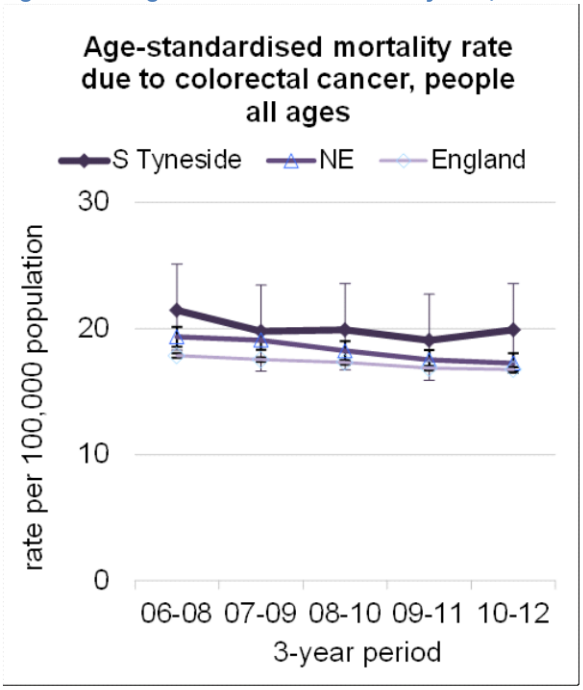
A local tobacco strategy is currently under review to consider all aspects of tobacco use in South Tyneside and to coordinate efforts to reduce the negative impact of tobacco on the health of the people we serve.

5.5 Colorectal cancer

5.5.1 Incidence and mortality

The mortality rate and registration rates for colorectal cancer are among the 29 core priority indicators. The age-standardised mortality rates are shown in Figure 328. South Tyneside's rates have consistently been higher than England's.

Figure 328: age-standardised mortality rate, colorectal cancer



South Tyneside

Year	South Tyneside deaths		*England rate*
	number	rate	
2006-2008	154	**21.4**	17.9
2007-2009	148	19.8	17.5
2008-2010	152	19.9	17.3
2009-2011	140	19.1	16.9
2010-2012	145	19.9	16.8

Figures in bold indicate that these are significantly higher or lower than England prevalence at 95% confidence (95% confidence limits are shown on chart). Data source: NHS Information Centre. Data for 2011-13 will be published in Dec 2014.

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, January 2014

South Tyneside is among the top 20% of former PCT populations with the highest colorectal cancer mortality rate among males

Figure 339: colorectal cancer key facts

Cancer type	Locality	No.Cases/Deaths	Rate/%	UK avge	Comparator to UK average rate
▼ Colorectal (bowel)					
Persons Incidence*	South Tyneside PCT	105	47.3 ◆	47.7	0 — 75
Male Incidence*	South Tyneside PCT	64	62.2 ◆	58.4	0 — 75
Female Incidence*	South Tyneside PCT	41	32.5 ◆	37.1	0 — 75
Persons Mortality*	South Tyneside PCT	45	19.1 ◆	16.8	0 — 30
Male Mortality*	South Tyneside PCT	26	24.8 ◆	20.9	0 — 30
Female Mortality*	South Tyneside PCT	19	13.4 ◆	12.8	0 — 30

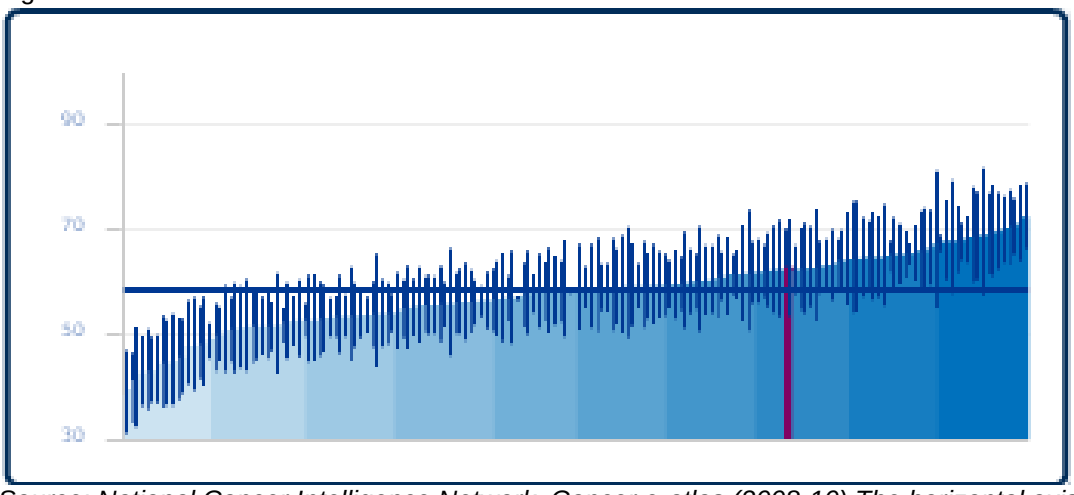
Source: National Cancer Intelligence Network, Cancer e-atlas

The male incidence and mortality rates for colorectal cancer are shown in Figure 4034 40 and Figure 4135 41 respectively. The rates for all of the following charts are given by NHS Boundary and include all PCTs in England, Health Boards in Scotland, and Health & Social

Care Trusts in Northern Ireland. National, GB and UK bars are also in included, but Welsh localities are not presented individually.

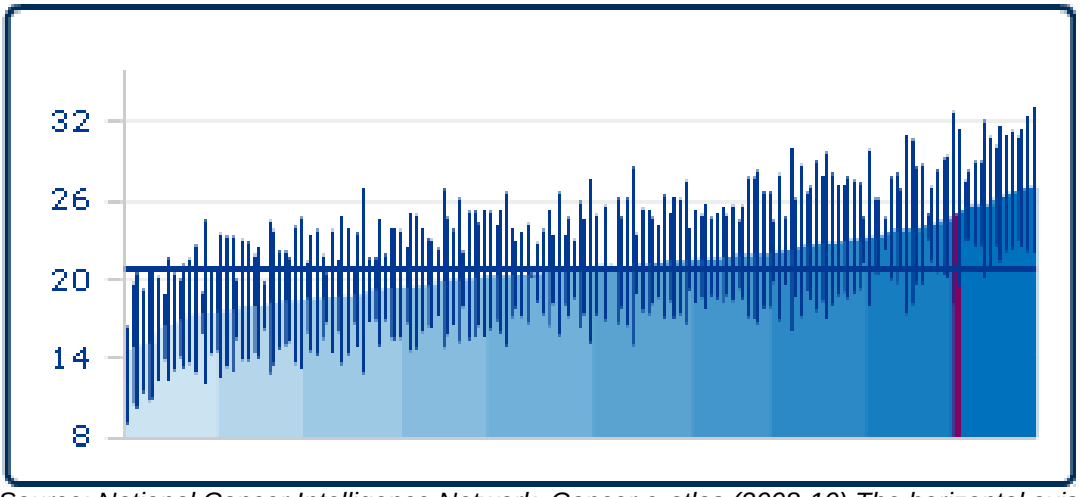
Columns are sorted by into deciles by value and each column has a confidence interval around the point estimate. The purple bar is the value for South Tyneside.

Figure 4034: Male incidence of colorectal cancer



Source: National Cancer Intelligence Network, Cancer e-atlas (2008-10) The horizontal axis gives each NHS boundary and the vertical axis shows the rate per 100,000 population

Figure 4135: male mortality from colorectal cancer



Source: National Cancer Intelligence Network, Cancer e-atlas (2008-10) The horizontal axis gives each NHS boundary and the vertical axis shows the rate per 100,000 population

5.6 Breast cancer

5.6.1 Incidence and mortality

South Tyneside has a lower than UK average incidence rate of (female) breast cancer (see Figure 42 and

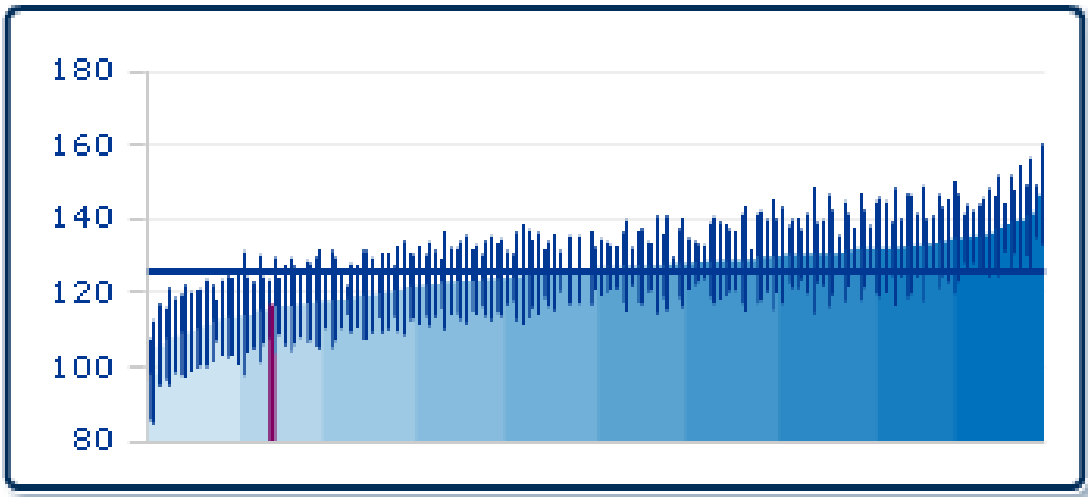
Figure).

Figure 42: female breast cancer key UK comparison

Cancer type	Locality	No.Cases/Deaths	Rate/%	UK avge	Comparator to UK average rate
▼ Breast					
Female Incidence*	South Tyneside PCT	120	116 ◆	125.8	0 150
Female Mortality*	South Tyneside PCT	30	25.7 ◆	24.8	0 30

Source: National Cancer Intelligence Network, Cancer e-atlas

Figure 43: incidence of female breast cancer

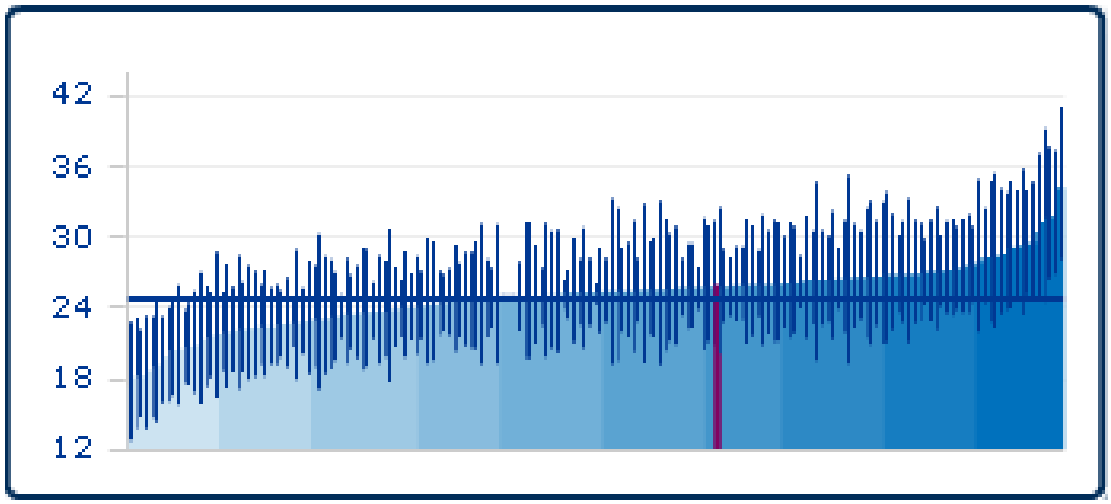


Source: National Cancer Intelligence Network, Cancer e-atlas (2008-10) The horizontal axis gives each NHS boundary and the vertical axis shows the rate per 100,000 population

South Tyneside is among the 20% of former PCT populations with the lowest breast cancer registration rate, but is among the 40% with the highest mortality rate (see

Figure 36). There could be a number of reasons for this, including low uptake of screening, women not going to their doctor with early symptoms, poor rates of diagnosis, late referral for treatment or less than optimal treatment.

Figure 36: mortality from female breast cancer



Source: National Cancer Intelligence Network, Cancer e-atlas (2008-10) The horizontal axis gives each NHS boundary and the vertical axis shows the rate per 100,000 population

5.6.1.1 Survival and taking action

Although not significantly different to the England rate at a 95% level of confidence, the one year breast cancer survival rate among South Tyneside females is among the 25% of lowest rates among all former PCT populations.

Further investigation of current breast cancer staging data is recommended to determine whether there is any evidence that local females are presenting at a later stage.

5.7 Cervical cancer

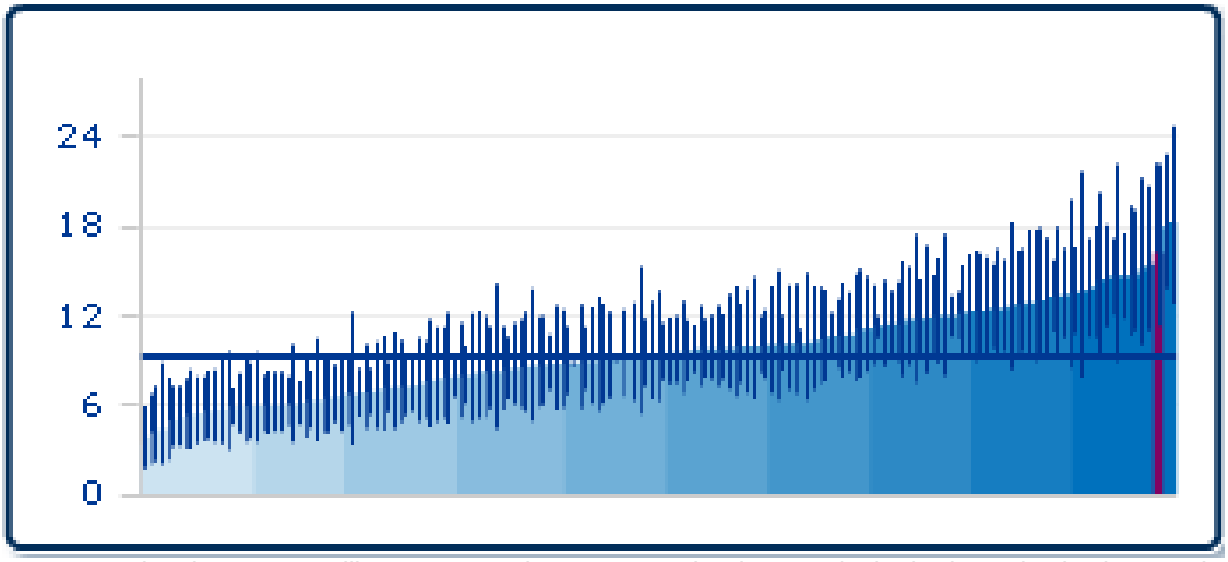
5.7.1 Incidence and mortality

South Tyneside is among the 5% of former PCT populations with the highest registration rate due to cervical cancer and the rate is significantly higher than the England rates (see Figure 5, 46 and 47). It is also among the 10% of former PCT populations with the highest mortality rate

Figure 45: cervical cancer incidence and mortality, key UK comparison

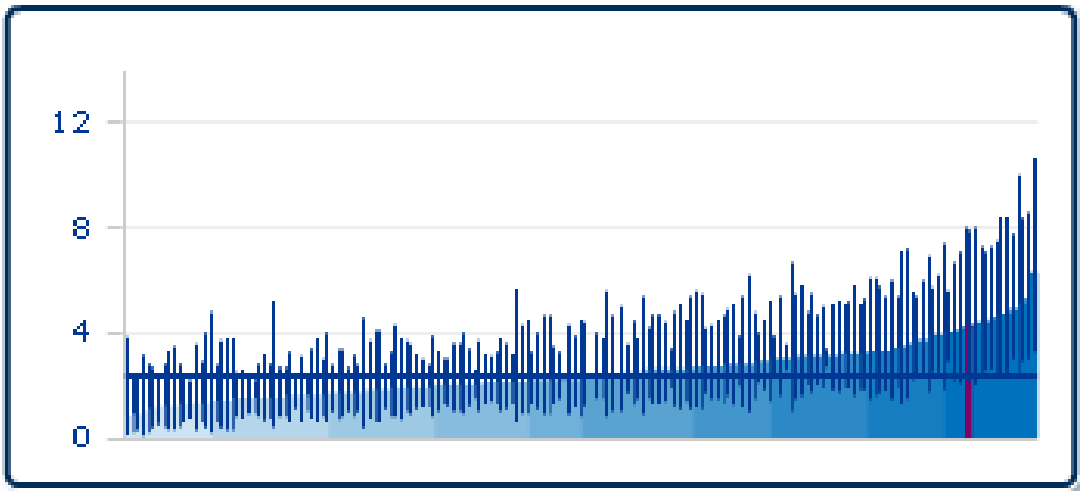
Cancer type	Locality	No.Cases/Deaths	Rate/%	UK avge	Comparator to UK average rate
▼ Cervix					
Female Incidence*	South Tyneside PCT	14	16 ●	9.2	0 20
Female Mortality*	South Tyneside PCT	4	4.2 ◆	2.4	0 10

Figure 376: incidence of cervical cancer



Source: National Cancer Intelligence Network, Cancer e-atlas (2008-10) The horizontal axis gives each NHS boundary and the vertical axis shows the rate per 100,000 population

Figure 387: mortality from cervical cancer



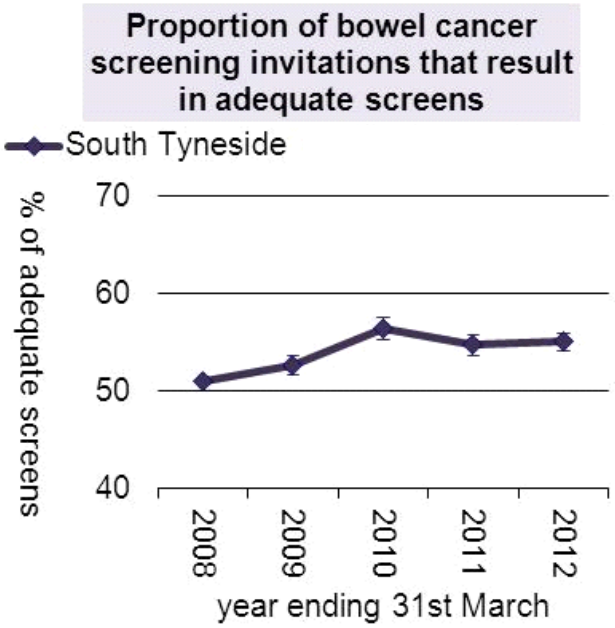
Source: National Cancer Intelligence Network, Cancer e-atlas (2008-10) The horizontal axis gives each NHS boundary and the vertical axis shows the rate per 100,000 population

5.8 Screening for cancer

5.8.1 Screening for bowel cancer

Coverage of the bowel screening programme (proportion of the eligible population that have been screened within the regulation time period) is not yet published. Following a rise from 51% in 2008, uptake (the proportion of screens sent out that are returned) has hovered around 55% from 2010 to 2012 (see Figure 48). There are no published regional or national benchmarks.

Figure 48: bowel cancer screening uptake



Specific lessons from screening equity audits and literature searches have been identified and will be incorporated into the developing cancer strategy.

5.8.2 Coverage of cervical screening

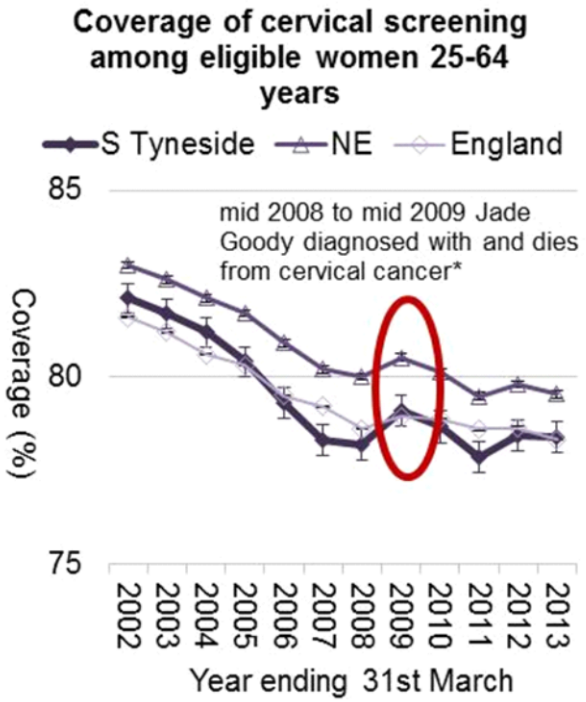
Coverage of cervical screening has fallen across England over the past 10 years. Coverage is measured as the proportion of eligible women in the target age range of 25 to 64 years who have been screened adequately within a recommended period. For women 25 to 49 years this is every 3 years. For women 50 to 64 years it is every five years.

Although coverage has fallen among the population of eligible women in South Tyneside across the year to 31st March 2013 and is two percentage points lower than in Gateshead and Sunderland, South Tyneside coverage is still above the England average.

Coverage among the 25-49 year and 50-64 year age groups is similar in South Tyneside (73% within 3.5 years and 74% within 5 years respectively).

Figure 39 shows combined coverage among the two age groups 25-49 years and 50-64 years. This is calculated as the number 25-49 years having been screened within 3.5 years plus the number 50-64 years having been screened within 5 years respectively, all divided by the total number of eligible women 25-64 years.

Figure 399: coverage of cervical screening among eligible women



Year	South Tyneside		*England coverage (%)*
	eligible population	coverage	
2009	36900	79.1	*78.9*
2010	37019	78.7	*78.9*
2011	37270	77.8	*78.6*
2012	37312	78.4	*78.6*
2013	37350	78.4	*78.3*

Data sources: Health and Social Care Information Centre. (2013/14 coverage due for publication Oct 2014.) L Lancucki, P Sasieni, J Patnick, TJ Day and MP Vessey (2012) "The impact of Jade Goody's diagnosis and death on the NHS Cervical Screening Programme", Journal of Medical Screening.

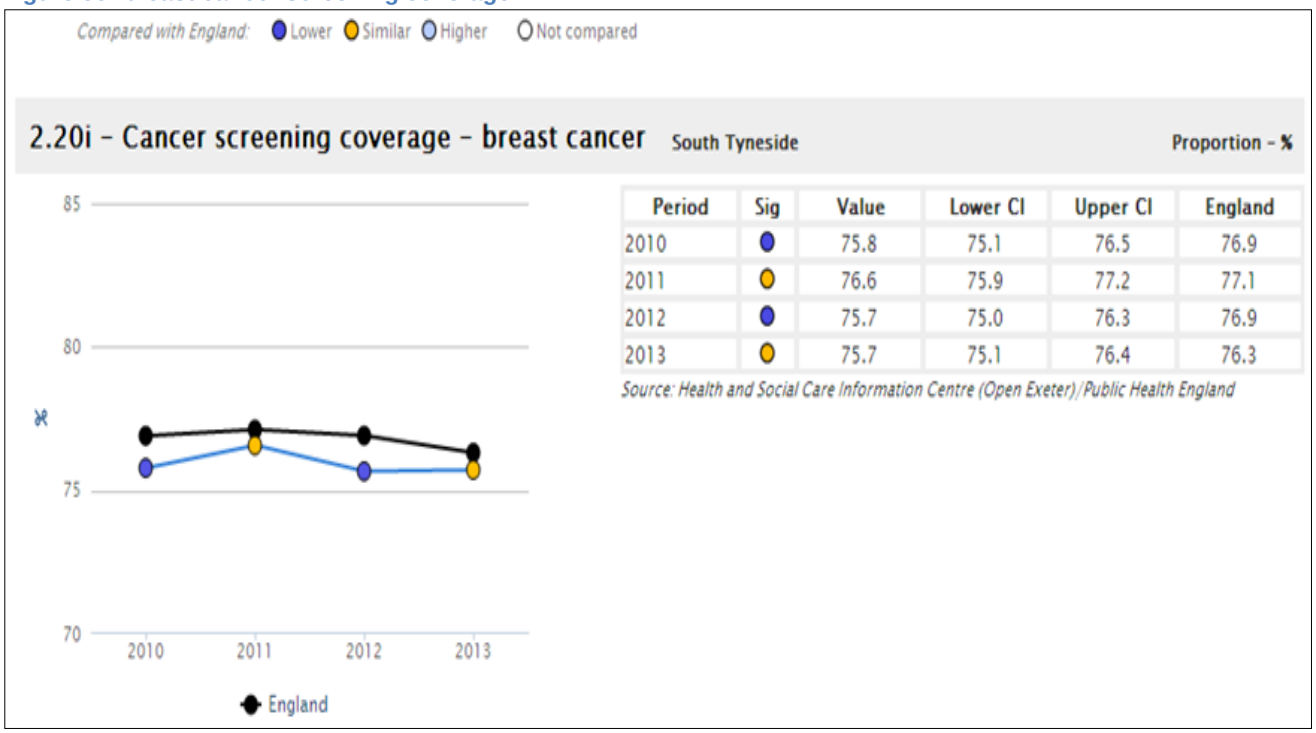
Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, November 2013

5.8.3 Coverage of breast screening

Coverage of breast screening fell by half a percentage point across England over the year to 31st March 2013 to 76.3% (see Figure 50). Over the previous three years it had remained steady at around 77%. Coverage is measured as the proportion of eligible women 53 to 70 years who have been screened adequately within the past three years.

In the year to 31st March 2013, coverage in South Tyneside remains just below the national average at 75.7% but is not significantly different at a 95% level of confidence.

Figure 50: breast cancer screening coverage



Period	Sig	Value	Lower CI	Upper CI	England
2010		75.8	75.1	76.5	76.9
2011		76.6	75.9	77.2	77.1
2012		75.7	75.0	76.3	76.9
2013		75.7	75.1	76.4	76.3

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, November 2013, from Public Health Outcomes Framework tool at www.phoutcomes.info, Public Health England

5.8.4 Variation in uptake of screening

NHS England this year published a health equity audit of adult screening programmes in Cumbria, Northumberland, Tyne and Wear. It showed that engagement with screening programmes in general is lower in areas of high deprivation, and in minority ethnic communities. People with a learning disability are also less likely to take up screening, and uptake tends to be decrease across the board in the later years of screening programme eligibility.

There is also significant geographic variation, both across CNTW and within local authority areas, including in South Tyneside. In many cases, the areas with lowest uptake are those where the impact of the screened-for disease is either likely to be, or known to be, greatest.

A piece of research conducted locally in 2011 exposed a number of misconceptions about cancer, despite 60% of respondents having a close relative diagnosed with cancer. For example, when asked about the relationship between cancer and age, only 1% of people correctly identified that people in their 80s were most likely to develop a cancer, and 59% thought it was not related to age. Such perceptions could impact on the likelihood of people accepting invitations to screening, as well as the likelihood of them seeking advice or help early with potential cancers.

5.8.5 What might impact positively on screening rates?

The NHS England study mentioned above included a review of the evidence of what works to increase uptake in vulnerable groups, and where such evidence is not available, what barriers might exist to screening uptake. The following are key recommendations which can be applied to South Tyneside:

- Endorsement of a screening invitation by a doctor, such as a GP;
- Champions – people from the local population who have taken up screening;
- GPs working with screening programmes to identify people with a learning disability to make appropriate adjustments to the invitation and screening process;
- Narratives of how screening has helped real people rather than dry facts and figures;
- Cultural awareness training of healthcare staff, use of minority languages for invitations;
- Use of chronic disease management clinics to promote screening awareness;
- Providing financial or logistical assistance to people who find it hard to access screening;
- Targeted programmes to address misconceptions about causes and treatments.

5.9 Times from referral to treatment

When a GP suspects that a patient may have cancer, they are normally referred as an urgent case. This is because the sooner a definitive diagnosis is made, the sooner treatment can begin. Such urgent referrals are expected to be seen by a specialist within two weeks, hence they are referred to as two-week referrals or waits (TWRs/TWWs). Occasionally, referrals are made via a non-urgent route, but it is expected that 93% of referrals for suspected cancer will be urgent.

Figure 51: Percentage of patients with suspected cancer referred as urgent (two-week referrals – TWRs)

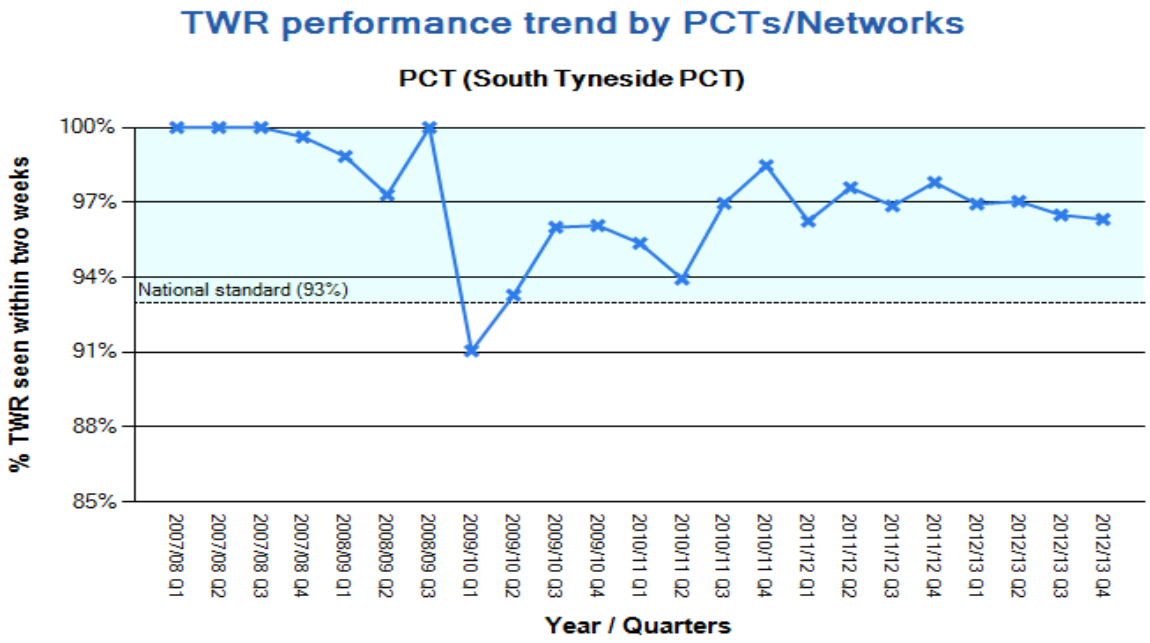


Figure 52: Cancer cases not referred as two week referral

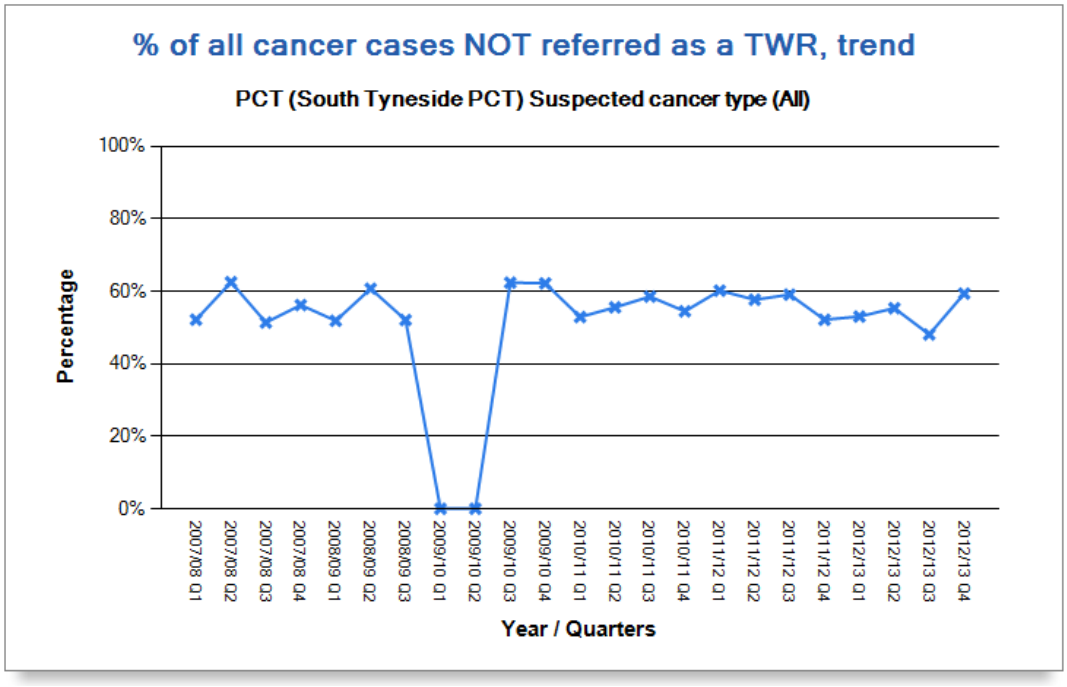
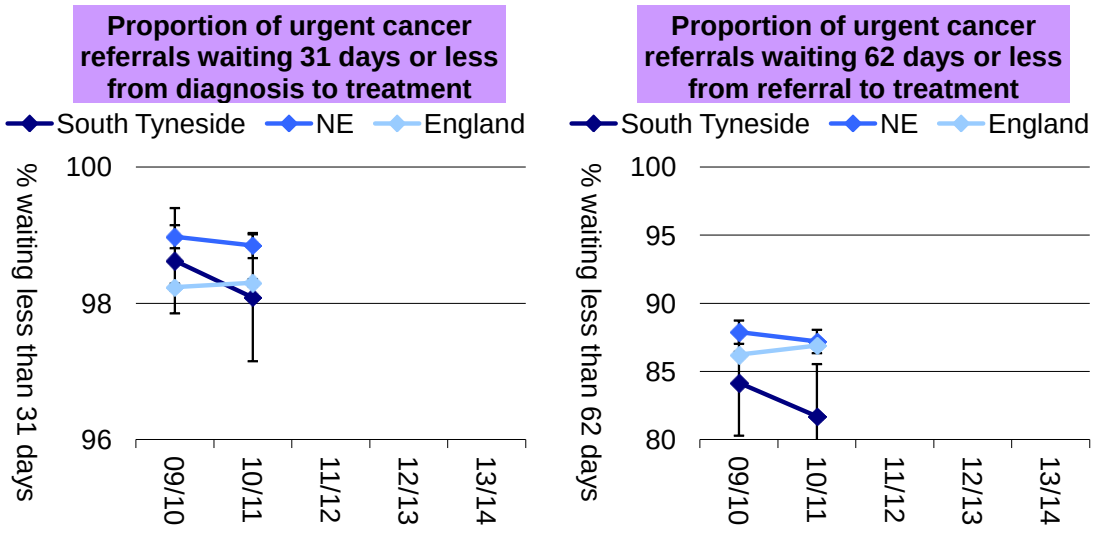


Figure 40: waiting times from diagnosis to treatment and referral to treatment



5.10 How to address the cancer problem

South Tyneside Council, in conjunction with South Tyneside CCG and NECS, organised a workshop in March 2014 to look at the systematic delivery of interventions to reduce cancer mortality and increase cancer survival for the residents of South Tyneside. The workshop aimed to:

- Encourage openness about what we are doing well and where we need to focus;
- Listen and learn from each other;
- Provide an external 'mirror' on cancer locally;
- Agree specific actions that we can take forward to reduce cancer mortality.

The workshop was facilitated by Dr Chris Bentley, who has previously worked with the Health Inequalities National Support Team from the Department of Health.

An action plan will now be developed to implement the lessons learnt from that process. Some key likely priorities are:

1. Raise the profile across the Authority to broaden the ownership of this critical issue, to ensure that priority is given to reduction of cancer excess mortality in the JSNA, the Health and Wellbeing Strategy and the CCG's commissioning and delivery plans.
2. Review the Terms of Reference and membership of the South Tyneside Cancer Locality Group to ensure representation of all relevant groups necessary to oversee development and delivery of a holistic strategy.
3. Map possible differences in cancer presentation, registration and staging, treatment adherence and survival to geography defined by deprivation scores. Important stakeholders (e.g. GPs) should be made aware of differential patterns.
4. Use established differential needs assessment to target programmes of awareness raising and supporting early presentation. Such programmes should capitalise on existing channels for community engagement, working to recruit inputs of partner agencies in the Health and Wellbeing Board and beyond.
5. Undertake a significant event audit across the whole pathway, focused initially on lung cancer. Working backwards from late presentation (including death before treatment), evidence would be reviewed of where across the pathway significant delays occurred, and proposals would be made to avoid such cases in future.
6. Build cancer awareness into the Making Every Contact a Health Improvement Contact programme within the health service, as well as with partner frontline service agencies. South Tyneside is recognised as having been a Pathfinder for such approaches.
7. Focus programmes to improve uptake on cancer screening invitations, with targeted approaches based on cancer needs assessment, harnessing contacts of other frontline agencies and community engagement channels.

6 Health and well-being strategy: (iii) Better employment prospects for young people: "the impact of employment"

6.1 Introduction

The term worklessness is used to define all those that are economically inactive – people of working age who are not working, not in full time education or training and are not actively seeking work.

Worklessness has been a key issue with successive governments developing training and employment initiatives to encourage people back into work and support those who are unable to do so. Cyclical unemployment has risen sharply since the 2008 recession and recovery remains slow, which has had an impact on efforts to reduce structural worklessness.

From a public health perspective, worklessness and ill-health are closely related. While unemployment and economic inactivity are associated with higher rates of poor health, mental illness and premature death, poor health can itself lead to difficulties in both securing and retaining employment. These two factors can become entwined, leading to a spiral of decline in disadvantaged populations. In turn, high levels of worklessness serve to put a brake on the economic regeneration that would help to solve the problem in the longer term. Getting people into sustainable employment is therefore a critical priority for driving economic prosperity and reducing health inequalities.

In the decade 1997-2007 the North East made good progress in reducing unemployment. Following the recession, which saw JSA claimants double in some areas, the makeup of the JSA register is now very different and a significant proportion of the current register is now made up of skilled people who have previously been in work and are looking to return to work quickly. The competition for jobs, including less skilled jobs is fierce, with over qualified candidates being prepared to take lower paid and lower status jobs to get a foothold back into the labour market. This makes it more difficult for the long term unemployed to return to work.

The reforms to the welfare benefit system will seek to push residents into employment particularly as many will find their benefits capped at a lower rate under the new system. Residents will need to be supported to understand the changes to the system and recognise the financial benefits of returning to work. The need for residents to work to support themselves financially will become even more apparent with the introduction of affordable rents at 80% of the private rented sector. Residents will come under increased pressure to find employment to enable them to remain in their home.

In May 2013, there were 17,210 South Tyneside residents of working age claiming out of work benefits. Numbers claiming each type of benefit are shown in Table 12.

Table 12: working age claimants of out or work benefits

Benefit	South Tyneside claimants
Jobseekers Allowance	6,600
ESA and Incapacity Benefit	8,310
Lone Parents	1,700
Carers	1,840
Others on income related benefits	600
Disabled	1,300
Bereaved	220

6.2 Who is at risk and why?

Rates of unemployment are highest amongst those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment.

The current programme of welfare reforms in placing a greater emphasis on the individual responsibility of benefits claimants to look for and secure work, rather than continuing to claim welfare benefits. South Tyneside has a high proportion of its working population claiming Employment Support Allowance and Incapacity Benefit, and many of these people will be expected to return to the labour market, having not worked for a number of years. It is unlikely that without significant support, these people will be able to find and sustain jobs of sufficient quality to provide them with an appropriate level and supply of income.

There is a strong correlation between the wards in South Tyneside that have the highest level of residents claiming welfare benefits and the rates of **child poverty.** The rate of child poverty in South Tyneside is currently 31%, although there are a number of wards in South Tyneside where child poverty stands at over 40%, compared to an England average of 20%. Child poverty blights childhoods and growing up in poverty means being cold, going hungry, not being able to join in activities with friends.

Child poverty has long-lasting effects. By the age of 16, children receiving free school meals achieve 1.7 grades lower at GCSE than their wealthier peers and leaving school with fewer qualifications translates into lower earnings over the course of a working life.

Poverty is also related to more complicated health histories over the course of a lifetime, again influencing earnings as well as the overall quality and length of life. Professionals live, on average, eight years longer than unskilled workers.

It is important to remember that many households that are classed as living below the poverty line are households where adults are in work. Low wages, part time work and childcare costs all conspire to reduce income levels.

Young people aged 16-24 have been disproportionately affected by the economic recession. The dramatic slowdown of the economy has meant that young people are competing for fewer vacancies with higher numbers of experienced and skilled workers. The recession has led to a significant increase in the overall claimant count for young people. South Tyneside now has a significant cohort of young people who do not have the relevant vocational qualifications and experience to be able to succeed in the economy.

Long term unemployment has also increased as a result of the economic recession. Long term unemployment doubled between 2008 and 2012 and is only just starting to reduce. South Tyneside has over 2,000 residents that have been claiming JSA for over 12 months and a lack of recent experience and relevant qualifications will prevent them from succeeding in the economy.

6.3 Level of Need in the Population

Economic inactivity is the measurement of working age residents who are out of work but not actively seeking work. South Tyneside has a higher rate of economic inactivity than the national average, but a higher proportion of the economically inactive population in South Tyneside state that they do want to work – the latest figures show that there are 6,800 economically inactive residents due to temporary and long term illness.

6.3.1 Young people

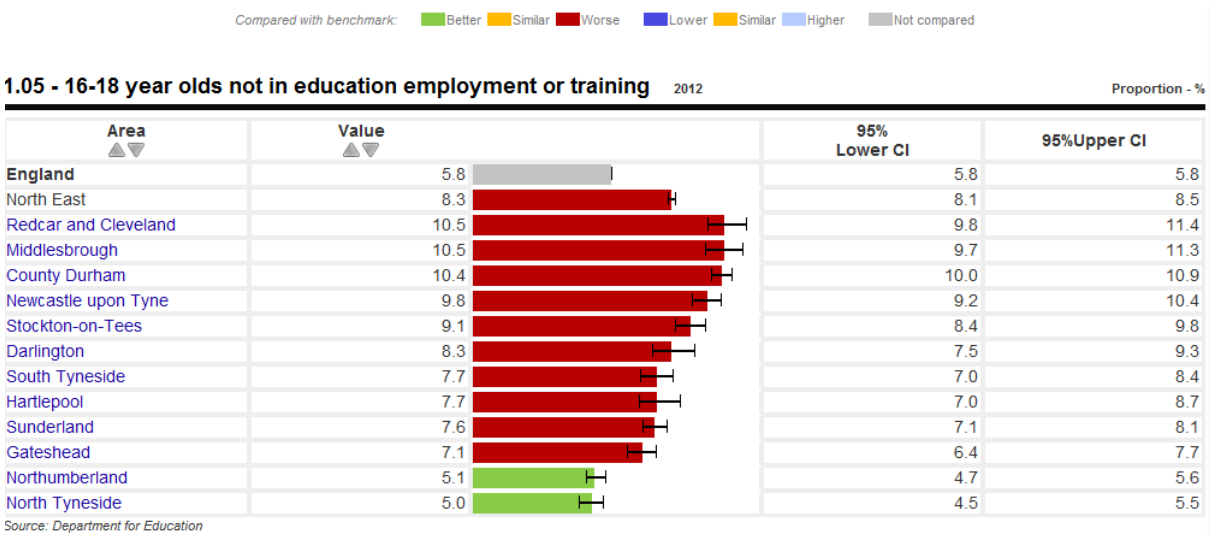
Youth unemployment has risen since the economic recession, now totalling 1,730, or 13.3%, long term youth unemployment has also risen with over 3,000 residents aged 18-24 having been out of work for more than 6 months. The percentage of unemployed young adults in the North East is higher than the national average, but there is also a significant gap between the North East average and South Tyneside.

The North East has the highest percentage of young adults Not in Education, Employment and Training (NEET) in England at 8.3%. In 2012, South Tyneside has a NEET rate of 7.7% (see Figure 41). Although below the North East average, this is significantly higher than the England average. This figure means that in South Tyneside there are 420 young people 16-18 years not in employment, education or training - out of a population of 5,500. The activity of 8% of these young people is unknown.

Research based on national statistics[1] identifies that those eligible for free school meals, those who have been excluded or suspended from school, those with their own child and those who have a disability are more likely to be NEET.

[1] Mirza-Davies J (2014) “NEET: Young People Not in Education, Employment or Training”, House of Commons Library, London available at www.parliament.uk/briefing-papers/sn06705.pdf (last accessed 1st May 2014)

Figure 414: 16-18 year olds not in education, employment of training, 2012

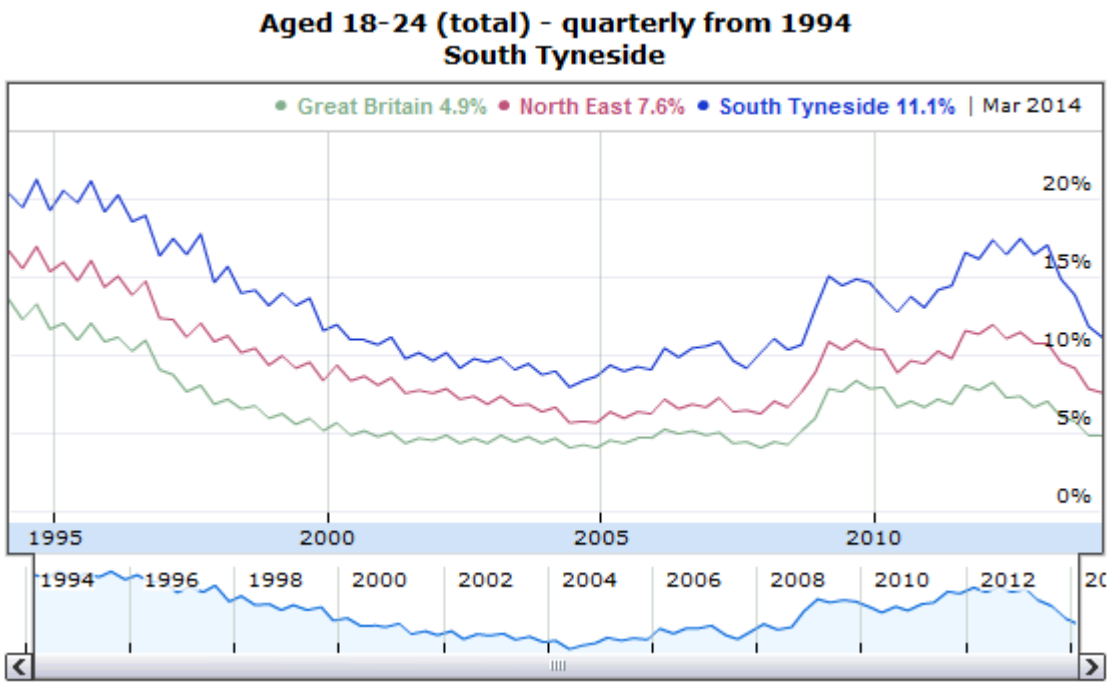


Area	Value	95% Lower CI	95%Upper CI
England	5.8	5.8	5.8
North East	8.3	8.1	8.5
Redcar and Cleveland	10.5	9.8	11.4
Middlesbrough	10.5	9.7	11.3
County Durham	10.4	10.0	10.9
Newcastle upon Tyne	9.8	9.2	10.4
Stockton-on-Tees	9.1	8.4	9.8
Darlington	8.3	7.5	9.3
South Tyneside	7.7	7.0	8.4
Hartlepool	7.7	7.0	8.7
Sunderland	7.6	7.1	8.1
Gateshead	7.1	6.4	7.7
Northumberland	5.1	4.7	5.6
North Tyneside	5.0	4.5	5.5

Source: Department for Education

The proportion of the population claiming Jobseekers' Allowance among the wider population of 18-24 year olds is above the North East and England averages and has been consistently so over the past 20 years (see Figure 42).

Figure 425: proportion of 18-24 year olds claiming Jobseekers' Allowance, 1994-2012



Source: NOMIS, Labour market profile of South Tyneside at http://www.nomisweb.co.uk/reports/lmp/la/1946157067/report.aspx?#ls (last accessed 1st May 2014 by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland

6.3.2 People of working age (16-64 years)

Figure 6 shows the proportion of people of working age (16-64 years) that are in employment. Although South Tyneside's proportion has reached a similar proportion to that of the North East, it remains consistently lower than that of Great Britain.

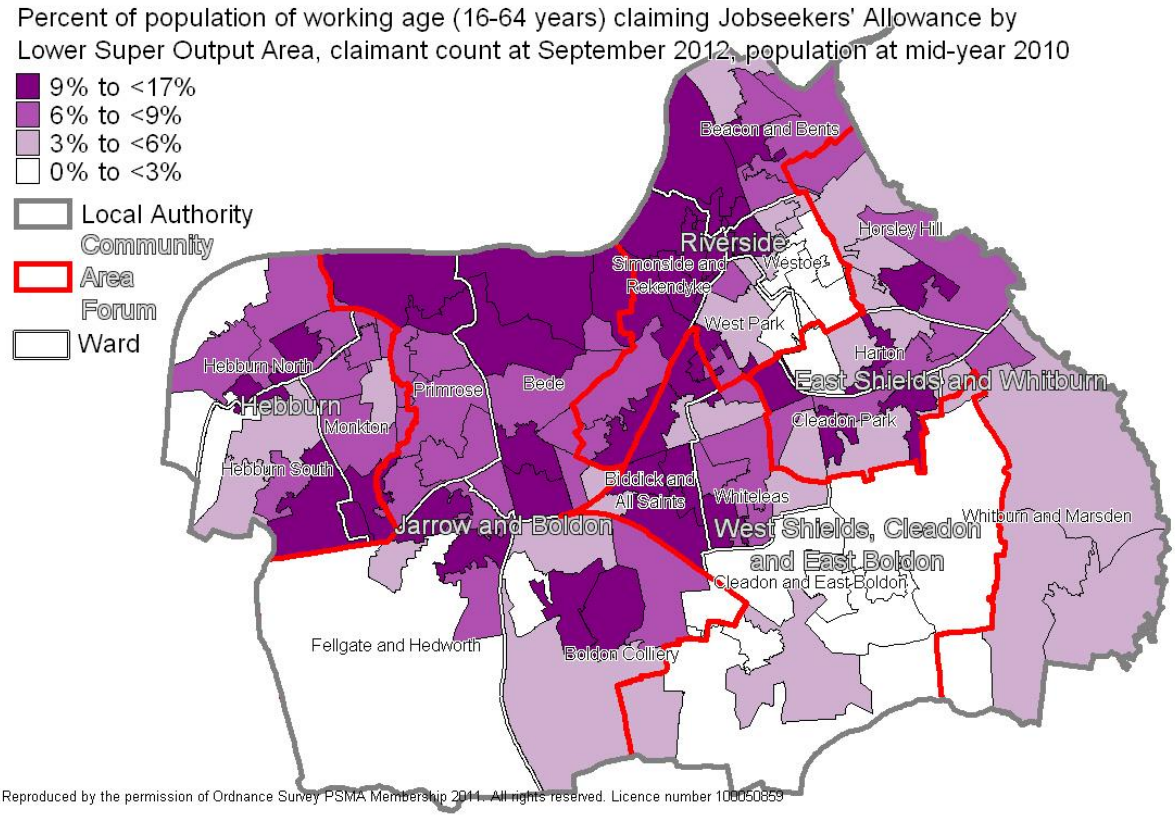
Figure 56: proportion of working age people in employment

Source: NOMIS, Labour market profile of South Tyneside at http://www.nomisweb.co.uk/reports/lmp/la/1946157067/report.aspx?#ls (last accessed 1st May 2014 by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland)

6.3.3 Geographical variation in proportions claiming Jobseekers' Allowance

There is noticeable variation by ward in the proportions claiming Jobseekers' Allowance, as shown in Figure 437, with wards in the Northern half of the district experiencing much higher rates.

Figure 437: variation in Jobseekers' Allowance claims, ward map



Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, 2013

6.3.4 Qualifications of working age people

South Tyneside is performing well in comparison to the rest of the region in terms of qualifications, with 70.2% of our working age population qualified to level 2 and above. Improvements have also been made in the proportion of our working age population that are qualified to level 3 and above but there is more to do.

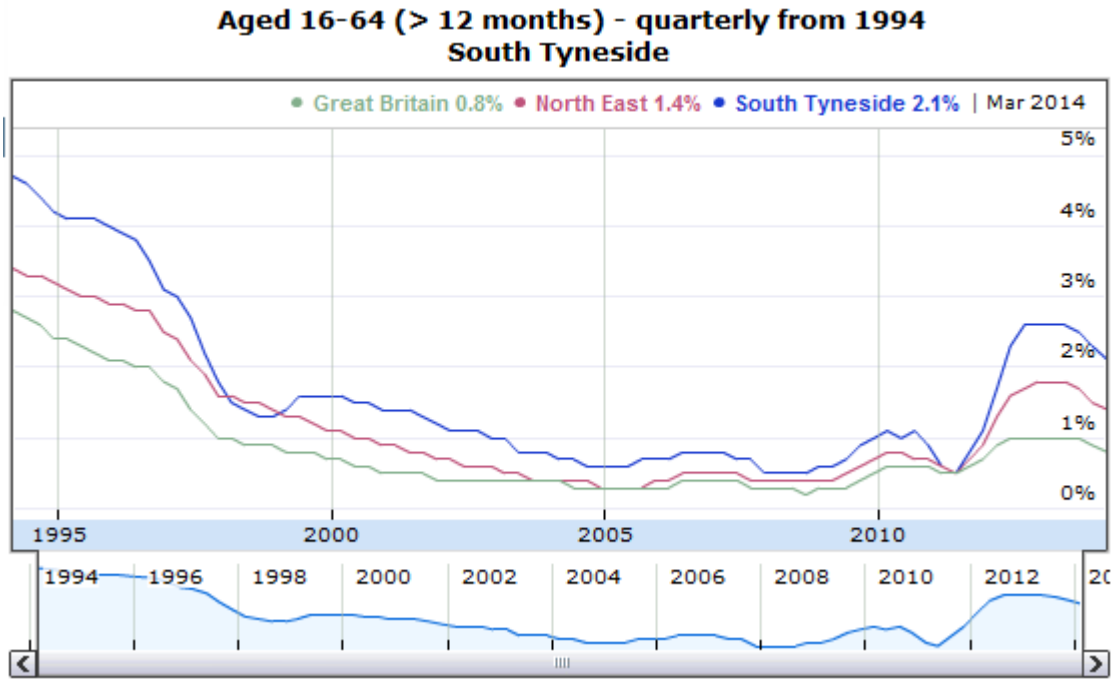
6.4 Trend Data / Projected Service Use

October 2007 represents the lowest rate of JSA claimant rates locally (3.8%), regionally (2.8%) and nationally (2%), the impact of the recession saw the claimant rate rise to highs of 8%, 5.8% and 4% respectively. Throughout 2013, claimant levels have fallen and now stand at 6.2% in locally, 4.5% regionally and 3% nationally but the JSA register still has over 2,200 additional claimants compared to October 2007. Sustained efforts to deliver inward investment, regeneration and job creation programmes are needed to create new jobs and businesses.

6.4.1 Trends in long-term unemployment

Trends in the proportion of the working age population that have been claiming Jobseekers' Allowance for more than 12 months are shown in Figure 448. South Tyneside has higher rates than the North East and Great Britain.

Figure 448: trends in long-term claimants of Jobseekers' Allowance



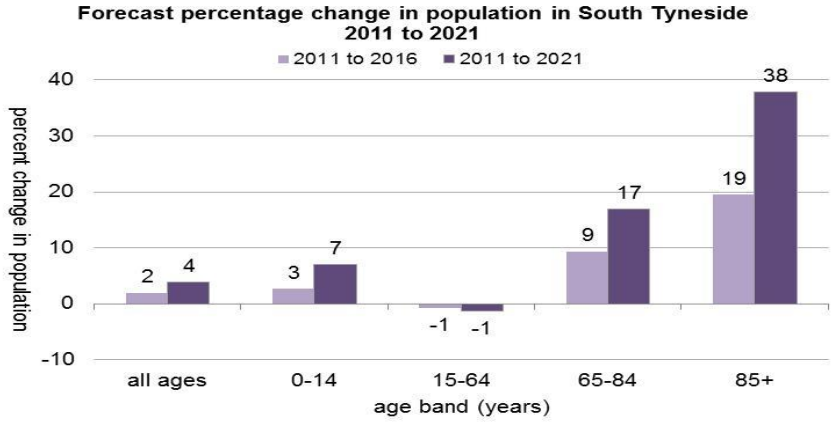
Source: NOMIS, Labour market profile of South Tyneside at http://www.nomisweb.co.uk/reports/lmp/la/1946157067/report.aspx?#ls (last accessed 1st May 2014 by *Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland*)

At March 2014 the count of people claiming jobseekers' allowance in South Tyneside was 2,000 having claimed for more than 12 months, 750 having claimed from 6-12 months and 2,600 having claimed for <6 months. This makes a total of 5,400 or 5.7% of the working age population that are currently claiming jobseekers' allowance.

6.4.2 Population projections for the working age population

Changes in population structure are likely to affect employment levels. As shown in Figure 459, South Tyneside is forecast to see a fall in the number of working age people but a doubling of some of the other age groups (the dependent population).

Figure 459: forecast changes in population structure



Source: Office for National Statistics, 2011 Census-based interim subnational population projections

Provided by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland)

8.7% of the working age population in South Tyneside are currently claiming **Employment Support Allowance or Incapacity Benefit**, which represents a reduction of 1,040, or 1.1% since May 2010. Based on current reduction rates, levels of support and continuing improving economic conditions, it will take until 2016 / 2017 years to reduce the claimant rate to the current regional average and until 2021 / 2022 to reduce the claimant count to the current national average.

6.4.3 Claimants with a disability or long-term health condition

The numbers and rates of those with disability or long-term health condition can be seen in Figure60. South Tyneside has higher proportions than the North East and Great Britain in the groups 'ESA or incapacity benefits' and 'disabled'.

Figure 61: claimants by statistical group

Working-age client group - key benefit claimants (August 2013)

view time-series | compare other areas | query dataset...

	South Tyneside (numbers)	South Tyneside (%)	North East (%)	Great Britain (%)
Total claimants	19,970	21.0	17.9	13.6
By statistical group				
Job seekers	6,000	6.3	4.6	3.2
ESA and incapacity benefits	8,280	8.7	7.8	6.1
Lone parents	1,690	1.8	1.6	1.3
Carers	1,850	1.9	1.9	1.3
Others on income related benefits	590	0.6	0.5	0.4
Disabled	1,340	1.4	1.3	1.2
Bereaved	220	0.2	0.2	0.2
Key out-of-work benefits†	16,560	17.4	14.5	10.9

Source: DWP benefit claimants - working age client group

† Key out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details

Note: % is a proportion of resident population of area aged 16-64

Source: NOMIS, Labour market profile of South Tyneside at http://www.nomisweb.co.uk/reports/lmp/la/1946157067/report.aspx?#ls (last accessed 1st May 2014 by Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland))

The current government programme of welfare reform will ensure that more benefit claimants are required to look for work and that the level of household income supported by welfare benefits reduces. This indicates that there will continue to be a demand for services to support residents back into sustainable employment.

6.5 What is Currently Being Delivered to Respond

6.5.1 Economic Growth and Regeneration

The North East Independent Economic Review identified that the North East economy requires around 60,000 net new private sector jobs to create a balanced economy. A recent study by Glasgow University suggests that by 2020 the north east economy will have an additional 4,000 net new jobs. The research also highlights that 462,000 jobs will become available via replacement demand.

South Tyneside has a clear strategy for regeneration and job creation. The creation of an International Advanced Manufacturing Park in partnership with Sunderland City Council

could see the creation of 5,200 new jobs with advanced manufacturing and engineering businesses.

The strategy for the regeneration of South Shields Town Centre will see the creation of jobs in business services, construction, hospitality and leisure and retail.

The North East economy is seeing an upwards trends towards a demand for higher level jobs and a declining demand for lower level and entry level jobs. This trend is expected to continue and in order for businesses to grow, employers need to access skills and experienced workers at level 3 as a minimum, but preferably at level 4.

The South Tyneside Employment and Skills Development Group have identified a new model for delivering careers advice in schools to ensure that our young people are leaving education with an informed view of the opportunities in the North East economy and that they have made informed choices to ensure that they meet with requirements of their chosen occupations. This model is being developed and delivered by private sector employers.

The most buoyant sectors in terms of entry level opportunities are in the health and social care sector, with the bulk of jobs in residential homes and domiciliary work and in sales roles.

6.5.2 Adult Learning

Whilst the regional projections around jobs growth are 4,000 up to 2020, there is only expected to be an increase of around 1,000 in the 18-64 population and therefore we need to increase the number of working age residents who are looking for and available for work. The Councils Adult and Community Learning service currently focus their delivery on those furthest from the labour market to provide support to help them back into employment. The support offered ranged from formal skills training to informal under pinning measures such as emotional resilience support and employability skills.

6.6 Evidence of What We Know Works

6.6.1 Access to Employment

In spite of the near elementary assumption that securing work and a salary invariably improves health, evidence is limited on the area. There are some groups that find the step into work problematic, particularly those leading chaotic lives or those leaving military service or prison and finding working patterns and relationships difficult to accommodate, they can oscillate between periods of employment and worklessness, leaving them vulnerable to accessing welfare benefits. Work programmes that offer ‘on-the-job’ supportive approaches to employment where the employee is the subject of a framework of counselling and mentoring that recognises absenteeism as lapses appear to hold a place in the evidence base.

6.6.2 Welfare to Work

Since the banking crash and 2010 elections government has not only sought to secure employment for Job Seekers Allowance claimants, but also those on sickness benefits. The assessment process aside which has received reports on its draconian health-demoting style, there is some early evidence that former claimants who have found employment are

benefiting from the world of work: a local understanding of the outcomes for this group would strengthen the literature. Equally, an examination of the success behind incentives and benefit sanctions; first, second and/or third; would assist in shedding more light on the efficacy of the measures.

6.6.3 Inequality and Debt

Those from low income backgrounds and family coupled to areas of high unemployment and/or underemployment appear as most at risk pointing toward a theory of learned helplessness. However, there is an increasing body of current evidence suggesting a substantial growth in a group referred to as ‘the working poor’; characterised by families, often with children, in employment but also in receipt of benefit. The Food Bank is a more recent addition to a list of programmes that assist in supporting people experiencing worklessness, including improved access to welfare rights and benefits checks, credit unions and budgeting courses

6.6.4 Mental Health and Suicide

Those with mental health problems are more likely to experience poverty and are very often associated with a downward socio-economic trajectory over their entire life course. There is a strong association between unemployment and suicide, particularly amongst men, but as yet there is still debate over whether this is a direct correlation. Measures that tackle mental health and employment simultaneously as opposed to two competing, uncomplimentary services have grown in significance; Increasing Access to Psychological Therapies (IAPT) being one of the most notable. Mental health interventions from both the statutory and voluntary sectors can include self help groups, talking treatments, counselling, as well as bereavement and befriending services.

6.6.5 Economy and Education

Improving employment prospects locally will ultimately yield the greatest returns in terms of health improvement, such as investment in the traditional manufacturing and service sectors as well as developments in new technologies. Health alliances forged with major employers across key sectors of the local economy provide opportunities to not only promote health in workplaces, but also prepare a future wider workforce for fairer and sustained employment. Levels of education and training correspond to health outcomes and increased access to further and higher education should by a core aim of any health and worklessness strategy, particularly for hard-to-reach NEETs.

6.7 Recommendations

6.7.1 Commissioning of Services

The Council should continue to show leadership through the commissioning of services by including Social Value Clauses into contracts for goods and services. As well as directly providing new job opportunities as a result of Council investment, the Council could also influence the quality of the jobs that are created by requesting service providers to offer contracts of employment that provide a minimum income for healthy living.

6.7.2 Economic Growth and Regeneration

In South Tyneside there are currently only around half the amount of jobs that we need to support our working age population. The Economic Growth strategy focuses on creating more and better jobs and ensuring that our residents have the necessary skills to succeed in the economy.

6.7.3 Schools

Our young people must leave school with the skills and qualifications that they need to ensure that they are successful in the economy. We need to continue to develop industry relevant pathways to employment for school age young people.

6.7.4 Adult Learning

Adult and Community Learning services should continue to focus on developing services that support residents who are furthest from the labour market to ensure that more of our working age population can participate in the labour market.

7 Health and well-being strategy: (iv) Better emotional health and well-being – *"Social Isolation Military veterans"*

7.1 Introduction

There is a need to carry forward the recommendations contained within the Regional Review of the Health Needs of the Ex Service Community 2011, conducted on behalf of the Joint Health Overview and Scrutiny Committee of North East Local Authorities. This noted that in a Local Health Needs Assessment of Military Veterans (MVs) the following should be addressed:

- Scoping/routine data gathering of MVs in South Tyneside
- MVs and access to housing
- MVs and access to employment
- MVs and access to health services, particularly mental health services
- MVs and access to probation/drug and alcohol services
- MVs and community capacity/self help/self care

7.1.1 Definition

The term military veteran refers to anyone who has experienced military service, or who is ex-military personnel. The Ministry of Defence definition of a veteran is: "anyone who has served in HM Armed Forces at any time, irrespective of length of service… including National Servicemen and Reservists." Military Veterans are also known as: former armed forces personnel, ex- servicemen/women, and simply, veterans. In 2006 it was estimated there were about 5 million veterans in the UK. Each year a further 20,000 personnel leave the UK armed forces.

The North East provides a disproportionately high number of recruits to the armed forces, many of whom will return to settle in the area upon discharge. Estimates place the size of military veterans in the region between 125,000 and 208,330; a figure which excludes partners and dependants and cannot be ascribed adequately (apportioned) to the twelve North East local authority areas.

7.1.2 The National Picture

- In 2011, it is estimated that there were 4.5 million veterans in the UK. Of these, approximately 85% were male and 15% female.
- Approximately 20,000 personnel who leave the forces each year represent approximately 10% of the total current armed forces.
- Veterans have a substantially older age profile than the general UK population. The average age of a veteran is 63 years, compared with 47 years as the average age for the general adult population. 60% of veterans are aged over 65, a much larger percentage than the proportion of the general adult population in that age range.
- Nationally 0.6% of veterans are from non-white ethnic minorities.
- 31% of veterans live alone, compared to 19% of UK adults.
- Younger veterans are more prevalent in the North of the UK.

7.1.3 The Local Picture

- There are approximately 1,500 early service leavers each year from 15 Brigade at Catterick and 40% of these are from the North of England, the majority young, single men who have been part of the infantry. These are over and above the 5,620 service

leavers nationally. The garrison at Catterick covers the geographical area Hull to Berwick to Carlisle and is the largest training garrison in Europe, with 40,000 regulars, reserves, cadets and dependents.[2]

- There is no systematic gathering of military veterans/community data locally, leading to an unclear and incomplete picture.
- One method of providing a local understanding of figures would be to extrapolate the national data and translate it to the South Tyneside population (7,000-12,000). This would also provide forecasts for the future annual additions to veterans leaving the armed forces, though both datasets would be estimations providing a statistical platform to launch any needs assessment. (not available)
- The Royal British Legion has requested their local branches to support the construction of the JSNA and provide numbers of veterans living in the area.

7.2 Why there are concerns with Military Veterans

7.2.1 Risk Factors

There is a strong body of evidence to indicate that veterans have worse health outcomes than the general population. Also, the King's Fund suggest that mental illness in serving and ex-service personnel is similar to the general population, (Centre for Military Health Research, King's College, 2009) and have identified the following risk factors were identified:

- being male;
- being young ;
- being in the Army, rather than another branch of service;
- holding a lower rank;
- experiencing childhood adversity;
- being exposed to combat;
- length of exposure to combat (12 months front-line service over a 3-year period);
- being a Reservist;
- having a mental health problem while in Service;
- being an early service leaver.

7.2.2 Health Status

On leaving the armed forces, healthcare becomes the responsibility of the NHS and all veterans are entitled to priority access to hospital and healthcare for any condition related to their service career.

- Over half (52%) of veterans report having a long-term illness or disability, compared with 35% in the general population.
- There are high incidences of alcohol problems, depression and anxiety disorders; in the 16-44 age group.
- The rate of mental health disorders was three times that of the UK population of the 16-44 age group.
- Post-traumatic stress disorder comprises a minority of cases of mental health disorders though features strongly in media reports.

[2] Regional Review of the Health Needs of the Ex-Service Community

- Young veterans who leave the services early are up to three times more likely to commit suicide than the general population.

7.2.3 Wider and Social Determinants

It is widely accepted that veterans are vulnerable not purely to poor health, but also to social exclusion. They can also face a number of barriers accessing health and welfare services.

- A larger proportion of veterans than the general population are reported to be homeless.
- The unemployment rate among adult veterans of working age is 6%, compared with 5% in the general working age population. However this overall rate hides the disproportionate unemployment rate among 18-49 year olds: in military veterans this is twice the national average.
- Co-related harmful drinking, violent behaviour and offending by men appear more prevalent amongst the veteran population than the general population.
- The number of veterans in the national prison population appears to be disproportionately high.
- There is no understanding of the divorce rates and relationship breakdowns across the military veteran community. Military divorce rates are double those for civilians.

7.3 Existing Provision

The Service Personnel and Veterans Agency (SPVA) is part of the MoD, acting as a single point of contact to provide advice for serving military personnel, ex-service personnel and their dependants.

The Veterans Welfare Service (VWS) gives support to veterans and their dependants that are eligible to claim for the SPVA pension and compensation schemes. Help and guidance can be given either through telephone contact or through a dedicated visiting service via a national network of welfare managers.

Combat Stress provides specialist residential and community outreach mental health care for veterans. Specialist short-stay treatment centres are in Shropshire, Surrey and Ayrshire.

Joint Service Housing Advice Office (JSHAO) provides service personnel, service leavers and ex-service personnel still occupying service family accommodation as irregular occupants with comprehensive advice on housing options (including civilian housing information, advice and where possible placement into social housing).

MOD Referral Scheme provides a route into low-cost, social housing for Service leavers, married or single. It is administered by the JSHAO.

Single Persons Accommodation Centre for the Ex-Services (SPACES) is designed to help single persons leaving the Service to find appropriate accommodation. It is an accommodation advice and placement service.

SSAFA Forces Help is a national charity helping all veterans and their dependants on a range of welfare issues, including housing.

Home Base is a service for people who are facing homelessness as they leave the armed forces. It is run by Community Housing and Therapy (CHT) and aims to help clients integrate successfully into civilian life.

Stoll (formerly Sir Oswald Stoll Foundation) is a charity with a mission to ensure vulnerable and disabled ex-Servicemen and women live as independently as possible. It provides housing and support for vulnerable veterans, including those who have experienced homelessness and other issues.

Prison In-Reach project provides support to veterans who are serving prison sentences and to their families, with the aim of aiding rehabilitation and reducing the risks of re-offending.

The Career Transition Partnership (CTP) offers a range of support to service leavers with identified health problems on discharge, including a resettlement package. Early service leavers (those with less than four years service or compulsorily discharged) are only entitled to access CTP in exceptional circumstances for very limited support, which includes counselling services for those who are considered vulnerable to social exclusion and signposting to relevant agencies for ongoing support.

Haig Housing can offer a wide range of housing assistance and options. The main housing assistance currently provided is through properties to rent. Rents are generally in line with local social housing providers (Local Authorities, Housing Associations, etc.) and are significantly lower than private rental charges in the same area. With over 1,300 properties spread throughout the UK, Haig's properties are, in the main, suitable for general needs housing. Any eligible ex-Service personnel and their families who find themselves in 'housing need' can apply. (See Haig Housing website.)

Veterans Aid (formerly EFC - the Ex-Service Fellowship Centres) aims to relieve distress among ex-Service men and women of the Royal Navy, Royal Marines, Army, Royal Air Force and the Merchant Navy and their widows or widowers who are in crisis.

The Veterans' Wellbeing Assessment and Liaison Service (VWALS) is a mental health and well-being service to support veterans and their families in the North East. It provides a single point of access to existing mental health support services across the region, making it easier to get signposted to help and support. VWALS was launched in June 2012 by the region's two mental health trusts and is open veterans, their families and carers.

Veterans & Reserves Mental Health Programme (formerly Medical Assessment Programme MAP) is available to veterans deployed on operations since 1982. Some veterans can access one of the six community-based mental health pilot schemes which provide treatment from NHS mental health trusts (Tees, Esk and Wear Valley pilot currently under evaluation).

Norcare is a housing and support charity in the North East that has opened military veteran centres in Gateshead and Newcastle. The centres offer supported accommodation with fully furnished rooms, as well as outreach services, such as training and employment support, welfare and debt advice, family liaison, counselling, health and wellbeing support and specialist help for issues such as trauma.

The Royal British Legion has co-produced a briefing with the Public Policy Unit about Joint Strategic Needs Assessments intended for use by regional staff members. It explains and describes the purposes of a local JSNA and outlines how *The Legion* locally can become involved in the construction and implementation of services that will improve the health of the military veteran community via the commissioning process. It also encourages *The Legion* to play an active role as conduit between military veterans and HealthWatch.

Armed Forces Networks - Finally, there are two Armed Forces Networks operating in the neighbouring local authority areas of Gateshead and Sunderland. Following consultation with a wide range of stakeholders with an interest in mental health services for service personnel and veterans, the "Fighting Fit in the North East" report recommended four models of service delivery:

- A Community Navigator Model;
- Enhancement of existing Improving Access to Psychological Therapies (IAPT) services;
- Improving the interface between community, primary and secondary care services; and
- A fourth, hybrid model, which draws on the key facets of the first three models

7.4 Gaps in Provision and Recommendations

7.4.1 Data Collection

The literature consistently reveals problems of identification, quantification and sequential tracking of military veterans. It is widely acknowledged that the community's status is very rarely recorded when individuals, including families and carers, access services. Systems to collect data might prove complex and costly but there is strong evidence to suggest positive outcomes from introducing routine national, regional and local methods of data collection.

7.4.2 Access to Services

It is unclear how many South Tyneside veterans and their dependants are benefitting from the specialist services listed above: it is also unclear how many veterans access mainstream health and social care services, such as IAPT, welfare benefits and housing, or if they are registered with a GP. Local systems for data collection should be considered, at least as a temporary measure to assess a range of service access.

7.4.3 Mental Health

In 2010, the Murrison Report, "Fighting Fit", studied the mental health of both serving and ex-service personnel to see what more could be done to assess and meet their needs. The report made the following principal recommendations.

- Incorporation of a structured mental health systems enquiry into existing medical examinations performed whilst serving.
- An uplift in the number of mental health professionals conducting veterans outreach work from Mental Health Trusts in partnership with a leading mental health charity.
- A Veterans' Information Service (VIS) to be deployed 12 months after a person leaves the Armed Forces.
- Trial of an online early intervention service for serving personnel and veterans.

7.4.4 Early Intervention

Transition from the forces to civilian life affects veterans from the 'early service leaver group' most markedly and they receive only minimal support. This social grouping is comprised predominantly of younger males from the lower ratings with an absence of family supports, poorer educational attainment and fewer skills and qualifications to enter the employment market.

7.4.5 Suicide

The Regional Suicide Prevention Steering Group is working with agencies representing military veterans to consider relevant suicide prevention initiatives across the North East.

South Tyneside requires close working arrangements with this body to ensure initiatives reach the borough.

7.4.6 Priority Healthcare Entitlement

Because of the nature of military service, it has been acknowledged that the healthcare needs of veterans can be different from those of the wider population. The Priority Healthcare Entitlement ensures military veterans receive the health care they require quickly. Enhanced awareness among acute and primary care providers, such as GPs, of the entitlement for priority treatment was introduced across South of Tyne and Wear, deploying a range of methods. The recent steps taken to improve awareness amongst professionals and services should be evaluated both qualitatively and quantitatively to assess take-up. In the event of low take-up, further appropriate training/learning may need to be provided as a requirement of the Clinical Commissioning Group (CCG) to meet entitlement obligations.

7.4.7 Regional Strategies

The North East Joint Health Overview and Scrutiny Committee carried out a regional review of the health of the ex-service community. Three work-streams investigated and produced reports on different aspects of the health and well-being of ex-service personnel: mental health; physical health; and social and economic well-being. The report identified 47 areas for improvement, including 12 areas specifically related to mental health. Key points include:

- A strong role for the Health and Wellbeing Boards in assessing needs and co-ordinating service provision.
- Guidance should also be developed specifically for primary care providers and GPs to explain the priority healthcare entitlement
- Explain how they can adapt their systems to accommodate priority treatment for ex-service community
- How to accept referrals from ex-service charities, including the Royal British Legion and Combat Stress, but also smaller local organisations providing for some of the most marginalised/excluded ex-service personnel.
- Local authorities and clinical commissioning groups should be actively engaged in joint planning and commissioning of veterans' services with the NHS.
- Local authorities should be actively engaged in the North East NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans' mental health issues, perhaps as a link to the local Health and Wellbeing Board.
- Primary care and NHS foundation trusts should take steps to improve awareness of veterans' mental health issues among health workers generally, including appropriate training and supervision.
- Some groups within the ex-service community may need special attention, including the prison population and 'early leavers' that have left the forces within four years.

7.4.8 Resettlement: Housing and Employment

The level of resettlement support is determined by the length of military service and is not dependent on the rank of the service leaver. Service leavers who are discharged compulsorily have no entitlement to formal support. Early service leavers are often discharged at very short notice making it difficult to provide appropriate support packages to prepare them for the transition to civilian life. South Tyneside should assess the need and viability of a Norcare-style centre for local veterans that encapsulates all the supports running from the Newcastle and Gateshead centres. An understanding of the rates of worklessness within the South Tyneside veteran cohort needs to be put in place and

compared to national and regional figures as accurately as possible. Results confirming disproportionate rates of unemployment, etc. among local veterans should then be recognised as falling short of the Marmot Review's ambitions centred on 'Fair Employment' (Fair Society Healthy Lives 2010)

7.4.9 The Prison and Criminal Justice Systems

Improved joint working and information sharing is required between statutory organisations and the prison and probation services dealing with military veterans in the criminal justice system.

7.4.10 Drug and Alcohol Services

There is both synthetic and anecdotal evidence to suggest alcohol is a far larger issue for military veterans than illicit drugs. Services need to become more veteran-sensitive, gathering and sharing both quantitative and qualitative information.

7.4.11 An Asset Based Approach

The asset-based approach and its potential value to South Tyneside are described in section 0.

There is strong evidence to suggest that a 'deficit' or an 'untapped' situation regarding asset based work is proving a barrier to health improvement across the veteran community. The viability and efficacy of targeting military veterans and the wider veteran community for asset based approaches should be assessed.

7.4.12 Capacity Building

Alongside a variety of methods and approaches to build capacity across the veteran community, consideration should be offered to either establishing a South Tyneside Armed Forces Network, or ensuring that the Sunderland and Gateshead networks are comprised of and cognisant to the needs of the borough's veteran community.

7.4.13 Service User Groups

The literature produced little evidence that the veteran community members themselves were informing service development and commissioning. There is even less evidence pointing to South Tyneside military veterans having been directly involved in constructing the shape and direction of services and projects.

7.4.14 Voluntary and Community Sectors and Multi-Agency Approaches

There is little or no understanding of the access rate to voluntary sector organisations and community projects/associations by veterans and their families (excluding specialist services and bodies). A trawl of information through this sector would highlight particular needs, such as use of food-banks, and particular groups within the veteran community, such as carers, dependants and the black minority ethnic populations. Multi agency working should be led through the Health & Wellbeing Board and include HealthWatch and the Legion.

7.4.15 Physical Health

The Operating Framework, NHS England 2011 requires that suitable arrangements are in place for returning veterans who have been injured in the course of their duty. Many war veterans are known to experience physical injuries as a result of their duties and support for

veterans with disabilities should include improved access to services such as Occupational Therapy and NHS health checks, as well as disability grants, allowances and benefits.

The North East options appraisal, which considers how funds to improve mental health services for veterans should be spent, notes current activity within the NHS South of Tyne and Wear area (Gateshead, South Tyneside and Sunderland):

- Within NHS South of Tyne and Wear, they have contacted local foundation trusts and GPs to confirm compliance with the Department of Health's guidance on offering priority treatment to veterans whose mental illness is attributable to their period of service. They have also asked GPs to record the status of each veteran as part of the referral.
- Veteran personnel receive priority access to psychological treatment from primary care, IAPT and secondary care mental health services. In addition, primary and secondary care staff access ongoing veterans' awareness training
- They have funded the North East Counselling Service to widen the choice of support for an additional 30 war veterans and their families in Gateshead. This service provides effective and responsive crisis interventions and therapeutic counselling.

7.5 Recommendations

- Introduce routine data collection to help to identify, quantify and track military veterans in South Tyneside including an assessment of service access.
- Enhance the support for those leaving the armed services to enter the job market.
- Maintain close working arrangements with the Regional Suicide Prevention Steering Group to ensure initiatives relating to military veterans are active in the borough.
- Substance misuse services need to become more veteran-sensitive, gathering and sharing both quantitative and qualitative information.
- Engage veterans in asset-based approach, capacity-building and user involvement
- There should be moves to support the establishment of a South Tyneside Armed Forces Network, or ensuring that the Sunderland and Gateshead networks can meet the needs of the borough's veteran community.
- Improve veteran access to universal services such as occupational health and NHS health checks, as well as disability grants, allowances and benefits.

8 Health and well-being strategy: (v) better quality services ""Developing better self care and self management across the whole population"

Within this section we consider the following aspects of better quality services:

- integration and self-care – improving the pathway for patients and increasing efficiency;
- chronic pain management – a focus on a particular health problem;

8.1 Case for Self Care in health and social care integration

South Tyneside is one of 14 Pioneer sites across the Country looking to improve the integration of services but South Tyneside has focused specifically on improving on self care and self management across all health commissioners, providers and with the local population. In this section we outline the background and intentions of this Pioneer work.

8.1.1 Integration and self care – the background

Integrated care is only effective if it improves outcomes for service users, not just the organisations providing the care. Our approach builds on the opportunities and challenges presented by the current climate of rising demand, financial constraints and government reforms, to support local people to systematically manage their own conditions and create a pathway of care totally focused on the needs of patients and families.

South Tyneside's Local Authority, CCG, and Foundation Trust share common boundaries, and – alongside our well developed third sector – have a long and successful track record of working closely together. While the CCG is a new organisation statutorily, it has worked with partners - from its early days of shadow functioning - to develop excellent relationships and ways of working, and the Local Authority's new public health responsibilities have made improving health and integrating health and social care a real local priority.

In South Tyneside the plan is for whole systems integration encompassing everything from preventive services to end of life care. This requires a cultural and power shift from traditional service provision to an enabling, empowering and integrated way of working across the whole workforce and with the local population.

This new 'people-centred' approach, links to the Making it Real personalisation campaign and the National Voices coalition, particularly the **'Voice, choice and involvement'** in everything from individual treatment decisions to major service design. Our aim is to increase self efficacy and help patients 'co-produce' their care, make informed choices about their health and treatment and increase the control they have over the way in which they manage their lives.

Through the work undertaken in the Asset Based Needs Assessment (see section 8) to determine what being healthy meant locally local, local people identified a lack of joined up care is one of the biggest frustrations. Against this background the Health and Wellbeing Board agreed to the development of integrated care models that will challenge professional attitudes and boundaries, and organise support services seamlessly around the needs of people, not organisations - with self care and self support as the golden thread through all of

our services. For older people already receiving acute care this will also include improved reablement and hospital discharge processes and the support provided to carers to build their resilience.

8.1.2 Strengthening self care and early help

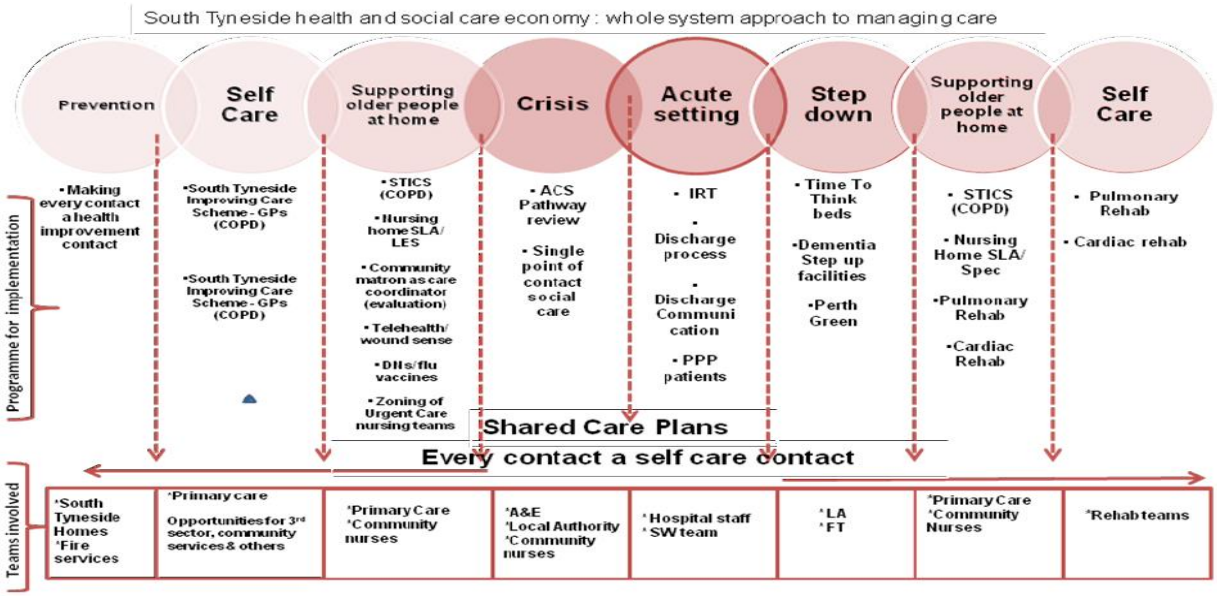
Through the application of the North East Transformation System (NETS) a solution focused 'kaizen' approach to address higher than average emergency admissions and re-admissions to hospital was undertaken. This helped develop robust plans to address key local barriers to integrated care and support, including improved communication on discharge to reduce the risk of re-admission, and integrated care plans which are well understood by patients, carers and professionals.

This work established that in order to deliver the scalable changes needed for local people to live a high quality of life for as long as possible there was a need to redouble efforts 'upstream', and focus on services and approaches that prevent ill-health.

This will require a change in culture as much as systems redesign, as well as joint workforce development and co-location initiatives to break down organisational barriers so that health and social care staff share the same goal of supporting people to take the right steps to support themselves . This needs to be underpinned by the active involvement of volunteers and voluntary organisations that can extend the reach of prevention and early help, and provide opportunities for people to remain active.

Figure 46 illustrates the local pathway and highlights the areas on which we want to focus: strengthening the **Self Care** stage (both at the very front and right across the pathway) developing standardised approaches across a range of statutory and third sector teams, and further integration at the **Acute** stages, and strengthening how patients 'step down' back to self care.

Figure 46: South Tyneside's whole system approach to managing care



The key intentions of the work are to:

- Develop and implement a standardised local approach to Self Care for delivery to identified patients at the “front end” of the pathway to support independence and well being, preventing their escalation into crisis
- Embed the promotion of self care practices into our workforce development programme for existing teams not only working at various parts in the pathway but across all tiers of delivery contributing to local people’s better health (including . District Nursing, Community Matrons, Discharge Teams, Community and Voluntary Sector
- Promote a greater understanding of the range of activities and support available that support independence and use social prescribing techniques to increase take up of non-clinical interventions
- Explore alternative commissioning models that promote accountability and risk sharing and the integration of care providers

8.1.3 Evidence for Self Care Action

Saving Lives: Our Healthier Nation (DH, 1999) and *Our Health, Our Care, Our Say: A new direction for community services* (2006) confirmed that that if people with Long Term Conditions are given the right skills and support to improve their health literacy and self management skills they will make more effective use of health services and be more able to adopt positive health behaviours. The 2008 Patient Prospectus *Your health, your way: Your NHS guide to long-term conditions and self care* highlighted the support needed to promote self care, which included

- Healthy lifestyle support: helping you improve your diet and exercise regime.
- Information: advice about your condition and its treatment.
- Training: helping you feel more confident about living with your condition
- Tools and equipment: making life easier at home.
- Support networks: help with finding people to share your experiences with.

Evaluation data from approximately 1,000 Expert Patient Programmes[3] that put these measures in place showed that

- 45 felt that they would not let common symptoms (pain, tiredness, depression and breathlessness) interfere with their lives.
- 38 per cent felt that symptoms were less severe 4 to 6 months after completing the course
- 33 per cent felt better prepared for consultations with health professionals.
- 16 per cent reductions in A&E attendances.
- 10 per cent reductions in outpatient visits.
- 7 per cent reductions in GP consultations.
- 9 per cent reductions in physiotherapy use.

Self management and social support programme for people with chronic illness suggests improved health status and improved self-efficacy with a benefits-cost ratio of 22:1 (and if social support provided by network group only with no professional input then ratio

[3] Department of Health (2007) *Helping patients to take control of long-term illnesses*

increases to 34:1)[4] And in 2011 the Healthcare Foundation showed that proactively supporting self-management and focusing on behaviour change can have a major impact on clinical outcomes and emergency service use.[5]

8.1.4 Prevention, Self Care, and Supporting People at Home: using a risk based approach to focus on those most in need

There is a need to We need to mobilise the total resource available in South Tyneside to improve the support and care that people receive. Statutory sector partners have agreed shared priorities via the Health and Well Being Board, alongside a concerted effort to harness the skills and reach of the community sector by working more closely together. Therefore we have identified a range of 'enablers' that need to be brought together into a whole system focused on people and supporting them change.

8.1.5 The enablers

8.1.5.1 Workforce Development

There needs to be a more harmonised approaches to workforce development by building on the existing 'South Tyneside common core of skills and knowledge' to ensure that all frontline health, housing, social care and voluntary sector staff in South Tyneside know how to respond effectively to signs of need, and prevent the lower level needs of local people from escalating to crisis point. Staff already play a role in promoting health and well-being and a joint workforce development programme has been built around the principles of 'making every contact a health improvement contact' providing an foundation for the promotion of self care interventions across a far broader audience.

8.1.5.2 Preventive services

Healthy Lives, Healthy People[6], emphasises the importance of tackling both physical and mental health as part of healthy lifestyles. Traditionally, there tends to be a 'silo' approach to the commissioning and provision of prevention services based on topic areas[7], and a recent publication from the Kings Fund[8] explored the effect of multiple negative health behaviours including, smoking, excessive alcohol use, poor diet and low levels of physical activity on health. They found that whilst the overall proportion of the population engaging in 3 or 4 of the unhealthy behaviours had declined between 2003 and 2008 these reductions have been mainly seen in the higher socio-economic and education groups. People with no qualifications were more than five times as likely as those with higher education to engage in four poor behaviours.

A Life-Course Perspective offers a broader way of looking at health and wellbeing, over a life span - not as disconnected stages (infancy, childhood, adolescence, adulthood, old age) unrelated to each other, but as an integrated whole. South Tyneside is tackling this 'silo' approach, by establishing a Change 4 Life Service – which looks across the life course, extending the reach of stop smoking physical activity, emotional wellbeing, and alcohol services that maintain their physical and emotional wellbeing by promoting self care.

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[4] Grossel E, T Cronan *(2000) Cost analysis of self management program for people with chronic illness. American Journal of Community Psychology, Vol 28, No 4: 455-480*

[5] De Silva *(2011) Evidence: Helping people help themselves*

[6] Department of Health (2010), Healthy Lives, Healthy People: Our strategy for public health in England

[7] Winters et al (20010) Wellness Services – Evidence based review and examples of good practice – Final Report, Liverpool Public Health Observatory

[8] Buck D, Frosini F (2012), Clustering of unhealthy behaviours over time, King's Fund www.kingsfund.org

8.1.5.3 Social prescribing

As well as giving social care clients greater choice and control over the support they receive, the introduction of individual budgets has stimulated the local market of services for older people. Improving this range and quality of services will be crucial, as the contributions of families and voluntary groups are often just as important as clinical interventions. Local GPs and social work teams need to encourage more 'social prescribing' of non-clinical interventions to improve the health and well-being of local people and carers and sustain their independence. For those not yet receiving care, Age UK's local 'COAST' project is identifying socially isolated over 75s 'at risk', and working with GP practices to introduce them to community based preventive support and social activities. This provides significant opportunities to improve access to social prescribing as part of our overall programme of self care implementation, providing alternatives to more traditional methods of intervention.

8.1.5.4 Volunteering

NICE's own recently published guidance has demonstrated the fundamental importance of supporting people to maintain and develop relationships. Loneliness is amenable to low cost interventions, and that these can reduce vulnerability and avoid the need for costly acute services in the future. In response the community and voluntary sector have developed creative solutions to help older people keep active and maintain their independence, such as befriending services that prevent social isolation.

Age UK's volunteers in South Tyneside give 11,000 hours of their time per year to support older people, and this has involved everything from a well-established befriending services, to 'Health Works' which has helped the elderly to cook traditional healthy meals on a budget and understand food labelling and weight management. Similarly, Groundwork have developed a popular local history project, 'Wagonways and Waterways' sustained entirely by volunteers. This supports the Walking for Health scheme, with walk leaders trained by the British Heart Foundation. South Tyneside needs to enagee, encourage and support people to be actively involved in managing their health and harness their skills and enthusiasm to expand the pool of support available to help the most vulnerable, and keep them active in the process.

8.1.5.5 Accessible services and information

Making services more accessible will be crucial to this, and there is a need to remodel and reconfigure public sector estate in South Tyneside to provide the platform for local providers to engage the hard to reach, and a range of leisure and cultural opportunities tailored to the needs of all local people. This will be based around accessible 'community hubs', multi-purpose hubs with a health and wellbeing focused service offer tailored to the needs of older people. Alongside this is the 'dementia village', with the provision of a range of memory protection services, day and respite care, and reablement all in one setting to support individuals and carers.

This will need to be underpinned by a user friendly directory of local services, working with service users to utilise digital technologies where appropriate – alongside 'community champions' who can promote the benefits of participation and volunteering. Volunteers are a huge asset supporting the promotion of self care opportunities, alongside a wellbeing directory which offers a wealth of local activities for local people and professionals – this will be built upon to ensure easy access

8.1.6 Crisis prevention and stepping down to self care

A key message from the joint review of the Adult Social Care pathway led directly to the creation of a single point of contact for adult social care to strengthen the effectiveness of an early help offer and prevent crisis escalation. There is a need to work closely with the Tyne and Wear Care Alliance to develop a comprehensive training programme for all residential and domiciliary care providers to improve both general awareness and the specific skills to support people with independence-limiting conditions like dementia. Alongside this is a need to further develop the application of telehealth and telecare to support independence and promote self care. Additionally, the development of initiatives such as shared care plans and a standardised communication process on discharge, as well as the development of a single point of contact for social care, will help to prevent crisis recurring.

GP practices now deliver comprehensive clinical and social assessments, and self care is now a core training module for our GPs and their practice staff. All GPs in South Tyneside were trained in the concept of “shared decision making” in 2012\13 in partnership with Newcastle University Medical School. This was tried and tested successfully in three outpatient specialties in which the CCG was over-performing (with resulting quantifiable savings and positive patient evaluations).

The intention to zone community nursing teams will also provide opportunities for better integration between community nursing services and general practices ensuring a patient centred focus which runs seamless across professional boundaries. A review of District Nursing Services, currently being implemented, also seeks to achieve this. Within this work, there are multiple opportunities for services to deliver self care interventions to assist people to self manage their conditions more effectively.

Significant work is under way across the system to support older people at home particularly post discharge from hospital. The intention to zone community nursing teams will also provide opportunities for better integration between community nursing services and general practices, ensuring a patient-centred focus that runs seamlessly across professional boundaries. A review of District Nursing Services, currently being implemented, also seeks to achieve this. Within this work, there are multiple opportunities for services to deliver self-care interventions.

8.1.7 Integrated accountable systems of care

There is a need to identify new commissioning models for acute care can incentivise integration and improve the patient’s journey. Work commissioned from Professor Bob Hudson of Durham University reviewed governance arrangements but also advised on commissioning best practice. This work highlighted the concept of ‘Integrated Accountable Systems of Care’ (IASC), which rest upon the idea of a ‘main contractor’ taking the lead and the responsibility for delivery on outcomes. In the USA, Accountable Care Organisations (or ACOs) have shown how to address a number of critical issues:

- **Solving the Problem of Payment by Activity** – and its associated duplication, waste and fragmentation

- **Current Silo-Based Micro-Commissioning** and micro-contracting leaves commissioners trying to micromanage very complex supply chains that dice patients up according to medical diagnosis.
- **Fragmented Delivery** - while patients invariably praise the contributions of individual practitioners they complain of:
  - ✓ being asked the same questions repeatedly
  - ✓ hanging around between bits of the service
  - ✓ having too many agencies involved in their care
- **Accountability for Integration** – who takes on the integrator' role within and across the NHS and local government

Under IASC a main contractor would:

- Contract for specific services from a range of different and mainly existing providers including a range of third sector organisations and private providers where appropriate
- Develop these different services into a coherent 'pathway' to ensure that the couplings between suppliers have sufficient strength to provide integrated support. It would be the main contractor's task to ensure that every part of the overall programme (say 'The Respiratory Programme') and each constituent pathway (say 'The COPD Pathway') is joined up.

8.1.8 Selecting the right clinical frame

In principle the number of hospital inpatients under the care of a main contractor should fall dramatically over time; because the main contractor (or 'Lead Provider') is at the centre of the pathway and can exercise control in a way no commissioner could do – as long as the commissioners are clear and robust in their expectations and procurement requirements.

Experience from this would inform our future thinking around developing more sophisticated models for integrated, accountable care.

Hitherto there has been no single accountable integrator of care who can ensure that the various components of a specified programme and pathway will really work together. There is a need to demonstrate how these models can be replicable in South Tyneside without destabilising the local health economy. Therefore deciding the 'Clinical Frame' is crucial: sufficient size to have an impact upon the whole system, but not so numerous that the agencies cannot cope.

NHS England (in its outcomes benchmarking support pack) identified the 'domains of difficulty' in South Tyneside as:

- life expectancy at age 75 (male and female)
- health-related quality of life for people with long-term conditions
- emergency admissions for acute conditions that should not usually require hospital admission
- emergency readmissions within 30 days of discharge from hospital
- permanent admissions to residential and nursing care homes (adults and older people)

However there is scope, given the extent of the numbers involved that to broaden this across the whole population, with emphasis on local people improving their self efficacy and in the longer term improving engagement in their own care.

8.1.9 Improving outcomes and managing demand

The success of this programme would be measured by a range of outcome indicators selected by our Health and Wellbeing Board and set out on their 'plan on a page'. Would include impact measures such as:

- increase in self-reported wellbeing
- reducing depression and isolation
- closing the life expectancy and inequality gaps that exist in the borough.
- Using surveys to capture patients' experience of care
- Reducing re-admissions to hospital within 30 days
- Reducing emergency admissions to hospitals for conditions not usually requiring acute care

But also the extent to which local people are "activated" or engaged and any evidence to demonstrate the extent to which there is improved health and well being as a result of that engagement in their own health.using tools such as

- Lodex to better understand the impact of services on individuals,
- Measuring the impact of giving service users and carers the skills to improve their self efficacy to challenge providers,
- drive up quality and improve health and wellbeing.

8.1.10 Commitment to integrate care from local stakeholders

South Tyneside already has strong local leadership and accountability systems in place which has secured the support of local executive and political leadership. This includes the local Health and Wellbeing Board, and the Joint Social Care and Health Executive Team (which comprises the chief executives of South Tyneside Council, South Tyneside CCG and South Tyneside Foundation Trust). There is also some of the measures needed to build on, including an 'Urgent Care Board' (modelled on 'out of hospital boards' elsewhere), and a workstream tasked to draft information sharing protocols that accelerate integrated working.

Consultation with service users and their carers needs to be central to development of a self management programme The key messages from the 'Big Care Debate' exercise in 2011 led directly to creation of a new initial contact centre so that advice and information was accessible in one place. Similarly the Council's Day Care Review used customer insight to reconfigure our buildings and shape services to make them as accessible as possible.

Alongside this, local HealthWatch will ensure that local people are engaged and that the voice of the service-user is listened to seriously, so that we deliver a better deal for people who are disadvantaged because of their condition, disability, where they live, their age, ethnicity or the setting of their care.

There is a need to shift the focus of services for people with a range of conditions that impact on their wellbeing and everyday life away from simply maintaining people in their current physical and mental health, to a focus on preventing reablement, with health and social care working together to provide targeted packages of support for the most vulnerable to maximise their independence.

8.2 Characteristics of the population experiencing chronic pain in South Tyneside[9]

The 2011 Health Survey for England[10] reported that 31% of adult men and 37% of adult women 16 years and over reported experiencing chronic pain. Chronic pain is defined within the survey as pain or discomfort that troubles a person all of the time or on and off for more than three months. The prevalence of chronic pain increased with age, from 14% of men and 18% of women aged 16-34 to 53% of men and 59% of women aged 75 and over.

There was a disparity between the poorest and richest households (the bottom and top fifths based on equivalised household income): 40 per cent of men and 44 per cent of women in the poorest households reported chronic pain, compared to 24 per cent of men and 30 per cent of women in the richest.

For the adult population of South Tyneside 16 years and over, this suggests that:

- as a minimum, 18,000 men and 24,000 women experience chronic pain[11]
- actual numbers could be much higher as South Tyneside is a more disadvantaged population compared to the England average, with more households in the lowest income bracket
- there are at least 5,000 men and 8,000 women over 75 years of age who experience chronic pain[2]
- 5,400 men and 7,700 women will have a high interference pain grade (either III or IV on a scale of I to IV)
- 2,000 men and 3,500 women aged 75 and over will have a high interference pain grade

The proportion of these people that have seen a health professional at a specialist pain service will vary depending on local provision. Nationally, over 40% of people with the most severely limiting pain (grade IV) had not accessed support.

Significant medical conditions which cause chronic pain are musculo-skeletal conditions affecting the lower back and all types of cancer. An epidemiological needs assessment for low back pain by Croft et al[12] (1997) noted the findings of an OPCS Survey[13] which estimated that the employment of 4% of people 16-64 years was affected by low back pain in the course of a 4 week period: one third because of time off sick and two thirds because low back pain was given as one reason for not being in work.

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[9] Public Health Advice, Information and Intelligence for Gateshead, South Tyneside and Sunderland, February 2013

[10] Health and Social Care Information Centre (2012) "Health Survey for England - 2011, Health, social care and lifestyles",

[11] Estimates based on Office for National Statistics mid-year 2012 populations by English Local Authority

[12] Croft P, Papageorgious A, McNally R "Low Back Pain" in Stevens A, Raftery J (Eds) (1997) "Health Care Needs Assessment: The epidemiologically based needs assessment reviews (second series)", Radcliffe Medical Press, Oxford

[13] Mason V (1994) "The prevalence of back pain in Great Britain", Office of Population Censuses and Surveys, Social Survey Division, London

In 1991-92 a prospective study of GP consultations estimated that 7% of adults in the UK will consult their GP at least once in a 12 month period because of low back pain[14]. Typically two thirds are prescribed medication.

8.3 Recommendations

- Fully implement the developing Change 4 Life Service, which looks across the life course, extending the reach of stop smoking physical activity, emotional wellbeing, and alcohol services that maintain their physical and emotional wellbeing by promoting self care to increase self reported well being and quality of life
- Harmonise approaches to workforce development integrating the self care approach across all organisations providing services to increase the number of people who use services to take control of their life
- Make further use of 'social prescribing' of non-clinical interventions to improve health and well-being of people and carers and sustain their independence
- Collaborate with third sector in developing and encouraging use of volunteer services to prevent social isolation and keep older people active and improve patient experience of care
- Zone the community nursing teams to provide opportunities for better integration between community nursing services and general practices
- The CCG to work to raise awareness of chronic pain issues, its impact and work with other agencies, including employers and benefits agencies to raise awareness of support benefits and allowances and to ensure appropriate uptake.
- There is a need to undertake a detailed Health Needs Assessment (HNA) of those incurring Chronic Muscular Skeletal pain, to understand their detailed health needs and its impact on their quality of life.

[14] McCormick A, Fleming D, Charlton J (1994) "Morbidity statistics from general practice. Fourth national study 1991-92.", Series MB5 no. 3, Office of Population Censuses and Surveys, HMSO, London

9 An asset-based approach to developing public health services.

Reflects the work conducted across the Five Community Area Forums areas in South Tyneside to understand local people's understanding of the issues that are important to their own health

9.1 Introduction

This report identifies the key issues included in an asset based approach to public health. It summaries the findings asset mapping conducted across the five community area forms by the Promoting Health Engagement Team.

9.2 Background

Tackling health inequalities is a key function of public health work. Much of the current understanding around this issue is based on the Marmot Review [15], which identified that:

- Health inequalities are not inevitable or immutable
- Health inequalities result from social inequalities

[15] The Marmot Review (2010) **Fair society, healthy lives. Strategic Review of Health Inequalities in England Post-2010.** London: The Marmot Review. www.marmotreview.org

- Action to reduce health inequalities need to be for everyone, with a focus on the most disadvantaged
- Reducing health inequalities is vital to the economy

South Tyneside Health and Wellbeing Board has identified its priorities as:
- Improving health and well-being and reducing inequalities through prevention and early identification of risk.
- Tackling youth unemployment
- Reducing social isolation in older people
- Improving the quality, integration and efficiency of local services provided by South Tyneside Council, NHS and partners[16].

9.3 Asset Based Work

Traditionally, public health has focused on health needs assessment as an approach to systematically reviewing the health issues of the population, which has then informed priority setting and resource allocation for improving health and reducing health inequalities[17].

Identifying health needs has been described as a 'deficit' approach, which focuses on the problems, deficiencies and problems within a community. It creates services to find solutions and fill gaps from a service provision perspective, which can lead communities and individuals to feel disempowered and dependent, as passive recipients of services[18].

There is increasing evidence that using an asset based approach can enhance the quality of information that is collected, by focusing on local people's perceptions and improve the services that are subsequently provided, by basing them on what people want. It has been described as 'a glass half-full' approach', and encourages active involvement in decision making[4].

An asset based approach starts with people's energy, skills, interests, knowledge and life experience[19]. People are not seen as passive recipients of services, but as active citizens, who have a range of assets that can be drawn on to improve health and health services.

Key issues include:
- Reducing health inequalities is fundamental to the work of public health and local government
- Recognising that the physical, mental and social wellbeing of the local population is influenced by the wider determinants of health, including material deprivation, employment/unemployment, education, housing and the environment
- Tackling wellbeing at a population level, combined with some focus on interventions for those in greater need i.e. proportionate universalism

[16] South Tyneside Council (2012) **Our Better Health and Wellbeing Strategy 2012-13 Action Plan.** South Tyneside: South Tyneside Council

[17] Cavanagh, S. and Chadwick, K. (2005) **Health needs assessment**. London: Health Development Agency

[18] Foot, J. with Hopkins, A. (2010) **A glass half-full. How an asset approach can improve community health and wellbeing**. London: Improvement and Development Agency (IDeA)

[19] Glasgow Centre for Population Health (2011) **Asset based approach for health improvement. Redressing the balance**. Glasgow: Glasgow Centre for Population Health

- Approaching wellbeing from an assets based perspective is most likely to attain the greatest benefit.

9.4 Asset Based Mapping

Many of the tried and tested ways of community engagement remain appropriate. Indeed, Asset Based Community Development (ABCD) specifically uses an approach which focuses on the positive strengths within individuals and communities and recognises the importance of social capital (the connections within and between social networks) as an important asset. The pilot used an asset mapping approach, which has been identified as 'the process of intentionally identifying the human, material, financial, entrepreneurial and other resources in a community'[20]. This focuses on both the assets of people as well as of place. It enables people to feel positive about where they live and the opportunities there can be for change.

9.5 Asset Based Engagement

The Promoting Health Engagement Team used an asset based approach across the five Community Area Forums using a systematic approach to engage with communities and stimulate interest. This involved speaking to people on the street, in a wide range of local organisations and focus groups.

Organisations and groups were positive about the work and were keen to take part the high number of responses suggests that residents were willing to engage and are interested in the topic. *"Good being able to talk and say how you feel without being judged/looked down on"*

9.6 The process

1. Pre-engagement work included cascading information to key partners

2. During the course of the work 154 organisations were contacted and 113 (73%) agreed to take part in the process Those that declined to be involved cited capacity issues, other pressures and consultation fatigue as main barriers.

   A Graffiti Wall was used to stimulate discussion around the question:

   WHAT DOES BEING HEALTHY MEAN TO YOU?

   As part of the ongoing process and divers nature of the groups taking part engagement tools were adapted for specific groups / services to allow carers and support workers to discuss the question with people on a 1:1 basis and help them express their opinions.

3. 11 street surveys were undertaken to capture the views of people who may not necessarily be engaged with local organisations and groups, comments received from 361 people.

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[20] Bonner Curriculum, **Community Asset Mapping: A Critical Strategy for Service**
http://www.bonner.org/resources/modules/modules_pdf/BonCurCommAssetMap.pdf

4. There was a high level of interest from specific groups / services resulting in 9 focus groups with 133 people being were conducted to ensure a wide range of views and detailed responses from local people.

9.7 The venues

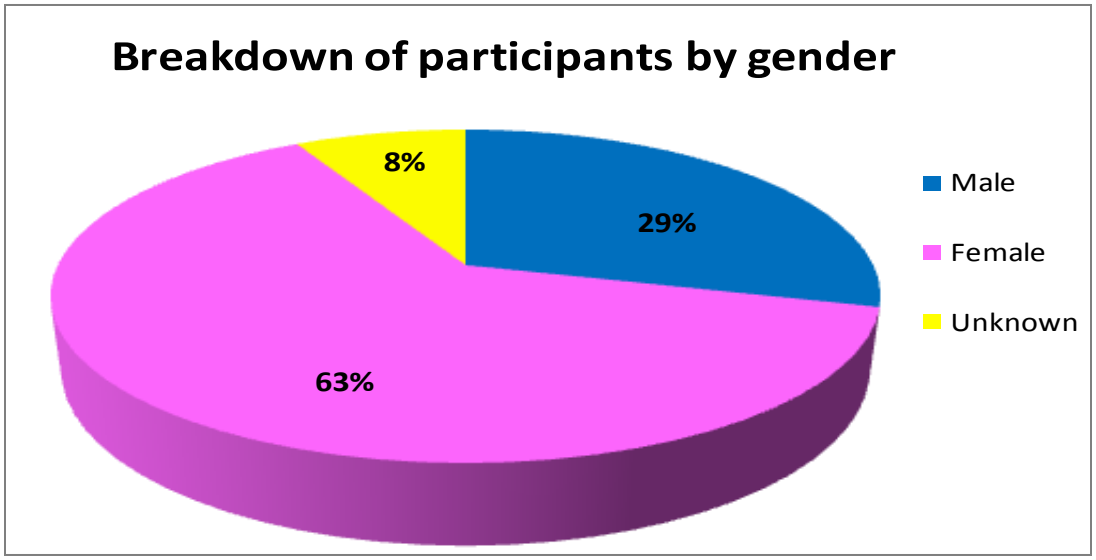
- Jarrow Community Association
- The Glen Primary Care Centre
- CREST (Compact for Race Equality in South Tyneside)
- Ocean Road Community Association
- WHIST (Women's Health in South Tyneside)
- Green Hope Oasis Project
- West Harton Churches Action Station
- Horsley Hill Children's Centre
- The Lonnen Community Base

9.8 Demographics of Respondents

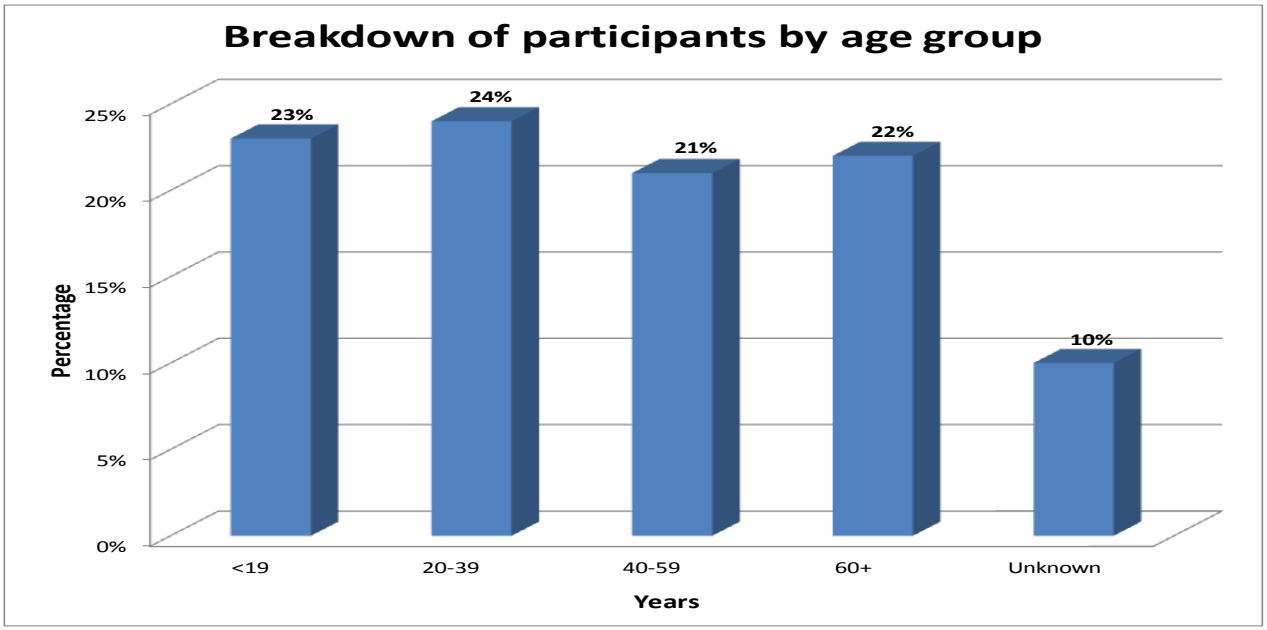
In order to target a wide range of people basic information relating to gender, ethnicity and age was collected.

- 2,789 people responded and over 5,6000 comments were received
- Ethnicity
  - White British = 89% (n=2,480)
  - BME groups = 5% (n=140)
  - Unknown = 6% (n=169%)

- Gender:
  - 29% male (n=802)
  - 63% female (n=1,772)
  - Unknown 8% (n=214)



- Age ranged between 3–95 years, grouped as per graph below:

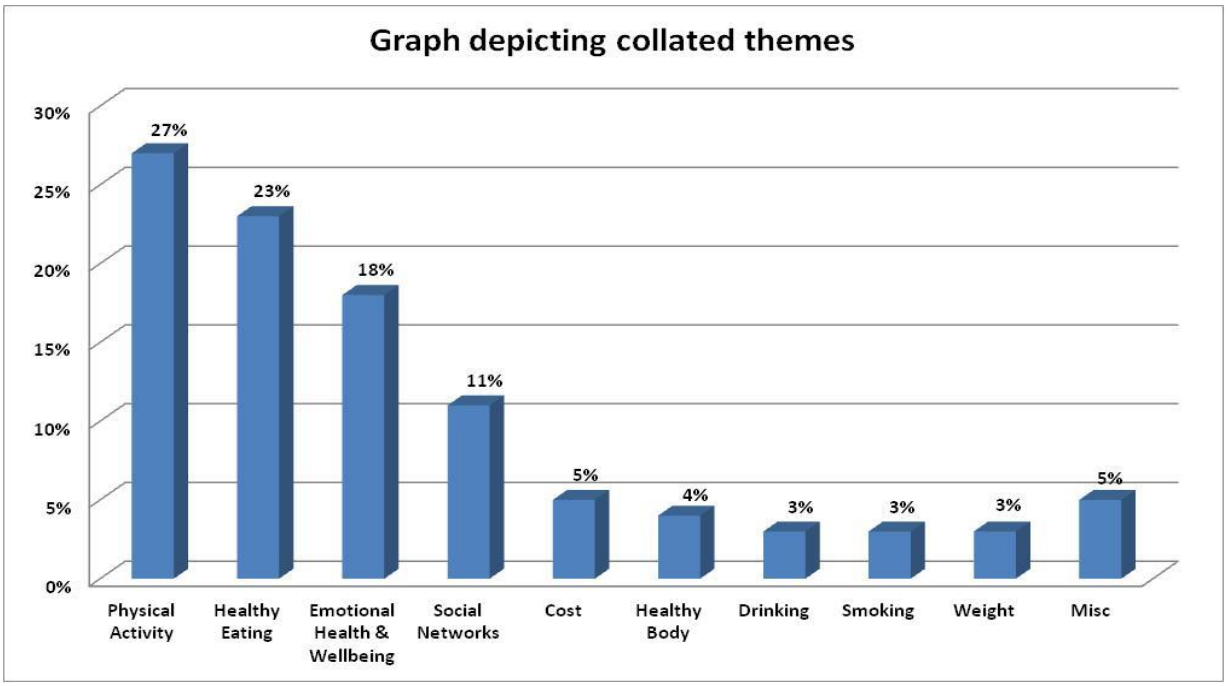


It should be noted that for those aged 60+ years nearly 50% (n=302) were over 70.

9.9 Findings

Comments were grouped according to subject identifying nine main themes, responses that did not correspond to one of these themes were categorised as miscellaneous. Selected quotes will be used to give substance to the narrative.

Themes are presented graphically below:



Jarrow and Boldon Highlights

- Wellbeing is identified as being the cornerstone of health improvement.
- Importance of an active mind and body, being independent
- Few people linked being active or eating healthily as important for losing weight: People recognise the benefits of regular activity and healthy eating independently of weight management.

  "I eat produce from the allotment and keep fit at the same time" (Female, 76 years)
- People want clear, concise information, increased support from health professionals, flexible weight management services and ways of extending the length of support from commercial slimming organisations
- Support for community centres to provide free / subsidised child care and activities for all, specifically breakfast, lunch and tea time clubs.
- People identified education on the effects of alcohol on the body, long term effects of excessive alcohol consumption, its links to domestic violence and an increase in the price as key strategies to stop or reduce drinking.
- Young people were more likely than adults to link drinking alcohol to taking drugs and smoking, extolling the virtues of not starting or encouraging people to stop
- Support from local stop smoking services, the smell of smoke on your children and the death of a close friend were strong motivators to help people stop smoking
- People don't feel as safe as they did years ago

- More activities for young people between the age of 5 to 15 years, particularly after 6.00 pm, youth workers and more police on the street preventing trouble, particularly in areas with high levels of anti social behaviour.

Bullying – need more community centres" (Young Person)

Hebburn Highlights

- Wellbeing is identified as being the cornerstone of health improvement.
- Importance of an active mind and body, being independent
- People want clear, concise information and better packaging / labelling of food.
- Raise awareness of loneliness, its links to depression and how people can get help.
- Support for community groups / centres to provide free / subsidised child care and activities (physical / social) for all, particularly those for families
- Responses highlight the role individuals, community groups and council services play in providing opportunities for people to stay healthy and widen social networks.
- Improvements relate to education and awareness raising, increasing the number of affordable activities for all, particularly those for families and regeneration of the area.
- Support from local services and GP staff, the smell of smoke on your clothes and children and enforcement of smoking areas away from doorways and public walkways help people stop smoking
- People don't feel as safe and would like a police presence on the streets
- For older people having access to the free bus pass helps them stay active and independent, staying in touch with friends and making new friends. Also having good social networks and support is essential to prevent loneliness and isolation.

"Going out with friends, using bus pass to be able to go out and meet people

and keep in touch with everyone" (Female, 74 years)

- The intergenerational event at Hebburn Comprehensive school was a great success demonstrating the achievement of local people working to secure funding for innovative programmes.

Riverside Highlights

- Wellbeing is identified as being the cornerstone of health improvement and the importance of access to self care, stress management, alternative therapies and personal development.
- Participants identified a need for more advice and support for people who lack motivation or isolate themselves due to depression.
- When promoting activities or services that are important to people's health information should be culturally appropriate, available in a preferred media (such as 'easy read', audio and large print version), and use pictures of 'people like me'.
- Getting clear, concise messages out via community leaders is import to engage BME communities.
- Respondents were enthusiastic in speaking of the impact specific groups and services had made to their lives, citing increases in confidence and self esteem, peer support and developing copying skills as being significant to their health and wellbeing.
- Having a sense of purpose, belonging and the desire to 'give back' came out clearly in the focus group, and the value of such groups providing a 'stepping stone' to other support services, activities and wider community.

- This work highlights the role community groups and services have in addressing deficits using a different model, one which develops strengths and resources rather than perpetuating need.

"Coming here (community group) helped show me that with the right help (positive support) I can figure out what's best for me" (Female, age unknown)

- Family and friends, employment, financial security and environment (home and immediate surroundings) are important factors that enable people to adapt and be resilient.
- The value of providers of specialist services holding sessions in community venues, and the need for more 'on the street support' for homeless people, those in crisis, and preventing young people drinking in the area.
- There is a growing fear among participants for their future wellbeing due to the rising cost of living, and also the future of the groups and services they attend due to changes and potential withdrawal of funding.
- Respondents indentified attitudinal, physical and socio-economic barriers to health and wellbeing and the need to:
  - Raise awareness and challenge discriminatory attitudes
  - Provide clear information on welfare changes and simplified processes for claims, entitlements and support when things go wrong
  - Security for community groups and services
  - Ensure carers have access to support services including access to respite facilities
  - Increase the number and type of activities in the community, ensuring they are affordable, accessible and culturally appropriate
  - Access to affordable food, food schemes and credit unions
- Access to personal development, self care courses and support for those which chronic conditions or complex needs, co-ordinated services for people with diabetes, pain clinics and programmes of support should be developed to avoid multiple trips and minimise travelling costs.
- By making improvements to accommodate the needs of people with physical, sensory, and/or learning disabilities the needs of other users are also met and accessibility improved for everyone.

Source: Wallis Mews LD Residential Home

West Shields, Cleadon and East Boldon Highlights

- Being physically active is a key factor in maintaining mobility, independence, helping people to control a variety of chronic conditions, and increasing social interaction and networks.
- Emotional health and wellbeing is identified as being the foundation of health improvement, stressing the importance of having a balanced life and staying active in mind and body.
- Participants highlighted talking through problems, taking an active role in their community and having enough money to live on as key factors to improving health and wellbeing.
- Contribution of community centres and resources such as open spaces, libraries and faith groups offer a variety of free and low cost physical and social activities.
- Access to affordable food, alternative activities and hobbies are important for physical and mental health.
- Community spirit – good friends, neighbours and appropriate support help people get out and about and stay independent; this is particularly relevant for older people to help them stay in their own home.
- Significant life events or warnings of adverse consequences are often triggers to admitting problems and seeking help / support people to make healthy changes
- Compensatory actions – using positive activities (exercise, eat healthy) in a bid to offset effects of unhealthy behaviours

"Not supposed to smoke but I do, eating well and exercise to live longer hopefully" (Female, 67 years)

- The impact key workers / volunteers have on motivating and supporting clients to improve self confidence, gain new skills, share existing skills and contributing to the success of the programme
- Barriers may be experienced differently according to topic, age, ethnicity, gender, or ability and may relate to physical, social or financial situations.
- Off-peak / subsidised activities favour those who don't work; you would have to take time off work to take advantage of these services.
- Fear of cuts in support / activities due to reduced funding for community groups / services and staff worries over job security.
- Low income and welfare changes present financial hardship for those affected, with many having to make sacrifices in order to cover basic necessities.
- People are having to cut costs – heating vs. eating, perception that because you live in 'a well to do area' you don't have money worries or have to be careful.
- Promotion and awareness raising communication should be more flexible (speak to real people not automated telephone service), use up-to-date technology and social network sites.
- Ensure that messages do not appear to be preaching or negative, use accessible resources that identify the positives of change, case studies and role models
- Identify ways of supporting community organisations / groups to expand local provision (physical and social), offering a wide range and physical and social opportunities which are affordable and have access to child care and transport.
- Access to safe and supportive environments, structured activities and peer support helps people to develop relationships and coping mechanisms to deal with everyday pressures and rediscover a sense of purpose.

"I'm here every day, it gives me something to do and can be with people who understand" (Male, 51 years)

- Training and support to address wider issues (welfare, housing, education, work), challenge attitudes (self and others) and social norms.
- More support for community organisations to increase the number and type of low cost activities available.
- Better access to counselling, peer support and befriending services.
- Explore alternative therapy and joined up services for those with conditions such as diabetes / chronic pain, trying to stop smoking or lose weight.

East Shields and Whitburn Highlights

- Importance of having access to healthy affordable food, education on healthy options, clear labelling, cooking demonstrations, promote healthy packed lunches and fruit in schools and nurseries and community resources such as gardening projects.
- Benefits of regular activity to reduce stress and help people cope with chronic conditions and local groups offering free/low cost activates as well as providing volunteering and social opportunities, craft classes and courses.
- Importance of local support groups and services for people with chronic conditions such diabetes, heart problems and multiple sclerosis and their families.
- The value of local amenities and outdoor spaces to stay physically, mentally and socially active.
- Wellbeing is identified as being the cornerstone of health improvement, self esteem, resilience, social networks and a sense of control being fundamental to helping people lead healthy lives.
- Exploring new interests, having someone to talk to, looking after yourself and staying active in mind and body is important to help people stay independent.
- The value of activities at children's centres and groups such as the Brownies to provide safe, supportive environments to allow children to make friends, develop social skills, confidence and healthy behaviours.
- The perception that for some people unhealthy behaviours such as comfort eating, smoking and drinking help them cope in times of stress and deal with difficult situations.
- Advertise events and local opportunities and raise awareness of the benefits of making healthy changes using different communication methods to get messages out – publicity, social media, word of mouth – use age appropriate, easy read materials and positive role models.
- Information, advice and support to manage money, where to get advice on entitlements, support services and promoting free / low cost activities and local groups.

"I'm on a low wage which impact on what we eat; unhealthy foods are cheaper, childcare is too expensive" (Male 32 years)

- Improvements included:
  - action to have joined up services for people with chronic conditions such as diabetes and setting up well women and pain clinics
  - increasing healthy food outlets in the area and decrease takeaways and explore options to set up breakfast and lunch clubs and food cooperatives
  - support for local organisations to increase the number and range of physical and social opportunities in the area

- Being heard, increased access to community activities, awareness raising and training to increase understanding and acceptance and reduce stigma is important for people with complex needs.

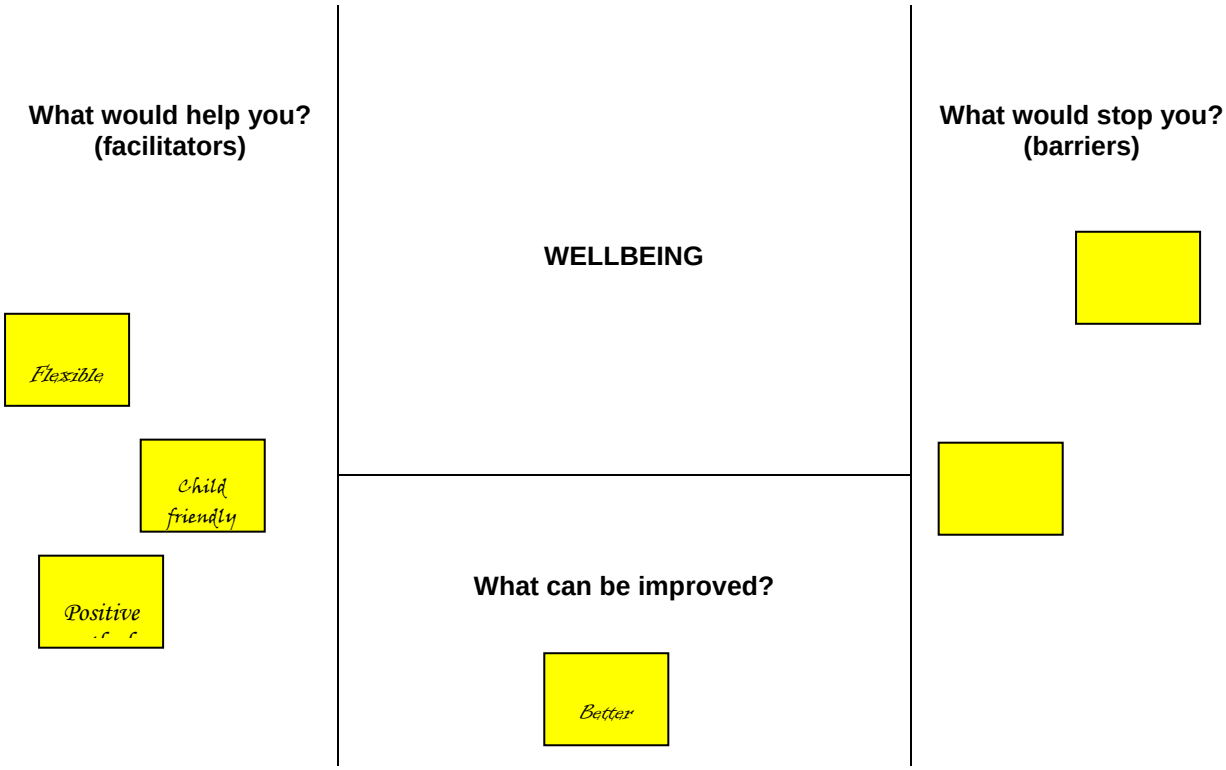
9.10 Focus groups

The aim of the groups were to bring together a group of individuals who had contributed to the Graffiti Wall to understand their views and experiences, building upon the previous work and a capturing more in-depth information. As an incentive to attend the workshop £10 Asda vouches would be given at the end of the focus group to thank participants for taking part.

Interest for participating in the focus group was generated during the work, including the street survey, a total of 133 people attend nine focus groups.

9.11 Sharing Findings from the Graffiti Wall

H-forms were developed to feed back the themes from Graffiti Wall, focus discussion and capture additional comments and experiences. The flip chart paper was pre printed with the topic and three questions, during the break the seven sheets were hung on the wall around the room. See below for example of the H-form:



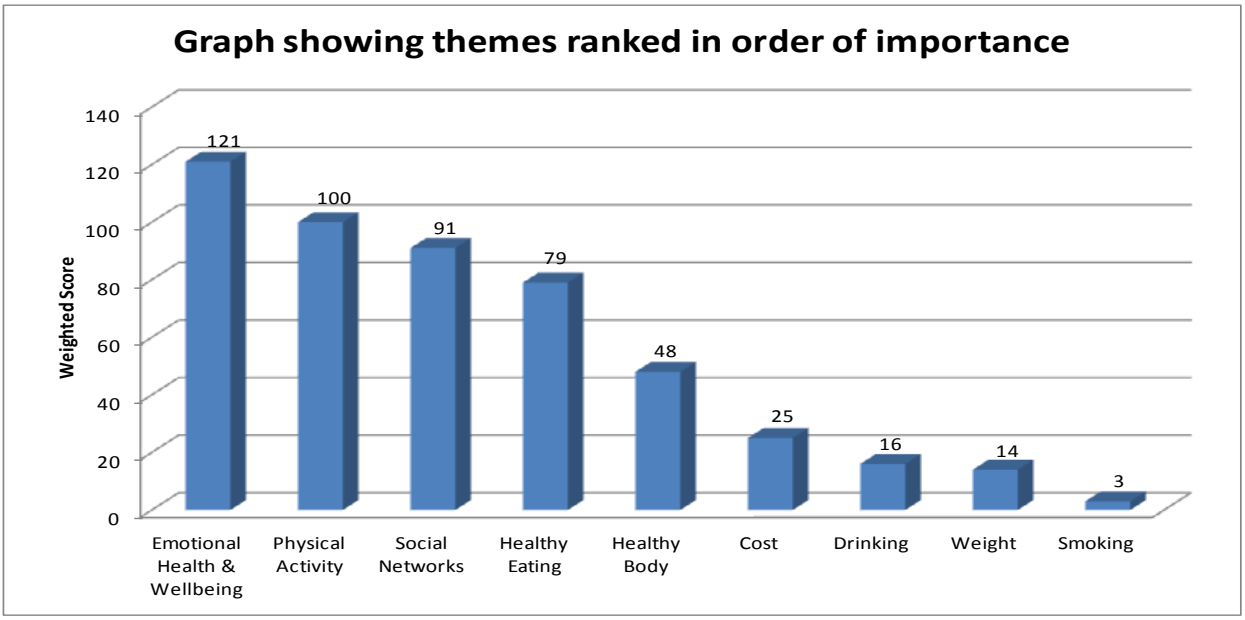
Participants were divided into four groups with a member of the team allocated to facilitate the process. Each group started with one theme and used post-it notes to record their thoughts and experiences, comments were then stuck on the H-form under the appropriate section, once completed the group moved clockwise to the next topic.

9.12 Prioritising

The next step in the process was to involve participants in the analysis by identifying their priorities. Bean Counting, using red, yellow and green dots was used to rate the themes, participants were asked to study the topics and consider which ones were most important to them. They then highlighted their top three choices using the following:

Key: 1st 2nd 3rd

The graph below highlights the key priorities for people involved in this work, the top three are 'Emotional Health and Wellbeing', 'Physical Activity' and 'Social Networks'.



9.13 Evaluation

The evaluation framework had three main aims:

- Identifying whether participants wanted feedback, and if so what would this look like
  - All participants wanted to receive feedback via their organisation or sent out in the post.
- Determine interest in attending a larger (South Tyneside wide) event – contact details were collected from participants interested in attending.
- Gather feedback on focus group:
  - What was good?
    - Themes – participants found the results surprising; finding out the different themes for the area
    - Hearing other's views; interesting hearing other people's opinions; very interesting information

- Different views from different ages – diverse; very helpful and good to get our views across; good ideas; discussing things in a group; everyone got together and you heard everyone's views
- Asda voucher very helpful; getting a stress ball and pen; canny cuppa
- The staff may you feel very comfortable; the format, staff excellent, good input
- Discussing what works for us all individually; getting things off your chest
- Talking to someone else who suffers with depression
- Meeting and talking about issues that can be treated with the help of other agencies
- Really enjoyed it; good; excellent; good all round; everything
- Conversations – being able to talk freely; hearing other people's views
- Good interaction; meeting people
- The venue – the view was lovely; nice place;
- Good being able to talk & say how you feel without being judged/looked down on; friendly atmosphere; relaxed; cool people
- Thought it was aright

- Not so good?
  - Mix up the ages (when breaking off into groups mixing up the ages would have been better).
  - No return of the bus fare
  - All good
  - Nothing all was excellent
  - Venue too hot
- What could be improved?
  - The room could have been a bit warmer
  - Bus fare returned
  - Good all round
  - Brilliant
  - Nothing – brilliant

- Make sure:
  - What people have said is taken seriously
  - Don't talk to people if you don't intend to take their advice
- How would you rate today's event?
  - On a scale of 1 being very poor and 6 excellent, 111 (83%) participants rated the event:

1	2	3	4	5	6
0	0	0	4 (4%)	27 (25%)	76 (71%)

9.14 Assets

Asset mapping is a process which has the potential to identify skills and capacity of individuals, provide an understanding of key networks and groups, as well as providing an inventory of organisations and building within the area.

This work has unearthed a wealthy of information, identifying:

- practical skills, willingness to help and knowledge of local residents
- the importance of networks and connections in the community, including friendships and neighbourliness
- the value of community groups, organisations and faith groups providing physical and social opportunities
- an appreciation of local outdoor spaces
- the power of local people coming together to conserve areas, bidding for and securing funding to restore the local park
- suggestions to improve the area, activities, and services

A total of 379 community assets and active groups were identified

9.15 Lessons Learned

The following provide a summary of knowledge and learning from pilot:

- Gaps relating to:
  - capturing personal and demographic information
  - targeting young people
- Implementing the asset mapping proved more time consuming than originally thought, underestimating the amount of work required to complete the process, particularly the time it takes to input and analyse the huge amount of data generated
- Importance of two way communication and promoting materials to be clear, concise and use positive messages
- Findings reveal activities which should be considered when reviewing or developing services, particularly the current review of services.
- Demonstrates the value of the wide range of activities, organisations and social networks identified which support people to improve mental health and wellbeing
- While the approach adopted has gleaned a wealth of information it has only scratched the surface and can be likened to the analogy of capturing data that is ‘a mile wide but an inch deep’ potentially missing valuable assets
- The concept of an asset based approach is new within the Joint Strategic Needs Assessment for South Tyneside and needs high level sign up / commitment to be further developed in the future.
- Need to understand how this work will inform:
  - JSNA
  - Health and Wellbeing strategy
  - Redesign and development of services

9.16 Conclusion

Adopting an asset based approach has proved an exciting opportunity and an extremely useful engagement tool. Helping people to think positively about their situation by focusing on identifying strengths rather than needs, enjoying the process and feeling listened to.

"Good being able to talk and say how you feel without being judged/looked down on"

Assets may be described in terms of people, places and resources; this first attempt has unearthed a wealth of local information that has the potential to bring about meaningful change by identifying sustainable initiatives.

We need to consider how the wealth of local resources can be incorporated into Social Prescribing initiatives and current pathways, for example enhancing self care, exercise referral and weight management initiatives.

Recognising that an asset based approach can offer a viable alternative health promoting strategy as well as enabling people to make healthier choices through their engagement with the assets in their lives.

9.17 Recommendations

1. Community Area Forum (CAF) members to embrace an asset based approach to promoting health in order to ensure local residents reach their full potential.
2. Use findings to strengthen the JSNA and Health and Wellbeing Strategy to inform the way services are commissioned.
3. Explore specific topics to inform lifestyle service commissioning, for example the review of substance misuse services.
4. Identify alternative methods of engaging with people from the wider black and minority ethnic (BME) communities to identify local assets and strengths that promote their health and wellbeing.
5. Identify resources to inform the public of local activities and encourage local organisations to incorporate their activities into the Wellbeing online directory to promote self referral.
6. Explore ways of developing local 'champions' to embed this work in the community to understand, locate and support asset based working to identify alternative approaches to improve health. This to be linked to making 'Every Contact a Health Improvement Contact' (a programme to encourage front line workers to deliver health promotion messages).
7. Investigate options to help grow community assets as part of reviewing small grants and brokerage project to reduce obstacles to obtaining funding and identify flexible ways to provide security and support projects in the community.
8. Consider holding a South Tyneside wide event to embed asset based working in the community, ensure important 'health assets' have been identified and focus on areas needing greater depth of understanding

9.18 Next Steps

- Share findings with key partners and wider community
- Build on the ‘assets’ approach and work with local people and elected members. This approach elicits a wealth of intelligence about local people and places.
- Embed evidence within the JSNA and assets assessment and use to tailor the use of resources effectively.
- Carry out in depth health needs and assets assessments of key groups – children in the looked after setting for example, sexual health.
- Bring together ‘people and place’ utilising the skills of Council staff and support tools from Public Health England to get a richer understanding of small areas and the needs and assets within to enable an enhanced targeting of effort.
- Move towards having one needs and assets assessment for the Council and partners.

10 JSNA Recommendations

10.1 Best start in Life

1. To continue to work with partner agencies to embed early approaches to reduce demand upon specialist and acute services

2. To work collaboratively with partners and the LSCB to reduce the prevalence of children and young people experiencing neglectful parenting through early identification and intervention.
3. To undertake a comprehensive analysis of the health and well being of looked after children and care leavers and implement to drive forward improved health outcomes for our most vulnerable.
4. To embed the Emotional Health and Well Being Strategy and priority actions across all tiers of need to ensure timely and appropriate interventions are offered to children and young people in accordance with identified need.
5. To work with Tier 3 CAMHS providers to improve timeliness of services offered and service take up.
6. To work collaboratively across the health and well being, safeguarding and community safety partnerships to reduce the impact of parental substance misuse and domestic violence upon children.
7. To develop and implement joint commissioning intentions and priorities in respect of children with complex needs and autism to reduce demand for out of Borough placements, including educational placements.

10.2 Increased Life Expectancy with reduced difference between communities

8. Increase screening uptake in vulnerable groups,
9. Map differences in cancer presentation, registration and staging, treatment adherence and survival to geography defined by deprivation scores. Important stakeholders (e.g. GPs) should be made aware of differential patterns.
10. Target programmes of awareness raising and work to support early presentation, capitalising on existing channels for community engagement,
11. Undertake a significant event audit across the whole pathway, focused initially on lung cancer.
12. Build cancer awareness into the Making Every Contact a Health Improvement Contact programme
13. Focus programmes to improve uptake on cancer screening invitations, with targeted harnessing contacts of other frontline agencies and community engagement channels.
14. GPs working with screening programmes to identify people with a learning disability to make appropriate adjustments to the invitation and screening process;

10.3 Better employment prospects

15. The Council and partners should continue to lead the way in promoting industrial pathways to employment for young people, as well as stimulating a cultural change in young people through the interactions between businesses and schools and

supporting those furthest from the labour market through Business, Employment and Skills services.

16. Health and Well Being Board partners should ensure that locally commissioned contracts providing local employment, influence the quality of local jobs and a minimum income for healthy living.
17. The Council should continue to focus on developing services that support residents who are furthest from the labour market to ensure that more of our working age population can participate in the labour market.

10.4 Better mental health & emotional wellbeing

18. Introduce routine data collection to help to identify, quantify and track military veterans in South Tyneside including an assessment of service access
19. Enhance the support for those leaving the armed services to enter the job market
20. Maintain close working arrangements with the Regional Suicide Prevention Steering Group to ensure initiatives relating to military veterans are active in the borough.
21. Substance misuse services need to become more veteran-sensitive, gathering and sharing both quantitative and qualitative information.
22. Engage veterans in asset-based approach, capacity-building and user involvement
23. There should be moves to support the establishment of a South Tyneside Armed Forces Network, or ensuring that the Sunderland and Gateshead networks can meet the needs of the borough's veteran community.
24. Improve veteran access to services such as occupational health and NHS health checks, as well as disability grants, allowances and benefits**.**

10.5 Better quality, integration & efficiency of services

25. Fully implement the developing Change 4 Life Service, which looks across the life course, extending the reach of stop smoking physical activity, emotional wellbeing, and alcohol services that maintain their physical and emotional wellbeing by promoting self care to increase self reported well being and quality of life
26. Harmonise approaches to workforce development integrating the self care approach across all organisations providing services to increase the number of people who use services to take control of their life
27. Make further use of 'social prescribing' of non-clinical interventions to improve health and well-being of people and carers and sustain their independence
28. Collaborate with third sector in developing and encouraging use of volunteer services to prevent social isolation and keep older people active and improve patient experience of care
29. Zone the community nursing teams to provide opportunities for better integration between community nursing services and general practices
30. The CCG to work to raise awareness of chronic pain issues, its impact and work with other agencies, including employers and benefits agencies to raise awareness of support benefits and allowances and to ensure appropriate uptake.
31. There is a need to undertake a detailed Health Needs Assessment (HNA) of those incurring Chronic Muscular Skeletal pain, to understand their detailed health needs and its impact on their quality of life.

11 Next Steps

11.1 Influencing the South Tyneside Joint Health and Wellbeing Boards Commissioning and Delivery

While the JSNA has identified needs, priorities and gaps in terms of population health, future commissioning of services also needs to utilise a number of tools and methods to understand the issues identified in more depth and more effectively. This includes undertaking more detailed Health Needs Assessment of specific issues, Health Impact Assessment and Health Equity Audit.

11.2 Health Needs Assessment (HNA)

A number of more detailed Health Needs Assessments need to be agreed in the future to fully understand in detail the health issues relating to key local priorities. This includes

- Eye Health Needs assessment. This reflects the need to understand the issues and problems experienced by an increasing number of people with visual impairment
- A detailed HNA of the health of Looked After Children to fully understand their specific health requirements
- A detailed HNA of those suffering from Musculo Skeletal pain to understand their detailed health needs and its impact on their quality of life.

11.3 Health Impact assessment

Programme and policies such as regeneration initiatives planned for South Tyneside and the implementation of the proposed Welfare Reforms, will benefit from the close examination a Health Impact Assessment provides to both identify the potential (and actual) impact on people's health and wellbeing and on health inequalities, but also practical ways to improve and enhance the proposal are informing and influencing decision making and should become part of South Tyneside's planning process

11.4 Health Equity Audit

The use of Health Equity Audit (HEA) provides a mechanism to determine the extent to which services, which influence health significantly in South Tyneside, are targeted at the right geographic areas and appropriate client groups when usage is compared to need. An HEA of Leisure Services provision has built on current HEA which have been undertaken to look at Stop Smoking Service delivery and the provision of Weight Management Services to ensure equitable access and service provision is taking place across South Tyneside.

Appendix 1: sources and data availability, 29 priority indicators

Last updated: 20th February 2014 by Andy Billett, Public Health Analyst for Gateshead, South Tyneside and Sunderland

It is recognised that, over the next 12-24 months, the primary source for monitoring some of these indicators will change. They are currently monitored locally, but some are part of the new Public Health Outcomes Framework (PHOF) data tool, recently published on the web by Public Health England. The tool can be accessed at www.phoutcomes.info. Currently the tool is only populated with one or two periods of data and so its value for monitoring trends in indicators over time is limited. As the tool is populated with more data, it will become the first point of reference for monitoring PHOF indicators.

Current root path = http://sotwsharepoint/teams/pilots/performance/Surveillance/Analysis (only accessible from within the old NHS SoTW computer network)

OF Ref.	Data item	Data source	File type	Sharepoint file path	Next release descriptor	Next release date
	Births, projected births	ONS Annual Births Extract (distributed by ONS Vital Statistics team in July or August) and ONS Subnational Population Projections by components of change (COC)	xls	/1. Population / Births / SoTWBirths.xls	i) 2012 births extract, ii) full 2011 Census based Subnational Population Projections by components of change	i) Jul/ Aug 2013 ii) Jul/ Aug 2013
	Number and proportion of children in care	Department for Education	xls	/3. Child health lifestyle / LookedAfterChildren / LACNumberAndRates SoTW.xls	Number and rate @ 31st March 2013	Nov-13
	Educational attainment	Department for Education	xls	/2. Wider determinants / Education / Percent5+GCSEs IncEngMathsByLATrends.xls	2012/13 revised	Jan-14
PHOF 1.15i	Rate of homeless households	Department for Communities and Local Government	xls	/2. Wider determinants / Homelessness / HomelessnessTrendsSoTW.xls	2012/13	Jun-14
	Proportion of the population of working age claiming Jobseekers Allowance	NOMIS at www.nomisweb.co.uk	xls jpg	/2. Wider determinants / Economy / Jobseekers AllowanceClaimantsSoTW Trends.xls	Data released qtrly, but for local monitoring will be refreshed annually, using Sep 2013 data	16th Oct 2013

OF Ref.	Data item	Data source	File type	Sharepoint file path	Next release descriptor	Next release date
	Proportion of young adults 18-24 years claiming Job Seekers Allowance	NOMIS at www.nomisweb.co.uk	xls	/2. Wider determinants / Economy / Jobseekers AllowanceClaimantsSoTW Trends.xls	Data released quarterly, but for local monitoring will be refreshed annually, using Sep 2013 data	Oct-13
PHOF 4.1	Infant mortality rate	Indicators Portal, Health and Social Care Information Centre	xls	/3. Child health lifestyle / InfantMortality / InfantMortalityRateTrends SoTW.xls	2010-2012	Dec-13
PHOF 2.4	Teenage conception rate	Office for National Statistics, "Conception Statistics, England and Wales, year"	xls jpg	/3. Child health lifestyle / SexualHealth / Teenage ConceptionRateTrendsSoTW .xls	2012	Feb-14
PHOF 2.3	Proportion of mothers smoking at time of delivery	Department of Health	xls	3. Child health lifestyle / SmokingPregnancy / Smoking DuringPregnancySoTW.xls	2013/14	Jun-14
PHOF 2.2ii	Breastfeeding - continuation	Department of Health	xls	3. Child health lifestyle / Breastfeeding /	2013/14	Jun-14
PHOF 2.6i	Obesity among primary school age children in Reception Year	National Child Measurement Programme, Health and Social Care Information Centre	xls	/3. Child health lifestyle / ChildhoodObesityPrevalence TrendsSoTW.xls	2012/13	Dec-13
PHOF 2.6ii	Obesity among primary school age children in Year 6	National Child Measurement Programme, Health and Social Care Information Centre	xls	/3. Child health lifestyle / ChildhoodObesityPrevalence TrendsSoTW.xls	2012/13	Dec-13
PHOF 3.3viii	Uptake of MMR 1st dose at 24 months	Health and Social Care Information Centre	xls	3. Child health lifestyle / ChildImms / ChildImmsSoTW	2012/13	Nov-13
PHOF 3.3x	Uptake of MMR 1st and 2nd dose at 5 years	Health and Social Care Information Centre	xls	3. Child health lifestyle / ChildImms / ChildImmsSoTW	2012/13	Nov-13
	Life expectancy at birth by LA population	ONS	xls	4. Life expectancy mortality all causes / LifeExpectancy / LifeExpectancyTrendsSoTW.xls	2009-11	Nov-Dec 2013

OF Ref.	Data item	Data source	File type	Sharepoint file path	Next release descriptor	Next release date
PHOF 0.1i	*Healthy life expectancy at birth by LA population (placeholder)*	*Health and Social Care Information Centre*				
	All age all cause mortality rate	Indicators Portal, Health and Social Care Information Centre	xls	4. Life expectancy mortality all causes / AAACM / AAACMRate3YrPooledSoTW.xls	2009-11	Oct-Dec 2013
PHOF 4.4i	Premature mortality rate due to circulatory disease	Indicators Portal, Health and Social Care Information Centre	xls	5. Circulatory Disease / CVD all / AllCircDiseaseU75MortalityRates.xls	2009-11	July 2013
PHOF 4.5i	Premature mortality rate due to all cancers	Indicators Portal, Health and Social Care Information Centre	xls	6. Cancer / AllCancers / Mortality / AllCancersDSRU75SoTW.xls	2009-11	July 2013
	All age mortality rate due to lung cancer	UK Cancer Information System	xls	6. Cancer / Lung / Mortality / LungCancerMortRatesAllAgesDSR3YrPooledSoTW.xls	2009-11	July 2013
	All age lung cancer registration rate	UK Cancer Information System	xls	6. Cancer / Lung / Incidence / LungCancerRegRatesAllAgesDSR3YrPooledSoTW.xls	2008-10	July 2013
	All age mortality rate due to colorectal cancer	National Cancer Information System	xls	6. Cancer / Colorectal / Mortality / ColorectCancerMortRatesAllAgesDSR3YrPooledSoTW.xls	2009-11	July 2013
	All age colorectal cancer registration rate	National Cancer Information System	xls	6. Cancer / Colorectal / Incidence / ColorectCancerRegRatesAllAgesDSR3YrPooledSoTW.xls	2008-10	July 2013
PHOF 2.20ii	Coverage of cervical screening	Health and Social Care Information Centre	xls	6. Cancer / Screening / Cervical / CervicalScreeningCoverageSoTW.xls	2012/13	Oct-13

OF Ref.	Data item	Data source	File type	Sharepoint file path	Next release descriptor	Next release date
PHOF 2.20i	Coverage of breast screening	Health and Social Care Information Centre	xls	6. Cancer / Screening / Breast / BreastScreeningCoverageSoTW.xls	2012/13	Feb-14
	Hypertension, diagnosed vs expected prevalence	Quality and Outcomes Framework, Health and Social Care Information Centre (diagnosed); Public Health England (expected)	xls	7. Adult health / LTCs / Hypertension / HypertensionPredictedSoTW.xls	2012/13	Nov-13
PHOF 3.2	Chlamydia diagnoses (crude rate per 100,000 15-24 years)	Public Health England	xls	7. Adult health / Sexual health / KeySTIratesGhdSTSun.xls	2013	Jul-14
PHOF 3.4	HIV late diagnosis	Public Heath England, monitored in PHOF tool at www.phoutcomes.info (hence not monitored locally)	n/a	n/a	2010-12	unknown
PHOF 2.14	Smoking prevalence	Integrated Household Survey, Health and Social Care Information Centre, secondary analysis of smoking prevalence data by London Health Observatory	xls	8. Adult Lifestyle / Smoking / SmokingPrevalenceTrendsSoTW.xls	Year ending 2012/13 Q4	unknown

Appendix 2: South Tyneside Health and Wellbeing Board – plan on a page